Law Journals

Indian Journal of
Health and Medical Law

Volume 4, Issue 2, 2021
DOI (Journal): 10.37591/IJHML
(July-December)

http://lawjournals.celnet.in/index.php/ijhml/index

Research IJHML

Evaluation of Childrearing Competence by Fertility Clinics in Different Countries

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Abstract

Mental health, cognitive growth, socialization, enjoyment of minimum living standards, success in life and generally child welfare altogether depend to a large extent on having competent parents. On the other hand, the couples' incompetence in performing parental task properly, would place a great economic burden on society. Since there would be more opportunity to intervene in artificial reproduction and as a result, prevention of such problems is possible, some countries have enacted laws or have developed guidelines in pursuit of securing child welfare, with varying degrees of child welfare protection, specificity in defining the scope of child welfare, implementation means, and limits for infertility treatment clinics in assessing child welfare. This study aims to analyze eight different countries' approach to child welfare protection in the context of access to Assisted Reproductive Technologies, their strengths and weaknesses in safeguarding child welfare, and making suggestions as how to develop laws and regulations which are better aligned with child welfare protection.

Keywords: Assisted Reproductive Technologies, access to treatment, parenting competence, prospective child's welfare, child welfare regulatory framework, codes of practice and guidelines

INTRODUCTION

Human reproduction as a desire to love and care for another human being of one's genes can be traced back to the dawn of human race, without which species would have not existed [1]. Whether motivated by companionship, financial security, contributing to the well-being of a loved one, social acceptance, religious beliefs, finding meaning in life, or continuation of generation, most human beings have an intrinsic interest in begetting a child [2]. The problem of infertility which has been referred to in ancient scriptures has also been with us as long as the recorded history of mankind and those unable to procreate have been struggling with emotional distress, grief, and depression since ancient times [3, 4].

However, infertility treatment once assumed as a myth, has now become a reality with no need for sex to reproduce. Sexuality and reproduction have, in fact, moved independently thanks to the evolution of Assisted Reproductive Technologies [5]. In search of treatments for the infertility problem and devoting decades of research on reproductive physiology, the medical profession eventually resolved the issue of infertility in 1978 and has offered hopes for those dealing with this medical condition. Although assisted reproduction using a husband's sperm was already commonplace and surrogacy dates back to biblical times, the birth of Louise Brown through In Vitro Fertilization (IVF) in 1978 has been recognized as a landmark in the field of infertility treatment [6]. Ever since, the area of Assisted Reproductive Technology has expanded rapidly in terms of quality, number of methods available, and success rates with thousands of children owing their

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Received Date: July 07, 2021
Accepted Date: August 02, 2021
Published Date: January 03, 2022

Citation: Zahra Mehrabi Tavana. Evaluation of Childrearing Competence by Fertility Clinics in Different Countries. Indian Journal of Health and Medical Law. 2021; 4(2): 19–38p.

existence to these medical techniques [7, 8]. Although a number of factors including individual circumstances (including the cause of infertility [9], and the age of patient [10]), and physicians' skills [11] play a crucial role in the success rate of Assisted Reproductive Technologies, the outcome of Assisted Reproductive Technologies is promising in many circumstances. For instance, there is 80 percent chance of pregnancy after three cycles of ICSI as one of the Assisted Reproductive Technologies [12].

However, the question arises as to whether the advancement of Assisted Reproductive Technologies warrants each and every individual's access to treatment services. In fact, should infertile couples easily access treatment services without their parenting competence or their ability to properly care for their child being evaluated or they should first be deemed as competent for parenting by infertility clinics (or any other authority responsible for undertaking the childrearing competence assessment program) in order to take advantage of fertility services. Please note that the term "parenting competence" should not be confused with the general term of "competency". Competency refers to individuals having the cognitive capabilities to engage in legally recognized activities including but not limited to entering into a contract, preparing a will, and making medical decisions while parenting competence denotes individuals' capability to provide children with consistent and routine care, and meeting their needs. For the purposes of this article, couples subject to the childrearing competence assessment program are equipped with cognitive abilities to comprehend the nature of the medical procedures and their potential risks and benefits, and execute a decision rationally [13].

Family is an institution upon which children depend for protection and meeting their social, emotional, physical, and financial needs. In this regard, competent parents can protect their children against harm; promote their emotional, mental, and physical health; and optimize children's potential and maximize the opportunity for using it. Yet, parenting competency is not inborn in humans but acquired and learned [14]. Although many parents may desire to do a good job of childrearing, their health condition or their excessive use of alcohol or illegal drugs may interfere with this desire, which can in turn trigger a variety of child welfare concerns. The prevalence of parenting incompetence and its adverse consequences was highlighted back in 1991 by the National Commission on Children appointed by Congress and former President George Bush. The Commission, which was initially established to investigate the causes for the erosion of the quality of children's lives in the United States, called attention to the fact that a significant number of parents fail to meet their children's needs [15].

Importantly, incompetent parenting is not a private matter with its adverse consequences solely limited to children, as society is also negatively impacted in many ways. Child maltreatment, neglect and abuse, lack of affectionate bond between parents and the child, lack of supervision, not attending to children's emotional needs and many other factors resulting from incompetent parenting may increase the likelihood of anti-social behavior, which is associated with financial costs to society. The expenditures of the child welfare system, law enforcement, the criminal justice system resulting from incompetent parenting, mental healthcare, and the medical treatment of chronic conditions due to child abuse and neglect are expenses borne by society [16–18].

Laws have been passed in some countries to protect children from being harmed before they come into existence. In fact, some legislatures in different countries maintain that incompetent couples' reproductive right should be curbed before children's existence in order to shield children from neglect, abuse, violence, trauma, harassment, and maltreatment. These countries first assess the capacity of infertile couples for competent parenting. Should these couples fail to be assessed qualified for raising a child based on the determined criteria, they would be impeded from receiving fertility services. Such countries as the United States, the United Kingdom, New Zealand, Australia, Canada, France, Iran, and Belgium (the case of the United States, France and Belgium is different as

discussed below) follow this policy as they have set limitations against incompetent couples requesting Assisted Reproductive Technologies to secure the prospective child's (The term "prospective child" in this article refers to the child conceived through Assisted Reproductive Technologies) welfare.

In addition to shielding prospective children from future harm in normative rules, some fertility societies including the U.K. Human Fertilization and Embryology Authority, the American Society for Reproductive Medicine, and the European Society of Human Reproduction and Embryology, have drafted guidelines and codes of practice in support of prospective children's welfare.

