CREATING A FAMILY FOR SAME-SEX COUPLES

PART OF THE PATHWAYS TO PARENTHOOD BOOKLET SERIES

ABOUT THIS BOOKLET

For many gay and lesbian couples, starting a family can be both daunting and joyful. Along with the wonder and richness of raising a family, there may be substantial legal and medical hurdles to face.

But there is good news. In the past few years, legislative changes – at both the federal and state and territory levels in Australia – have increasingly recognised the legal standing of same-sex couples and promulgated their rights, including broader access to Assisted Reproductive Technology (ART).

These developments, together with advances in fertility treatment, mean that there are now more options available for same-sex couples than ever before. The diversity of ways in which you may form your family might seem a little overwhelming, but there are resources and tools available to help you and your partner navigate the many considerations in your journey to build a family.

The first step is to have open discussions with your partner about what your mutual expectations are for parenthood, including whether you want a genetically related child or an adopted child.

You'll also want to begin familiarising yourself with the legal and financial implications associated with your different choices. And of course, it's important to understand the medical procedures that might be available to you, along with the risks and benefits of each one.

This booklet explores the options for same-sex couples. It reviews the biology that affects fertility and explains the issues that are unique to same-sex couples who want to start or grow their family.

It's important to remember that same-sex couples may encounter some of the same infertility issues as heterosexual couples, but medical fertility specialists can help. There are treatments available for many infertility problems, so the sooner you seek treatment for infertility, the greater the chances for successful conception.

Congratulations on taking this first step in your family-building journey.

Merck acknowledges the contribution of Dr Julie Lindstrom in the preparation of this booklet.

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The information contained in this booklet is a general guide only and should not be relied upon, or otherwise used, in place of medical advice. You should consult with an appropriate healthcare provider on (1) any specific problem or matter which is covered by any information in this booklet before taking any action, or (2) for further information or to discuss any questions or concerns. Whilst we have taken reasonable steps to ensure the accuracy of the contents of this booklet, it is provided on the terms and understanding that Merck Serono Australia Pty Ltd (and its respective officers and employees) and all other persons involved in the writing, development, publication, distribution, sponsorship or endorsement of this booklet, to the fullest extent permitted by applicable law are not responsible for (1) any error or any omission from this booklet, (2) make no warranties, representations or give any undertakings either express or implied about any of the content of this booklet (including, without limitations, the timeliness, currency, accuracy, correctness, completeness or fitness for any particular purpose of the booklet or its content), (3) are not responsible for the results of any action or inaction taken on the basis of any information in this booklet, (4) are not engaged in rendering any medical professional or other advice or services, (5) expressly disclaim any and all liability and responsibility to any person in respect of anything done by any such person in reliance, whether wholly or partially, upon the whole or any part of the contents of this booklet.

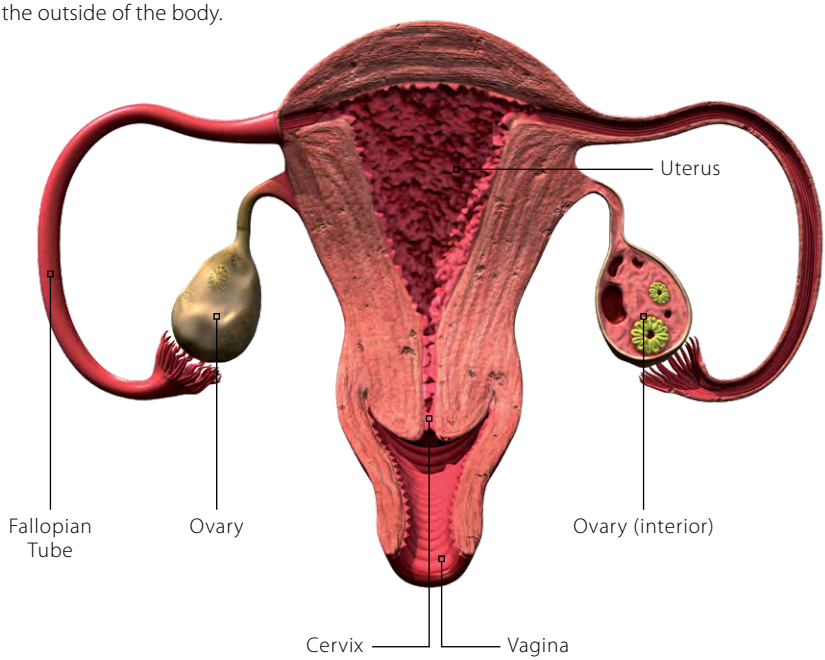
BIO 101 – THE BIRDS AND THE BEES

As just about every adult knows, it takes an egg from a woman and sperm from a man to make a baby. Regardless of the path you choose, understanding the process of fertility and conception will shed some light on the role of the male and female reproductive systems in how you create your family.

Female Reproductive System[1,2]

The ovaries store a woman's lifetime supply of immature eggs. Females are born with about 1 to 2 million eggs at birth, reduced to about 3–400,000 at puberty. Each month, during her reproductive years, usually only a single egg matures and 1,000 eggs are lost, slowly absorbed by the body. The ovaries produce the female hormones oestrogen and progesterone, which are both needed for menstruation and pregnancy.

The sperm and egg meet for fertilisation in the fallopian tubes. A fertilised egg attaches itself to the lining of the uterus (the endometrium) and the embryo continues its development in the uterus. The vagina is the passage that leads from the cervix, the opening to the uterus, to the outside of the body.



Adapted from Mayo Clinic.[3]

Menstrual Cycle[4]

The menstrual cycle is an important part of conception. The term 'menstrual cycle' describes a series of hormonal and physical changes which typically take place over 28 days, including the maturation and release of an egg, the preparation of the uterus to receive and nurture a fertilised egg (embryo), and the shedding of the lining of the uterus (endometrium) if conception does not take place (menstruation or 'a period'). The menstrual cycle is divided into three distinct phases.

