Fertility Access
R·I·G·H·T·S
A working group of the Victorian Gay and Lesbian Rights Lobby

A RESPONSE TO POSITION PAPER 1

of the Victorian Law Reform Commission's Enquiry

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

6 JUNE 2005

INTRODUCTION

THE FERTILITY ACCESS RIGHTS LOBBY

The Fertility Access Rights Lobby (FAR) was established in November 1999 to raise awareness of the discrimination and health risks inherent in the restriction of access to assisted reproductive technology specified by the Victorian Infertility Treatment Act (1995). Voluntary membership up until December 2004 has included over 100 people from diverse areas including lesbian and gay parents, prospective parents, single heterosexual parents, health care providers, counsellors, family therapists, lawyers and human rights advocates. FAR joined the Victorian Gay and Lesbian Rights Lobby to become a working group of that broader organisation in December 2002.

FAR's aims include:

- advocacy for law reform to open access to donor insemination and adoption for lesbian, gay and single people; through representation on the Attorney General's Advisory Committee on Gay and Lesbian issues, development of fact sheets, written articles and meetings
- community building to create connection between people creating diverse families
- community education about lesbian and gay family formation and support

FAR has been supported by a range of organisations including VicHealth, the ALSO Foundation, Reichstein Foundation, Victorian Gay and Lesbian Rights Lobby, Gay and Lesbian Health Victoria, Women's Electoral Lobby, National Women's Justice Coalition, Women's Health Victoria, Women's Health West, Victorian AIDS Council, the Australian Council of Single Women and their Children, the Bouverie Centre (Family Therapy), the Australian Lesbian Medical Association, Port Phillip and Darebin Councils. Various community education events have been sponsored by Absolutely Women's Health, the health promotion unit the Royal Women's Hospital, and law firms including Slater and Gordon, Blackburn, and Kelly and Counsel.

In August 2003, FAR organised the first Rainbow Families Conference, a community event that was attended by 150 people. In February 2005 a second Rainbow Families conference was held involving more than 250 people, including a large children's program. An active Rainbow Families email group established at the first conference has maintained connections between a diverse and active population of people interested in lesbian and gay families.

THE LOVE MAKES A FAMILY CAMPAIGN

The Fertility Access Rights Lobby established the Love Makes a Family community education and lobbying campaign in December 2004, with support from the Victorian Gay and Lesbian Rights Lobby, and auspicing from the ALSO Foundation which enabled FAR to successfully apply for limited funding to the Reichstein Foundation.

Since then, the campaign has been very active in the GLBTI (gay, lesbian, bisexual, transgender and intersex) community, as well as in the broader community, supporting and encouraging people involved in or supportive of GBLTI and other diverse families to get active in changing both the law (through participation in the VLRC's Enquiry) and social attitudes.

The Love Makes a Family Campaign currently has a coordinating group, along with a number of working groups and an actively-involved email list (additional to the Rainbow Families list, with a membership of approximately 80). Activities to date have included media work, public forums stalls at a variety of community events, liaison with GLBTI and mainstream organizations and publication of resources including a website at www.lovemakesafamilyaustralia.org.

THIS SUBMISSION

This submission has been developed to be consistent with the Fertility Access Rights Lobby and Victorian Gay and Lesbian Rights Lobby submissions made in the initial round of consultations in 2004, which were themselves developed by FAR Lobby Members including a medical practitioner, lesbian parents, community activists, VGLRL committee members and lesbian families researchers.

Recommendations made in the Prospective Lesbian Parents 2004 submission have also been considered (developed through consultation with 25 prospective and current lesbian parents/couples), as have responses to the Love Makes A Family survey and the Victorian Gay and Lesbian Rights Lobby survey conducted during Midsumma 2005, and via the Love Makes a Family website. A draft of this submission has been circulated for comment to the Love Makes a Family coordinating group, FAR members, and the Rainbow Families and Love Makes a Family email lists.

