



Women's Health West

**Submission to the
Victorian Law Reform Commission
in response to**

Position Paper 2: Parentage

**of the Commission's Enquiry
'Assisted reproductive technology
and adoption – should the current eligibility criteria
in Victoria be changed?'**

31 August 2005

Introduction

Women's Health West has been working to advance the health, safety and wellbeing of women in Melbourne's Western Region since 1988. Women's Health West is the largest regional women's health service in Victoria, and the largest family violence support service in the Western Region.

Women's Health West regards health as much more than the absence of illness or injury. We believe health and wellbeing are determined by various environmental, economic, social and cultural factors including gender, sexuality, ethnicity, class, age and ability. Broad social issues that impact on women's health and wellbeing include sexual and family violence, social isolation, poverty and restrictions on reproductive freedom. Discrimination also affects the health of various groups such as immigrant and Indigenous women, single mothers, women with a disability and lesbian/same-sex attracted women and their families. Discrimination is often both social and institutional. Homophobia, for example, is both present in social attitudes and embedded in institutions including health and community services, law, and the operations of government.

Women's Health West's activities include health promotion with marginalised groups in the community. In 2003 we worked with lesbian and same-sex attracted women in the Western Region to organise 'Go Girls!', a one-day health promotion forum. It aimed to provide a safe space for lesbians and same-sex attracted women from the Western Region to come together, receive health information on a range of issues and express their own health needs. The forum included several speakers and workshops – amongst the most popular on the day – for lesbian and same-sex attracted women who are already parents, or who are planning parenthood.

The Go Girls! forum was also an opportunity for Women's Health West to learn more about the health needs and issues of lesbians/same-sex attracted women, who are a far from homogenous community. One of the most important overall learnings can be summarised in the words of Dr Ruth McNair – GP, academic and lesbian health lobbyist – who said, 'Homophobia is a health hazard, not homosexuality'. This is echoed in the findings of *Beyond Symptoms*, the WHW regional health needs analysis: 'Lesbians are not at greater risk of reduced health outcomes because they are lesbian, but rather because they face discrimination, stigmatisation and a dominant culture that vilifies them or renders them invisible.' (WHW 2002)

Social and institutional homophobia has a range of impacts on the health and wellbeing of lesbian/same-sex attracted women and their children. Impacts of social homophobia on mental health and emotional wellbeing can include loss of family and community of origin, social isolation and depression. *Beyond Symptoms* found that 'Ignorance and insensitive practices on the part of health service providers can also result in discrimination (VGLRL 2000). This may result in lesbians delaying or avoiding treatment, under-using particular health services (e.g. breast and cervical screening) and using a variety of services including alternative practitioners which may result in fragmented care.' (WHW 2002)

Homophobia in the law, for example in the area of domestic and parental relationship recognition, and access to ART impacts not only on emotional wellbeing, but on a range of other aspects of the health of lesbian/same-sex attracted women and their children.

Responses in this submission arise from research, learnings from the Go Girls! Forum and information gathered from contact with specialist legal and health practitioners and community consumer and advocacy groups, including the Fertility Access Rights Lobby, Prospective Lesbian Parents and the Lesbian Parents Project Group.

Responses to the Commission's Interim Recommendations and key questions

The Commission's Principles

2.36 The question for the commission is whether the law that governs the legal parentage of children born to single women or women in same-sex relationships is in need of reform, particularly if eligibility criteria for access to ART are expanded. The commission was guided in its consideration of this question by the following principles.

- In considering the law that determines who is to be recognised as a legal parent of a child, the best interests of the child should be the paramount consideration. This is consistent with the *Convention on the Rights of the Child*.
- The best interests of children require certainty about the status of their parents. Certainty about parental status at the earliest possible time minimises the potential for disputes and litigation about a person's obligations and status in respect of the child, and promotes stability in the child's life.
- It is in the best interests of children for their parents to be subject to all of the usual parental obligations and responsibilities.
- It is in the public interest for people who become parents to be subject to all of the laws that flow from the parent-child relationship.
- It is important for people to appreciate the responsibilities that accompany parenthood, in particular the needs of donor-conceived children, and to plan their arrangements before the child is born.
- The law should aim to eliminate discrimination against children and parents based on their family type and relationship status. Legal recognition of diverse family types is an important way of countering discrimination.