This study will first scrutinize the laws and regulations of the United States, the United Kingdom, New Zealand, Australia, Canada, France, Iran, and Belgium as they relate to the parenting competence assessment program, followed by how guidelines and codes of practice have approached the issue of child welfare in the context of Assisted Reproductive Technologies. Language barriers have impeded the author's ability to review countries' legislation on the child welfare assessment program where their official language is other than English. This article will conclude by outlining the pros and cons of each of the foregoing legal and advisory frameworks and suggesting a more protective framework for child welfare in Assisted Reproductive Technologies.

NORMATIVE RULES

The United States

A law regulating access to infertility treatment services (being mindful of the prospective child welfare) does not exist in the U.S. The U.S. being labeled the wild west in the infertility sphere has been an attractive destination for those deterred in conceiving a child in their home country due its laissez-faire approach to Assisted Reproductive Technologies [19]. There has been resistance to enact regulations restricting access to infertility treatment services for several reasons.

U.S. legislators maintain that individuals possess reproductive autonomy, and neither public nor private entities can override such freedom [20]; interfering with infertile couples' procreative liberty would discriminate against them since such limitation is not enforced against fertile couples [21]; such law would lead to eugenics practices [22], and the likelihood of inequality of access increases since each infertility clinic would devise and implement its own standard. Not only the issue of access to infertility treatment services has remained unregulated under U.S. laws, the realm of Assisted Reproductive Technologies itself has not been regulated by the congress and state legislatures (except for some sporadic legislations including the Fertility Clinic Success Rate and Certificate Act of 1992). The regulation of assisted reproduction has, in fact, been assigned to the profession itself. The American Society of Reproductive Medicine and the Society for Assisted Reproductive Technology, the dominant professional societies in this area of medical practice, have developed a voluntary accreditation program which requires clinics to adhere to its guidelines and practices standards. There are no legal consequences for clinics that elect not to pursue accreditation under this program. The unresolved debate surrounding the legal status of embryos, the Congress and state legislatures' reluctancy to enter into a sphere of rapid technological changes, Assisted Reproduction being outside the purview of what the Congress usually legislates, and infertility not viewed as the sort of problem that society has a responsibility to remedy are among the reasons provoking the Congress to leave Assisted Reproduction to the profession's discretion [21].

American jurisprudence has also been reluctant to recognize rights for children born through Assisted Reproductive Technologies even after their existence, let alone prospective children. Children whose interests have been overridden in their parents' access to Assisted Reproductive Technologies and have suffered significant harms and disabilities cannot claim their rights under the American jurisprudence. It has been argued that children are better off being born disabled than not being in existence [23].

In light of the designation of the regulating responsibility to the profession itself, the American Society for Reproductive Medicine has developed recommendations with regard to child welfare which are not of a binding nature and solely apply to clinics that are members of the American Society for Reproductive Medicine [24]. The report on child welfare titled “child-rearing ability and the provision of fertility services” concludes that fertility clinics "may withhold services from prospective patients on the basis of well-substantiated judgments that those patients will be unable to provide or have others provide adequate child-rearing for offspring” [25].

However, the practice of infertility treatment clinics has deviated from the U.S. legislature and jurisprudence’s existing approach to child welfare in Assisted Reproductive Technologies, and the majority of clinics believe in their responsibility to screen infertile couples before providing them with fertility services. A survey conducted on 210 Assisted Reproductive Technologies providers to determine their commitment and willingness to assess infertile couples’ parenting competence, the information collected about each candidate, the final decision-maker, and the number of candidates turned away each year for medical reasons and for social/psychological reasons confirm this issue. According to this study, nearly all Assisted Reproduction programs collect information on physical and mental health and drug use [26].

Nevertheless, since the professional guideline of the American Society for Reproductive Medicine does not direct fertility clinics on the circumstances which services can be denied, clinics’ practice varies considerably. Under one study, 60% excluded those with excessive alcohol consumption; 45% excluded those who used marijuana, and 30% excluded those with a history of schizophrenia [27]. Another study on access to treatment services in American clinics bespeaks the importance of child welfare and even shows higher rates of refusals from infertility treatment clinics. Under this study, 73 percent of clinics stated that they refuse to treat patients with a history of schizophrenia, and 90 percent do not treat patients who use alcohol excessively [25]. When parenting competence criteria are not specified, not only prospective children would not be properly protected, this would foster inequality of access to treatment for patients with comparable situations. This manner of dealing with parenting competence puts both child welfare and individuals’ rights (including right to non-discrimination and equality) at jeopardy.

A positive point about assessing parenting competence in the majority of U.S. fertility clinics is that a committee decides about couples’ eligibility for fertility services rather than making an individual responsible for decision making [26]. As one would expect, collective decision making reduces the likelihood of arbitrary and biased decisions; serves as a basis for gathering different perspectives on a specific case; assists in resolving hard and challenging cases, brings a complete set of experience and knowledge; decreases the probability of mistakes in decision making; enhances understanding of the underlying issues; and contributes to better resolutions generally. If the committee is composed of individuals each specializing in an area relevant to competence assessment, maximum benefits can be produced.

All of this shows that while the U.S. gives great value upon procreative liberty in theory, it is very mindful of child welfare in practice. As a matter of fact, U.S. clinics’ practice implies that issues such as excessive alcohol consumption, drug abuse, and mental health disorders are not just private matters as their adverse effects are transmitted to children, and therefore, a child welfare assessment scheme is necessary.

The UK

When it comes to the limitation of incompetent couples' infertility treatment, the UK's legislation should be considered as a pioneer in this field. The 2008 Human Fertilization and Embryology Act has been attentive to child welfare in assisted reproduction by including a separate section dealing with this issue. Although there is room for further development, the UK has emerged as a world

leader in the sphere of regulating Assisted Reproductive Technologies and child welfare assessments. Heated debate has been around on child welfare assessments and this notion made up eight of 80 hours in which the Act was debated in the Parliament, highlighting its controversial nature [28].

In the 1990 Human Fertilization and Embryology Act, the term "the need of that child for a father" was included instead of "the need of that child for supportive parenting". Hence, lesbian couples and single individuals were excluded from receiving treatment services. However, the existence of various family types in the UK and the fact that having a father does not ensure child welfare and development led UK legislators to remove such term from the act in 2008 and replace it with "the need of that child for supportive parenting" [29]. Furthermore, progressive domestic judicial decisions as well as the rulings of the European Court of Human Rights called into question the presumption of competent parenting being restricted to heterosexual couples [28].