Follicular Phase – Days 1 to 13[4]

During the follicular phase, the hypothalamus and pituitary glands in the brain release a hormone called follicle stimulating hormone (FSH). FSH stimulates the development of a follicle, which is a tiny fluid-filled sac in the ovary containing a maturing egg.

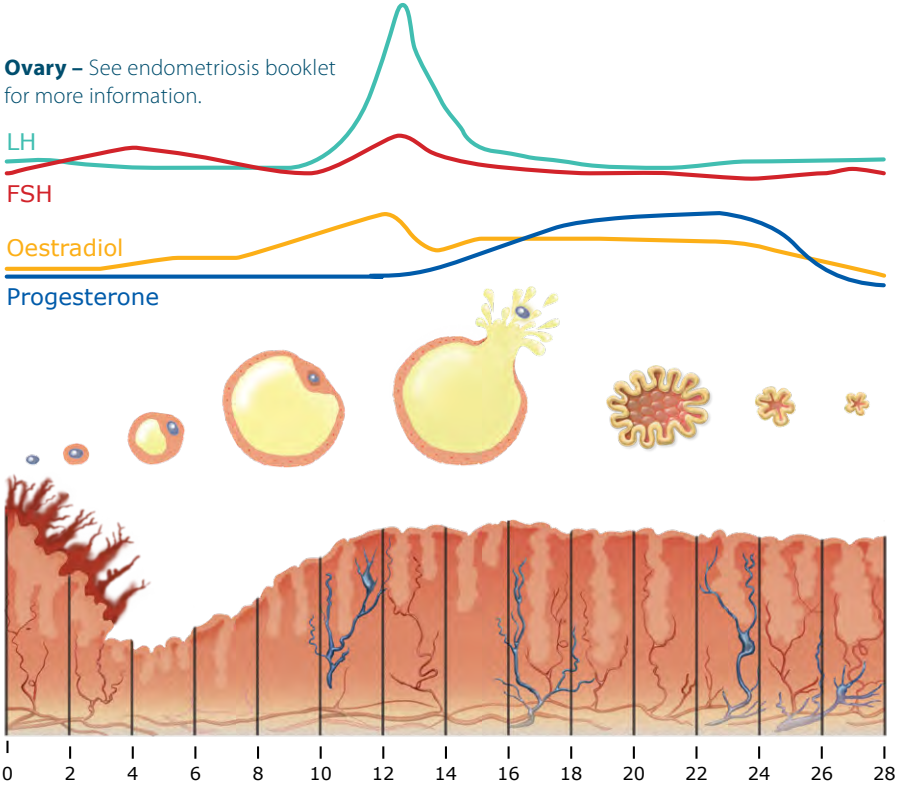
During this phase, the growing follicle is also producing oestrogen. Oestrogen promotes the growth and thickening of endometrium, preparing it to receive an embryo if conception occurs. Oestrogen also causes mid-cycle changes to cervical mucus. These changes help prepare the cervical mucus to receive and nourish sperm.

Ovulatory Phase – Around Day 14, depending on the length of the cycle[4]

The ovulatory phase begins with a large increase in the level of luteinising hormone (LH). This hormone is released by the pituitary gland and it activates the final maturation of the egg. LH causes the DNA in the egg to divide so it is ready for fertilisation, the follicle to break open to release the mature egg into the fallopian tube, and it stimulates the transformation of the empty follicle that produced the mature egg into a structure called the corpus luteum.

During her reproductive years, a woman usually releases a single mature egg each month. This process is known as ovulation. Cervical mucus is most receptive to sperm around this time and the majority of pregnancies occur within a three day window just prior to ovulation.

It is a common misconception that the ovulatory phase begins around Day 14 of a woman's cycle; it is more accurate to say that this phase commences 14 days before the start of a woman's menstrual cycle, which may not be an exact 28 days. A cycle begins on the first day that a woman experiences a full day of bleeding. Once a woman has worked out how long her personal cycle lasts, she should subtract 14 days from the predicted end of the cycle to determine time of ovulation.



Endometrium – See endometriosis booklet for more information.

Adapted from Boron WF, Boulpaep EL. 2012.[4]

Luteal Phase – Days 15 to 28[4]

During this phase, the follicle that produced the egg becomes a functioning gland called the corpus luteum. The corpus luteum produces progesterone, which prepares the endometrium (lining of the uterus) for the implantation of the fertilised egg. The luteal phase is fixed and always lasts 14 days give or take 2 days.

Fertilisation[4]

The ovulatory phase of the menstrual cycle is the optimal time for fertilisation. Following ejaculation, sperm swim through the cervical mucus, into the uterus and along the fallopian tube, where they meet the egg. Although millions of sperm can be released, only one sperm can fertilise an egg. The egg has the capacity to be fertilised for about 12 to 24 hours after it is released from the follicle.

Implantation[4]

After fertilisation, the embryo travels through the fallopian tube toward the uterus. Inside the uterus, the embryo implants itself into the lining on about the 20th day of the cycle and continues to grow into an embryo and eventually a foetus. The corpus luteum continues to produce progesterone to preserve the uterine lining and help maintain the pregnancy. If fertilisation does not occur, the egg passes through the uterus, and the corpus luteum ceases to function on about Day 26. The uterine lining then breaks down and is shed several days later as the next menstrual cycle begins.

