



## **Women's Health West**

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

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

30 June 2004

## 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. Women's Health West believes that 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 and poverty.

Discrimination, for example in the form of racism, dispossession, ableism and homophobia, also affect the health of particular groups, such as immigrant and refugee women, Indigenous women, women with disabilities and lesbian/same-sex attracted women. Discrimination is often both social and institutional. Homophobia, for example, is both present in social attitudes and embedded in institutions including Australian and Victorian law.

Women's Health West's activities include health promotion and community development activities with marginalised groups in the community. In 2003 our health promotion program included a project working with lesbian and same-sex attracted women in the Western Region to organise 'Go Girls!' a one-day health forum for this community. The aim of this forum was to provide a safe space for lesbians and same-sex attracted women from the Western Region to come together, receive appropriate health information on a range of issues, discuss 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 parents, or who are planning motherhood.

The Go Girls! forum was also an opportunity for Women's Health West to learn about the health needs and issues of lesbians/same-sex attracted women – a very diverse group. One of the most important learnings from the day 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 health needs analysis for the Western Region: "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. Impacts of social homophobia on mental health and emotional wellbeing can include loss of family and community, social isolation and depression. As found in *Beyond Symptoms*: "Ignorance and insensitive practices on 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."

Homophobia in the law, for example in the area of relationship recognition, families, and access to ART impacts not only on emotional wellbeing, but in a range of other aspects of the health of lesbian/same-sex attracted women and their children. This submission addresses only some of the questions asked in the Consultation Paper; those which most directly relate to the impact of the laws on the health and wellbeing of lesbian/same-sex attracted women (and to some extent single heterosexual 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 and the Prospective Lesbian Parents Group.

**Questions 2, 3 and 4: What are the effects on people of the current restrictions to access of ART treatment? Do the restrictions affect the physiological or psychological health of people who are excluded? Are there financial or other effects? Are there principles of circumstances that would justify the adverse effects of restrictions.**

There are no principles or circumstances that would justify the adverse effects of the current restrictions. These effects are very broad, and include:

- The impact of discrimination against a person being enshrined in the law on their emotional wellbeing cannot be underestimated, particularly when it relates to such fundamental areas of people's lives as their families and children.
- Laws also play a major impact in determining community attitudes. The impact of these laws include increased stigma and marginalization of lesbian/same-sex attracted women and their children within the community. Institutionalised homophobia, particularly in the law, legitimizes and promotes social homophobia, with resulting impacts on the wellbeing of lesbian/same-sex attracted women and their children.

Lesbian/same-sex attracted women may be forced to travel interstate to access clinics in jurisdictions with less homophobic laws. The impacts of travelling interstate monthly, usually at short notice and sometimes for days at a time, include:

- Impacts on wellbeing: accessing ART interstate adds enormously to the stress of what is already a very emotionally draining process. This can have a very detrimental impact on emotional and physical wellbeing, with a flow-on impact on chances of conception.
- Financial impacts: adding the cost of travel and accommodation to the already high costs of ART means that women are spending tens of thousands of dollars on attempting to conceive.
- Impacts on employment: it is very difficult for some women to negotiate the necessary time off at short notice, particularly if they are not 'out' to their employer or their employer is not sympathetic. This can result in even higher stress levels and possible loss of livelihood.
- Health impacts arise from the difficulty of managing care from different providers in different states working within different legal and medical frameworks.
- Unnecessary medical intervention: lack of donor sperm (exacerbated by the practice of allowing donor to prescribe whether their sperm can be used by lesbian/single women) and pressure from 'reproductive tourism' ie women traveling from Victoria and SA means that many interstate clinics will only allow four, three or even just one treatment of uninvasive donor insemination before requiring women to undergo much more expensive and invasive IVF. Thus, women are being forced to have unnecessary medical procedures.
- Lack of choice of donor sperm: different legal regimes in other states mean that the (limited) donor sperm on offer is 'anonymous' rather than 'identity release' – that is, the states' laws do not require that a child produced through donor sperm has the right to information about their donor, as is the case under Victorian law. For further discussion, see below.
- Risk of limited donor sperm: many women are concerned about the lack of donor sperm referred to above, and the impact on the genetic diversity of children of lesbian parents. Some clinics, including some of those closest to Victoria have as few as one or two donors who consented to their sperm being used by lesbian/single women. In such a close-knit community, the prospect that their children could be biologically related to those of friends or acquaintances is dismaying to many women.

Some lesbian/same-sex attracted and single women barred from accessing ART in Victoria may instead choose to attempt conception with a known donor. For some women, self-insemination with a known donor may be their first preference, and they will very successfully create families in this way, involving their known donor to a greater or lesser extent. However, other women may choose this method of conception because of issues with accessing interstate clinics such as those discussed (affordability, wanting children to have access to information about their biological heritage etc).