The Human Fertilization and Embryology Act's Code of Practice (2021), Guideline 8.15 defines supportive parenting as a commitment to the health, well-being and development of the child. Under this guideline, all prospective parents are supportive unless there is any reasonable cause for concern that any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centers have such concern, wider family, and social networks within which the child will be raised may be taken into consideration. The burden of proof would be on those seeking to refuse treatment to infertile couples. The presumption of couples' supportive parenting also implies that an in-depth scrutiny of prospective parents' parenting abilities is unnecessary in almost all cases.

Hence, the Human Fertilization and Embryology Act does not impose any restrictions on homo-sexual couples or single individuals in their access to fertility services. As long as homosexual couples and single individuals are likely to guarantee a supportive environment for their children, no barrier would be encountered by them. The determining factor is supportive parenting.

Lee at al conducted a research on 20 clinics (approximately one-quarter of the 77 clinics licensed in the UK to carry out IVF treatment) in the UK to comprehend their approach to the child welfare assessment requirement. This study reflects that while clinics do not overlook the importance of child welfare assessment and in fact, support such requirement, they decline to refuse treatment in most cases. Clinics also advocated for non-discrimination against particular groups of patients on the grounds of gender, race, sexual orientation, disability, religious belief or age. In spite of clinics' support for non-discrimination and homosexuals' favorable treatment, single individuals were regarded by some as potentially problematic parents. This attitude is more stimulated by UK clinics' belief that single individuals may be inefficient in providing supportive parenting. It is important to note that the practical input of medical professionals as well as all clinic staff including those with administrative and counseling roles determines who would be eligible for treatment in the U.K [30].

To conclude, the Human Fertilization and Embryology Act has endorsed the importance of evaluating prospective parents' competence in childrearing by including the child welfare section. However, clinics have only refrained from providing services in exceptional circumstances.

New Zealand

The prospective child's welfare has also been a matter of concern for New Zealand's legislators. The Human Assisted Reproductive Technology Act of 2004 emphasizes the importance of the prospective child's welfare through two of its principles. First, principle (a) of Section 4 states that "the health and well-being of children born as a result of the performance of an assisted reproductive procedure or an established procedure should be an important consideration in all decisions about that procedure". In addition, "the human health, safety, and dignity of present and future generations should be preserved and promoted" as reflected in principle (b) of the same section. However, these are merely two principles enshrined in section 4 and five other principles should also govern the

conduct of all persons exercising power under this Act. In fact, consideration of the health and well-being of women, informed consent, values of Maori, different ethical, spiritual and cultural perspectives in the society, and informing the donor offspring of its genetic origin count as other principles of section 4. All of these principles are of equal importance and none of them supersedes the others [31]. Thus, health care providers dealing with infertile couples who want to receive fertility services, are to balance the health and well-being of prospective children against other guiding principles and whatever principle deemed to have more importance would be preferred.

Despite the unsatisfactory level of protection of prospective children, and lack of guidance on what child health and well-being entails, and how the procedure is ought to work, the inclusion of the prospective child's health and wellbeing as an important consideration to be taken by responsible authorities is a crucial step towards driving incompetent couples' reproductive rights out of sacredness which cannot be negated or overridden.

Australia

The prospective child's welfare and well-being has been stipulated in Australian legislation as well. However, no federal law exists requiring infertility treatment centers to prioritize the prospective child's welfare over the prospective parents' rights and protecting the prospective child's interests in assisted reproduction reside at the state level; Only three states consider the prospective child's welfare as important in deciding about infertile couples' eligibility for treatment services: Victoria, South Australia and Western Australia.

Victoria

The State of Victoria as the first common law jurisdiction to regulate Assisted Reproductive Technologies through legislation [32] has dealt with the prospective child's welfare in assisted conception. The Assisted Reproductive Treatment Act of 2008, Section 5 sets out five guiding principles which are of descending importance: (a) the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount; (b) at no time should the use of treatment procedures be for the purpose of exploiting, in trade or otherwise—(i) the reproductive capabilities of men and women; or (ii) children born as a result of treatment procedures; (c) children born as the result of the use of donated gametes have a right to information about their genetic parents; (d) the health and wellbeing of persons undergoing treatment procedures must be protected at all times; (e) persons seeking to undergo treatment procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion. As it can be seen, the paramountcy of the welfare and interests of any person born or to be born as a result of a treatment procedure serves as the first principle Victorian treatment clinics should adhere to and should the prospective parents' rights conflict with the prospective child's welfare, the latter trumps. However, the Act does not give any direction with regard to the nature of child welfare, how child welfare is to be implemented, who would determine couples' qualification for services, and generally the details of child welfare assessment, thus leaving infertility treatment clinics with count- less questions.

Notwithstanding, despite the ambiguity of child welfare under Victorian legal system, three class of couples are undoubtedly denied infertility treatment services: violent or sexual offenders, those whom a child protection order has been issued against, and couples who are likely to abuse or neglect their children based on the treatment provider's belief. However, in case of treatment denial, couples may apply to the Patient Review Panel for a review [33, 34].

Section 15(3) of the Assisted Reproductive Treatment Act of 2008 sets out what the panel must consider when reviewing an application. The guiding principles referred to in Section 5 of the Act (i.e. whether carrying out a treatment procedure is for a therapeutic reason and is consistent with the best interests of the child-to-be) are determining factors for the eligibility or illegibility of couples to receive treatment services under the Victorian Assisted Reproductive Treatment Act of 2008. Should

the Patient Review Panel concur with the infertility treatment clinic, treatment services would be inaccessible to incompetent couples. Pursuant to Section 96 of the Assisted Reproductive Treatment Act of 2008, the denial decision of the panel would, however, not be the final decision as further application can be made to the Civil and Administrative Tribunal.