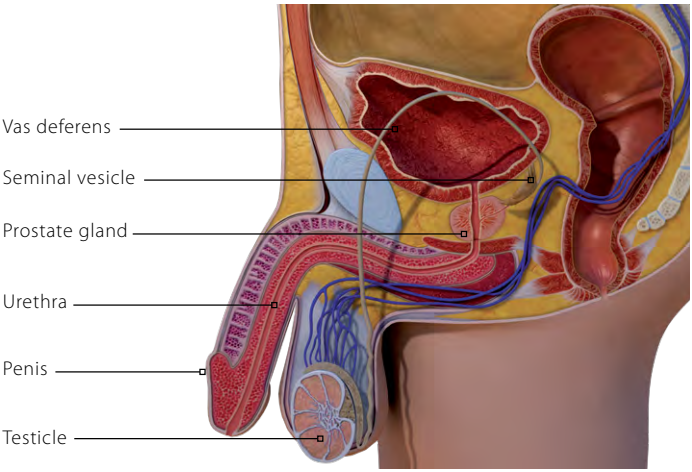
Male Reproductive System

Sperm Production[4]

As in the female reproductive system, normal anatomy of the reproductive organs and regulation of hormones are important for male fertility. The same hormones that regulate female reproductive functions also regulate the production of sperm in the male. FSH stimulates sperm production and LH stimulates the production of testosterone. Testosterone helps to maintain sperm production.

Sperm are highly specialised cells comprised of a head, where chromosomes are stored, and a tail, which enables movement. Sperm are produced by glands called the testes (testicles) located in the scrotum. The scrotum maintains a lower than normal body temperature to help sperm develop properly. As sperm are produced, they pass from the testes to the epididymis, an organ at the back of the testes that stores and nourishes sperm as they mature.

When a man ejaculates, sperm from the epididymis travel along the vas deferens, a tube connecting to the urethra within the penis. This movement of sperm is facilitated by fluids from the seminal vesicle and prostate glands, which combine to make up semen. Once deposited into a woman's vagina, sperm are immobilised within 2 hours. However, sperm within the cervical mucus can stay alive and retain the ability to fertilise an egg for 48 to 72 hours.



Adapted from Boron WF, Boulpaep EL. 2012.[4]

FAMILY BUILDING OPTIONS

A Legal Overview for Prospective Parents[5,6]

Before looking at the practicalities of creating your family, it is worth briefly considering the legal guidelines that apply to same-sex parenting. In Australia, this is particularly important as the laws relating to Assisted Reproductive Technology (ART; the means to conceive a child without sexual intercourse, sometimes referred to as Assisted Conception) are generally determined by individual states and territories. This means that there may be regional differences in terms of access to ART and the legal standing of parents, co-parents and potentially, donors who contribute eggs or sperm. For this reason, it is important for you and your partner to familiarise yourselves with the laws that apply in your locality. By contrast, in New Zealand, the Government's 2004 Act covers ART legislation uniformly across the country.

The Sex Discrimination Act 1984 Cth (s22) prohibits discrimination in providing services on several grounds, including on the basis of sexual orientation, intersex status, marital or relationship status. Consequently, in Australia, in matters relating to social security, family assistance and child support, Medicare Safety Net, parental leave, educational assistance and family law (among others), same-sex couples have similar access to benefits and services as other couples. Non-discriminatory legislation also operates in New Zealand.

Surrogacy is permitted in all states; however, there are variations in legislation between the states which will be looked at in more detail later in this chapter.

In Australia, both at state/territory and federal levels, the non-birth mother in lesbian couples is now recognised as a legal parent, provided there was consent to the treatment (IVF or artificial insemination) that resulted in the child's conception and they were in a de facto relationship at conception. Similarly, at the federal level, most same-sex couples are considered their children's legal parents provided they were in a legally recognised de facto relationship at the time and mutually consented to have the child.

Creating Your Family

In tandem with social legislation developments, fertility treatment options have also expanded for same-sex couples. For female couples, your choice ultimately depends on the age and health of each partner, as well as the desire of each partner to carry a child. For male couples looking to start or build a family, your favoured method will depend on several factors, including sperm quality and surrogacy options.

A discussion with your General Practitioner (GP) is an obvious place to start. Ask for a referral to a fertility specialist for a medical assessment as this can guide which path to conception you and your partner choose. A good first step for many men is to have their semen analysed, which can help determine the viability of its use for conception and for directing possible fertility treatment options and next steps.

Before you agree to undergo any kind of treatment, take some time to talk to your doctor about its likelihood of success and its risks. You may also wish to enquire about a timeline for each phase of treatment. That way, if a certain treatment isn't working, you'll know when it may be appropriate to consider more advanced treatments.

You should also be aware that while access to fertility services is now more inclusive than ever, according to the various state laws there are a number of checks and requirements necessary for all prospective clients. These may include a check to ensure no prior convictions for violence, and counselling so that the implications of assisted conception are fully understood.

Following are some options that may be available for same-sex couples looking to start or build their family, which may be applicable to one or both of the partners or a surrogate.

Assisted Conception Treatments[7,8]

Personal circumstances, including any infertility and its potential cause, will dictate the type of treatment approach that is used. These commonly include:

Ovulation Induction (OI) – The term for the use of medical therapy to treat women who do not ovulate by themselves. Hormonal medications are used to stimulate the ovaries or egg sacs in order to produce an egg, which can then be fertilised by the male's sperm. Ovulation Induction can be used in conjunction with intrauterine insemination (IUI) with donor sperm.

Artificial Insemination (AI) – AI involves the placement of a prepared sample of semen into the cervix or uterus by a healthcare provider. The semen may be from a donor (known or anonymous) see below, or in the case of traditional surrogacy, from the intended parent after quarantine of the semen. The woman's ovulation is tracked with a combination of blood tests, urine ovulation prediction kits or ultrasound scans. The insemination is performed on the day after the ovulation/LH surge as a general rule. Typically, the procedure is painless, does not require anaesthetic, and has little interruption to daily activities.

