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Belgian legislation and jurisprudence on medically assisted reproduction

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Introduction

In Belgium - a pioneer country in the practice - medically assisted reproduction techniques have developed enormously over the past 40 years. Considered as a "liberal" state in this field, its legislation - dating from 2007 - is not very restrictive, the responsibility for the choice and use of techniques being delegated to the medical profession.[1] Given this situation, it is the country, along with Spain, the most requested in Europe in order to follow a path of medically assisted procreation. In 2018, 5,994 births took place as a result of this route, which represents 5.1% of the total births in the country, out of 39,489 cycles undertaken.[2]

Chapter 1: The legal regime of medically assisted reproduction - the law of 6 July 2007

Section 1 : The genesis of the law of 6 July 2007

§1 Before the law of 6 July 2007

The law of 6 July 2007 was adopted following a long process, accompanied by controversy as to the appropriateness of a legislative framework specific to the issue of medically assisted reproduction. Before this law, there was no specific legal framework for the conditions of access to medically assisted reproduction, the procedure to be followed or the control to be carried out. As a result, it was within the fertilisation centers that the rules and good practices relating to medically assisted procreation were initially created, spontaneously. Because of the great freedom given to these centers, the conditions for access to the practice varied from one center to another, some of them being stricter, in consideration of their ethical or religious convictions.[3]

However, before 2007, there were still royal decrees that provided for certain aspects of the organization of the practice. One of these royal decrees aims to include the "reproductive medicine" program in the care programs.[4] Another royal decree regulates the financial side: a

[1] J. SOSSON et H. MALMANCHE, « Etat du droit belge en matière de procréation médicalement assistée et de gestation pour autrui », *in* Les mutations contemporaines du droit de la famille, 2020, p. 37.
[2] C. BROCHIER, « La procréation médicalement assistée en Belgique », *in* Dossier de l'Institut Européen de Bioéthique, 2017, p. 1.
[3] M. DERESE et G. WILLEMS, « La loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes », *R.T.D.F*, 2008/2, pp. 283-284.
[4] Art. 1, A.R du 15 février 1999 fixant les normes auxquelles le programme de soins « médecine de la reproduction » doivent répondre pour être agréées.

reimbursement by the compulsory health care insurance is foreseen for the pharmaceutical specialties necessary for *in vitro* fertilization, but only under certain conditions.[5][6]

Furthermore, there is an allowance[7] for hospitals with an accredited "B" reproductive medicine program.[8] In Belgium there are two types of centers: the so-called "A" centers and the so-called "B" centers. The "A" centers deal with the treatment of assisted reproduction up to the oocyte retrieval phase. There are 16 "A" centers. They then refer to the so-called "B" centers, which have an embryology laboratory, for the embryo transfer. These "B" centers can perform *in vitro* fertilization and process or store the gametes or embryos. There are 18 "B" centers.[9]

However, in parallel to these royal decrees, a law of May 11, 2003 accepts, under certain conditions, scientific research on *in vitro* embryos.[10]

In addition to these legal frameworks, the fertilization centers have at their disposal - in a general way and within the framework of their very free practice of medically assisted reproduction - the Code of Medical Ethics, the opinions of the Belgian Bioethics Advisory Committee (Comité consultatif de bioéthique) and the guidelines of the Ethics Committees created within the hospitals.[11]

§2 The adoption of the law of 6 July 2007

Discussions on the appropriateness of a legislative framework began with several opinions of the Belgian Advisory Committee on Bioethics (Comité consultatif de bioéthique). These opinions dealt with gamete and embryo donation, the fate of supernumerary embryos, post-mortem medically assisted reproduction and surrogate motherhood, and were useful in the debates leading to the 2007 law.[12][13]

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[5] A.R 21 décembre 2001 fixant les procédures, délais et conditions concernant l'intervention de l'assurance obligatoire soins de santé et indemnités dans le coût des spécialités pharmaceutiques.

[6] M. DERESE et G. WILLEMS, « La loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes », *R.T.D.F*, 2008/2, pp. 281-282.

[7] A.R 25 avril 2002 relatif à la fixation et à la liquidation du budget des moyens financiers des hôpitaux.

[8] M. DERESE et G. WILLEMS, « La loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes », *R.T.D.F*, 2008/2, pp. 281-282.

[9] https://fertilly.com/fr/cliniques/belgique/#:~:text=En%20Belgique%2C%20la%20Procr%C3%A9ation%20M%C3%A9dicalement,provenant%20de%20donneurs%20ou%20donneuses.

[10] M. DERÈSE et G. WILLEMS, *Ibid*, p. 283.

[11] *Ibid.*, p. 284.

[12] Voy. Avis n°19 du 14 octobre 2002 relatif à la destination des embryons congelés ; Avis n°22 du 19 mai 2003 relatif au choix du sexe pour des raisons non médicales ; Avis n°27 du 8 mars 2004 relatif au don de sperme et d'ovules ; Avis n°28 du 21 juin 2004 relatif au don d'embryons ; Avis n°30 du 5 juillet 2004 relatif à la gestation pour autrui.

[13] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 286-287.

The adoption of the law was subject to controversy. During the preparatory work, two schools of thought clashed. The first considered that the law should not intervene in the field of medically assisted reproduction, in particular because the practices were sufficiently regulated by the fertilization centers, that this would constitute an interference in the freedom of science, the private life of individuals and the relationship between the patient and his doctor, but also because there is no framework for natural procreation and that there would be no reason to provide for such a framework for non-natural procreation.[14] The second group thought that a legal framework was indispensable and therefore found counter-arguments to these criticisms.[15] They considered that the practices of the fertilization centers were indeed good, but that it was necessary to protect oneself against slippage, which does not interfere with the freedom of individuals. Moreover, the practices differ from one center to another, which would be contrary to the principle of equality between individuals.[16] The purpose of this law was in fact to create a balance between the autonomy of the centers and the people involved in the practice of medically assisted reproduction and the imposition of requirements to avoid abuses.[17] Moreover, it was considered - by observing the legal frameworks abroad - that a framework was also necessary in Belgium.[18]

In 2004, a senator tabled a legislative proposal on medically assisted reproduction.[19] On the basis of this proposal, the Bioethics Working Group of the Belgian Senate drafted a report that led to the tabling of a new version of the legislative proposal in March 2005.[20] This new version was subsequently amended following certain debates, and the consolidated proposal was tabled in November 2005.[21] The text, after having been submitted to the Council of State for its opinion and then amended by the Senate's Social Affairs Committee, was sent to the House of Representatives, adopted and promulgated on July 6, 2007.[22]

This law was therefore created in order to regulate the practices already existing and accepted within fertilization centers, which vary from one center to another, in order to avoid any abuse.[23]

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[14] M. DERÈSE et G. WILLEMS, *Ibid.*, pp. 284-285.
[15] *Ibid.*
[16] *Ibid.*, p. 286.
[17] *Ibid.* p. 287.
[18] *Ibid.*
[19] Proposition de loi relative à la procréation médicalement assistée, *Doc. parl.*, Sén., sess.ord. 2003-2004, n°3-418/1.
[20] *Doc. parl.*, Sén., sess.ord. 2004-2005, n°3-1067/1, p. 3.
[21] Proposition de loi relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes, *Doc. parl*., Sén., sess. ord. 2005-2006, n° 3-1440/9, p. 61.
[22] M. DERÈSE et G. WILLEMS, *Ibid.*, pp. 288-292.
[23] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 39.

Section 2: The regime of the law of July 6, 2007

§1 Definitions

Article 2 of the law contains a list of 22 definitions.[24] The first definition concerns medically assisted procreation, considered as a "*set of modalities and conditions of application of the new medical techniques of assistance to reproduction in which is carried out: 1° either artificial insemination, 2° or one of the techniques of in vitro fertilization, i.e. techniques in which, at some point in the process, access is given to the oocyte and/or the embryo*". The law of July 6, 2007 therefore concerns artificial insemination and *in vitro* fertilization, but not surrogate motherhood.[25] Other concepts such as: embryo, *in vitro* embryo, supernumerary embryo, cryopreservation, author of the parental project, fertilization centers are also defined.