South Australia

The State of South Australia serves as the other Australian state where importance has been accorded to the prospective child's welfare. Section 4A of the Assisted Reproductive Treatment Act provides that: "The welfare of any child to be born as a consequence of the provision of assisted reproductive treatment in accordance with this Act must be treated as being of paramount importance, and accepted as a fundamental principle, in respect of the operation of this Act." Therefore, if treatment centers encounter a situation where the prospective parents are not likely to ensure the prospective child's welfare, they are obliged to disregard incompetent couples' interests in childrearing and prioritize the prospective child's welfare under this Act. However, infertility treatment clinics are again left unguided when determining infertile couples' childrearing competence, as it was the case in the State of Victoria. The Act sets out only a situation where the prospective parents would jeopardize the prospective child's welfare should they be provided with treatment services: When one or both of the couples deal with any illness or disability which would impair his/her ability to undertake the parenting role, the prospective child's welfare would be at risk. Thus, due to the detrimental effect of some illnesses on child welfare, the couples' general practitioner should confirm that neither of the couple copes with such issues. Previously, the Assisted Reproductive Treatment Act required couples to sign a statutory statement that they are not serving a prison sentence or are not subject to outstanding charges for an offense that may result in imprisonment; they have not been convicted of a sexual offense involving a child; they have not been convicted of an offense involving violence; and they have not had a child permanently removed from their guardianship other than by adoption. This requirement was removed from the legislation in 2012 [33]. Previously, the Assisted Reproductive Treatment Act also outlawed the provision of treatment services to homosexual and single individuals. In light of legal challenges in the Supreme Court as well as changes in social attitudes on parenting and modern family structures, restrictions based on the relationship status of prospective parents have been removed in South Australia [35].

Western Australia

There are no screening criteria in the Human Reproductive Technology Act of Western Australia, but the welfare of the child is addressed in several sections of the Human Reproductive Technology Act. Section 4(d)(iv) of the Human Reproductive Technology Act mentions that one of the objectives of the Act is to ensure the prospective welfare of any child to be born consequent upon a procedure to which this Act relates is properly taken into consideration. Section 23(e)(ii) of the Human Reproductive Technology Act also states that "an in vitro fertilisation procedure may be carried out where consideration has been given to the welfare and interests of any child likely to be born as a result of the procedure". However, there is no guidance on what is meant by child "interests" or "welfare" and how the screening program would be implemented.

France

France has also been attentive to the necessity of having an act regulating access to infertility treatment services and has enacted laws in this area [36]. The first regulation on bioethics was passed in 1994 with amendments to its provisions in 2004, and most recently in 2011. The Bioethics Law of 2011 which has made significant changes to the Bioethics Laws of 1994 and 2004 replaces the previous laws [37]. These laws do not only deal with infertility treatment and a variety of bioethics matters are regulated under these laws. These matters include but are not limited to organ donation, research on embryos, and genetic testing [36].

Under the recent law, eligibility for infertility treatment services is subject to meeting certain conditions to ensure child welfare. First, applicants should be heterosexual-either married or

unmarried- in order to qualify for treatment services. Limitation of homosexual and single individuals in accessing treatment services has caused a phenomenon called “cross border reproductive care” to evade the restrictions in France [38].

The restriction of treatment services to heterosexual couples reflects the value France gives to traditional family structure. It has been maintained that homosexuals’ and singles’ inability of childbearing is not caused by a medical dysfunction, their infertility is of a social nature rather than medical and therefore, they cannot be considered in need of therapeutic treatment. Moreover, children need parents who can attend to their physical and psychological needs, which homosexual couples and single individuals do not possess according to French law [39]. However, there have been moves towards granting access to single women and lesbian couples in a recent proposed law. The bioethics law drafted by French President Emmanuel Macron's government includes language to expand access to procedures such as artificial insemination and in vitro fertilization, or IVF to single women and lesbian couples [40].

In addition to couples’ sexual orientation, infertile couples should both be alive, live together, and be of reproductive age at the time assisted reproduction procedures initiate. Therefore, the break- up of a relationship, old age or the death of either couple will put an end to the assisted reproduction procedure [20].

It should be mentioned that although the French Bioethics Law seeks to ensure the prospective child’s welfare through these requirements, no regulation exists requiring fertility clinics to take the prospective child’s welfare into consideration before providing treatment services.

Canada

Canada’s Assisted Human Reproduction Act (2004) can be deemed as one of the most comprehensive regulations addressing Assisted Reproductive Technologies [41]. This piece of legislation contains two principles which are relevant to child welfare: Principle (a) and (e) of Section 2. Under principle (a) “the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use”. Consequently, if the health or well-being of the future child is at risk, there would be no justification for infertility treatment under this principle. However, questions remain as to what is the exact criterion of child welfare assessment and who bears the responsibility for assessing couples’ childrearing ability.

Furthermore, principle (e) in the Canadian law provides that “persons who seek to undergo assisted reproduction procedures must not be discriminated against on the basis of their sexual orientation or marital status”. Thus, under this principle, homosexual couples and single individuals would not face any barriers in receiving infertility treatment services.

Belgium

Many patients and practitioners around the world find Belgium as the "bioethical paradise" where minimal regulation exists on Assisted Reproductive Technologies. Infertile couples in Belgium can access a variety of treatment alternatives without any state intervention, putting them at advantage as compared to other infertile couples in the world [42, 43]. Freedom of access to infertility treatment services without harsh rules and regulations imposed on infertile couples has caused many couples in countries such as Netherlands and France to travel to Belgium for treatment purposes [44].

The “Law on Medically Assisted Reproduction and the Disposition of Supernumerary Embryos and Gametes” enacted in 2007 governs such issues as the prospective child's welfare in Assisted Reproductive Technologies in Belgium. In Belgium, the prospective child's welfare is not a matter of legal mandate which infertility treatment clinics have to observe. In fact, infertility clinics are under

no legal obligation to consider the prospective child's interests and needs. They have the discretion to assess infertile couples' parenting competence if they deem necessary. Nevertheless, if infertility clinics come to the resolution that the determination of the prospective parents' childrearing competence is required, they do not know what class of couples jeopardize child welfare and therefore, should be excluded from the treatment program. Again, the Act merely authorizes infertility clinics to give more weight to the prospective child's welfare without shedding light on the definition, criteria and assessment process of child welfare [43].

Iran

Iran counts as one of the jurisdictions where some requirements should be met in order for infertile couples to receive infertility treatment services. Nevertheless, such restriction solely exists in the area of embryo donation. The Iranian Act on Embryo Donation to Infertile Couples enacted in 2003 governs the legal issues related to embryo donation [45-47]. In addition, the bylaw for the Iranian Act on Embryo Donation to Infertile Couples which was drafted jointly by the Iranian Ministry of Health, and the Ministry of Justice and passed by the Council of Ministers on March 09, 2005 clarifies the issue of embryo donation [45].