RESPONDING TO THE TEN KEY QUESTIONS

1. Do the Commission's recommendations adequately protect children from unacceptable risks?

While FAR welcomes the Commission's intention in seeking to protect children from unacceptable risks, we have concerns not only about the longer-term implications of legislating to exclude certain 'categories' of people from treatment, and also about how such regulations may be enacted in clinic practice. This is discussed further below, and in response to Interim Recommendations 2 to 4.

Despite these misgivings, FAR has engaged with further questions and recommendations about how such an approach might be regulated and practiced, should this direction be adopted.

2. Do the Commission's recommendations leave sufficient room for clinic discretion in the majority of cases?

FAR notes that some clinics already 'turn away' people seeking treatment, and welcomes additional transparency and right to appeal in processes which exist already. We also note that the approach which argues that such decisions are 'between a woman and her doctor' are based on an assumption that clinical services make decisions around treatment that are based solely on medical need (however that is defined in legislation/regulations).

The experience of many lesbian, gay, bi and trans Victorians, including of lesbian women seeking fertility treatment in Victoria, is that this is not the case. The values and assumptions of clinicians come into play at every point, and FAR welcomes all recommendations of the Commission that increase transparency and specifically prohibit discrimination on the basis of sexual orientation and marital status, and recommend that this be extended to prohibiting discrimination on the basis of all other categories including race, ethnicity and disability. However as stated we are very concerned about an approach that grants clinics the power to exclude anyone from treatment – please refer to our discussion under Interim Recommendations 2 to 4.

3. Are the situations where a presumption against treatment applies appropriate? Should the presumptions be expanded or restricted?

Please refer to our discussion under Recommendations 2 and 4.

4. What steps should clinics take to find out whether a prospective patient falls into one of categories where there is a presumption against treatment?

Please see our discussion under Recommendation 16.

5. What categories of people should be appointed to the ITA review panel and ethics committee?

It is not only professional backgrounds that matter in the make-up of such panels or committees, but also the values and assumptions of those present around parenting and family, including community representatives. We suggest that there should be capacity for more community representatives, in recognition that different parts of the community may well hold very different, often opposing, views on such issues. Please refer to our discussion below.

6. Should the legislation impose requirements about the proportion of men and women on the review panel and ethics committee?

Yes, we believe this would be useful. There should be a requirement of at least 50% women, or a majority of women, in recognition that women are disproportionately affected by decisions around reproduction, and of the history (and ongoing existence) of male domination in many of the more powerful professions associated with reproductive technologies.

7. Should posthumous use of gametes and embryos be permitted, and if so in what circumstances?

Yes, where express written consent has been given.

8. If a person is permitted to use the gametes of his/her deceased partner in a treatment procedures, should there be a period of time within which the gametes must be used?

No, however the person should be encouraged to explore the issues and implications through counselling.

9. Should there be a transitional provision to deal with cases where gametes or embryos of a deceased person are already in storage, but the person did not express his/her intentions about posthumous use, and the surviving partner wishes to use the gametes or embryos in a treatment procedure?

FAR does not have a particular position on this issue, however we note that such treatment would be allowed in other Australian jurisdictions, and thus Victorian law preventing such use, or preventing the person 'exporting' gametes for such use interstate is inconsistent and discriminatory.

10. Do you have any other comments about the interim recommendations?

Please see our discussion points below, in particular our response to Recommendations 1 and 17.

RESPONDING TO THE INTERIM RECOMMENDATIONS AND ISSUES

INTERIM RECOMMENDATION 1

The Infertility Treatment Act should set out principles to guide the administration of the Act, and the carrying out of activities regulated by the Act. These principles are:

- the health and wellbeing of children born as a result of the use of assisted reproductive technology (ART) must be given priority in decisions concerning the use of such technologies;
- at no time should the use of reproductive technologies be for the purpose of exploiting (in trade or otherwise) either the reproductive capabilities of men and women or the children resulting from the use of ART;
- all children born as a result of the use of donated gametes have a right to information about their genetic parents;
- the health and wellbeing of people undergoing ART procedures must be protected at all times;
- people seeking to undergo assisted reproductive procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion.

