I conceived 20 years ago using donor sperm at a fertility clinic in downtown Toronto. I was part of an early wave of lesbian/bisexual/queer-identified women who were accessing reproductive technologies to build their families. Today my daughter is 19 and I am the coordinator of the LGBTQ Parenting Network, a program located at the Sherbourne Health Centre that provides resources, support, and information to LGBTQ parents and prospective parents. We also do research, advocacy and training. Since 1997 I’ve been teaching a course called Dykes Planning Tykes (DPT), a 12-week course for lesbian/bisexual/queer women who are considering parenthood. In 2003, DPT spawned Daddies & Papas 2B, a similar course for gay/bisexual/queer men, and since then we have developed two other courses that address the family planning concerns of people across the queer and trans spectrum: Trans-Masculine People Considering Pregnancy and Queer & Trans Family Planning(s). These courses, run jointly with Queer Parenting Programs at the 519 Church St. Community Centre, provide prospective parents with a place to get information, to grapple with important decisions, to meet and hear about the journeys of other LGBTQ parents, and, most importantly, to build communities.

In 1991, when I was pregnant, there were no resources like these. No groups, no courses, nowhere to go for information. There were doctors and fertility clinics which required lesbians to undergo psychiatric assessments in order to gain access to donor sperm; one doctor in Toronto even asked lesbians to write a “letter to the doctor” to convince him to provide access to sperm and insemination services. Non-biological parents had no legal right to their children - women were courageously committing themselves to...
There were doctors and fertility clinics which required lesbians to undergo psychiatric assessments in order to gain access to donor sperm.

children with no guarantees that they would be protected in their parenting roles. The gay fathers who were visible were mostly those who had children in heterosexual contexts and then “came out.” They were struggling with disclosing their sexual orientation to their children and spouses, with the consequences of a homophobic legal system, and with their own identities. Trans parents were virtually invisible – and where they were visible they were subject to excruciating discrimination.

Things have changed enormously since then. Non-bio parents have access to second-parent adoptions and can be legally recognized as parents; two women using anonymous sperm donation to conceive can put both their names directly on the Statement of Live Birth; a court in London, Ontario recognized three people (a lesbian couple and the man they are parenting with) as legal parents of a child. Trans people are becoming more organized and visible and are advocating for their rights, including the right to parent. They are exploring the reproductive options available to people both before and after a gender transition and are initiating research on the issues facing trans parents and prospective parents, as well as the resiliencies and strengths trans parents offer their children.

Glossary

** Bisexual:** A person whose intimate, affectionate, romantic or sexual feelings may be for people of any sex.

** Cisgender:** Refers to a non-trans person, i.e. someone whose biological sex matches their internal gender identity.

** Heterosexism:** The assumption that everyone is and should be heterosexual and that heterosexuality is the only normal form of sexual expression for mature, responsible human beings.

** Homophobia/Homonegativity:** Irrational fear and/or hatred of, aversion to, and discrimination against people perceived to be gay or lesbian.

** Lesbian/gay:** People whose primary intimate, affectionate, romantic or sexual feelings are for people of the same sex. The term gay is sometimes used to refer to both men and women, although many women prefer the term lesbian. Both words describe more than sexual orientation; for many lesbians and gay men also reflect a sense of community, shared history, culture and experience.

** LGBTQ Cultural Competence:** A deep level of knowledge translated into behaviours and practices that recognize and acknowledge the histories, cultures and values of LGBTQ communities.

** Queer:** An identity proudly used by some people to defy sexual or gender restrictions.

** Transgender:** An umbrella term used to describe people whose gender varies or is complex, including those who are transsexuals, crossdressees, or two-spirited.

** Transsexual:** A person who was born of one sex, and grows up to identify and live as the opposite sex. Some transsexuals may undergo surgery and/or hormone therapy in order to make their bodies fit what they feel is their true gender.

** Two-spirited:** An umbrella term used in First Nations communities to describe people who house both male and female spirits.