An infertile couple interested in receiving an embryo, should apply for embryo donation before the Family Court and such application should be signed by both partners. Only legally married couples may ask for such procedure from the Family Court and the court will make a decision after considering several factors. Based on the Family Court's decision, the infertility treatment clinic would provide or withhold treatment services from infertile couples [48].

According to the Act on Embryo Donation to Infertile Couples and its bylaw, the embryo recipients should meet the following criteria: They should be recognized as infertile; should possess moral competence; should not suffer from hard-to-treat diseases and addiction; should enjoy physical and mental health; should have legal competence; and should hold Iranian citizenship [45, 48].

In this context, infertile couples should first be issued a medical certificate by a licensed infertility clinic that they suffer from infertility. The woman's ability to receive an embryo should also be shown in addition to being infertile. In fact, the woman should be able to carry the fetus in her womb [47].

The moral competence of infertile couples should also be endorsed by the Family Court. However, the definition and criteria of moral competence as well as the method of determining such competence are vague under the Act on Embryo Donation to Infertile Couples and its bylaw. Some Iranian statutes have shed light on this issue. For instance, Article 14 of the Act of Governmental Employment and Article 1173 of the Civil Code enumerate the instances of moral incompetence.

These articles list addiction, gambling, corruption, child abuse, and domestic violence as instances of a person's moral incompetence. Nevertheless, the lack of clarity regarding what constitutes moral competence under the Act on Embryo Donation to Infertile Couples and its bylaw would trigger practice inconsistency among infertility treatment clinics as it has been the case according to a research conducted by Alireza Milanifar et al. Alireza Milanifar et al undertook a study to analyze how family courts decide about embryo donation and they accordingly reviewed 80 court decisions. This study showed that family courts did not mention what should be determined. Mostly they considered the method of moral competence determination. Among 80 decisions, 14 courts relied on local researches, 1 court took advantage of a police report, 13 courts found local affidavits more effective, and 26 courts relied on the principle of validity (omnia praesumuntur rite esse acta). In 24 cases, it was only mentioned that the court determined the general competence of the couple. In 2 cases, there was no mention of the couple's moral competence [48]. As it can be seen, the ambiguity of the Act on Embryo Donation to Infertile Couples and its bylaw has resulted in courts' varied practice in determining moral competence.

Suffering from difficult-to-treat diseases also impedes infertile couples from receiving an embryo under the Act on Embryo Donation to Infertile Couples. It appears that such limitation aims to protect the prospective child from orphanage, low-quality parenting or the transmission of the disease to the embryo. The Act's bylaw declares diseases such as hepatitis and AIDS as difficult-to- treat diseases. However, mere recognition of a disease as difficult-to-treat should not prevent in- fertile couples from receiving an embryo and other factors including different types and stages of a disease should also be evaluated [45].

Patients addicted to illegal drugs are barred from receiving an embryo under the Act on Embryo Donation to Infertile Couples [45]. The Act on Embryo Donation to Infertile Couples gives no insight on the authority qualified to determine individuals' addiction. However, studies performed to see how embryo donation is undertaken in practice confirm that the Iranian Legal Medical Organization (an independent organization which provides expert opinions in the field of forensic medicine and medical expertise) bears such responsibility [47].

Mental and physical health of infertile couples serves as the other condition for receiving an embryo under the Act on Embryo Donation to Infertile Couples [45]. Enjoying mental and physical health are determined by the Iranian Legal Medical Organization [47]. Similar to other qualifications required for receiving an embryo, the Act on Embryo Donation to Infertile Couples remains silent on the definition of mental and physical health, the level of health, method of determination, and generally the specifics of such issue.

Legal incompetence also hinders infertile couples' ability to receive an embryo [47]. Article 1207 of the Iranian Civil Law sets forth minority, extravagance, and insanity as indicators of legal in- competence. In other words, minors, the insane, and those incapable of managing their money carefully and not wastefully are legally incompetent under the Iranian Civil Law.

Article 1210 of the Iranian Civil Law categorizes girls under the age of 9 and boys under the age of 15 under the minor group. Nonetheless, due to practical problems with setting these ages as minority ages, individuals reaching the age of 18 are considered adult. In light of the legality and prevalence of child marriage in Iran as well as its negative consequences for the prospective child's welfare and the increased likelihood of high-risk pregnancy [49], such requirement can be considered reasonable and praiseworthy.

Infertile couples should also be able to manage their financial affairs efficiently and carefully to ensure the prospective child will not face financial hardship. Interestingly, clause 2 of Article 1210 of the Iranian Civil Law sets forth that by reaching a certain age individuals would possess such ability. However, no correlation can be found between a certain age and thrift. Many people could still lack the understanding and capability to manage their money carefully even after adulthood.

Finally, insanity as one of the elements of legal incompetence disqualifies infertile couples from receiving an embryo. It appears from the language of the Act on Embryo Donation to Infertile Couples that the Family Court would determine infertile couples' legal competence including their insanity.

The Act on Embryo Donation to Infertile Couples also restricts the provision of embryo to infertile couples who hold an Iranian citizenship and thus, excludes foreigners from receiving an embryo [45, 48]. The purpose of Iranian legislators in restricting embryo donation to Iranian nationals is unclear. Embryo donation to foreign nationals neither negates the prospective child's welfare nor does it interfere with the treatment success. A sound foundation for a well-knit family unit and a decent living environment could be provided by competent parents regardless of their nationality.

It should be noted that two requirements-the economic status and the criminal record of the infertile couple-were included in the draft bill of the Act on Embryo Donation to Infertile Couples, but were deleted from the final Act [46].

According to Article 4 of the Act on Embryo Donation to Infertile Couples, the Family Court should announce its decision immediately without going through the formalities of the Law of Civil Procedure. If the Family Court does not consider the applicants qualified for receiving an embryo, the applicants can appeal the Court's decision [45, 47].

As a final note, the Act on Embryo Donation to Infertile Couples and its bylaw only emphasize the necessity of evaluating couples' parenting competence without providing any guidance on the details including the procedure for implementing such program. In addition, although considering parenting competence before embryo donation is praiseworthy, excluding other Assisted Reproductive Technologies is questionable. Patients demanding other Assisted Reproductive Technologies are no less required to be competent for parenting and the inclusion of other Assisted Reproductive Technologies is strongly recommended.