The Fertility Access Rights Lobby (FAR) supports the overall intention of Interim Recommendation 1, believing that:

- the rights and best interests of the child should remain central to the *Infertility Treatment Act* and the *Adoption Act*.
- a child's right to equality before the law and freedom from discrimination should be protected. That all relevant legislation should be amended to provide protection against discrimination on the basis of sexual orientation, family formation and the sexual orientation of a person's parents.
- a child's right to life and development should be protected. That eligibility for ART should be broadened to include all people who require ART in order to conceive and bear a child. That services such as freezing and screening of known donor sperm be provided. These measures will protect children against the risk of infection by unscreened donor sperm.
- a child's right to information about their biological heritage should be protected. That the laws and regulations in this area be broadened to facilitate contact between donor and child/ren produced through his donation earlier than age 18 if this is in the best interests of the child and desired by all parties. FAR does express concern, however, at recent news that Victorian legislation guaranteeing a child's right to identifying information at age 18 also means that donor's will be able to contact children born as a result of their donation. FAR strongly argues that the volition to make contact should rest solely with the children born through ART, and that legislation should be amended to ensure that this is the case.

FAR supports the statement in Section 2.36 (Pg 11) that "the elimination of discrimination in this area will also promote the health and wellbeing of children born to single women and people in same sex relationships in a direct way, by allowing more women to access to the benefits and safe guards offered through the licensed clinic system."

FAR supports the Interim Recommendation that the reproductive capacities of women and men, and children born as a result of ART should not be exploited, in the sense of exploitative use. However, we

do not necessarily believe that this should automatically preclude legislation allowing and regulating surrogacy.

There are a wide range of positions on surrogacy in GLBTI communities represented within FAR. For example, there are those who do not believe that banning surrogacy – in effect a victimless crime – stops it from happening. Instead, it creates an 'underground' of private surrogacy arrangements which, unregulated and unprotected by legislation, may well result in much great exploitation of women that would be potentially the case was surrogacy legalised. Those requiring surrogacy to achieve parenthood also seek out other options including travelling interstate for heterosexual couples (who fit the 'criteria' for NSW clinics offering surrogacy) or overseas for the very few gay men who can afford this option (currently priced at $150,000 plus).

FAR is currently in the process of formulating a detailed position on surrogacy engaging with a range of issues including potential exploitation of women, right to parenting information by children born through surrogacy, and the options for gay men to become parents. We look forward to the opportunity discuss and explore these issues in greater detail in response to the coming VLRC Position Paper on Surrogacy.

We also note that application of the principle proscribing 'trade' in gametes has historically meant that gamete donors have not been able to receive any monetary compensation for their donation, which we argue is a key reason for the extreme shortage of both donor sperm and ova – witness the contrast with jurisdictions such as the US, where compensation of donors is allowed. The impact of this historic policy and consequent donor sperm shortage for lesbian women is the very high number of half-siblings being born to women within a relatively small, tight-knit lesbian community.

The shortage of clinic donor sperm also effectively raises the 'price' of donor insemination services in interstate clinics – this, along with concerns about the restricted gene pool – excludes many women from treatment and/or pushes them into potentially less 'safe' or stable known donor arrangements. Conception with a known donor is the preferred option for some lesbian/single women, however FAR argues that this should be a matter of a preference freely chosen, not forced on women by economics and other issues.

INTERIM RECOMMENDATIONS 2 – 4

2. If, before a woman undergoes treatment, a doctor or counsellor believes that any child that might be born as a result of a treatment procedure may be at risk of physical abuse, sexual abuse, emotional/psychological abuse, or neglect because of:

(a) an ongoing problem concerning the physical or mental health of the person seeking treatment or that of his or her partner (if any); or

(b) some other concern the doctor or counsellor has about the person seeking treatment or his or her partner (if any);

the doctor or counsellor must seek advice about whether or not to proceed with a treatment procedure from a clinical ethics committee within a relevant hospital, which must include a child development expert, a psychologist or psychiatrist with expertise in the prediction of risk of harm to children and a doctor with experience in ART.