§2 Access to Medically Assisted Procreation

A. The profile

Article 2, f) of the law defines the author of the parental project as "*any person who has made the decision to become a parent by means of medically assisted procreation, whether or not it is carried out from his or her own gametes or embryos*".[26] This is a very broad definition. The legislator has therefore not provided specific criteria concerning the profile of applicants. Medically assisted reproduction is open to all: to single people, married people, couple but not married, homosexual, heterosexual. Belgium is the preferred destination for single or homosexual women, especially French women, to undergo medically assisted reproduction.[27] Moreover, the law does not require couples to demonstrate a certain stability. There are no nationality or residence requirements.[28]

It is the fertility centers that are responsible for accepting or refusing access to applicants for medically assisted reproduction. In the event of refusal, these centers may invoke a conscience clause, provided for in Article 5 of the law. This section states that "*Fertility centers shall be as transparent as possible about their options regarding access to treatment and shall be free to invoke the conscience clause in respect of requests made to them. Fertility centers must notify the applicant(s) of their refusal to proceed with the request within one month of the decision of*

[24] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.
[25] Art. 2, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[26] *Ibid.*
[27] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.
[28] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 40.

the physician consulted. This refusal must be formulated in writing and must indicate: 1° either the medical reasons for the refusal; 2° or the invocation of the conscience clause provided for in paragraph 1 of this article; 3° if the applicant(s) have expressed the wish to do so, the contact details of another fertilisation center to which they can turn."[29] There are therefore three principles to be respected: the centers must be transparent as to the conditions of access to medically assisted procreation, they must record the refusal of care in writing by invoking article 5 of the law, and finally they must indicate to the applicants the address of another fertilization center if this has been requested.[30] Thus, the centers have a great deal of autonomy in terms of access.[31] Many clinics set up appointments with a psychologist to assess whether it is appropriate to start treatment.[32]

In addition, article 6 of the law states that the fertilization center must verify, *in those cases in which it is appropriate*, that the causes of sterility, infertility or hypofertility have been verified and treated according to the current state of science.[33] In fact, it has been considered that medically assisted reproduction can only take place after one of the aforementioned diagnoses of sterility, infertility or hypofertility, and that no treatment has been successful. However, the phrase "*where appropriate*" ensures that the requirement of Article 6 is not formulated in too absolute a manner: it is therefore not a mandatory prerequisite.[34] An individual cannot be forced to undergo medical treatment, nor can a woman who is close to the acceptable age limit for assisted reproduction.[35]

This autonomy of fertilization centers was the subject of a decision by the French-speaking Court of First Instance of Brussels.[36] It was considered that this autonomy should be implemented with humanism. In this case, an *in vitro* fertilization with egg donation was refused to the applicant - considered too emotionally unstable - which is not a fault in itself, given the autonomy granted to the centers by the law of July 6, 2007.[37] The faulty behaviour consisted in the absence of a written explanation of the medical reasons justifying the refusal or the use of

[29] Art. 5, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[30] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 301-302.
[31] G. GENICOT, *Ibid.*
[32] https://fertilly.com/fr/cliniques/belgique/#loi
[33] Art. 6, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[34] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 298-300.
[35] *Ibid.*
[36] Tribunal de première instance francophone de Bruxelles, sect. civ., 75e ch., 02/06/2017, 10/14430/A.
[37] Tribunal de première instance francophone de Bruxelles, sect. civ., 75e ch., 02/06/2017, 10/14430/A - L'autonomie des centres de procréation médicalement assistée doit être mise en œuvre avec humanisme, *Consilio*, 2019/3, pp. 115-127.

the conscience clause provided for in article 5 of the law. Moreover, the center did nothing after the decision to refuse to provide the patient with guidance and help her to understand and assimilate the decision. This shortcoming also constitutes a fault in the obligation to inform the patient. The applicant ultimately obtained compensation for the hospital's faults, but this was modest.[38]

B. Age

There is, however, a limit: it is a condition of age. Article 4 of the law states that "*Gamete retrieval is open to women who have reached the age of majority and are no more than 45 years old. The request for embryo implantation or gamete insemination is open to women who have reached the age of majority and are no older than 45 years. The implantation of embryos or insemination of gametes cannot be performed on women over the age of 47. By way of derogation from paragraph 1, the removal for cryopreservation of gametes, supernumerary embryos, gonads or fragments of gonads may be carried out, on medical indication, in a minor*".[39]

The preparatory work justifies these age limits for women on medical and ethical grounds. However, there is no age limit for the male author of the parental project or for sperm donors.[40] The reason for the absence of an age limit for men is not to prevent the woman from having recourse to the treatment when she meets the age requirements but her partner is over the age limit.[41]

§3 The Convention

A very important aspect of the law concerns the autonomy of the actors and transparency. The principle of consensualism is provided for at all stages of the procedure of medically assisted procreation. The authors of the parental project and the fertilization center must establish an agreement, provided for in article 7 of the law, prior to any procedure.[42] The purpose of this agreement is to regulate all aspects of the medically assisted reproduction process in order to avoid any disagreements that may arise.[43]

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[38] *Ibid.*
[39] Art. 4, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[40] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 40.
[41] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 296-297.
[42] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.
[43] M. DERÈSE et G. WILLEMS, *Ibid*, p. 307.

It is expected that this agreement will contain information on the identity, age and address of the person(s) planning to have children, as well as the contact details of the fertilization center. When a couple is involved, this Agreement must be signed by both individuals. In addition, two copies of the agreement must be made, one for the fertilization center and one for the parents.[44] The contract will also contain the medically assisted reproduction technique that will be used, as well as the choices made by the authors of the parental project, notably as to the fate of the gametes or embryos when the cryopreservation period is exceeded, or as to the advisability of carrying out a pre-implantation genetic diagnosis.[45]

However, modification is possible. Article 8 provides that: "*the instructions of the author(s) of the parental project may be modified until the last instruction given is completed, subject to the expiry of the period for the conservation of gametes or supernumerary embryos. These modifications shall be the subject of a written document, signed by all the parties to the agreement referred to in article 7. In the case of a couple, these modifications must be made by mutual agreement and the written document referred to in the previous paragraph must be signed by the two authors of the parental project*".[46]

§4 Authorized techniques

As previously stated, medically assisted reproduction consists of artificial insemination or *in vitro* fertilization. This procreation can be understood as "*techniques tending to induce a pregnancy in a woman who wishes to have a child*".[47] These techniques involve the manipulation or use of gametes, i.e. reproductive cells, sperm and eggs, gonads - organs that produce reproductive cells, testicles and ovaries - or embryos, results of the fusion of gametes.[48]

The law is divided into four main parts: medically assisted reproduction (articles 3 to 8), supernumerary embryos (articles 9 to 36), gametes (articles 37 to 65) and pre-implantation genetic diagnosis (articles 66 to 72). This structure has not been carried out chronologically: during the process of medically assisted reproduction, questions relating to pre-implantation

[44] Art. 7, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[45] M. DERÈSE et G. WILLEMS, *Ibid*, p. 307.
[46] Art. 8, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[47] A-C. SQUIFFLET, *Procréation médicalement assistée et gestation pour autrui*, Limal, Anthémis, 2017, p. 35.
[48] *Ibid.*; Rapport, Doc. parl., Ch. repr., sess. ord. 2006-2007, n o 51-2567/004, pp. 5-12 (ci-après, « Rapport, n o 51-2567/004 »).

genetic diagnosis and gametes arise first, prior to procreation as such, and it is only after these stages that the question of the fate of potential supernumerary embryos will arise.[49]

The law therefore allows the use of gametes or embryos. When these have been mobilized as part of a medically assisted procreation process but have not been directly implanted, there are 4 options.[50] First, the authors of the parental project can request the freezing of the embryos or gametes in order to use them in their assisted reproduction process.[51] Secondly, they can plan to either use them in a research protocol or in a donation program. Finally, they may require the destruction of these embryos or gametes.[52]

Moreover, as the law of July 6, 2007 has a very broad scope, all treatments provided for by this law are also subject to the law of August 22, 2002 on patients' rights. However, as provided for by article 3 of the 2007 law, *in vitro* fertilization and cryopreservation of embryos, gametes, gonads and gonad fragments can only be carried out in fertilization centers.[53]

A. Cryopreservation

Article 10 of the law provides that when embryos have been created but not implanted in the woman author of the parental project, freezing may be provided for, with a view to carrying out the current or future parental project. The second paragraph, however, limits this cryopreservation by providing that: "*in the event that cryopreservation has not been carried out for the purposes set out in paragraph 1 or on expiry of the cryopreservation period set out in articles 17 and 18 of this law, the supernumerary embryos may : - be integrated into a scientific research protocol in accordance with the law of 11 May 2003 on research on in vitro embryos, - be destroyed, - be assigned to an embryo donation programme*".[54] Article 9 provides that no new gamete retrieval for the purpose of creating embryos may be carried out as long as there

[49] G. GENICOT, « Section 2 - La maîtrise du début de la vie : la procréation médicalement assistée », *in Droit médical et biomédical*, 2e édition, Bruxelles, Larcier, 2016, p. 715.
[50] M. DERÈSE et G. WILLEMS, *Ibid*, p. 308.
[51] *Ibid.*
[52] *Ibid.*
[53] G. GENICOT, « Section 2 - La maîtrise du début de la vie : la procréation médicalement assistée », *in Droit médical et biomédical, Ibid*., p. 715.
[54] Art. 10, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.

are still cryopreserved supernumerary embryos.[5556] Section 40 of the Act provides for the same fate as section 10 for gametes.[57]

Articles 17, 18, 46 and 47 state that the time limit for cryopreservation of embryos is five years, and the time limit for cryopreservation of gametes is ten years. However, the time limit may be reduced at the request of the authors of the parental project, but also extended when particular circumstances require it.[58]