GUIDELINES AND CODES OF PRACTICE

Confining our analysis of couples' access to treatment services to normative rules would be incomplete without reviewing guidelines and codes of practice developed by fertility societies. These guidelines not only shed light on regulations' ambiguities but have the potential to convert into normative rules. The code of practice presented by the Human Fertilization and Embryology Authority serves as the sole guideline the author has encountered with in connection to access to fertility services in the *countries* level. Fertility societies on the *continent* level of Europe and America have issued guidelines in support of child welfare as well. The author aims to review guidelines of the European Society of Human Reproduction and Embryology, the American Society for Reproductive Medicine as well as the Human Fertilization and Embryology Authority's Code of Practice.

The Human Fertilization and Embryology Authority

Countries' fertility clinics lack guidelines on the prospective child's welfare in the context of Assisted Reproductive Technologies. For instance, the Canadian Fertility and Andrology which works towards advancing reproductive science and medicine in Canada has developed numerous practice guidelines on fertility and infertility but has remained silent on the prospective child's welfare. The U.K. Human Fertilization and Embryology Authority, established by the 1990 Human Fertilization and Embryology Act, which regulates assisted conception and human embryo research (as one its major duties) [50] has been found to be the only fertility society among countries to develop thorough and precise guidelines on the prospective child's welfare.

In this section, the issues the Human U.K. Fertilization and Embryology Authority considers to have negative outcomes for child welfare will be first examined, followed by the means through which prospective parents' childrearing competence are assessed.

Welfare Criteria

The enactment of the Human Fertilization and Embryology Act and formulating a separate section on the prospective child's welfare signify the value U.K. gives to the prospective child's welfare and interests. However, giving importance to child welfare is necessary but not sufficient and should be accompanied by welfare criteria to bring about the desirable results legislators had in mind. The Human Fertilization and Embryology Act of 1990, Section 25(2) mandates that the Human Fertilization and Embryology Authority shall maintain a code of practice on the child welfare provision to ensure the clarity of the child welfare requirement. Needless to say, such code of practice does not carry the legal force of a normative rule and fertility clinics' non-compliance with any

provisions of the code shall not render them liable to any proceeding. Nonetheless, the Human Fertilization and Embryology Authority's ability to revoke or vary clinics' license is the legal effect for non-observance of the code of practice which could deter clinics from violating the code of practice [51].

The Human Fertilization and Embryology Authority has developed guidelines which cover the scope of the child welfare provision, the child welfare assessment process, factors to take into account during the assessment process, obtaining further information during the assessment process, and treatment refusal.

The Human Fertilization and Embryology Authority has enumerated the harms future or present children are vulnerable to. In its Code of Practice, Guideline 8.14, the Authority has specifically listed serious medical, physical or psychological harm and the inability to care for children as childrearing incompetence factors. The demonstration of a risk of significant harm or neglect to the child to be born or any existing child bespeaks that minor harm would not be a sufficient ground for depriving infertile couples from receiving treatment services. According to the Human Fertilization and Embryology Authority, if infertile couples were to be denied treatment services due to insignificant harm to the child welfare, this would place too much emphasis on the interests of the prospective or any existing child at the expense of patient choice [52].

It is worth mentioning that according to the Human Fertilization and Embryology Authority, fertility clinics should not exclude couples from fertility services merely because of social factors including age. The Human Fertilization and Embryology Authority asked infertility treatment centers to pay attention to social factors such as the stability of the relationship, the commitment to having children, and the age of the prospective parents in the previous guideline. However, it removed the social factor from the guideline after putting out to public consultation whether such factor should remain. Therefore, the social factor itself cannot be determinative as to whether in- fertile couples can access treatment services. However, if social factors pose a significant psychological harm to the child or render infertile couples incapable of taking care of their child, this would raise doubt on couples' parenting competence [52].

As previously mentioned, medical harm is among the risk factors the Human Fertilization and Embryology Authority deems important for child welfare assessments. The Authority maintains that a group of children born through Assisted Reproductive Technologies will suffer from contagious or genetic diseases following birth. This may be ascribable to their parents' genetic diseases which increase the likelihood of the transmission of such illnesses from 25 to 50 percent [53].

Likewise, the Human Fertilization and Embryology Authority advises fertility clinics to withhold fertility services from infertile couples when couples' past or current circumstances lead to any child (future or present) experiencing serious physical or psychological harm or neglect. These conditions include but are not limited to previous convictions relating to harming children, child protection measures taken regarding existing children, and violence or serious discord in the family environment [52]. The authority reiterates that the association between homosexuality and psychological harm to the child should not be taken for granted. According to the Human Fertilization and Embryology Authority, such issues as financial difficulties are to the detriment of children's welfare to a larger extent and therefore, children's welfare by and large rests on the quality of family life rather than its structure. To the authority, although homosexuality has raised concerns on homosexuals' ability for competent parenting, children of homosexual couples fare well in terms of mental and emotional health [53]. This opinion is in line with the removal of the term "the need of that child for a father" and replacing it with "the need of that child for supportive parenting" in the 2008 Human Fertilization and Embryology Act.

Finally, the Human Fertilization and Embryology Authority adds that any past or current circumstances which are likely to lead to an inability to care throughout childhood for any child who may be born, or that are already seriously impairing the care of any existing child of the family (including but not limited to mental or physical conditions, drug or alcohol abuse, and medical history) should not be overlooked by infertility treatment centers [52].

Welfare Assessment

The Human Fertilization and Embryology Authority has given guidance on how the child welfare assessment would be implemented in its code of practice. In this context, infertility treatment clinics identify and assess a risk of significant harm or neglect through two means. Treatment centers mainly learn about the risk of significant harm or neglect through the patient history form completed by patients. This form contains such questions as previous convictions related to harming children, child protection measures regarding children, serious discord or violence within the family environment, physical or mental conditions, drug or alcohol problems, and the likelihood of the child being born with transmittable or inherited disorders. If the prospective parents' response to the questions raises considerable cause of concern for the treatment center that the child to be born or any existing child will suffer from significant harm or neglect, further investigation will be conducted. Administrative and laboratory staff information can be considered as the second means through which a risk of significant harm or neglect is determined. For instance, administrative and laboratory staff might report that the patient was angry at the clinic or over the phone or revealed significant information about their circumstances. This also would provide a basis for further investigation [30].

Pursuant to the Human Fertilization and Embryology Authority, Code of Practice, Guideline 8.16, if the patient fails to provide information, there is evidence of deception, the information provided is inconsistent or suggests a risk of significant harm or neglect to any child, clinics should obtain consent from the prospective patient (and their partner if they have one) to contact any individuals, agencies or authorities for any further investigation. A refusal to provide consent should not, in itself, be grounds for denying treatment but the decision on the patient's eligibility to receive treatment should be taken in reference to refusal to consent to disclosure of information.