Women's Health West strongly supports all of the Commission's principles outlined above.

Our submission is also based on the following additional key principles:

- That the best interests of children are served when their family structures are given fully equal recognition and protection under the law, and that this in turn has a positive impact on reducing discrimination in social attitudes against same-sex parented families.
- That children should not be in any way disadvantaged under law by the time, method or place of their conception ie that equal protection should apply to all children conceived via donated gametes, including through recognition and protection of their parental and sibling relationships, and clarification of the status of their donor/s.
- That women should have control over their own fertility, and reproduction should remain as autonomous as possible ie women should not be effectively 'coerced' into potentially unnecessary medicalisation of their fertility by laws that impact on their prospective children.
- That a number of interim recommendations made by the Commission are interdependent (e.g. third parent adoption by donors depends on certainty of parental status of the non-birth/non-biological parent) and that final recommendations should be presented as a 'suite' rather than as independent recommendations.

Interim Recommendation 1

The law should recognise the birth mother's female partner as a parent of the child.

Women's Health West strongly supports this recommendation, and argues that the principle should be extended to male same-sex parents.

Interim Recommendations 2 to 7

2. The *Adoption Act 1984* should be amended to provide that the female partner of a woman who gives birth to a child conceived as the result of a treatment procedure carried out in a clinic licensed pursuant to the *Infertility Treatment Act 1995* should be deemed to have adopted the child (without extinguishing the birth mother's status) and to be the adoptive parent of the child if:

- she consents to the birth mother undergoing the procedure leading to the child's conception;
- she receives appropriate counselling, including information as to the legal parentage of the child; and
- she is living with the birth mother on a genuine domestic basis at the time of the treatment procedure.

3. Deemed adoption should take effect at the time the child is born.

4. A woman who is deemed to be the adoptive parent of the child should be entitled to be registered as a parent of the child on the Registry of Births, Deaths and Marriages. A letter from the clinic should be sufficient to satisfy the registrar that the partner is the adoptive parent of the child.

5. The *Births, Deaths and Marriages Registration Act 1996* and Regulations should be amended to replace references to 'mother' and 'father' with 'parent(s)'. The registry should also be required to produce revised birth registration forms and birth certificates.

6. Section 8 of the *Status of Children Act 1974* should be amended to provide that 'Where the name of the ~~father~~ parent of a child is entered in the register of births in the Register maintained under the *Births, Deaths and Marriages Registration Act 1996* in relation to the child a certified copy of the entry purporting to be made or given under section 46 of that Act shall be prima facie evidence that the person named as the ~~father~~ parent is the ~~father~~ parent of the child'.

7. The operation of section 10 of the *Status of Children Act 1974* should be expanded to enable the Supreme Court to make declarations of parentage in relation to children to whom Interim Recommendation 2 applies.

Key Question 3. If a same-sex couple has had a child as a result of treatment provided in a Victorian clinic prior to the introduction of the proposed amendments and can provide evidence that they complied with the consent and counselling requirements of the *Infertility Treatment Act*, should the non-birth mother be deemed to have adopted the child?

Women's Health West supports the principle of the deemed adoption recommendation, in particular its attempt to bring same-sex parented children under the protection of various federal laws including those related to child support, Medicare, transport accident and workplace compensation, tax and family law. We also support all subsequent amendments to Victorian legislation relating to birth registration and certificates.

However on advice from affected community members and the Fertility Access Rights Lobby, Women's Health West also supports an approach in line with that taken in other Australian states including the ACT and WA, through amendment of the Victorian *Status of Children Act 1974* and all other relevant legislation to recognize same-sex domestic partnerships, as defined in the *State Law Amendment (Relationships) Act 2001*.

This approach represents full equality with opposite-sex parents for the purposes of Victorian law, in line with the principles outlined by WHW above, and would automatically and retrospectively cover all children, whether conceived within or outside a Victorian clinic. Such an automatic provision would also be in children's best interests, as it would not require their parents to 'opt in' to a mechanism that they may not know about, feel comfortable with or be able to afford.