** Transphobia** (or less commonly, transprejudice) refers to discrimination against transgendered or transgender people, based on the expression of their internal gender identity, the negative valuing, stereotyping and discriminatory treatment of individuals whose appearance and/or identity does not conform to the current social expectations or conventional conceptions of gender.
children. Gay/bisexual/queer men are increasingly bringing kids into their lives through adoption, co-parenting and surrogacy. Our courses are packed – people sometimes have to wait years to get in. Many LGBTQ people now feel entitled to parent.

However, our right to parent is not without opposition. As witnessed during the same-sex marriage debate a few years ago, many oppose same-sex marriage because they oppose our right to be parents and fear that our children will suffer in our families. Sadly, trans people are currently being subjected to “ethical” debates in academic journals about whether or not they should be granted access to assisted reproduction technologies (ART). Reminiscent of earlier debates about the rights of lesbians and gays to become parents and to have access to assisted reproduction services, these arguments are based on prejudice and lack of information. Not to mention that they place ART practitioners in the dubious role of gatekeepers – deciding who does and who does not have the right to parent. Moreover, as Jake Pyne points out in a recent review of literature related to transgender parenting, the authors of these articles “noted the high levels of discrimination which trans people face as a possible reason to restrict trans people’s access to ART, yet failed to address the paradox inherent in denying a social right on the basis that one has been damaged by the denial of social rights.”

Those who argue for caution in offering ART services to trans people also ignore the medical literature that supports the idea that trans people should be offered the option of gamete banking before starting a gender transition process and that “…no evidence suggests that being born to and raised by transgender parents triggers the kind of harm that would justify exclusion of trans-identified men and women from ARTs as a class.” (Murphy, 2010).

While some ART services are opening their doors to people across the LGBTQ spectrum, including trans people, it is unfortunate that we continue to have to respond to these debates. I could write for pages about how tired we are of these arguments, about the years we have spent defending our right to parent, proving our children are “normal,” that they turn out just the “same as” children growing up in cisgender (see Glossary), heterosexual families. Countless research projects have been conducted to “prove” that our children are fine. More recent research, in fact, points to the ways our children are uniquely blessed: they are more aware of and open to social diversity of all kinds; they conform less to gender stereotypes; they have higher self-esteem than children growing up in heterosexual families; and they tend to live in families where there is more equitable division of labour. We know our kids are fine. And the research confirms this.

Opposition to our families tends to assume the superiority of a particular model of the family – the traditional nuclear family – a family consisting of a cisgender, heterosexual married couple with one or more children who are biologically and genetically related to the parents. This model of the family is considered “natural” and is the model upon which most North American social policy related to the family is based. Ironically, it does not describe what most North American families actually look like.

Many are parenting outside of the nuclear dyad and many have parenting relationships with children to whom they are not biologically related – adoptive parents, step-parents, “other” mothers, and anyone who makes use of third-party reproductive technologies to create families.
... our families don’t look like that traditional, nuclear, heterosexual family – and we enter fertility clinics with some unique and important differences from the heterosexual couple who is seeking assistance to conceive.

There are countless groups of people whose families do not fit this model – single parents, divorced or separated parents, extended families, blended families. Many are parenting outside of the nuclear dyad and many have parenting relationships with children to whom they are not biologically related – adoptive parents, step-parents, “other” mothers, and anyone who makes use of third-party reproductive technologies to create families. We all suffer from this rigid definition of what makes a family.

The assumption of cisgender heterosexuality and a nuclear family structure (an example of “heterosexism” – see the Glossary) also confronts LGBTQ people when we enter fertility clinics and sperm banks to access assisted human reproduction services. It hits us in the face when we are handed a form that assumes a female and a male partner; when we see images on the walls of only two-parent heterosexual families; when our partners and other significant people in our families are ignored by our health care providers. Because many of us are accessing assisted reproductive technologies to create our families, we are walking into clinics in increasing numbers. One Toronto-based fertility clinic estimates that 20 - 30% of their clients are part of LGBTQ communities.