According to the Human Fertilization and Embryology Authority, Code of Practice, Guideline 8.18, following these procedures, should the clinic arrive at the decision that the prospective child or any existing child of the family is likely to be at risk of significant harm or neglect, it is under the obligation to refuse treatment. Under Guideline 8.20 of the same Code of Practice, the decision on the patients' ineligibility for treatment cannot be made unless the grounds for refusal are explained, any circumstances that may enable the center to reconsider its decision are introduced, and any remaining options or opportunities for obtaining appropriate counseling are specified, all of which being in writing. Further, pursuant to Guideline 8.19 of the Human Fertilization and Embryology Authority's Code of Practice, clinics should also give patients the opportunity to respond to the reason or reasons for refusal before any final decision.

Guideline 8.5 of the same Code of Practice notes that the assessment shall be repeated if the center has been out of contact with the patient for two years or more, the patient has a new partner, a child has been born to the patient since the previous assessment, or the center has reason to believe that the patient's medical or social circumstances have changed significantly.

Fertility Societies 'Guidelines

The European Society of Human Reproduction and Embryology and the American Society for Reproductive Medicine as two fertility societies active in the Europe and America Continents have developed guidelines on specific moral issues including child welfare in medically assisted reproduction. To the author's knowledge, other fertility societies have not declared their perspective on the provision of treatment services to incompetent couples which confines our discussion to the guidelines published by these two fertility societies.

The European Society of Human Reproduction and Embryology

The European Society of Human Reproduction and Embryology is composed of Task Force on Ethics and Law which has been resolving the ethical dilemmas surrounding the practice of Assisted Reproductive Technologies for over a decade. The Task Force on Ethics and Law has produced a number of guidelines which could help clinics implement the child welfare assessment program [56]. According to the Task Force on Ethics and Law, the fertility doctor's causal and intentional contribution to the parental project render him/her co-responsible for the welfare of the future child [57] specially when assisted reproduction is collectively funded with the society [54] and therefore, it has enumerated the required criteria to be eligible for treatment services as follows.

Risk Factors

Medical Conditions

The Task Force on Ethics and Law has accorded importance to the medical condition of prospective parents from two different dimensions. First, transmittable, genetic and infectious diseases (including HIV, hepatitis B and C) may impede prospective parents from receiving treatment services. Second, to the Task Force on Ethics and Law, when the prospective parents' medical condition increase the likelihood of the prospective child's suffering from serious health risks (such as serious physical disability) and consequently, the prospective child's functioning and or life expectancy are affected, there would be no reason to offer treatment services to infertile couples [57].

Psychosocial Factors

Child abuse, violence in the family, addiction, mental retardation, psychiatric disorders, poverty, singlehood, widowhood and similar issues known as psychosocial factors are also regarded serious enough to act to the detriment of the prospective child's welfare [57]. The Task Force on Ethics and Law has not considered homosexuality and transsexuality as a risk factor for competent parenting. According to the Task Force on Ethics and Law, the type and structure of the family itself cannot lead us to conclude that certain individuals are not qualified for competent parenting, and it is upon the clinics to base their decision on the reasonable welfare standard without restricting their focus on the type and structure of family. To the Task Force on Ethics and Law, the application of stricter and less permissive criteria for homosexuals and transsexuals would imply a discriminatory double standard [58].

Lifestyle factors including obesity and low to moderate drinking does not concern the Task Force on Ethics and Law as the child to be born would not suffer from serious harm. In light of extensive literature and data on the negative impact of excessive alcohol consumption on child welfare, the Task Force on Ethics and Law advises fertility clinics to withhold services from heavy drinkers unless the individual changes his/her lifestyle [54].

Information Gathering

As mutual trust should remain between the physician and the patient, the Task Force on Ethics and Law asks clinics to accept the information provided by patients as true. Contacting outsiders shall not be permitted unless the physician has reason to believe that the information provided by the patient is inaccurate or doubts his/her parenting capacity. Under these circumstances, the physician should obtain consent to contact outsiders. The patient's dissent may result in treatment denial.

Following these procedures and the physician's confidence on serious risk of harm to the prospective child, two strategies may be applied: either the physician makes the provision of services contingent upon some conditions depending on specific risk factors (additional testing, postponement, changing circumstances like clarification of the relationship, psychological support) or gives an upright refusal due to the unchangeability of circumstances [54].

The American Society for Reproductive Medicine

The American Society for Reproductive Medicine as a fertility society dedicated to advancing the practice of assisted reproduction in the continent of America has also published ethical guidelines for

fertility clinics [55]. The Ethics Committee which works within the society has provided guidance on ethical matters in connection to assisted conception [59].

The Ethics Committee has advised clinics to withhold fertility services from incompetent couples, albeit after a thorough review by members of a multidisciplinary treatment team. Those who are psychologically unstable, abuse drugs or present any type of significant risk to the welfare of the child, are generally unfit for parenting, according to the Ethics Committee. To the Ethics Committee, persons with disabilities should not be denied fertility services merely because of their disability except when significant harm to future children is likely [60]. By the same token, homosexuals and transsexuals should be protected against discriminatory behavior and should not be excluded from treatment services due to bias or stereotypes about their parenting capability [61]. To the Ethics Committee, no stricter policy should be applied to single individuals or homosexual couples when they are treated with respect in adoption and foster parenting. In this context, all states recognize single individuals' as well as homosexuals' right to be foster parents and the majority of states authorize the noted class of people to adopt children [62].

The Ethics Committee does not repudiate that constitutional rights protect infertile couples against interference. The duty of noninterference with reproductive rights does not, however, imply that physicians or the state should provide treatment services, the Committee has emphasized. In addition, constitutional rights protect individuals against interference or discrimination by government or governmental entities without regulating the behavior of persons in the private sector. Thus, the private sector physician may decline to provide treatment services subject to anti-discrimination laws [60].

The Ethics Committee also adds that the principle of provider autonomy lends support to with-holding services from those whose parenting capacity has been questioned. The autonomy principle enables treatment providers to enter into physician-patient relationship and terminate the relationship whenever they desire as long as their behavior is consistent with anti-discrimination laws [60].

The Committee has also made it clear that written policies or procedures which outline the information required of prospective parents as well as conditions precluding medical treatment for in-fertility should guide fertility clinics in the child welfare assessments [60].