We are advised that combining this approach with the Commission's recommended 'deemed adoption' and 'abridged adoption' (see below) approaches may raise legal issues around people 'adopting' children who for the purposes of Victorian law are already theirs, however we urge the Commission to seek a solution to such issues given the benefits of the *Status of Children* approach.

If the Commission retains the 'deeming' approach, we argue for its extension to all children conceived where consent and counselling can be shown. This could include not only children conceived through a Victorian clinic after the law changes (as the Commission recommends), but also:

- Children conceived through the Victorian clinic system before the law changes;
- Children conceived before *and* after the law changes through the Victorian clinic system for storage and screening of "known donor sperm for self-insemination", which has the same consent and counselling requirements; and
- Children conceived outside the Victorian clinic system after the law changes, for example through home insemination (including where the storage and screening service is not used), where consent is demonstrated through a consent and counselling process conducted by an accredited counsellor (see below).

Women's Health West has argued in both its previous submissions for removal of discriminatory access to Victorian clinics. However we note that some women will continue to prefer home insemination, and we argue strongly for their right to do so. Control over reproductive decision-making is crucial to women's freedom and equality. Legislating for medical control over a safe and simple procedure would be a regressive step. It reduces women's control over their own bodies, and because it cannot be policed, has the potential to create an underground trade in gametes which is not in the best interests of the child.

For this reason we also argued in our response to Position Paper 1 for retention of the service (currently only available at Melbourne IVF) of storage and screening of "known donor sperm for self-insemination", however we note that the expense (approximately \$800 minimum) and relative inaccessibility of the service will continue to deter some women from using it. Hence we would also argue strongly that such a service should be free, or at least heavily subsidised by Medicare. This would ensure more women will use it, which is in the best interests of the child.

We argue that all women and men attempting to conceive using donor gametes should be strongly encouraged to seek medical support in the form of screening for HIV and other STIs and pre-pregnancy health tests. Decriminalisation of home insemination as recommended in Position Paper 1 should help improve the willingness of health providers to give this kind of support. To assist this process we also recommend promotion of relevant information to GPs, community and women's health nurses and to all prospective parents.

In addition we recommend that the deeming provision be extended, as outlined above, to families who conceive their children outside the clinic system. We argue that a combination of encouraging screening and medical support, along with a counselling and consent process conducted by an accredited counsellor, is adequate to protect the interests of children.

Women's Health West is strongly supportive of a consent and counselling process that is useful for all parties. It should include the provision of accurate, exhaustive legal information, as well as exploration of all the relevant issues such as parenting roles and expectations, levels of contact, health issues, economic arrangements, issues for children of donor gametes and dealing with changing expectations. We acknowledge that the task for counsellors is a complex one, and suggest that support and resources be made available to ensure that, for example, they are able to cover the complex legal issues, and that can refer people to an appropriate health provider for all the necessary health checks and screening.

We suggest that this counselling be available not only prior to conception, but that there be the option of ongoing counselling as required, for example if needs or expectations change. We refer the Commission to the Bouverie Centre submission, given their research and family therapy expertise, for more discussion of a recommended process. We also recommend a training/accreditation process be developed in consultation with experts and affected community members, and that it be promoted to all counselling staff in Victorian fertility clinics.

Key Question 1

We seek your views and comments, particularly from family law and adoption experts, about whether the concept of deemed adoption would be effective for the purposes of federal law.

Women's Health West has no expertise in this area, but have been advised by community advocacy groups who have sought legal advice that it is far from certain whether deemed adoption will be effective for the purposes of federal law. Given the current homophobic federal political environment, we ask whether the attempt to bring same-sex families in through the 'back door' of adoption might carry the risk of provoking test cases and/or amendment to federal laws such as the *Family Law Act*, to exclude deemed and other 'new' forms of adoption.

Interim Recommendations 8 to 10

8. Where a woman without a male partner becomes pregnant as the result of a donor treatment procedure carried out:

- outside the licensed clinic system; or
- in another state, territory or country; or
- before the legislation was amended;

it should be possible for the partner of the birth mother to adopt the child (without extinguishing the birth mother's status).

9. In these circumstances it should be presumed that:

- exceptional circumstances exist which warrant the making of an adoption order; and
- the making of a parenting order under the *Family Law Act 1975* in relation to the child would not make adequate provision to serve the welfare and interests of the child.