3. Where a clinical ethics committee decides that a person or couple should not be treated:

(a) the person or couple may apply to the ITA review panel to have the decision reviewed; and

(b) a clinic must not treat that person or couple unless the committee's decision is reviewed by the ITA review panel, and the panel decides there is no barrier to treatment or decides that subject to compliance with certain conditions there is no barrier to treatment.

4. A licensee should not treat a person without the approval of the ITA review panel where the person seeking treatment and/or his/her spouse or partner (if any):

(a) has had charges proven against them in Victoria or elsewhere for a serious sexual offence; or

(b) has been declared a serious violent offender under the Crimes Act 1958 (Vic) or any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia); or

(c) has had a child protection order (but not an interim protection order) made in respect of one or more children in their care under a child welfare law of Victoria or any equivalent law of the Commonwealth or any place outside Victoria (whether or not in Australia).

With regard to Interim Recommendations 2 to 10, FAR believes that these are controversial and complex issues. We acknowledge that panels similar to the recommended ITA review panel already exist and that clinics like Melbourne IVF have "turned away" up to three or four patients seeking treatment each year for at least five years on the grounds of mental health issues or criminal convictions. (*Herald Sun*, 14 May 05, p 20). In this sense, FAR welcomes additional transparency and right to appeal in processes that exist already.

However, FAR has serious concerns about the whole approach of regulating around people's 'fitness' to parent. Australia has a shameful, relatively recent (and in some cases ongoing) history of deciding – through legislation, regulation, the decisions of courts and the practice of welfare and health authorities – which 'categories' of people were not fit to be parents. This has resulted, at different times, in children being removed for example from Indigenous parents, from lesbian, gay and transsexual parents, from poor and homeless parents, and from parents with intellectual, psychiatric and/or physical disabilities. It has also resulted in sterilisation, often without informed consent, of various categories of people, in particular women with intellectual, psychiatric and/or physical disabilities.

To specifically legislate the capacity to exclude certain categories of people from treatment is to place enormous power into the hands of those making such decisions, including those charged with reviewing them (such as for example the proposed ITA review board). Legitimating the idea that it is acceptable to exclude some people from treatment (and thus from parenthood) also opens a 'wedge' for further 'categories' of people to be excluded from treatment by subsequent legislators with more discriminatory notions of what constitutes acceptable 'family'. It has uncomfortable echoes of the arguments for eugenicist policies that were openly promoted by some politicians in Australia into the mid-1940s. The Commission's argument that the use of 'taxpayer's money' for ART justifies such legislative approaches is not strong enough, in our view, to justify the issues and risks it raises.

Thus while FAR may agree that, for example, it is desirable that people convicted of violent sexual crimes do not have access to public funds in order to become parents, we are not convinced that the potential benefit (in few cases) of this is worth the risk of the abuse of such processes, either in practice, or in future expansion of the categories of people excluded from treatment through legislation or regulation by future policy-makers. We also have particular concerns about some of the proposed criteria for potential exclusion, discussed below.

However, despite our opposition to this overall approach of legislating exclusion, FAR believes it is important for us to engage with the Commission's specific questions about what processes should be put in place should such an approach be taken. FAR does appreciate that the Commission is interested in creating a formal system that implements "a decision-making process that is transparent, procedurally fair and consistent." To this end FAR concurs with the statement in Section 2.59 (p 17) that, in regards to Interim Recommendation 4, "priority to be given to the health and wellbeing of children, but recognises that decisions to exclude people from treatment should be subject to proper review and consideration".

FAR also supports the statement in Section 2.46 (p 14) that "the proposed process will ensure that decisions about access to treatment are not based on discriminatory assumptions about parenting

capacity of particular groups of people". Nonetheless FAR expresses serious concern about prospect of legislating to allow practitioners to potentially exclude people on the basis of concerns arising from their 'physical or mental health', or on the basis of 'other concerns'. The latter is extremely and inappropriately vague, giving far too much leeway to practitioners in our view. The former is very concerning given the history and ongoing practice of removal of children from parents with psychiatric/intellectual disabilities, and the extreme inadequacy of parenting support and welfare provisions for parents with mental health or psychological concerns.