Donor Insemination (DI) – Clinic-based DI utilises sperm collected from a donor who has been screened for various health problems. This donor may be someone you know and have chosen, who has 'donated' sperm to you through a medical facility, or it may be a donor who has been recruited by the clinic. Collected sperm is frozen for six months during the testing to ensure safety, and once cleared for use may be administered using the same procedures as for AI. This is one option for conception that can be used by single women or lesbian couples. Some women opting to use a known donor may use home insemination. It is important to know that some clinics will provide stored, screened sperm from a known donor for use at home if desired.

Assisted Reproductive Technologies (ART)[9–11]

ART is the umbrella term for a variety of medical procedures used to bring eggs and sperm together without sexual intercourse. These are typically more complex procedures than those listed above and may be used to address diagnosed fertility issues.

***In Vitro* Fertilisation (IVF)** – During IVF, medications are used to stimulate the development and release of a woman's eggs. The eggs and sperm are then collected and placed together in a laboratory dish to fertilise. If the eggs are successfully fertilised, the embryos are cultured for 2 to 5 days and then one (or 2) of the embryos is transferred into a woman's uterus. Hopefully, the embryo will implant and begin to develop. Success of an IVF cycle is largely determined by age, along with other factors.

Intra-cytoplasmic Sperm Injection (ICSI) – After collection of the eggs and sperm, ICSI involves a laboratory technician, using a microscope & microinjection devices, to inject a single sperm directly into each egg. ICSI is often used if the male has very low sperm count, low sperm motility or poor quality sperm, or if there has been prior failed fertilisation with IVF. If fertilisation occurs after ICSI, the embryo(s) are transferred into the uterus as outlined above.

Egg and Sperm Donation – For gay partners and lesbian couples who may have egg quality issues or premature ovarian failure, there is the need to use donor eggs. Egg donation involves one woman (a donor) providing her eggs to another couple to create embryos. The egg donor then undergoes an egg retrieval procedure and IVF or ICSI is performed in the usual manner using sperm from the gay couple or a sperm donor for the lesbian couple. The resulting embryos may be transferred fresh into the lesbian partner wishing to conceive, once the appropriate waivers and counselling for infection are completed. For the gay couple, the embryos can be frozen and quarantined for use in a surrogate, or if using a traditional surrogate (see below), the embryos may be transferred fresh. Different states/territories have varying legislations on the use of traditional surrogates and IVF clinics have individual policies as well. If intending on a fresh embryo transfer the recipient also receives medications so that her cycle mirrors the cycle of the donor and her body is prepared to receive the embryo(s).

For women utilising donated sperm, it may be necessary to use the services of a fertility clinic. Clinic-recruited sperm donors are health screened (for serious infection and genetic conditions) and counselled. They give consent to the use of their sperm, relinquish their parenting rights over any children conceived and agree to their identity being released to the child at age 18 years (or before this time under regulated circumstances). Fertility clinics can also provide sperm screening (and storage) for known donors whose semen is used in either clinic-based conception procedures or in an at-home insemination procedure undertaken by the woman.

For gay male couples, the egg donor may be known or selected using the services of a fertility clinic. The age of the egg donor is one of the most important factors affecting the outcome of IVF. Fertility declines with age so the donor should ideally be between the ages of 21 and 34. Once selected, the donor will undergo extensive screening that includes medical, psychological, genetic and infectious disease tests.

Egg and Embryo Freezing – Cryopreservation, also known as 'freezing,' involves storing embryos or eggs at a very low temperature so they can be thawed and used later. Most fertility clinics offer this option. There is a finite time for embryo and egg storage of 5 to a maximum of 10 years in some circumstances.

Preimplantation Genetic Diagnosis (PGD) – Is a technique that can be used during ART to test embryos for a variety of genetic disorders. PGD testing is done before the embryo is transferred to the uterus. This decreases the risk of having a child with a serious inherited disorder. The procedure can detect Down syndrome, cystic fibrosis, haemophilia A, Tay-Sachs disease and Turner syndrome, along with other disorders.

Chromosomal screening for whole missing or added chromosomes, like Down syndrome, can be performed on all embryos if patients request this to be done. This may be preferable in surrogacy cases to increase success rates and reduce miscarriage rates. Single gene disorders, like cystic fibrosis or haemophilia, require an affected parent to carry the condition in order for it to be screened. This would need to be discussed in detail with your treating doctor as it may be complex and require time to prepare for such testing.

Things to Consider

It's important to know that advanced fertility treatment can be stressful for couples. Your fertility specialist will help set expectations, provide injection training, monitor treatment response and check for side effects. Patient response and pregnancy success rates can vary. Follow doctors' instructions and report any adverse events such as severe abdominal pain, which can be serious.

Surrogacy[12]

Surrogacy describes the situation where a woman gestates a child *in utero* and, at the time of birth, hands the child over to the commissioning parents who were unable to carry the pregnancy. The child is usually genetically related to either one or both parties of the commissioning couple. In traditional surrogacy, the woman who gestates the child also donates the egg. This is sometimes called 'genetic plus gestational' surrogacy (though this is not allowed in Victoria and may be against individual fertility clinic policies).

Surrogacy and ART[12]

Gestational or IVF surrogacy is where the biological embryo of the commissioning couple or person, is implanted into a surrogate woman. The child is not genetically related to the gestational carrier. This practice has removed what many cite as the major obstacle for the surrogate, that of giving up her own biological child.

Legislation related to surrogacy varies across Australia. In general, altruistic (unpaid) surrogacy is legal in all states though The Northern Territory has no specific legislation on surrogacy.

Importantly, commercial or paid surrogacy is illegal in all Australian states and New Zealand and it is viewed as a criminal offence in various jurisdictions. However, certain costs and assistance can be paid to a surrogate in an altruistic arrangement. The definitions of reasonable costs (which ensure there is no material gain) are typically determined by each state's legislation, and it is important to get full information for the region relevant to you.