10. The Department of Human Services should be able to intervene in the adoption application if the applicant is manifestly not a fit and proper person to adopt the child.

As stated, Women's Health West prefers a *Status of Children*-type approach that gives equal protection to all children conceived using donor gametes for the purposes of state law. However, we also support the principle outlined by the Commission for an 'abridged' form of adoption, arguing that it should be available to non-birth/non-biological parents of children conceived outside a Victorian clinic *prior* to the law changing. As argued in response to Interim Recommendations 2 to 7, all other children of same-sex parents (whether conceived before or after the law changes) should be covered by the deemed adoption mechanism.

Key Question 2

We seek your views and comments about how an abridged form of adoption could operate in practice.

If the Commission retains its recommendation of 'abridged adoption', Women's Health West argues that the process should be very simple. Given our argument (above) that it should only apply to same-sex parents who planned, conceived and have raised their children together since birth, the process should be as simple as the lodging of a letter or statutory declaration (along with any other documentation available, such as the original birth certificate, Family Court parenting orders etc) with the relevant authorities.

We argue strongly against any form of surveillance or 'intervention' by the Department of Human Services. If, as we argue, this 'abridged' form of adoption is the remedy offered to same-sex parents who have raised their children together from birth, such an intervention would be inappropriate. The problem the Commission seeks to remedy in the case of these parents is an unjust and discriminatory law. This law has meant that while the male partner of a woman who gives birth can automatically be recognised as the parent, even if he is not the biological father, the female partner of a woman who gives birth cannot.

In remedying this historical injustice, whether through the 'abridged adoption' or some other mechanism, the Victorian Government (and the Commission) should not subject same-sex parents to unwarranted intrusion or surveillance by a government department. We have mechanisms in Victorian law and DHS procedures for action in cases where someone parenting a child is "manifestly not a fit and proper person" to do so, in the laws and procedures related to child protection and mandatory reporting.

Women's Health West argues that if some process is desired apart from the lodging of documents, this might be more appropriately carried out by an accredited counsellor as outlined in our response to Interim Recommendations 2 to 7. This would represent greater equality with other same-sex parents covered by the deeming provision.

Interim Recommendation 11

Where a single woman conceives a child as a result of donor insemination and subsequently enters into a genuine domestic relationship with a woman or a man, her partner should be able to apply to adopt the child.

Women's Health West supports this recommendation, and argues that this principle should be extended to male same-sex parents, for example a gay man who conceives a child through surrogacy, provided his own legal parentage is clear. We presume that this issue will be tackled in

Position Paper 3. This represents equality with heterosexual relationships.

Interim Recommendation 12

Consequential amendments should be made to the *Births, Deaths and Marriages Registration Act* 1996 and, where appropriate, to all other Victorian legislation that contains provisions relating to parent–child relationships, to recognise that a child may have two parents of the same sex.

Women’s Health West supports all necessary amendments to Victorian legislation to support the deemed adoption and abridged adoption options, as well as the *Status of Children* approach we argued for in our response to Interim Recommendations 2 to 7.

Interim Recommendation 13

Section 10F of the *Status of Children Act* 1974 should be amended to provide that where a woman without a legally recognised male partner becomes pregnant as the result of a treatment procedure using donor sperm, the man who donated the sperm is presumed for all purposes not to be the father of any child born as a result of the pregnancy, unless he becomes a parent of the child under the *Adoption Act* 1984.

Women’s Health West supports all necessary legislative changes to provide that where a woman without a male partner (whether single or a woman in a same-sex relationship) conceives using donated sperm, the donor is presumed for all purposes not to be the father or parent of the child, unless he becomes a parent under the *Adoption Act*. We argue that this should also apply to donated eggs and embryos, and raise the issue of how this principle might impact on men or women who engage in surrogacy. We presume this will be tackled in Position Paper 3.

Interim Recommendation 14 to 17

14. The *Adoption Act* 1984 should be amended to permit more than two people to be recognized as the legal parents of a child.

15. Where a woman gives birth to a child conceived as the result of a donor treatment procedure, the man who donated the sperm should be able to become a legal parent of the child without extinguishing the legal parental status of the birth mother (and her partner if she has one).