Because of limited access to sperm in our daily lives, many lesbian/bisexual/queer women access anonymous or I.D. release donor sperm and/or donor conception with known sperm donors or co-parents to build our families. Sometimes we show up at clinics with our donors and/or our co-parents – people we will be parenting with but who we may not be in romantic/sexual relationships with.

Gay/bi/queer men visit clinics as sperm donors, as co-parents or sometimes as part of surrogacy arrangements involving egg donors and gestational surrogates. Trans men come to clinics seeking donor insemination for themselves or may be accompanying a partner or co-parent who is attempting pregnancy. A trans woman may want to freeze sperm before transitioning, or may come in with a female partner who wants to be inseminated with the trans woman’s sperm. A trans woman and her partner/coparent(s) might also want to set up a surrogacy arrangement with an egg donor and gestational carrier.

What’s usually true is that our families don’t look like that traditional, nuclear, heterosexual family – and we enter fertility clinics with some unique and important differences from the heterosexual couple who is seeking assistance to conceive.

LGBTQ communities have experienced a history of gate-keeping in relation to ART services and so we sometimes walk into clinics wondering if we will be granted service at all. One lesbian participant in a recent research study was required to have a police check and a social work home study before being granted access to donor sperm. Many trans people do not feel confident that they will be treated with recognition or respect when they enter a fertility clinic.
Research conducted in Ontario with lesbian/bi/queer parents in 2003/04 led to the development of a series of practical recommendations to aid ART services in delivering cultural competence for LGBTQ communities:

• Staff that are trained to be culturally competent in relation to LGBTQ communities - to be aware of and sensitive to the needs, concerns and sensibilities of LGBTQ clients, including the specific needs of trans-identified clients.

• Intake and procedure forms that explicitly make room for family configurations that do not assume male/female relationships, or a 2-parent model – i.e., that recognize the sometimes complex family configurations that LGBTQ people, and others, are forming.

• Involvement of all parties desired by patients, including partners, known sperm donors and co-parents.

• Language and treatment that recognize that LGBTQ people are often accessing fertility clinics and sperm banks as part of routine family planning, and not as infertility clients. Provide opportunities for women to make informed choices about interventions that are consistent with their known or presumed infertility.

• Cues that services are LGBTQ positive. These might include positive space imagery or posters and brochures depicting LGBTQ families. Individual service providers can provide cues that they are open to LGBTQ families through choice of gender-neutral language, and pay attention to the ways that questions are posed.

• Information available about local LGBTQ services, supports and resources. Where feasible, offer LGBTQ-specific services or services in partnership with LGBTQ communities and/or service providers.

• Expand the selection of donor semen, particularly with respect to donors of diverse ethnocultural origins and open identity donors.

• Strive for a unified standard of care across geographic regions, and facilitate access for people living outside of major urban centres.

Practitioners committed to cultural competency in relation to LGBTQ communities can use these recommendations to inform their learning and their practice.

While much of the Assisted Human Reproduction Act (AHRA) was struck down by the Supreme Court in 2010, the non-discrimination clause remains in effect. It is unclear at this point how this clause will be enforced, and we look forward to the delineation of a process that will provide recourse if we feel we are being discriminated against in the provision of service.

When LGBTQ people walk into a fertility clinic, often it is the first step on our path to family creation. Although, of course, some of us do experience fertility challenges, for the most part we use ART in order to access sperm and egg donations, to freeze gametes or facilitate surrogacy arrangements. And yet, because we are entering a system designed to address these issues, we are often pressured to agree to medical interventions which make sense only in the context of infertility. The psychological issues often facing heterosexual couples who are struggling with infertility – guilt, anger, shame and depression – are most often not the issues we are grappling with. In fact, the stress that we experience is most often due to lack of awareness and sensitivity to our particular circumstances and communities on the part of service providers at fertility clinics and sperm banks. When asked about her experiences with a fertility clinic, one of our clients noted, “We need counselling to get over the counselling we are given.”