The impacts of these laws on lesbian/same-sex attracted and single women who are forced into

self-insemination with a known donor include:

- Risk of HIV/AIDS and other sexually-transmissible infections. There is a risk to both mother and foetus if counseling and screening for the known donor are unavailable.
- Counselling is mandated for all parties using ART through clinics in Victoria. Without access to counseling and other supports, mother(s) and donor may not adequately understand their rights and responsibilities with regard to the process of conception and in relationship to the child, creating the potential for conflict and stress.
- Lack of legal clarity around and protection of families created through self-insemination with a known donor can create high levels of stress, impacting on the emotional wellbeing of all parties, including child(ren). This is discussed in more detail below.

**Questions 6 and 7: should some of all types of self-insemination be treated as a criminal offence? Should self-insemination be allowed regardless of who performs the insemination?**

Self-insemination should not be a criminal offence, regardless of who performs it. Criminalisation under the current Act has never been enforced (and is impossible to enforce), and it not stopped women from self-inseminating. It has made it much more likely that women will do it unsafely, putting both their health and that of the foetus at risk.

Even if current restrictions to ART were removed, some women would still choose self-insemination as a means to conceive, generally with their partner (if they have one) performing the insemination. These women should be encouraged to seek medical advice and support in doing so. Impacts of the current legal status of self-insemination include:

- Lack of information and support from GPs and other health providers. The restrictions on ART and the legal status of self-insemination means that some women have been told by health care providers that they cannot be assisted in any way. This results in health risks to mother and foetus (see below) as well as some women performing self-insemination incorrectly, and thus not conceiving. This results in stress and in some cases in women seeking unnecessary interventions such as IVF.
- Fear that self-insemination is a criminal act results in women being unwilling to seek advice that might result, for example, in proper screening procedures for donor sperm, referral to counseling or other support services or investigation of possible infertility conditions.
- Lack of assistance in the form of counseling for the donor and screening for donor sperm means that there is a health risk to mother and foetus of HIV/AIDS, Hepatitis B and other infections.

**Question 9: Is it still necessary to screen out donors on the basis of certain high-risk activities? Does the current system unnecessarily exclude sectors of the population including gay men?**

Yes, it is necessary to screen out donors on the basis of high-risk activities. Donors are tested for all known STIs and sperm is quarantined for six months (much longer than the standard window period for infections), however such screening would provide protection against as yet unknown and untested infections.

However, the current legislation unnecessarily excludes potential donors, in particular gay men, by focusing on sexual orientation (asking 'have you had male-to-male sex in the past 12 months'). Instead, the form should require information about high-risk behaviours such as unprotected anal sex with casual/non-monogamous partners and sharing of needles for intravenous drug use.

The current forms prevent gay men from becoming donors to the general 'sperm bank' and discourage them from making directed donations to particular women/couples. As such it exacerbates the problem of sperm shortage for all women, particularly lesbian/single women due to the practice of allowing donors to choose what 'kind' of person their sperm will go to (see below), with impacts as discussed above.

**Question 11: To what extent should the *Infertility Treatment Act 1995* refer to the child's rights and interests?**

The best interests of children should be central to this and all other legislation dealing with families and children. At present, the *Infertility Treatment Act* and the laws more generally have a number of potentially negative impacts on the rights and interests of children of lesbians/same-sex attracted women and single heterosexual women:

- There is no legal provision for protection against discrimination on the basis of family structure or parents' sexual orientation. As discussed, the experience of discrimination has direct impacts on emotional, and often consequently physical wellbeing. All children should be treated equally under the law and protected from discrimination, as provided in the Convention for the Rights of the Child.
- The Victorian law does not recognize both parents in a lesbian couple-headed family as parents. The relationship between a child and her/his non-birth mother is not protected, for example if the couple separates, or if the birth mother dies. This impacts on the child's right to be raised by both parents – recognized in the Convention for the Rights of the Child – and significantly on their development and emotional wellbeing.
- Children should have the right to information about their genetic heritage. Lobbying by interest groups of people who have been conceived through ART has established that this is important to children's emotional wellbeing, and as such this right has for many years been recognized and protected in Victorian law for the children of heterosexual parents who are conceived through ART.

However by barring the vast majority of lesbians/same-sex attracted and single heterosexual women from accessing ART in Victoria, Victorian law forces these women to travel interstate to access less discriminatory laws. Most other states do not recognize or protect children's right to identifying information about their donor. Thus many children conceived through interstate clinics will never have access to information about their genetic heritage.