The removal for cryopreservation of gametes, supernumerary embryos, gonads or fragments of gonads may be performed on a minor only on serious medical indication. This will be the case when a minor suffers from a condition that requires treatment that is risky for his/her fertility.[59]

In the case where the authors of the parental project actually choose cryopreservation, article 12 for supernumerary embryos and article 41 for gametes provide that the fertilisation center concerned must, prior to the signing of the agreement, respect an obligation to provide general information and psychological support, as well as specific information on the conditions and the time limit for conservation, as well as on the possible uses to which the embryos may be put at the end of the period.[60] The authors must determine in the assisted reproduction Agreement what will happen to the surplus embryos in case of separation, difference of opinion, inability to make a decision, death of an author of the parental project and after the expiry of the deadline. In the case of gametes, the authors of the parental project must specify their choice in the Convention in the event of incapacity to decide or death of the author who requested conservation, as well as in the event of expiry of the deadline.[61] When the Agreement so provides, a divorced or separated woman may continue the process of medically assisted reproduction with the cryopreserved embryos or gametes produced with her former partner.[62]

The fertilisation center may accept the request for implantation of cryopreserved supernumerary embryos, but must first ensure that the effective consent of the two authors of the new

[55]Art. 9, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[56] M. DERÈSE et G. WILLEMS, *Ibid*, p. 308.
[57] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.
[58] *Ibid*.
[59] G. SCHAMPS, « L'autonomie de la femme et les interventions biomédicales sur son corps en droit belge », *in* Aouij-Mrad, A. et Feuillet, B. (dir.), *Le corps de la femme et la biomédecine*, 1e édition, Bruxelles, Bruylant, 2013, pp. 48-49.
[60] Art. 12 et 41, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[61] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 309-310.
[62] G. SCHAMPS, *Ibid*, p. 50.

implantation has been obtained prior to any medical procedure. The same rule applies in the case of gametes.[63]

Another ethical aspect of cryopreservation that needs to be considered and was the subject of debate in the Bioethics Advisory Committee resulting in Opinion 57 of December 16, 2013 is "social freezing." This practice is the preservation of eggs in anticipation of age-related infertility. Some members of the Committee are in favor of making a distinction between medical causes of conservation and non-medical causes, i.e. the fact of postponing procreation for reasons of work, study, financial means or lack of a partner.[64] Other members consider, on the contrary, that it is preferable to adopt a neutral position regarding the reason for cryopreservation.[65] Indeed, legally, there is no prohibition against freezing eggs in anticipation of aging. It was emphasized by the Committee that it is not for society to make moral judgments about why a woman wants to freeze her eggs. Some authors respond to this argument that "social freezing" may be an over-medicalization of a natural process.[66]

B. Allocation to a research program

This allocation of supernumerary embryos or gametes to a research programme must have been provided for in the Convention.[67] This choice may be made for embryos or gametes that have not been cryopreserved with a view to a subsequent project, but also for those that have been cryopreserved but not used, in particular because the time limit has been exceeded, the authors of the project no longer agree, or one of the authors has died or become incapable of making a choice. In addition, article 37 of the 2007 law provides that gametes may be collected specifically for inclusion in a scientific research protocol.[68] However, this cannot be commercialized.[69]

The decision to allocate supernumerary embryos or gametes to a research program can be withdrawn until the research begins. The law states that the possibility of withdrawing the decision for supernumerary embryos is in accordance with the law of 11 May 2003 on research on *in vitro* embryos. In addition, Articles 21 and 50 provide that the period of conservation of

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[63] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27 ; Art. 12 et 41, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[64] N. GALLUS, *Procréation médicalement assistée et gestation pour autrui*, Limal, Anthémis, 2017, pp. 205-225.
[65] *Ibid*.
[66] *Ibid.*
[67] Art. 10, 13, 37 et 42, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[68] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 322-323.
[69] *Ibid.*

gametes and supernumerary embryos that have been assigned to a scientific research program is determined by the fertilization center concerned.[70]

With regard to supernumerary embryos, the provisions of the 2007 law concerning scientific research programs should be read in conjunction with the law of May 11, 2003 concerning research on *in vitro* embryos, which establishes the conditions under which research on supernumerary embryos is permitted. In particular, cloning is prohibited.[71]

C. Donation of supernumerary embryos or gametes

Appropriateness of the donation

Supernumerary gametes or embryos may not be kept by the authors of the parental project. It may also happen that these gametes and embryos are kept but the parental project is abandoned. However, the gametes may be specifically reserved for a donation program, without a parental project being at stake.[72] Once again, the fertilisation center is obliged to inform the authors of the project of the consequences and outcome of such a decision before signing the agreement. Articles 30 and 59 of the law of July 6, 2007 state that once the donation procedure has been initiated, the donation is irrevocable.[73]

In addition to this hypothesis, a donation may be necessary for the authors of the parental project who are not able to carry out a procreation with their own genetic material. In fact, they may need a donation of sperm, eggs or embryos from a third person.[74]

Articles 32 and 61 of the law stipulate that the recipient of the embryo or gamete must submit a request for implantation or insemination by registered letter to the fertilization center consulted. The written document made by the recipient must be signed by both authors when it is a couple. The center in question must respond to the request within two months of the date it was sent. These articles also provide that in the event of a favourable response to the request, the Convention must be concluded, and that in the event of an unfavourable response, the aforementioned article 5 must be applied.[75]

[70] M. DERÈSE et G. WILLEMS, *Ibid*, p. 325.
[71] *Ibid*, pp. 325-326.
[72] M. DERÈSE et G. WILLEMS, *Ibid*, p. 326.
[73] *Ibid.*
[74] *Ibid.*, p. 327.
[75] Art. 32 et 61, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.

It is the fertilisation center that decides on the period of conservation of supernumerary embryos and gametes within the framework of the donation.[76]

Anonymity

The principle is the anonymity of donations. However, if the donor and the recipient agree, a non-anonymous gamete donation is possible.[77] This practice was in fact established before the law by fertilization centers, and was retained by the law in order to take into consideration the difficulty of obtaining oocyte donations by allowing a person or a couple to begin the process of medically assisted procreation on the basis of genetic material from a friend or family member.[78] This non-anonymity does not affect the child born as a result of the donation. Indeed, this child will not have the right to access the donor's information if his parents do not share it with him. This non-anonymous donation is not possible for embryo donations.[79]

Fertility centers are responsible for making all donor information inaccessible. However, for medical reasons, information that does not allow the donor to be identified may be transmitted after the birth of the child.[80] The child's right to know his or her origins was therefore discussed during the adoption of the law. The legislation section of the Belgian Council of State issued an opinion on 24 January 2006 in which it expressed reservations about the implementation of a system that would prevent a child from having absolute access to its origins. Several authors support this opinion, considering that by providing for the total disappearance of the donor, this has the effect of confiscating part of the child's origins, and of disregarding Belgium's international commitments.[81] The knowledge of one's origins is indeed an essential element of the construction of identity for any individual.

The Advisory Committee on Bioethics considered, in particular, that it was not appropriate to provide a legal framework for the secrecy of the mode of conception with respect to the child. The choice of informing the child about his or her mode of conception must remain in the hands

[76] G. SCHAMPS, « L'autonomie de la personne en matière médicale : du début à la fin de la vie », *in* Van Drooghenboreck, J.-F. (dir.), *Le temps et le droit*, 1e éd., Bruxelles, Bruylant, 2013, p. 551.
[77] Art. 22 et 57, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[78] M. DERÈSE et G. WILLEMS, *Ibid*, p. 338.
[79] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 41.
[80] *Ibid.*
[81] G. MATHIEU, « L'anonymat du don dans le contexte des procréations médicalement assistées : une nécessaire réforme du droit belge à la lumière des droits humains », *in* Dandoy, N. *et al.* (dir.), *Individu, Famille et Etat: Réflexions sur le sens du droit de la personne, de la famille et de son patrimoine*, 1e édition, Bruxelles, Larcier, 2022, pp. 1081-1093.

of the authors of the parental project, even if it is preferable to inform the child as soon as possible in order to avoid any trauma.[82]

In addition, some fertilization centers accept "direct donation" or "cross donation". Direct donation" is when the recipient arrives at the center with the donor. Cross donation" is when the recipient receives an anonymous donation, and in exchange a relative of the recipient donates gametes that will be used for someone other than the applicant.[83]

Free of charge

Gamete or embryo donation is voluntary and free of charge. However, an indemnity may be provided. This may cover travel expenses, loss of salary, and hospitalization costs inherent to the donation of oocytes by the volunteer. This indemnity is provided for in article 6 of the law of December 19, 2008 on obtaining and using human body material intended for human medical applications and for scientific research purposes.[84]

The purpose of this free-of-charge provision is obviously to avoid any risk of abuse. The commercialization of embryos and gametes is prohibited.[85] There is therefore a clear distinction between "remuneration", which is prohibited for products of the human body, and " defraying", which is accepted.[86]

Prohibition of eugenics and sex selection, prohibition of simultaneous insemination or implantation

Articles 23 and 52 prohibit the donation of supernumerary embryos and gametes of a eugenic nature, as defined by article 5, 4° of the law of May 11, 2003, i.e. focused on the selection or amplification of non-pathological genetic characteristics of the human species. These articles then state that donation based on sex selection, as defined by article 5, 5° of the law of May 11, 2003, is prohibited, i.e., donation based on sex selection, with the exception of selection that makes it possible to remove embryos or spermatozoa with sex-related diseases.[87] However, Articles 24 and 53 state that donor-recipient matching cannot be considered eugenic.[88][89]

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[82] M. DERÈSE et G. WILLEMS, *Ibid*, p. 332.
[83] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 41.
[84] *Ibid.*
[85] G. GENICOT, « Section 2 - La maîtrise du début de la vie : la procréation médicalement assistée », *in Droit médical et biomédical*, 2e éd., Bruxelles, Larcier, 2016, p. 710.
[86] *Ibid.*
[87] Art. 23 et 52, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[88] Art. 24 et 53, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[89] M. DERÈSE et G. WILLEMS, *Ibid*, p. 342.