16. In order for the donor to become the legal parent of the child:

- the donor must apply to adopt the child;
- the birth mother (and her partner if she has one) must consent to the donor’s application to adopt the child;
- the parties must receive appropriate counselling and legal advice;
- the application must be made within one year of the child’s birth.

17. Where the donor adopts the child, he should be registered as a parent of the child on the births register and birth certificate.

Key Questions 4 and 5

4. Should egg donors also be able to opt in to become a legal parent of the child?

5. Should the donor’s partner also be able to opt in to become a legal parent of the child?

Women's Health West supports the recommendation that a donor be able to apply to adopt a child, provided the parents of the child (whether same or opposite-sex) consent as outlined. We emphasise that this should in no way undermine the legal status of the non-birth/non-biological parent.

We argue that the principle of third parent adoption should be extended at least to allow egg donors and/or the donor's partner if he/she has one to also apply to adopt the child. We are aware of children in the community being raised by, for example, a gay couple and a lesbian couple parenting together, as well as gay couples and single women parenting together. Indeed, Women's Health West is aware of families in which children are raised by co-parents who are not in domestic partnerships, nor biologically related to the children. We argue that adoption should be available to all adults actively involved in parenting children.

Interim Recommendation 18

The *Status of Children Act 1974* should be amended to include the following provision:

- (1) If a woman undergoes a procedure as a result of which she becomes pregnant, she is conclusively presumed to be the mother of any child born as a result of the pregnancy;
- (2) If the ovum used in the procedure was produced by another woman, that other woman is conclusively presumed not to be the mother of any child born as a result of the pregnancy.

Women's Health West supports this recommendation, which strongly supports the central importance of the act of carrying and birthing a child. However as argued above, an egg donor should be able to apply to adopt the child with the legal parent/s' consent, as recommended for sperm donors in Interim Recommendation 15.

We raise the question of what this recommendation may imply for subsequent recommendations relating to surrogacy, ie that it would support a model where the surrogate (whether 'gestational' or 'traditional') is presumed to be the mother at the child's birth, so that for fulfillment of a surrogacy arrangement she must voluntarily relinquish her parental status to the intending parents. We presume these issues will be tackled in greater detail in Position Paper 3.

Interim Recommendation 19 to 21

19. A guiding principle in the *Infertility Treatment Act 1995* that 'all children born as a result of the use of donated gametes have a right to information about their genetic parents' is sufficient, coupled with appropriate counselling, to underline the importance of informing children about their genetic origins.

20. Parents who have children born through the use of donated gametes should be provided with ongoing counselling and support and adequate resources sufficient to enable them to inform their children about their genetic origins. New and emerging ways of encouraging and equipping parents to tell their children should be investigated by counsellors and clinicians.

21. Donors should not be able to obtain identifying information about their donor-conceived offspring, but should be able to register their wishes with the ITA for identifying information about or contact with the child, for release to the child if the child initiates an inquiry about the donor.

Key Questions 6 and 7

6. Should embryo donors be able to apply for identifying information about the child?
6. Should the removal of the donor's right to apply for identifying information have retrospective effect?

Women's Health West supports the recommendation that parents of children conceived with donor gametes be supported and encouraged to tell their children about their genetic origins with ongoing counselling, support and resources. We agree that any law compelling parents to do so is not really enforceable, and any provision that might result in the issue being "forced" (e.g. the donor having the right to contact the child without consent) is not in the best interests of children. Therefore Women's Health West supports the recommendation that donors, including embryo donors, not be able to obtain information about their donor-conceived offspring, and that removal of this right should, if possible, apply retrospectively. We argue that all processes concerned with storage and release of information regarding donor-conceived children should focus first and foremost on the rights and best interests of the children.

Interim Recommendations 22 and 23

22. A service connected to the Registry of Births, Deaths and Marriages, similar to the Adoption Information Service, should be established to manage the donor registers. The donor registers should be transferred from the Infertility Treatment Authority to this new service.

23. Women who self-inseminate with sperm from a known donor should be required to notify the name of the donor to the Infertility Treatment Authority (or the Registry of Births, Deaths and Marriages if the donor registers are transferred) to be recorded in the donor registers.