While, of course, there are some well-intentioned and skilled ART practitioners, including counsellors, in the bigger picture our most significant hurdle, when accessing ART services, is overcoming the systemic homophobia/transphobia and heterosexism we so frequently encounter in the health care system.

Disclosure issues are different for us too. Much ART counselling focuses on questions of how and when to disclose the use of ART to the children conceived by these methods. Again, these issues are experienced very differently by our communities. For the most part, for obvious reasons, disclosure is not a choice for us – most of us tell our children from the start about how they were conceived. Many LGBTQ communities share a history and a culture that values and promotes honesty and truth-telling generally, and, in this case, in particular with regards to children and child-rearing. Too many of us have suffered as young people from secrets we were forced to keep and/or from silences that denied our experience. We do not want to impose secrets and/or silences on our children.

Instead of focusing on the psychological issues of infertility or issues of disclosure, counselling for LGBTQ people accessing ART services would be more effective if it helped us explore:
decisions concerning donors and potential family configurations;
how to handle the individual and systemic discrimination we inevitably encounter;
how to deal with religious / cultural views that view LGBTQ parenting as "unnatural;"
legal information related to how to protect all parents and children in our families;
information about supports available to us as LGBTQ parents.

In 2001 the LGBTQ Parenting Network held a series of focus groups to inquire

Trans people are exploring the reproductive options available to people both before and after a gender transition and are initiating research on the issues facing trans parents and prospective parents, as well as the resiliencies and strengths trans parents offer their children

about the priorities of LGBTQ parents and prospective parents. Near the top of identified needs was the need for "LGBTQ-positive" professionals. Becoming an "LGBTQ-positive" professional is not simple; it requires a deep level of knowledge translated into behaviours and practices that recognize and acknowledge the histories, cultures and values of LGBTQ communities. This is what is sometimes referred to as "cultural competency." Cultural competency in relation to LGBTQ communities includes recognizing what a significant client population we are in relation to ART services and understanding the unique issues we face in our quest to build families.

In 2010 much of the AHRA was struck down as federal law, and key aspects of the regulation of ART services were placed in the hands of the provinces. Aside from Quebec, no province has in place a comprehensive set of policies and regulations in this area. At the Sherbourne Health Centre in Toronto we coordinate a working group of researchers, lawyers, doctors, midwives and community service providers to address LGBTQ concerns in relation to the AHRA, the Sperm Regulations and the practices of ART services. LGBTQ communities are key stakeholders in the world of ART and it is critical that groups such as this one be included in processes to establish provincial regulation of assisted reproduction services. Our working group currently sits on

We sit on these committees to remind those working on them that not everyone who walks into a fertility clinic is a heterosexual, cisgendered couple dealing with fertility issues. We sit on these committees to attempt to put LGBTQ realities and concerns front and centre in the minds (and hearts) of policy makers, educators, medical professionals and service providers. In years past we would not have been included in these committees, debates and processes. Our presence as users of ART services was invisible and our particular concerns not taken into account. We are hopeful that times are changing, that LGBTQ communities have been brought to the table and that, perhaps, our voices will be heard.

The LGBTQ Parenting Network, Sherbourne Health Centre and the Researching for LGBTQ Health team at the Centre for Addiction and Mental Health have recently completed a study of LGBTQ experience with fertility clinics in Ontario – the Creating Our Families Project. Based on the results of this study and with funding from the Canadian Institutes of Health Research we will be offering free interactive workshops to fertility clinic staff to assist you to more equitably serve LGBTQ communities. These workshops will be available in spring 2012 to fertility clinics across Ontario. For more information contact creatingfamilies@canmail.net To contact the author: parentingnetwork@sherbourne.on.ca

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