Other important aspects of surrogacy arrangements may also vary across different precincts, so comprehensive legal advice and counselling is recommended (indeed, they are required by law for most Australian states). The law and procedures for arranging a surrogacy agreement, as well as those determining parentage of children born through surrogacy, may also vary across jurisdictions, reinforcing the necessity for obtaining legal advice.

Considerations for HIV-Positive Prospective Parents

If you or your partner is HIV-positive, speak to your healthcare provider or an HIV Specialist for more information about your options and risks.

Adoption

If considering adoption we would recommend consulting your local authority for more complete information, since procedures vary according to location.

Fertility Considerations

In addition to understanding ART options as they relate to the family building process, it's also important to remember that anyone can be affected by infertility, and for same-sex couples, fertility issues may be uncovered after starting the family building process with ART.

Female Factors[13]

There are a number of biological issues that can cause infertility in women. In heterosexual relationships, there may be a fertility problem if a woman is younger than 35 and unable to conceive after a year of unprotected intercourse, or if older than 35 and unable to conceive after six months of trying. Similarly if you have been home inseminating and have not conceived after several cycles you may also have a fertility problem. This may or may not be an issue for you or your surrogate.

Ovulatory Issues[13]

Approximately 25% of all infertile women have problems with ovulation. The normal ovarian cycle is so complex that even small changes may disrupt the cycle and prevent ovulation. The problem is often caused by disorders of hormone regulation either at the level of the brain or the ovary. This can be caused by faulty communication between the brain and the glands responsible for releasing the hormone. Sometimes, abnormal ovulation may be associated with having an extremely low body weight or being overweight, also significant changes in weight (loss or gain).

Physical Issues[13]

If the problem is not with the ovulation cycle, then there are some physical problems that can cause fertility issues in women. If you or your surrogate fit into any of these categories, you should contact your doctor:

Blocked Fallopian Tubes – though there are many causes for this, including past infections or sexually transmitted diseases (STDs), blockages prevent the sperm and egg from uniting.

Cervical Disorders – some cervical problems can prevent the sperm from entering the uterus.

Endometriosis – this disease causes cells that normally line the uterine cavity to also grow outside the uterus on the ovaries or other pelvic organs. Up to 50% of women with infertility problems have endometriosis.

Polycystic Ovarian Syndrome (PCOS) – one of the leading causes of infertility in women. PCOS is a condition in which cysts develop in the ovaries due to abnormal hormone levels, sometimes causing lack of regular ovulation. More information on PCOS can be found in the Pathways to Parenthood booklet - Polycystic Ovary Syndrome (PCOS).

Medical Issues[13]

Women suffering from medical conditions may also have lower fertility secondary to their systemic illness. Consider seeking early medical advice if you suffer from a chronic illness. Conditions like diabetes, kidney disease, thyroid disorders and autoimmune condition, to name a few, require early pre-pregnancy advice to avoid bad pregnancy outcomes for mums and babies.

History[13]

Here are some red flags for women. If you or your surrogate fit into any of these categories, you should contact your doctor:

- Over age 35
- Irregular or absent periods
- Two or more miscarriages
- Prior use of an intrauterine device (IUD)
- Endometriosis/painful menstruation
- Breast discharge
- Excessive acne or hirsutism (body hair)
- Prior use of birth control pills and no subsequent menstruation

Male Factors[13]

While gay men may think female fertility issues don't affect them, it's important to remember that surrogates may also experience difficulty carrying a child, despite extensive screening. It's also important to know that there are a number of factors that can lead to fertility problems in men.

Sperm Disorders[13]

Many male fertility issues are related to sperm disorders. Disorders of sperm quantity or quality will generally be detected during the preliminary screening process when considering AI, IVF or surrogacy:

- Sperm count (number of sperm)
- Motility (ability to move)
- Morphology (size and shape) impacts forward progression and quality of movement

Physical Problems[13]

Other physical problems can cause fertility issues in men. If any of these apply to you, then you should contact your doctor:

- Erectile dysfunction – inability to get or sustain an erection
- Undescended testis – testis has not reached its normal position in the scrotum, causing it to function abnormally and potentially not produce sperm
- Retrograde ejaculation – ejaculate containing the sperm flows backwards into the bladder instead of leaving the penis
- Scrotal varicocele – the most common cause of identifiable male infertility, this occurs when a varicose vein is around a testicle, which may hinder sperm production

Medical and Family History[13]

For men, the following issues can lead to reduced fertility. If any of these apply to you, then you should contact your doctor:

- Mumps after puberty
- Previous urologic surgery (vasectomy reversal)
- Prostate infection
- Family history of cystic fibrosis or other genetic disorders
- Diabetes
- Obesity
- Testicular trauma
- Anabolic steroid use
- Prolonged exposure to high heat (e.g. hot tubs, saunas) can lower sperm quality
- Exposure to toxic substances on the job, such as pesticides, radioactivity, X-rays and electromagnetic or microwave emissions, may lead to sperm abnormalities

Factors That May Affect Both Genders[13]

There are some factors that may cause fertility issues in both men and women:

- History of sexually transmitted disease
- History of pelvic/genital infection
- Previous abdominal surgery
- Chronic medical condition (e.g. diabetes, high blood pressure)
- History of chemotherapy or radiation therapy

Lifestyle[13]

Keep in mind that certain lifestyle choices can affect your fertility. You might want to consider talking to your doctor if any of these apply:

- Alcohol consumption and smoking have been shown to compromise fertility in both men and women
- High caffeine consumption was found to be a risk factor for not achieving a live birth (either by not becoming pregnant or by having a miscarriage)
- Being underweight, overweight or obese may reduce a woman's and man's chance of conceiving
- Some drugs for heart disease and high blood pressure may cause infertility in men and be unsuitable for use in pregnancy
- Illegal drugs, such as cocaine, or inappropriate use of prescription drugs, can affect sperm production and function

The bottom line is, if you feel like some of these apply to you, your partner or a potential surrogate, then talk to your doctor. Don't dread and prolong making the call, most of the causes of infertility listed are treatable.