In addition, articles 25 and 54 of the law of 6 July 2007 prohibit the simultaneous implantation of embryos from different donors of supernumerary embryos or the simultaneous insemination of gametes from different gamete donors.[9091]

Articles 26 and 55 specify that supernumerary embryos from the same donor or pair of donors or gametes from the same donor may not lead to the birth of children to more than six different women.[92]

D. Receiving oocytes from the partner

Partner egg retrieval is a medically assisted reproduction technique for female couples. It can also be called the "shared maternity method". This method is carried out through a process of *in vitro* fertilization in which oocytes are collected from one of the partners of the couple, are fertilized with sperm from a donor to create embryos, one or more of which will be implanted in the uterus of the other partner. One of the partners thus transmits her genes while the second partner will be pregnant with the child.[93]

There is a 2016 opinion from the Belgian Advisory Committee regarding the receipt of oocytes from the partner in a lesbian couple for *in vitro* fertilization.[94] The Committee considers that this method can be performed for medical or non-medical reasons. In addition, it is considered that if the couple is seen as an entity, it seems that the partner cannot be considered as a donor and therefore it is not a donation. There is a consensus within the Committee that both women must be thoroughly informed about the consequences of *in vitro* fertilization and will have to sign a contract, but also that fertilization centers have the right to refuse this practice by virtue of Article 5 of the law of July 6, 2007 and its conscience clause. However, there is still some controversy as to the appropriateness of *in vitro* fertilization in this context because of its higher cost to society.[95]

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[90] Art. 25 et 54, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[91] M. DERÈSE et G. WILLEMS, *Ibid*, pp. 344-345.
[92] Art. 26 et 55, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[93] https://www.leaetcapucine.com/post/tout-ce-que-vous-devez-savoir-sur-la-m%C3%A9thode-ropa-m%C3%A9thode-de-pma-pour-les-couples-lesbiens
[94] Comité consultatif de bioéthique, Avis n° 67 du 12 septembre 2016 relatif à la réception d'ovocytes issus de la partenaire au sein d'un couple lesbien en vue d'une fécondation *in vitro* (ROPA = Reception of Oocytes from Partner).
[95] Comité consultatif de bioéthique, Avis n° 67 du 12 septembre 2016 relatif à la réception d'ovocytes issus de la partenaire au sein d'un couple lesbien en vue d'une fécondation *in vitro* (ROPA = Reception of Oocytes from Partner).

§5 Some specific issues

A. Preimplantation genetic diagnosis

Preimplantation genetic diagnosis is defined in article 2, t) as the "*technique consisting, in the context of in vitro fertilization, of analyzing one or more genetic characteristics of in vitro embryos in order to gather information that will be used to select the embryos that will be implanted*".[96] Title VI of the law of July 6, 2007 is devoted to this diagnosis. This diagnosis must have a medical purpose, i.e. to avoid the birth of a sick or disabled child by using healthy embryos.[97]

Again, as with donation, the use of such a mechanism for the purposes of eugenics or sex selection - except where such selection makes it possible to exclude embryos with sex-linked diseases - is prohibited. The principle is therefore that such diagnosis is permitted except in the cases provided for by the law. Article 67 of the law states that "*The following are prohibited 1° preimplantation genetic diagnosis of a eugenic nature, as defined by article 5, 4°, of the law of May 11, 2003 on research on embryos in vitro, i.e. focused on the selection or amplification of non-pathological genetic characteristics of the human species; 2° pre-implantation genetic diagnosis based on sex selection as defined by Article 5, 5° of the Law of 11 May 2003 on research on in vitro embryos, i.e. based on sex selection, with the exception of the selection that allows the removal of embryos with sex-related diseases*".[98]

An agreement must be established between the author(s) and the fertilization center, if the conditions for such a diagnosis are met. This agreement must mention the agreement of the author(s) to this diagnosis, and in the case of a couple the agreement must be signed by both authors of the parental project. Two copies must exist: one for the fertilization center and another for the individual or individuals who are the authors of the parental project and who have decided to proceed with a preimplantation genetic diagnosis.[99] Prior to this Convention, Article 66 provides that the fertilization center must provide fair information about the diagnosis to the author or authors of the parental project.[100]

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[96] Art. 2, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[97] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.
[98] Art. 67, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[99] Art. 69, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[100] Art. 66, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.

This diagnosis can only be carried out, according to article 71, in a fertilisation center and in a human genetics center that have established a specific collaboration agreement.[101] Article 72 of the law provides that the number of centers authorized to carry out this diagnosis must be determined by the King through a Royal Decree deliberated in the Council of Ministers, issued after obtaining the opinion of the National Council of Hospitals, and this number may not be less than eight.[102]

B. "Medicinal" babies

Article 68 of the law of July 6, 2007 also deals with preimplantation genetic diagnosis and more precisely with a delicate question that is the subject of much controversy: the technique of the medicinal baby. This article states that: "*By derogation to article 67, the preimplantation genetic diagnosis is exceptionally authorized in the therapeutic interest of a child already born from the author(s) of the parental project. It is up to the fertilisation center consulted to estimate that, in the hypothesis mentioned in paragraph 1 of this article, the parental project does not have as its sole objective the achievement of this therapeutic interest. This assessment must be confirmed by the human genetics center consulted, whose opinion will be attached to the file*".[103] This diagnosis may therefore be carried out in the therapeutic interest of a child already born to the authors of the parental project, but the fertilisation center must ensure that the new parental project does not have this therapeutic interest for the child already born as its sole objective and that the child to be born is desired for its own sake.[104]

This issue of " medicinal " babies has important ethical implications. Many parliamentary debates have taken place on this controversial issue.[105] During these debates, some considered this practice to be problematic because the unborn child would be seen as being intended only for the purpose of curing the child already born, and it would therefore be difficult to know whether this unborn child is intended for its own sake or is used only as a "miracle baby" for the other child. The psychological risks of the unborn child must therefore be taken into

[101] Art. 71, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[102] Art. 72, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[103] Art. 68, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[104] G. SCHAMPS., « L'autonomie de la femme et les interventions biomédicales sur son corps en droit belge », *in* Aouij-Mrad, A. et Feuillet, B. (dir.), *Le corps de la femme et la biomédecine*, 1e éd., Bruxelles, Bruylant, 2013, pp. 50-51 ; M. DERÈSE et G. WILLEMS, *Ibid*, p.
[105] G. GENICOT, « La maîtrise du début de la vie : la loi du 6 juillet 2007 relative à la procréation médicalement assistée », *J.T.*, 2009/2, n° 6336, pp. 17-27.

consideration in such a process. On the other hand, others consider that the parents may want another child, who could also medically help another child already born.[106]

C. Post-mortem medically assisted reproduction

The law of July 6, 2007 authorizes the *post-mortem* implantation of supernumerary embryos or the *post-mortem* insemination of gametes, although this practice is destined to be exceptional.[107] Articles 15 and 44 state that if the authors of the parental project have requested cryopreservation of supernumerary embryos or gametes with a view to a subsequent parental project, this *post-mortem* procreation is possible. However, this medically assisted procreation can only be carried out if certain conditions are respected. Indeed, this *post-mortem* procreation must have been expressly provided for in the agreement between the authors of the parental project and the fertilization center referred to in articles 7 and 13 of the 2007 law.[108] There is also a time limit: this insemination or implantation can only take place at the earliest six months and at the latest two years after the death of one of the authors of the parental project.[109]

There are obviously many controversies about the appropriateness of this *post-mortem* medically assisted reproduction. Some criticize this practice in relation to the best interests of the child. Indeed, for some authors, it would be contrary to the principle of the best interest of the child to create an orphan child for the sole selfish will of the surviving parent, and the deliberate and voluntary organization of an orphan filiation leads to many discussions about its ethical character.[110] At the same time, the Advisory Committee on Bioethics affirms that an individual can decide on the fate of his or her body after death, and some consider that this can extend to his or her gametes if free and informed consent has been given.[111] The requirement of express written consent in the Convention on Medically Assisted Procreation is therefore an essential element in order to obtain the certainty that the author of the parental project agrees to the continuation of the project after his death.[112]

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[106] M. DERÈSE et G. WILLEMS, *Ibid,* pp. 349-350.
[107] G. GENICOT, « Section 2 - La maîtrise du début de la vie : la procréation médicalement assistée », *in Droit médical et biomédical*, 2e éd., Bruxelles, Larcier, 2016, p. 727.
[108]Art. 15 et 44, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[109] N. GALLUS, « Chapitre 9 - Procréation médicalement assistée », *in Filiation*, 1e édition, Bruxelles, Bruylant, 2016, pp. 167-168.
[110] N. GALLUS, « Chapitre 9 - Procréation médicalement assistée », *Ibid.*, 2016, p. 168.
[111] *Ibid*, p. 168.
[112] *Ibid*, p. 169.