In spite of advocating for treatment refusal in cases of parenting incompetence, the Committee does not believe that clinics should refuse to provide fertility services to incompetent couples in all circumstances and does not assume services' denial as a moral obligation. In fact, some clinics may favor incompetent couples' autonomy over the prospective child's welfare. As long as the clinic has solid reasons to believe that the prospective child will not deal with significant harm or they are not discriminating against an individual on grounds of race, religion, sexual orientation and alike, they are free to accept or deny individuals for treatment. Therefore, some clinics may proceed with the parental project while others may act otherwise [60].

CONCLUDING DISCUSSION

There is no denying that the child welfare assessment program carried out by infertility clinics is a sensible and worthwhile exercise, given the need to protect children from the risk of harm and neglect as well as shield the society from the negative consequences of incompetent parenting. The study of laws and regulations of the United States, the United Kingdom, Australia, New Zealand, Belgium, France, Canada, and Iran revealed the fact that each of these countries accord importance to childrearing competence. However, neither of these jurisdictions define the details of the child welfare assessment program, leaving the door open to interpretation by fertility clinics or any authority in charge of assessing infertile couples' childrearing competence.

While U.S. clinics prioritize the prospective child's welfare over the prospective parents' interests by withholding fertility services from certain class of couples (such as drug abusers), no law has been

legislated on the child welfare assessment program. Likewise, although France enumerates some indicators of childrearing incompetence, no law has been enacted requiring fertility clinics to evaluate infertile couples' childrearing competence before providing treatment services. Belgium also gives fertility clinics a discretion to decide about infertile couples' eligibility for treatment services and there is no legal mandate requiring fertility clinics to consider the prospective child's welfare before offering treatment services. Fertility clinics are only authorized to take the prospective child's welfare into consideration in Belgium. Although laws being enacted for child welfare assessments, Canada, Australia, New Zealand, and Belgium do not illuminate the nature of child welfare, how child welfare is to be implemented, who would determine couples' qualification for treatment services, and generally the details of child welfare assessment, thus leaving infertility treatment clinics with countless questions. As for Iran, although the criteria for parenting competence are explained, the details including the procedure of implementing such program, the scope of each criteria, and how to assess parenting competence are not specified, not to mention that the parenting competence criteria are under doubt themselves.

The study of fertility regulators' and fertility societies' position on the child welfare assessment program also showed that the European Society of Human Reproduction and Embryology, the U.K. Human Fertilization and Embryology Authority, and the American Society for Reproductive Medicine have also accorded importance to the prospective child's welfare. However, these fertility regulators and societies have brought more clarity to the childrearing competence program through their detailed codes of practice and guidelines. More credit should be given to the U.K. Human Fertilization and Embryology Authority which stipulates the details of the child welfare assessment program step by step, an issue which can serve as a model for countries advocating the child welfare assessment program.

Having examined some countries regulations, fertility societies' codes of practice and their weaknesses, it is proposed that the factors of parenting competence be enumerated, as practiced in the United Kingdom. This proposed model would better ensure the well-being of children to be born as a result of Assisted Reproductive Technologies, reduce the degree of discretion exercised by responsible authorities (whether they be fertility clinics, courts, or any other authority depending on each country), and minimize the likelihood of different treatment of individuals with similar circumstances. Factors such as previous convictions relating to harming children, violence or serious discord in the family environment, mental or physical conditions, drug or alcohol abuse, and medical history, where the medical history indicates that any child who may be born is likely to suffer from a serious medical condition, need to be taken into account. Further, particular circumstances of each case would need to determine if an individual is eligible for fertility services. The mere fact that a person is presumed to be for example, physically or mentally incompetent would not suffice and additional factors including the length of the health condition and the impact of the negative factor on interpersonal, vocational, and social relationships should be considered (which would in turn affect their ability to take care of their child efficiently) as well. It is after the consideration of these factors that any determination as to couples' parenting competence and their eligibility to receive fertility services should be made.

In addition, laws must indicate with reasonable clarity the scope and manner of exercise of the relevant discretion conferred on fertility clinics, courts, or any other authority in charge of the child welfare assessment program. Such law should be reasonable in the particular circumstances; carried out by competent authorities on a case-by-case basis, and provide adequate safeguards and effective remedies against illegal or abusive limitations.

It is also suggested that a committee comprised of specialists and experts in a dimension of parenting competence evaluate infertile couples' qualification for infertility treatment services. The views of all the committee members should be taken into account. It is through collective decision-

making that arbitrary assessment and uncertainty are less likely. In fact, a committee in charge of assessing individuals' parenting competence can help the committee members overcome their biases. While people may be unaware of their own biases, they are remarkably good at detecting others' biases. Sharing information across independent individuals who each are knowledgeable about a dimension of parenting competence also leads to more reliable information. When each of the members evaluates an aspect of parenting competence, the decision reached at can be relied on with a greater certainty as compared to circumstances where an individual (such as a general practitioner) takes the assessment responsibility alone.

Further, should a couple be considered as incompetent for parenting and therefore, ineligible for treatment services, the grounds for refusal should be explained to them, and they should be referred to appropriate counseling, if necessary. Incompetent couples should also have the opportunity to challenge the refusal decision and present evidence in support of their parenting competence. The right to express their opinion should also be given to infertile couples before any decision is made. Incompetent couples wishing to receive treatment services undoubtedly will not greet denial decision with enthusiasm as they have longed for experiencing parenting and have turned to fertility clinics in hope of overcoming their infertility. However, should infertile couples assessed as incompetent be given the chance to advocate for their parenting competence prior to decision-making, they will at least view the child welfare assessment programs as a process in which balance between public interest as well as the prospective child's rights and incompetent couples' reproductive rights are sought and the decision adopted is objective, built on solid proof. They would not consider the process as one-sided in which the prospective child's welfare is only taken into account.

It is aspired that countries other than those mentioned in this article enact laws in support of childrearing competence assessments to protect the prospective child's welfare and the public interest. There is no denying that many fertile couples may be as incompetent as infertile couples. Nevertheless, less control may be exercised over fertile couples who conceive a child without seeking fertility clinics' assistance. The involvement of public interest in cases which the society bears the financial burden of providing Assisted Reproductive Technologies also sets the stage for subjecting incompetent infertile couples to the child welfare assessment program. The moral responsibility of fertility providers to the child-to-be also warrants the implementation of the child welfare assessment programs against infertile couples.

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