GETTING HELP

As a same-sex couple, you will know you have choices in determining how to start your family. In many cases, medical intervention of some sort will be an obvious option and the first step is a consultation with your GP.

Your GP may refer you directly to a gynaecologist or fertility specialist, whose focus is on reproductive health or you may be referred to a fertility clinic. It may also be recommended that male prospective parents visit a urologist or andrologist to have an independent sperm analysis.

Any potential fertility concerns will be addressed with a thorough evaluation of a prospective parent's medical and personal history, through physical examination and medical testing.

The Role of the Fertility Specialist

The role of a fertility specialist is to help those wishing to get pregnant and includes coordinating AI and ART procedures for same-sex couples looking to build their families. They can also help identify and treat fertility issues in both men and women, single and those in a relationship.

Fertility doctors (specialists in Obstetrics and Gynaecology or Endocrinology) may additionally be Certified Reproductive Endocrinology and Infertility (CREI) sub-specialists. This means they have undertaken additional years of subspecialty study to ensure comprehensive management of patients with reproductive endocrine disorders and infertility.

The Role of the Urologist

A urologist can help men, in particular, during the family building process, as they specialise in the male reproductive system. Urologists are trained to diagnose, treat and manage patients with urological disorders.

What Questions Should I Discuss with my Partner Before my Medical Visit?

- For women, will one of you be providing the egg and where will you get the sperm? Who is going to carry the baby?
- For men, will one of you contribute the sperm? Where will you get the egg? Do you have a surrogate willing to assist?
- Will both partners be tested for fertility issues?

You may also make these decisions after speaking with your healthcare provider.

What Questions Should I ask During my Medical Visit?

Being prepared with questions will ensure you get the most out of your visit. How many times have you left a doctor's office only to remember that question you were meant to ask?

Don't be shy and if you don't understand the answers, don't hesitate to ask your healthcare provider to repeat them or to put them in layman's terms.

Possible Questions for Your Fertility Specialist (For Same-sex Couples)

- Based on my test results, do I have potential fertility issues?
- If I do have potential fertility issues, how will this impact on who will carry the baby?
- Based on the test results, what are my treatment options and how much do they cost?
  – Will Medicare or my insurance pay for the testing and/or treatments?
  – Will your clinic help me determine what my insurance will cover for infertility?
- What is your IVF success rate for gestational carriers?
- What can you tell me about the risks associated with each of these procedures?
- How will I communicate with you during this whole process?
- Does your clinic provide emotional counselling or can you refer me to a counsellor who deals with same-sex couples?
- Do you recommend any complementary healthcare practices such as massage or acupuncture?

Here are some additional questions that may help you, your partner or your surrogate if undergoing OI and/or IVF.

Ovulation Induction (OI)

- How many OI cycles do you recommend before moving to IVF?
- At what point would you convert me/her to IVF or cancel my OI cycle?
- What are the risks involved?

In Vitro Fertilisation (IVF)

- What is the success rate for IVF in terms of live births per embryo transfer?
- What are the risks involved?
- How many embryos do you typically transfer per cycle?
- Can you help us access donor egg, embryo or sperm programs?

Questions for Advocacy Organisations

- What kinds of programs and services do you offer?
- Do you have a local chapter or any upcoming events in my area?
- Do you offer any financial assistance programs?

Always speak to your doctor first. Additionally, there are some resources listed over the next few pages that can provide further information and support.

Support Organisations

Access Australia

www.access.org.au
Ph: 1800 888 896;
Email: info@access.org.au

Access Australia is a national organisation, which provides numerous services and resources for people having difficulty conceiving. Its services include:

- fact sheets, newsletters and personal stories
- putting you in contact by phone or email with others sharing a similar infertility experience
- a register of infertility self-help groups
- listing of infertility clinics accredited by the Reproductive Technology Accreditation Committee (RTAC)
- listing of professional infertility counsellors across Australia
- lobbying governments for equal access to affordable, quality assisted conception treatment.

Andrology Australia

www.andrologyaustralia.org
Ph: 1300 303 878
Email: info@andrologyaustralia.org

Andrology Australia provides factsheets, journal articles and the latest news on male reproductive health.

Donor Conception Support Group

www.australiandonorconceptionnetwork.org
Email: donorconceptionnetwork@gmail.com

The Australian Donor Conception Network is a self funding organisation run by volunteers. Its members include those who are considering or using donor sperm, egg or embryo, those who already have children conceived on donor programs, adult donor offspring and donors. It offers social events for members to share their experiences, Facebook groups to enable members to stay in touch, informative emails, a library of books and links to other helpful organisations.

Endometriosis Australia

www.endometriosisaustralia.org
Email: admin@endoaustralia.org

Provides information on state contacts. Endometriosis Australia endeavours to increase recognition of endometriosis, provide endometriosis education programs, and help fund endometriosis research. They strive to build strong relationships with existing endometriosis support networks throughout the country.

Endometriosis New Zealand

www.nzendo.org.nz
Ph: +64 3 379 7959 (phone support line);
Email: info@nzendo.org.nz

Endometriosis New Zealand promotes awareness of endometriosis, provides information, education and raises funds to support endometriosis related initiatives. It includes disease information specifically designed for teenagers, a support group network, regular seminars and workshops and a free phone support line.