These conditions must be put into perspective with the law of August 22, 2002 on the rights of the patient[113], and more precisely its article 8 on patient consent. The rule is that free and informed consent must be express, but it can also be tacit in certain limited cases concerning " common " medical acts. In the case of an important intervention, consent must therefore be express, without any formal requirements, and does not have to be in writing, unless the law requires otherwise.[114] In the present case, article 7 of the law of July 6, 2007, provides that an agreement on medically assisted procreation must exist, and one of the elements that must be included in this agreement is the fate of supernumerary embryos in the event of death.[115]

This problem of express and written consent to *post-mortem* reproduction is illustrated in Belgian jurisprudence, notably in a very recent judgment. A judgment of the Court of Appeal of Liège dated June 7, 2022 concerns - in an unprecedented way - the question of medically assisted *post-mortem* reproduction, and more precisely the *post-mortem* implantation of supernumerary embryos.[116] The Court had to rule on a litigious clause contained in a medically assisted procreation agreement concluded between the authors of the parental project and the fertilization center, since no choice had been made in the agreement as to the appropriateness of a *post-mortem* implantation.[117] The issue at stake is the following: the man of a married couple accepts, in the Agreement, the cryopreservation of gametes but decides that in case of death, these gametes should be destroyed. A second Convention, concerning in vitro fertilization and the fate of supernumerary embryos, was signed by the same married couple a few months later, but without any indication as to what would happen to the genetic material in the event of the man's death. In fact, the Convention contains a "yes" or "no" box to be ticked after the following sentence: "*In the event of the death of the male partner, the requesting couple wishes that it should be possible to carry out a post-mortem implantation of embryos at the end of a period of six months starting from the death of the partner and, at the latest, within two years following the death of the said author as provided for in the legislation*".[118] The authors of the parental project in question had not ticked any boxes in the Convention. After the death,

[113] Art. 8, Loi du 22 août 2002 relative aux droits du patient.
[114] M. PAULUS, « Procréation médicalement assistée post mortem : ne pas choisir, c'est renoncer ? », *R.T.D.F.*, 2022/2, p. 274.
[115] *Ibid.*, p. 275.
[116] Liège, 7 juin 2022, *For. fam.*, 2022/3, p. 114.
[117] M. PAULUS, « Procréation médicalement assistée post mortem : ne pas choisir, c'est renoncer ? », *R.T.D.F.*, 2022/2, pp. 272-279.
[118] *Ibid.*, pp. 272-273.

the center therefore refused to proceed with the implantation of the supernumerary embryos *post mortem*.[119]

The surviving author of the parental project then tried to take legal action against this decision of the fertilization center, but was dismissed in the first instance, the court considering that the condition of consent provided for by the law of July 6, 2007 had not been respected. On appeal, the Court of Appeal of Liège reformed the judgment of the court of first instance and condemned the fertilization center to the *post-mortem* implantation of the supernumerary embryos.[120] The Court considered, by virtue of article 5.64 of the Civil Code, that it was appropriate to seek the common intention of the authors of the parental project, and not to assimilate the absence of a ticked box to an absence of express consent. It is then on the basis of testimonies that the Court will conclude the intention of the deceased, which was to authorize this practice *post mortem*.[121]

Again, this interpretation opens the door to much debate and controversy. Some critics of this decision consider that such an interpretation is contrary to the 2007 law, which provides for explicit consent within the Convention.[122] Moreover, the 2007 law was adopted following a long process at the end of which ethical compromises were made, notably on the issue of *post mortem* procreation, which was allowed under strict conditions, including express consent within the Convention.[123] Some also criticize the use of the law of obligations and article 5.64 of the Civil Code for the case of *post mortem* medically assisted reproduction, claiming that the law of July 6, 2007 and its requirement of written consent was sufficient to resolve the case at hand, allowing for a different conclusion.[124]

[119] M. PAULUS, « Procréation médicalement assistée post mortem : ne pas choisir, c'est renoncer ? », *R.T.D.F.*, 2022/2, pp. 272-279.
[120] M. PAULUS, « Procréation médicalement assistée post mortem : ne pas choisir, c'est renoncer ? », *R.T.D.F.*, 2022/2, p. 273.
[121] *Ibid.*
[122] *Ibid*, pp. 276-277.
[123] *Ibid.*
[124] *Ibid*, pp. 276-278.

Chapter 2: Filiation

Section 1: General considerations

Filiation is not an aspect that has been regulated in the law of July 6, 2007. This law contains only two provisions on this subject: articles 27 and 56. These articles lay down the basic principles regarding filiation and state that from the time of implantation of supernumerary embryos or insemination of gametes, the rules of filiation as established by the Civil Code apply in favour of the author(s) of the parental project who have received said gametes. The second paragraph of these articles then states that no action relating to filiation or its patrimonial effects is open to the donors of embryos or gametes and that no action relating to filiation or its patrimonial effects may be brought against the donor(s) of embryos or gametes by the recipients and by the child born of this insemination.[125]

It is therefore the rules of "common law" and not the rules specific to medically assisted reproduction that will apply and be implemented when a child is born from this practice.[126]

These rules of common law in matters of filiation are generally based on biological ties. However, this common law often does not correspond to the reality of the situations of the authors of parental projects of medically assisted reproduction who are involved in various family configurations and various modes of conception.[127]

Medically assisted reproduction can be "homologous" or "heterologous". Medically assisted reproduction will be "homologous" when it is carried out using the genetic material of the authors of the parental project. In this case, there will normally be no problem in establishing filiation with the child, since the situation is similar to natural procreation carried out with the same genetic material.[128] Medically assisted reproduction is "heterologous" when it is carried out using the gametes of a third person. It will be more difficult to establish filiation when the authors have carried out a "heterologous" medically assisted reproduction, since at least one of the authors of the parental project has no biological link with the child.[129]

Belgium is trying to organize itself legally or at least to "manage" within its jurisprudence in order to allow the establishment of filiation between the child and his or her parents of

[125] Art. 27 et 56, Loi du 6 juillet 2007 relative à la procréation médicalement assistée et à la destination des embryons surnuméraires et des gamètes.
[126] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *in* Dandoy, N. et Willems, G. (dir.), *Les grands arrêts du droit au respect de la vie familiale*, 1e édition, Bruxelles, Larcier, 2022, pp. 343-344.
[127] S. CAP, *Ibid.*, pp. 343-344.
[128] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, pp. 343-344.
[129] *Ibid.*

intention.[130] The child would then be considered as a "conventional child": the Convention on medically assisted procreation would be the indispensable support of a bond of filiation organized sometimes outside of a biological reality. A law is therefore needed to organize the status of filiation, but the Convention is the necessary foundation of the link between the parents who are the authors of the parental project and the child.[131]

Section 2: The heterosexual couple

A distinction must be made between cases where the heterosexual couple carries out homologous or heterologous medically assisted procreation, but also whether this couple is married or unmarried, since the establishment of the bond of filiation with the authors of the parental project will depend on these various variants.