Key Question 8

Should there be any penalty on a woman who refuses to provide the name of the donor to be recorded on the Central Register?

Women's Health West supports transfer of management of donor information to a new service connected to the Registry of Births, Deaths and Marriages, provided stringent conditions on storage and release of information continue to apply. We support encouragement of women who self-inseminate with known donor sperm to record information about their donor with this registry, but argue strongly against any penalty on women who refuse to provide such information. Such a provision could not be universally policed, and is thus likely to be discriminatory in effect.

We note in this context that lesbian and gay parents tend to be very open with their children about their origins, and that most same-sex parents who use known donors do so in order that the child can have some form of ongoing knowledge of and contact with their donor throughout their lives.

We argue for a range of reasons that no woman should be compelled against her will to reveal information about the genetic origin of her child. The circumstances of the child's conception may be painful (e.g. rape), or the woman may fear the legal implications of recording such information, given the uncertain and complex interaction of federal, state and case law in these matters.

There is no law at present compelling women in heterosexual relationships to reveal the genetic origin of their children, and we strongly oppose the current push by 'men's rights' groups for such a law (e.g. compulsory DNA testing at birth). We argue that it would be most unfair to penalise women without male partners who do not wish to record such information.

Interim Recommendations 24 and 25

24. Donor-conceived children under the age of 18 should be able to apply for information identifying donors, but access to the information should only be granted if a counsellor is of the opinion that the child has sufficient maturity to be able to understand the nature of the information.

25. If a donor-conceived child applies for information identifying the donor before he or she is 18 years old, that information should be able to be released to the child without the consent of the donor.

Key Question 9

Should the decision about whether a child aged under 18 may access information about the donor be reviewable by a body such as the Victorian Civil and Administrative Tribunal?

Women's Health West supports the right of children conceived through gamete donation to apply for access to identifying information about their donor/s before the age of 18, given the evidence that this information tends to be important to children at earlier developmental stages. We agree that this information should be able to be released provided the child is considered mature enough to understand.

We also agree that this could happen without the donor's consent in the case of donors who donate prior to the law changing, given the evidence that some children may benefit from this information before the age of 18. However, donors who donate after the law changes should be asked for their consent, and earlier donors should be contacted and offered the opportunity to talk through their concerns before such contact information is given. We note that many donors are already asked by clinics whether they would be willing to be contacted before the child is 18, and that many indicate willingness to do so. The decision by a counsellor as to the child's maturity to receive such information should be reviewable, whether by VCAT or some other, perhaps more appropriate body.

Interim Recommendation 26 to 28

26. The Adoption Act 1984 should be amended to allow the court to make an adoption order in favour of a same-sex couple.

27. The Adoption and Permanent Care Procedures Manual should be reviewed to accommodate applications by same-sex couples.

28. The Adoption Act 1984 should be amended to allow the court to make an adoption order in favour of one person in accordance with the same criteria that apply to couples.

Women's Health West supports amendment of adoption laws and procedures to allow adoption by same-sex couples and single people. This is particularly welcome given the large number of same-sex and single people who are currently acting as foster carers to needy children. It is intolerable that long-term, excellent foster carers of such children should be barred from applying to adopt them should this become an option.

We do, however, note with concern the discussion preceding Interim Recommendation 27 around concerns that children 'be exposed to people of both sexes'. We note in this context the findings in *Outcomes for Children Born of A.R.T. in a Diverse Range of Families*, Victorian Law Reform Commission Occasional Paper (McNair, R 2004, page 2), that a person's ability to parent well and

provide positive role models for children of both sexes depends not on their gender or sexual identity, but rather on 'family cohesion, minimal conflict, good quality parent-parent and parent-child relationships, consistent parenting style ... and positive intergenerational family relationships'.

Women's Health West agrees that children should have strong relationships with a diversity of people, including adults of both sexes. However we are disturbed that this concern in some ways echoes the homophobic views of those opposed to reform in this area, for example that all children 'need a mother and a father'. While we are certain this was not the Commission's purpose, we are concerned that recommendations not unintentionally reinforce existing prejudices among policy-makers and staff responsible for setting and implementing adoption and permanent care processes.