Polycystic Ovarian Syndrome Association of Australia (POSAA)

Email: info@posaa.asn.au

POSAA is a self-help association for women with polycystic ovarian syndrome (PCOS) and those who suspect they have it.

SANDS

Australia
www.sands.org.au
Ph: (03) 8652 5020;
Email: support@sands.org.au

New Zealand
www.sands.org.nz
Ph: 027 44 91 019;
Email: info@sands.org.nz

SANDS is a self-help support group comprised of parents who have experienced the death of a baby through miscarriage, stillbirth, or shortly after birth. It provides 24-hour telephone support, information resources, monthly support meetings, name-giving certificates and other support.

Fertility NZ

www.fertilitynz.org.nz
Ph: 0800 333 306;
Email: support@fertilitynz.org.nz

Fertility NZ is New Zealand's national network for those seeking support, information and news on fertility problems. It provides various services including:

- regional support and contact groups
- general advice and contact service
- comprehensive information brochures
- a forum for confidential feedback on any issues or concerns
- a chatroom where you can seek on-line support from people in similar situations.

Assisted Reproductive Technology

Websites of the statutory authorities that administer aspects of the ART laws in the states of Victoria and Western Australia provide broad information on ART legislation, donor registers, application procedures and links to resources, including publications.

Reproductive Technology Council (WA):
http://www.rtc.org.au

Victorian Assisted Reproductive Treatment Authority:
http://www.varta.org.au

Fertility Society of Australia:
www.fertilitysociety.com.au

Royal Australian and New Zealand College of Obstetrics and Gynaecology:
www.ranzcog.edu.au

Websites of state Health Departments also have information on ART and relevant legislation, while the various offices of Births, Deaths and Marriages address issues of parentage and donor registration.

Gay and Lesbian Parenting

A number of support and lobby groups for gay and lesbian parents provide comprehensive information with regular legislative updates as they apply.

Gay Dads Australia:
http://www.gaydadsaustralia.com.au

Gay and Lesbian Rights Lobby:
http://glrl.org.au

Rainbow Families:
http://www.rainbowfamilies.com.au

Parents Family and Friends of Lesbians and Gays (PFLAG):
http://pflagaustralia.org.au/

Australian Gay and Lesbian Law Blog
http://lgbtlawblog.blogspot.com.au/

OTHER FACTORS TO CONSIDER

Having Realistic Expectations about Getting Pregnant

For same-sex couples who want to start or build a family, setting realistic expectations about having a baby can be critical to your peace of mind. Even if you don't have fertility issues, a same-sex relationship makes the use of reproductive technologies necessary for a pregnancy in most cases, which can take time and may require numerous attempts. The good news is that same-sex couples can have biological children, and appear to be doing so in increasing numbers, but you'll need patience and knowledge of what to expect during your journey.

Dollars and Sense

Having a child is expensive in itself, but using AI, ART or surrogates to conceive and carry a child to birth can add costs above and beyond what is normally incurred. Other costs, such as legal and administration fees, may not be included and each clinic will have its own prices.

In Australia, Medicare will help cover many of the costs associated with fertility treatment or ART procedures, while New Zealand citizens may be eligible for up to two government-funded cycles of IVF. Support organisations, such as Access Australia and Fertility NZ, keep a close watch on government policy to ensure government reimbursement remains. With so many treatment options available today, the range of costs can vary dramatically. Some preliminary tests and medications may cost up to several hundred dollars, whereas multiple techniques could cost several thousand. The costs involved in your treatment will vary depending on how much and the type of assistance you require, as well as the fertility clinic or specialist you choose.

Private Health Insurance[14]

If you are considering any fertility treatments, the first step is to review your health insurance policy with a fine-toothed comb. IVF and other assisted reproductive services aren't automatically covered on policies that cover natural births and obstetrics. Even on policies which include IVF, where treatment comprises several steps, only the component which involves an admission to hospital may be covered under private hospital insurance (these may include the day surgery fees from the hospital and anaesthetist). Typically, egg collection procedures, surgical sperm retrieval if required, and embryo transfers are covered in private policies when performed in a registered day surgery facility. If deemed "socially infertile" your private insurance may not cover your hospital admissions, you should confirm what your insurance will and will not cover.

Services which occur outside of a hospital admission, including consultations and tests, may be reimbursed by Medicare or paid out of your own pocket.

Before you begin treatment, it is recommended that you ask your private health insurance company about the most appropriate level of cover for you. Check to confirm what services you will be required to pay for and that you have completed any required waiting periods. The standard waiting period of IVF treatment is 12 months but some policies also restrict benefits for up to three years. Check with your doctor and IVF clinic for more information and quotes. Further general information on private cover can be accessed at the website of the Australian Government's Private Health Insurance ombudsman: **www.ombudsman.gov.au/about/private-health-insurance**

Treatment Costs in Australia

Most fertility clinics or specialists in Australia will provide you with a detailed list of the costs involved in IVF and assisted reproduction procedures. A timeline of when fees are due and the proportion of costs covered by Medicare (where applicable) will also be detailed. You should be reassured that a large portion of the costs for pathology/diagnostic tests and some treatment procedures can be reimbursed through Medicare and private health insurance depending on your level of cover. In addition, registering for the Medicare Safety Net Scheme will provide you with increased rebates, see next page.

What is the Medicare Safety Net?

In addition to the standard automatic Medicare rebate you receive, the Medicare Safety Net covers a certain amount of the out-of-pocket costs for medical services provided after a particular threshold amount per calendar year is reached. Out-of-pocket costs are the difference between the Medicare benefit and what your doctor charges you. This includes specialist consultations and outpatient IVF services. In order to be eligible, all of your family members must register for the Medicare Safety Net (even if they are not listed on your Medicare card) as individual medical costs are combined and you will reach a threshold sooner. Individuals are automatically registered. Many couples accessing fertility treatment for the first time are unlikely to have reached the Medicare Safety Net threshold prior to beginning treatment. This means that your first treatment cycle is likely to cost you more than the subsequent treatment cycles within the same year. Please note that at the end of December each year, your amount towards the threshold will return to zero and not roll over to the next year.