§1 The rules of common law

First of all, in the case of homologous artificial insemination or homologous *in vitro* fertilisation in a heterosexual couple, the rules of ordinary law of filiation apply. This is the least complicated case of the establishment of filiation following a medically assisted procreation process. The legal mother of the child, according to article 312 of the Civil Code, will be the woman who gives birth and the indication of her name in the birth certificate is mandatory.[132] If the woman who gives birth is married, there is a presumption of paternity towards the husband who will therefore be presumed to be the father of the child under article 315 of the Civil Code. If the couple is not married, the man may make a recognition of paternity - before or after the birth of the child - but this recognition requires the consent of the mother under Article 329bis, second paragraph of the Civil Code. If the mother refuses to give her consent to the recognition of paternity, the family court may grant a decision allowing such recognition, but only if it is considered to be in the interest of the child.[133] There is also an action for judicial establishment of filiation against the man, which can be requested by the mother or the child within thirty years when the couple is not married and which allows to impose paternity on the author of the parental project.[134]

When medically assisted reproduction is heterologous, even if a child is born from an egg donation, maternal filiation will always be established with regard to the woman who gives

[130] J. SOSSON ET H. MALMANCHE, *Ibid.,* p. 43.
[131] N. GALLUS., « Chapitre 9 – Procréation médicalement assistée », *in Filiation,* 1e ed., Bruxelles, Bruylant, 2016, p. 170.
[132] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui,* Limal, Anthémis, 2017, p. 125.
[133] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui*, *Ibid.,* p. 126.
[134] *Ibid.*

birth: the reality of the birth prevails over any dispute of filiation with regard to this woman, even if she does not in herself have a genetic link with the child.[135] The woman is therefore protected from any problem concerning the establishment of filiation with the child, but this is not always the case for the man who is the author of the parental project. The problem is that in the context of this heterologous medically assisted reproduction as far as heterosexual couples are concerned, the implementation of the common law of filiation may lead to the impossibility of "attaching" the child to the father of intention, the author of the parental project. In such cases, there are jurisprudential interpretations that have attempted to remedy these problems.[136]

In the case of a married couple having recourse to a heterologous medically assisted reproduction treatment consisting of sperm or embryo donation, there is no problem in establishing filiation with respect to the mother's husband. In fact, the presumption of paternity with respect to the woman's husband provided for in article 315 of the Civil Code applies.[137] The only rule in the Civil Code concerning medically assisted reproduction concerns this case. It is article 318, §4, which provides that "*The claim to contest the presumption of paternity is not admissible if the husband has consented to artificial insemination or to another act having procreation as its purpose, unless the conception of the child cannot be the consequence*".[138] Thus, filiation towards the husband is "secured".[139]

The establishment of filiation is more complicated for the man of the unmarried heterosexual couple, who had recourse to a sperm or embryo donation. Indeed, there is no presumption of paternity towards the man who is not married to the mother. In the event of disagreements between the authors of the parental project or in the event of the death of the man, certain obstacles to the establishment of filiation between the unmarried man and the child may arise, given that the common law rules of filiation require the existence of a biological link.[140]

An action for authorization of recognition is available to the unmarried man - under article 329bis, paragraph 2, third subparagraph of the Civil Code - in the event that the woman refuses to give her consent to the recognition. However, the judge will reject the application if there is evidence that the man is not the biological father. This proof being very easy to provide in the case of heterologous procreation, the man will often be deprived of the legal establishment of

[135] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, p. 345.
[136] *Ibid.*, p. 344.
[137] *Ibid.*, p. 345.
[138] C.civ., art. 318,§4.
[139] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, p. 345.
[140] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, p. 346.

filiation.[141] Conversely, a man who refuses to assume the paternity of the child will also create a blockage. Indeed, if the unmarried man of the parental project refuses to legally recognize the child, the mother will have to file a search for paternity under article 332 *quinquies*, paragraph 3 of the Civil Code, but this article provides for the rejection of the request by the court if it is proved that the man is not the biological father of the child.[142] An action in search of paternity will also have to be brought by the mother if the unmarried male parent died before he legally recognized the child. Again, in this case, the absence of a biological link will be a barrier to establishing filiation between the man and the child.[143]

§2 The impact of articles 27 and 56 of the law of 6 July 2007

In parallel with this requirement of a biological link required in the context of these two actions - action for recognition and search for paternity - the question arises as to the usefulness and role of the aforementioned articles 27 and 56 of the Act of 6 July 2007 in establishing filiation between the unmarried man and the child born of a heterologous medically assisted reproduction. Indeed, these articles provide that "*the rules of filiation apply in favour of the author or authors of the parental project*".[144] Questions have arisen as to the impact of these articles and of the commitment made by the authors of the parental project on actions for recognition or for a search for paternity, despite the absence of a biological link. Allowing filiation between the child and the unmarried man through articles 27 and 56 might seem satisfactory. However, this solution would go completely beyond the scope of these articles contained in the 2007 law.[145]

Indeed, if one adheres to the will of the legislator in the preparatory works, it seems that this principle allowing the rules of filiation to be applied in favour of the authors of the parental project applies only to relations between recipients and donors and is intended only to avoid an action being brought by one of them against the other. Moreover, these articles 27 and 56 of the law of July 6, 2007 are not of a nature that would allow them to derogate from the law of filiation.[146] Despite these positions refuting the possibility of using these articles to circumvent the requirement of a biological link between the child and the unmarried man in order to establish filiation, some case law demonstrates a bolder reflection on this subject.[147]

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[141] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.,* p. 346.
[142] *Ibid.*
[143] *Ibid.*
[144] M. DERÈSE et G. WILLEMS, *Ibid.*, p. 354.
[145] M. DERÈSE et G. WILLEMS, *Ibid.*, pp. 354-355.
[146] *Ibid.*
[147] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.,* p. 347.

First, the Court of First Instance of Dinant pronounced a judgment on March 5, 2009[148], in which it broadly interpreted articles 27 and 56 of the law of July 6, 2007, by accepting - in the context of a search for paternity action brought by the mother - the establishment of filiation between children born of heterologous medically assisted reproduction and the unmarried man who was the author of the parental project and who died before being able to recognize paternity.[149] The judge therefore allowed articles 27 and 56 to serve as a basis for the paternity action and to set aside the requirement of a biological link. However, some authors consider that this solution provided by the judge to respect the will of the authors of the parental project is unconvincing from a purely legal point of view.[150]

A similar decision was rendered a few years later, but this time concerning not an action to search for paternity but an action to authorize the recognition of paternity.[151] The Belgian judge accepted the establishment of filiation between an unmarried man and the child born of heterologous procreation, whereas the mother refused to give her consent in the context of an action for recognition of paternity.[152] This May 29, 2012 decision of the Brussels Court of Appeal states that Articles 27 and 56 were intended to set aside or modify the ordinary law rules of the Civil Code regarding filiation requiring a biological link. These articles would indeed allow to replace these rules by equivalent rules benefiting the father who is the author of the parental project and who has signed a medically assisted reproduction agreement.[153] It would therefore be, in this decision as well as in the decision of March 5, 2009, by virtue of the commitment made in the Convention on medically assisted reproduction that articles 27 and 56 would allow the establishment of filiation even in the absence of the biological link normally required by the common law. However, these two decisions concern two men who were willing to invest in the parental project. It is therefore unclear how a court would interpret a search for paternity action against an unmarried man who no longer wishes to be associated with the medically assisted reproduction project.[154] Furthermore, it is important to highlight the fact that the doctrine is divided regarding these decisions and solutions interpreted from articles 27 and 56 of the law of July 6, 2007.[155]

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[148] Civ. Dinant (1re ch.), 5 mars 2009, *Rev. trim. dr. fam.* p. 1095.
[149] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.,* pp. 347-348.
[150] *Ibid.*
[151] Bruxelles (3e ch.), 29 mai 2012, *T. fam.*, 2013, p. 201.
[152] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.,* p. 348.
[153] *Ibid.*
[154] *Ibid.*
[155] *Ibid.*

An opinion of June 21, 2004 of the Advisory Committee on Bioethics was, moreover, rendered before the adoption of the 2007 law, in which the Committee had nevertheless emphasized the importance of adopting a principle concerning unmarried couples who have a parental project, making it possible to avoid the possibility that the partner may refuse to recognize the child or that the mother or the child may contest the paternity. To this end, the Committee had issued a proposal to legally require recipients of a donation and authors of the parental project to sign a document establishing them as "incontestable parents".[156]

§3 The ruling of the Constitutional Court of February 7, 2019

The February 7, 2019 ruling of the Constitutional Court is an important ruling in the evolution of the establishment of filiation between the child and the unmarried man who does not contribute his genetic material to the procreation. The basic rule, as explained above, is the application of the common law rules of filiation for heterosexual couples, despite the obstacles encountered and the attempts of some jurisdictions to distance themselves from the rigidity provided. However, this February 7, 2019 ruling will be the repair of this legislative inconsistency.[157]

In this case, the Mons tribunal was confronted with a search for paternity action of a deceased unmarried man who had not contributed his genetic material to the procreation. The court had decided - contrary to the decisions of March 5, 2009 and May 29, 2012 - that Articles 27 and 56 did not allow for a departure from the requirement of Article 332 *quinquies*, paragraph 3 and that the request should therefore be dismissed. The judge nevertheless decided to question the Constitutional Court.[158]

The Constitutional Court will affirm that Article 332 *quinquies*, paragraph 3 - requiring a genetic link - violates Articles 10, 11 and 22 of the Belgian Constitution by depriving a child born of heterologous medically assisted reproduction by an unmarried heterosexual couple of the possibility of establishing his or her filiation with respect to his or her father of intention.[159] The Court concluded that the impugned provision is "*unjustified when applied in the context of*

[156] G. SCHAMPS, « Les incidences de la biomédecine sur la parenté : le hiatus entre les actes liés à la procréation médicalement assistée et l'établissement de la filiation en droit belge », *in* Crespo-Brauner, M.-C. et Feuillet-Liger, B. (dir.), *Les incidences de la biomédecine sur la parenté*, 1e éd., Bruxelles, Bruylant, 2014, pp. 65-66.
[157] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, p. 350.
[158] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation *in vitro* », *Ibid.*, p. 351.
[159] N.GALLUS, « L'apport de la jurisprudence de la Cour constitutionnelle au droit de la filiation », *Pli juridique*, 2021/55, pp. 29-30.