- Some women who are barred from accessing ART and who cannot afford to travel interstate may resort to self-insemination with a known donor. This may be the positive choice of some lesbian/same-sex attracted and single heterosexual women.

However given that these arrangements are not protected by law, if they are entered into as a 'last resort' with parties who do not have the requisite relationship of trust and communication, there is a greatly increased risk conflict between mother(s) and donor, which is potentially very detrimental to child(ren)'s health and emotional wellbeing.

- Conception through self-insemination with unscreened donor sperm can also result in increased risk to mother and foetus of infection. This is particularly the case where there is a

lack of trust and open communication between mother(s) and donor.

It should be noted that 'the best interests of the child' are often cited by opponents of reform in this area, who do not believe that the best interests of children can ever be served by being raised by lesbian/same-sex attracted or single women.

However, 30 years of research in Australia and abroad has demonstrated that there is no difference in the wellbeing, adjustment and development of children raised by lesbian/same-sex attracted women when compared with children raised in heterosexual nuclear families. (McNair, Dempsey, Wise and Perlesz 2002; Hunfeld, Fauser and Passchier 2002).

Research has also demonstrated that there is no difference in the sexual orientation of children raised in such families (Patterson 1992) and while research has shown that children experience some bullying at school related to their family structure and parents' sexuality, the overall level is no different to that experienced by other children (Ray and Gregory 2001; Tasker and Golombok 1995).

**Question 19a: Should infertility to be a requirement for eligibility for assisted reproduction, and if so, how should it be defined?**

**Question 19b: If not, how should the phrase 'unlikely to become pregnant' be defined?**

Infertility should not be a requirement for eligibility for ART. The criteria of 'medical infertility' is currently applied inconsistently, revealing it as a strategy for denying services to certain women based on the ideological belief that they should not be mothers. That is, 'medical infertility' is a stringent requirement of lesbian/same-sex attracted and single women to access ART, however if a heterosexual married/de facto woman is fertile yet cannot conceive with her male partner, she can access any and all ART services.

To split the definition of 'infertility' under the Act into 'medical' and 'social'/'psychological' infertility (women unwilling to have sex with a man to conceive), and to deny the latter access to ART on that basis, is effectively to pathologise lesbian sexuality.

Assisted Reproductive Technology should be available to anyone who is 'unlikely to become pregnant' without such assistance, whatever the reason. The phrase should be retained within the Infertility Treatment Act and defined broadly to include anyone who requires ART to conceive including single and lesbian/same-sex attracted women.

**Question 22: should people donating semen to an unknown recipient be able to stipulate qualities or characteristics of the recipient?**

No. It is standard practice at most fertility clinics that donors are invited to stipulate whether their donation can go to single/lesbian women, however this in effect institutionalizes discrimination on the basis of sexuality/marital status. Such a question would not be asked about potential recipients from other categories e.g. based on race, age, ability etc. The effect is to reduce the number of donors available to lesbians/same-sex and single women, with impacts discussed under questions 2, 3 and 4.

**Questions 29 and 30: Are there public health and/or other benefits in allowing licensed clinics to provide screened donor sperm to women for the purpose of self-insemination? Should licensed clinics be able to do so?**

Yes. Even if current restrictions on access to ART were lifted, many women would continue to choose self-insemination with a known donor. Freezing and screening of known donor sperm, counselling and information about self-insemination would address many of the concerns outlined under questions 6 and 7. Licensed fertility clinics are the most appropriate venues for such services as they already have the facilities in place and an understanding of many of the issues.

**Questions 31 and 32: Should there be eligibility requirements for access to donor sperm for self-insemination? If so, what should they be? Should women wishing to self-inseminate have access to sperm from the clinics or should they be required to find their own donor?**

There should be no eligibility requirements for access to donor sperm other than those outlined above for access to ART in general. Women should be able to choose either donor sperm from a clinic or to use their own donor. Many women may not know someone who would be willing to donate for them, and to exclude them from access to donor sperm would be discriminatory.

**Question 33: Should the provisions of the Infertility Treatment Act that apply before women can undergo treatment (for example counselling requirements) also apply before women can access donor sperm for self-insemination?**

Yes, the same consent and counselling requirements that apply for current users of ART in Victoria should also apply to women using clinic donor or known donor sperm for self-insemination. Provided that the provider is sensitive to all the issues relevant to non-traditional families, counselling can be of great benefit to all parties involved in such arrangements before, during and after the conception process, including the birth mother, non-birth mother, donor and partner if he has one.

Counselling can greatly assist all parties to understand their roles, rights and responsibilities during the conception process and in relation to the child(ren), details of the process, how to cope if attempts to conceive are unsuccessful, and what issues need to be considered in making agreements around care and contact of the child(ren).

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