For more information on the Safety Net threshold amount relevant to you, and to register, call Medicare on **132 011** or by filling in an online form available at **https://www.humanservices.gov.au/individuals/services/medicare/medicare-safety-net**

Publicly Funded Treatment Costs in New Zealand

Joining a PHO (Primary Health Organisation) will entitle you to subsidised visits to your GP and may also cover the costs of certain laboratory tests. Specialist care through the public system is free but waiting times will vary depending on your region and the type of treatment required. Private health insurance may pay a certain amount of your costs towards certain tests depending on your level of cover. For more information visit **www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations**

Government-funded Fertility Treatments

If you are a New Zealand citizen or have permanent residency, you may be eligible for two 'packages' of government-funded fertility treatment. A 'package' includes:

- One full IVF cycle including transfer of any frozen embryos, or
- Four cycles of intrauterine insemination (IUI), or
- Other treatment such as ovulation induction, donor sperm insemination or surgical sperm retrieval

For more information visit **www.fertilitynz.org.nz/information/faq**

Legal Parentage and Related Considerations

Donor Sperm or Eggs

There are important considerations when using donor eggs or sperm, or a surrogate. For couples using a fertility service, you will generally find that the psychological, ethical and legal aspects of family forming using these methods is thoroughly reviewed and is a regulated part of the process. For those people using donated sperm that is not managed by a clinic, it is a good idea to consult your doctor, lawyer and possibly a specialist counsellor for their guidance. Importantly, in terms of parental rights and responsibilities, across Australia, legislation states that egg and sperm (and even embryo) donors are not the legal parents of children artificially conceived with their reproductive tissue. The recipient/s who have consented to the procedure are the legal parents.

Similarly in New Zealand, donors have no legal rights or responsibilities for any conceived child. In both countries, information about donors is kept on official registers and may be accessed by the child once they are 18 years of age. This does not preclude earlier interaction between child and donor. Indeed, while egg and sperm donors may not be listed on a child's birth certificate and are not legal parents, Australian Federal law nevertheless allows people with 'an interest' in a child's welfare (e.g. donor, surrogate, grandparent) to apply for a court order allowing them contact or other arrangements. If you are engaging a known donor, you may find it particularly useful to have a written agreement, especially if there is a prospect of ongoing contact. Such an agreement is not legally binding – Australian law does not allow you to make a legally enforceable agreement about a child – but it could be beneficial for clarity among all parties.

Surrogacy

As noted previously, the laws governing surrogacy agreements vary across Australian states, and rights of same-sex partners regarding parentage and the procedures to establish legal parentage can differ. It is in your interest to make arrangements in a state where the legislation is most aligned with your needs. Having said this about the broader legal landscape, it is also very important to understand that any individual surrogacy agreement that is reached is not a legally enforceable or binding one – the agreement is not a contract. The birth mother (and her partner) are considered the legal parents until an official transfer of parentage is approved. Fortunately, the legislative changes in various states in recent times have helped codify and facilitate this transfer.

In New Zealand there is currently no law on surrogacy. Intending parents are usually referred by their fertility clinic or specialist to the National Ethics Committee on Assisted Human Reproduction (NECAHR), which gives approval on a case-by-case basis according to a set of guidelines. These guidelines include a requirement that the surrogacy be non-commercial. Despite any surrogacy arrangement, a birth mother is the legal mother of a child and has rights in relation to day-to-day care, contact and guardianship.

If all this information seems daunting to you, be reassured that in Australia, full legal and ethical consultation will be part of the process of any surrogacy arrangement before it can go ahead.

Remember, qualified professionals can help you navigate the emotional and legal complexities.

Addressing Societal Stereotypes[15]

The question inevitably arises, 'To tell or not to tell?' As a same-sex couple planning to start or build a family, you may be walking around with a tremendous burden on your shoulders. Regrettably many a lot of people in society still don't get it when it comes to gay or lesbian couples having kids, let alone expressing the desire to have them. Some of those people may be members of your own family. Therefore, you may want to confide only in people you feel comfortable with. Remember, you don't owe anyone an explanation for your decision to start a family, especially if you also have fertility issues. These topics are personal. It is up to you and your spouse or partner if you want to share this information. Unfortunately, some stigmas may exist regarding homosexuality, which can lead to false assumptions about parental abilities and the resulting wellbeing of their children. But when the time comes to tell your family or even your boss, you have science on your side. If necessary, you can explain that studies show children of lesbian and gay parents fare as well as those of heterosexual couples in terms of emotional, cognitive, social and sexual functioning.

It is the nature of the familial relationships and family interactions that have a greater influence on the development of the child – not your gender preference. You can also point out that several misconceptions have been shown to be false, including that homosexual parents address parenting fundamentally differently than heterosexual parents.

Remember that having children is one of our most innate drives as human beings, and every couple should have the right to build their own family. While the process is no doubt more complicated for gay couples, it may be possible in today's society for you to become parents and have genetically related children.

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Looking for more information?

Other booklets in the ***Pathways to Parenthood*** series are available at www.fertilityportal.com.au/merck:

- Your step by step guide to treating infertility
- Overcoming male infertility
- Endometriosis
- Polycystic ovary syndrome (PCOS)
- Ovulation induction (OI)
- Intrauterine insemination (IUI)
- ***In vitro*** fertilisation (IVF) & intra-cytoplasmic sperm injection (ICSI)
- Female infertility and assisted reproductive technology (ART)
- Managing the stress of infertility

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