a paternity action concerning a child born through the use of heterologous medically assisted reproduction".[160]

The Court analyses the question from the point of view of the difference in treatment between children born as a result of heterologous procreation within a heterosexual couple, as a result of homologous procreation or procreation within a female couple. The result of the establishment or not of the second filiation link will thus depend on these variants. These differentiation criteria were considered by the Court to be objective, but they had to be assessed in light of the objectives pursued by the provision.[161] In doing so, the judges took into account the fact that the legislature had not foreseen the case of filiation to an unmarried man following heterologous procreation when the provision at issue was adopted. At the same time, the Court notes that in other provisions - notably article 318, paragraph 4, mentioned above, which provides for the case of a married heterosexual couple - the legislature gives precedence to the will of the authors of the parental project over the biological bond.[162] Articles 27 and 56 are also taken into account in the Court's reasoning, which finds that the intention of the legislature was to give precedence to intentional filiation over biological filiation.[163]

The Court then stated that the establishment of a second parent-child relationship must be considered, save in exceptional circumstances, to be in the best interests of the child. Moreover, this double filiation link is also considered to be an essential element of the child's identity. Article 332 *quinquies*, paragraph 3, therefore prevents the establishment of the paternity of the author of the parental project as a result of heterologous medically assisted reproduction, which constitutes a disproportionate infringement of the child's right to respect for private and family life, as well as of his or her best interests.[164]

Specifically, the consequences of this ruling of February 7, 2019, will be that judges who have to rule on similar cases will have to disregard the application of Article 332 *quinquies*, paragraph 3 of the Civil Code, and will be able to cite and mobilize this ruling of the Constitutional Court in order to render their judgment, without having to ask a new preliminary question.[165]

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[160] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 353.
[161] *Ibid.*, pp. 351-352.
[162] *Ibid.*
[163] *Ibid.*
[164] G. WILLEMS, « 1. - La définition de la vie familiale », *in* Dandoy, N. et Willems, G. (dir.), *Les grands arrêts du droit au respect de la vie familiale*, 1e éd., Bruxelles, Larcier, 2022, p. 14.
[165] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 353.

Section 3: The female couple

The establishment of a double bond of filiation in the case of a female couple originally required that one of these women go through the stage of adopting the child born from a process of medically assisted reproduction, involving a judicial procedure and a review of the child's interest. This principle was overturned by the adoption of the law of May 5, 2014 establishing the filiation of the co-parent, and which inserted articles 325/1 to 325/10 within the Civil Code.[166]

Indeed, blockages as to the establishment of this double bond of filiation sometimes existed during the adoption process, as certain conditions required in order to proceed with the adoption could cause problems, especially in case of separation or disagreement of the couple.[167] It was therefore deemed preferable to secure filiation for the female couple through the law of May 5, 2014. These difficulties could materialize in that the legal mother could refuse to consent to the adoption of the child by her partner under Article 348-3 of the Civil Code, while the condition of cohabitation provided for in Article 343, paragraph 1, b) of the Civil Code was no longer necessarily met[168], which had the consequence of preventing the co-author of the parental project to be legally bound to the child.[169]

Again, the Constitutional Court intervened, finding a violation of the Constitution in two rulings on July 12, 2012.[170] The Court considered that it was not acceptable that the mother's companion be excluded when there is a common parental project between the two women.[171] The legislator then took into account this case law and allowed the establishment - by the law of May 5, 2014 - of a filiation link with regard to the co-parent, which is a link of origin and no longer a link established by judicial decision, by applying legal rules aligned with the rules of "carnal" filiation.[172] The authors of the proposed law considered that it was already difficult and sometimes long enough to go through a process of medically assisted reproduction than to have to go through a long procedure of adoption.[173] Of course, various reservations and controversies

[166] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui*, *Ibid.*, p. 142.
[167] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 349.
[168] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui*, *Ibid.*, p. 142.
[169] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 349.
[170] C. const., arrêts n°93/2012 et 94/2012.
[171] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 349.
[172] *Ibid.*
[173] Proposition de loi portant établissement de la filiation du co-parent, Doc. parl., Sénat, sess. 2013-2014, n° 5-2445/1, p. 5.

surrounded the adoption of this law, even though the legislator finally decided to take this important step allowing security for both women in the couple.[174]

This law of May 5, 2014 will then be introduced into the Civil Code by a chapter entitled "Of the establishment of filiation with respect to the co-parent". This chapter contains a specific regime for the filiation of a child born of a parental project shared between a couple of women and allows the establishment of a double bond of filiation.[175] In reality, the legislature has chosen to "copy and paste" the rules applicable to maternal and paternal filiation, by replacing the reference to the biological bond with a reference to the consent of both women to the medically assisted reproduction project.[176] In fact, the biological link is in principle absent with regard to the co-parent, so it was necessary not to base the decision on this link but on the consent to the project materialized by the agreement signed with the fertilization center.[177] Therefore, for the couple of women there is a presumption of comaternity provided for in article 325/2 of the Civil Code, an acknowledgement of comaternity provided for in article 325/4 of the Civil Code, and a search for comaternity provided for in article 325/8 of the Civil Code.[178]

Obviously, the contrast between these legal provisions introduced by the law of May 5, 2014 for women's couples and the classic regime provided in the Civil Code for heterosexual couples is disconcerting. Specific provisions to address the issues faced by female couples have been created, whereas this is not the case for heterosexual couples.[179]

Section 4: Filiation in the case of *post-mortem* reproduction

Once again, difficulties exist in establishing filiation between the father and the child when medically assisted reproduction is *post mortem*.

First of all, the establishment of filiation in this specific case has not been regulated by the legislator. Moreover, if the couple is married, the presumption of paternity will not apply. Indeed, the implantation or insemination cannot take place before six months after the man's death. The presumption of paternity only applies when the child is born during the marriage or within 300 days following the annulment or dissolution of the marriage, which could never be

[174] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 349.
[175] *Ibid.*, p. 350.
[176] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui*, *Ibid.*, p. 144.
[177] S. CAP, « 4.3.1. - L'insémination artificielle et la fécondation in vitro », *Ibid.*, p. 350.
[178] *Ibid.*
[179] *Ibid.*

the case in this instance.[180] Recognition of paternity will also not be possible in the case of *post-mortem* medically assisted reproduction. Indeed, in order to be able to make a recognition of paternity, the child must be conceived. The child is presumed to be conceived in the period from the 300th to the 180th day before its birth.[181] In Belgian law, it cannot currently be considered that the conception of the child can take place at the time of cryopreservation or *in vitro* fertilization. The conception of the child therefore corresponds with the beginning of the pregnancy, i.e. at the moment of insemination or implantation in the context of medically assisted reproduction.[182] The only possible action is therefore a paternity action, which can be brought by the mother or the child within 30 years from the birth.[183]

From an inheritance point of view, even if filiation is established between the father and the child born of a *post-mortem* medically assisted reproduction, this filiation will have no effect on the succession. In fact, the child must have been conceived when the succession is opened.[184]

Chapter 3: Surrogate motherhood

Section 1: The absence of a legal framework

§1 General considerations

The law of July 6, 2007 does not apply to surrogate motherhood. There is currently no legal regulation in Belgium specifically for surrogate motherhood. This practice is therefore neither prohibited nor authorized.[185]

Several legislative proposals related to surrogate motherhood, however, have been introduced - by parliamentarians with various political affiliations - in the House of Representatives during the 2010-2014 and 2014-2019 legislatures. The Senate, in 2015, released a major report reflecting a wide-ranging work of reflection on the issue of surrogacy.[186] This work is the result of numerous hearings allowing each Belgian political party represented in the legislative assemblies to give its point of view as to the advisability of adopting legislation on surrogate

[180] G. SCHAMPS, « Les incidences de la biomédecine sur la parenté : le hiatus entre les actes liés à la procréation médicalement assistée et l'établissement de la filiation en droit belge », *in* Crespo-Brauner, M.-C. et Feuillet-Liger, B. (dir.), *Les incidences de la biomédecine sur la parenté*, 1e éd., Bruxelles, Bruylant, 2014, p. 72.
[181] *Ibid.*
[182] J. SOSSON, *Procréation médicalement assistée et gestation pour autrui*, *Ibid.,* p. 138.
[183] *Ibid.*
[184] G. SCHAMPS, *Ibid.*, p. 72.
[185] P. TAPIERO, « 4.3.2. - La gestation pour autrui », *in* Dandoy, N. et Willems, G. (dir.), *Les grands arrêts du droit au respect de la vie familiale*, 1e éd., Bruxelles, Larcier, 2022, p. 368.
[186] *Ibid.*, p. 369.

motherhood.[187] The report highlights a consensus on the common will to legally regulate surrogate motherhood, but also on certain common guidelines to be contained in the law in question.[188] In addition, the majority of the parties are in favour of a ban on commercial surrogacy.[189] This report should logically form the basis for the discussion of the legislative proposals introduced or to be introduced.[190]

Many authors, politicians, as well as jurisdictions have highlighted the need for action and legal regulation of surrogate processes.[191]

§2 In practice

Despite the absence of a legislative framework, surrogate motherhood is practiced in Belgium, either in private or through a medical center. However, this practice is not widespread in fertilization centers, due to the limited number of medical indications, the lack of a legal framework that makes the practice insecure, and the psychological, ethical and medical aspects that may discourage medical services.[192]

Some fertilization centers nevertheless agree to accompany patients in a surrogate process. These hospitals set their own terms of access.[193] These terms and conditions may include the civil status of the intended parent(s), i.e. whether surrogacy is open to a single woman, a single man, a homosexual or heterosexual couple, as well as the civil status of the surrogate mothers.[194]

The centers may also determine whether or not the intended parents need to provide some or all of the genetic material. In fact, there are two types of "surrogacy". There are "low-tech" processes where the surrogate mother provides her eggs, and "high-tech" processes where the eggs are provided by the intended mother or by a donor.[195]

In addition, centers may include the need for a prior relationship between the intended parents and the surrogate mother, the requirement that the surrogate mother has been pregnant before,

[187] J. SOSSON et H. MALMANCHE, « Etat du droit belge en matière de procréation médicalement assistée et de gestation pour autrui », *in* Les mutations contemporaines du droit de la famille, 2020, p. 50.
[188] P. TAPIERO, *Ibid.*, p. 369.
[189] J. SOSSON et H. MALMANCHE, p. 50.
[190] *Ibid*., p. 51.
[191] P. TAPIERO, *Ibid.*, p. 369.
[192] C. AUTIN, « Gestation pour autrui : expérience d'un centre belge de procréation médicalement assistée », *in La gestation pour autrui : vers un encadrement ?*, 1e éd., Bruxelles, Bruylant, 2013, p. 9.
[193] J. SOSSON et H. MALMANCHE, p. 49.
[194] *Ibid.*
[195] G. WILLEMS, « La gestation pour autrui : brève synthèse des réflexions relatives à un éventuel encadrement législatif », *A.D.L.*, 2014/1, pp. 113-121.

and requirements regarding the residence or nationality of all parties.[196] In any case, surrogate motherhood will not be commercial.[197]

The University Hospital of St. Pierre in Brussels is an example. This center only performs "high-tech" surrogate pregnancies, so that the surrogate mother has no genetic link with the child and the intended parents are always the genetic parents. The choice in this center has been not to accept cases requiring gamete donation and surrogacy.[198] In addition, the indications for the use of surrogacy considered by this center are classified into three categories. First, there are absolute indications: the presence of congenital absence of uterus, hysterectomy or non-functional uterus is examined. Then there are relative indications: are there pathologies that contraindicate pregnancy? Finally, there are questionable indications consisting of repeated miscarriages or repeated *in vitro* fertilization failures.[199]

The Saint-Pierre center has also developed a procedure for handling surrogate pregnancies. First of all, there is an evaluation of the surrogacy project divided into five steps. The first step is the telephone reception, which involves the center's secretariat, which will explain to the authors of the parental project the conditions for access to a surrogate pregnancy as well as the procedure that they will have to follow. At St. Pierre's Hospital, the conditions for entering into a surrogacy process are the above-mentioned medical indications, as well as the age of the intended mother, who must be under 43 years old, and the age of the surrogate mother, who must be under 40 years old. The surrogate mother must already be a mother, in good health and without obstetrical risk.[200] After this telephone reception, there will be a consultation with a specialized lawyer, then a consultation with the gynecologist, but also a consultation with the psychiatrist or psychologist. The last step in the evaluation of the surrogacy project will be the presentation of the project to the medical team. This presentation will be followed by a collegial decision and the announcement of this decision to the couple.[201]

After the evaluation of the project and if it is accepted, the intentional couple and the surrogate mother will have to meet again in order to establish the medical file and the list of examinations to be performed before the treatment. The administrative formalities will also have to be

[196] G. WILLEMS, « La gestation pour autrui : brève synthèse des réflexions relatives à un éventuel encadrement législatif », pp. 113-121.
[197] *Ibid.*, p. 50.
[198] C. AUTIN, *Ibid.*, p. 11.
[199] C. AUTIN, *Ibid.*, p. 11.
[200] *Ibid.*, p. 12.
[201] *Ibid.*, pp. 12-15.

settled.[202] The surrogate treatment can then finally begin: it will be an *in vitro* fertilization. In addition, during the whole process, all parties to the surrogacy procedure may request the support of a psychiatrist or psychologist.[203]

§3 The Surrogacy Agreement

As Belgian law currently stands, the Surrogacy Convention is null and void. Indeed, it would disregard the general principles of the indisponibility of the human body: the body of the surrogate mother and of the child cannot be the object of a contract. This Convention would also undermine the principles of the status of persons by diverting the legal rules for establishing filiation.[204]

Section 2: Filiation and adoption

Despite the nullity of the surrogacy agreement between the intentional parents and the surrogate mother, Belgian law on filiation and adoption is used in practice to find solutions to link the child born of surrogacy to its intentional parents.[205]

Under Belgian law, the woman who gives birth is considered the legal mother of the child, according to the principle *Mater semper certa est*, and independently of the intervention of another woman in the procreation process. The surrogate mother will therefore be considered the legal mother of the child she has given birth to.[206]

In addition, two situations must be differentiated: the case where the surrogate mother is married and the case where she is not married.

First, when the surrogate mother is not married, the father of intent or the co-parent of intent will be able to establish filiation through a recognition of the child under article 319 of the Civil Code, if the surrogate mother consents. This is not the case for the spouse of the father of intention or the co-parent.[207] Indeed, the classical rules of filiation do not allow the maternal filiation to be attributed to the mother of intention.[208] It will therefore be necessary to go through an adoption process.[209]

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[202] C. AUTIN, *Ibid.*
[203] *Ibid.*
[204] P. TAPIERO, *Ibid.*, p. 368.
[205] G. WILLEMS, « La gestation pour autrui : brève synthèse des réflexions relatives à un éventuel encadrement législatif », *A.D.L.*, 2014/1, p. 114.
[206] P. TAPIERO, *Ibid.*, p. 370.
[207] *Ibid.*
[208] G. WILLEMS, « La gestation pour autrui : brève synthèse des réflexions relatives à un éventuel encadrement législatif », *Ibid.*, p. 115.
[209] P. TAPIERO, *Ibid.*, p. 371.

Secondly, when the surrogate mother is married, the process is more complicated for the father of intention.[210] The surrogate mother's husband or co-parent will be legally recognized as the father or co-parent of the child by virtue of the presumption of paternity or co-parenthood. An action to contest paternity or co-paternity will then have to be brought by the father or the co-parent of intention in order to reverse the presumption and allow the establishment of his or her own filiation with the child born of the surrogate mother.[211] According to article 318, paragraph 5 of the Civil Code, a double proof must be provided: the non-paternity or non-comaternity of the surrogate mother's husband or wife, but also the biological paternity or comaternity of the parent of intention. However, the same legal provision states that this claim is not admissible if the surrogate mother's spouse has consented to an act having procreation as its purpose.[212]

The intended mother will be able to adopt the child, but this requires the consent of the surrogate mother. For male couples, the adoption of the child is also possible for the second intentional father. Since 1996[213], Belgian courts have been ruling on the adoption of children born through surrogate motherhood. The courts consider that the children should not be punished and that it is in their best interest to be legally attached to their parents.[214] Most of the time, Belgian courts and tribunals consider that the requirements of "just motives" and "respect for the child's interest" required in order to be able to adopt are fulfilled and therefore pronounce the full adoption of the child by the parents of intention.[215]

In addition, the issue of filiation had also been the subject of debate and controversy in the report prepared by the Senate in 2015. Some consider that the solution would be to directly legally attach the child born from surrogate motherhood to the parents of intent, without first legally attaching the child to the surrogate mother.[216] Others take the opposite position and consider it necessary to continue to operate through adoption, which allows the surrogate mother to change her mind by refusing to consent to the adoption and thus to the transfer of filiation.[217]

[210] J. SOSSON., « Mère porteuse mariée : danger ? », *Rev. trim. dr. fam.*, 2014/3, pp. 629-637.
[211] P. TAPIERO, *Ibid.*, p. 370.
[212] P. TAPIERO, *Ibid.*, p. 370.
[213] Tribunal de la jeunesse de Bruxelles, 4 juin 1996, *Jurisprudence de Liège, Mons et Bruxelles*, p. 1182.
[214] J. SOSSON ET H. MALMANCHE, *Ibid.*, p. 52.
[215] *Ibid.*
[216] P. TAPIERO, *Ibid.*, p. 371.
[217] *Ibid.*

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