In addition we note that it was only relatively recently that 'homosexuality' was actually separated from ideas of 'mental illness', and that such attitudes persist within medical and associated professions. If the exclusion-based approach is taken, we recommend that the criteria around 'physical and mental health' be removed, and that advocates be made available to support people throughout any process, i.e through the clinic ethics committee or the ITA review panel.

We also argue that the suggested processes inappropriately places the 'burden of proof' on the people seeking treatment – ie being required to argue before a large professional panel why they should be given treatment. We note that this is likely to be an extremely intimidating process, which would disadvantage people with psychiatric and/or intellectual disabilities and those without the confidence and/or education to argue eloquently on their own behalf. At the very least, we believe that advocates should be made available to those coming before such committees or panels.

FAR is also aware that institutionalised homophobia is an ongoing concern for many in our communities, and offer as evidence for this within fertility services the continuing practice of allowing sperm donors to exclude lesbians and single women from being the anonymous recipients of their donations. We argue that no other form of institutionalised discrimination –allowing donors to prevent their donations being used by Aboriginal people, or Muslims for example – would be contemplated, let alone supported by clinics. We are also concerned by anecdotal experience in jurisdictions such as the UK and New Zealand that despite non-discriminatory laws, some doctors are excluding people from treatment on the basis of personal homophobic beliefs about the "best interests of children".

We strongly recommend all measures to guard against such outcomes should the exclusionary approach be taken, including that the Terms of Reference of any panels or committees empowered to exclude people from treatment (and briefings to practitioners, medical or otherwise, with the power to 'raise' such concerns) clearly state that homophobia, sexism, racism and discrimination on the basis of ability, religion or other grounds are unacceptable, unlawful and discriminatory and should bear no relevance on the discussion or decisions of the practitioner, panel or committee.

INTERIM RECOMMENDATIONS 5 - 10

5. The Infertility Treatment Authority should establish a review panel to decide whether or not a person is eligible for treatment where:

(a) one of the presumptions against treatment in Interim Recommendation 4 applies to a person or his/her partner (if any); or

(b) a person or couple has applied for review of a clinical ethics committee recommendation that they not be treated because of a concern about the health and wellbeing of any child that might be born as a result of a treatment procedure.

6. The purpose of the ITA review panel will be to consider whether or not a person (or couple) who:

(a) meets the criteria in recommendation 4 (a, b or c); or

(b) has been refused treatment by a clinical ethics committee pursuant to recommendation 2 and has made an appeal to the panel, may or may not proceed with treatment.

7. The review panel must give the person or couple who may be denied treatment the opportunity to explain why they should be allowed to proceed with treatment.
8. If the review panel decides that a person should not be treated, a clinic must not treat that person or couple.
9. If the review panel decides that a person should not be treated unless he/she (or partner) meet certain conditions, a clinic must not treat that person (or couple) until those conditions have been met.
10. Where the review panel decides there is no barrier to treatment, or there is no barrier to treatment once certain conditions have been met, the decision of the panel must be conveyed to the clinic and to the person (or couple) seeking treatment. In such circumstances a clinic will not be compelled to treat the person (or couple).

ISSUE

2.60 The commission has developed a tentative model for the composition of the review panel and the factors that should be taken into account when a case comes before it. We seek your views and comments about these suggestions.

2.61 We suggest the membership of the review panel comprise a:

• child development expert;

• person with expertise in the clinical medical practice of ART;

• member of the Infertility Treatment Authority;

• person with expertise in psychology or psychiatry;

• person with expertise in a relevant area of law;

• person with knowledge of the ethics of clinical medical practice;

• person with understanding of the concerns of people with ongoing disability or illness; and

• layperson sitting in the capacity of a community representative.

We also seek comments about whether the legislation should impose requirements about the proportion of men and women on the panel, as is the case for the South Australian Council on Reproductive Technology.50

As stated above, while FAR has concerns about the whole approach, we welcome any recommendations which increase transparency of proposed process, and those which enable a right of appeal by those excluded from treatment. We also suggest that advocates or other supports be made available to people brought before such a committee or panel. We suggest that the panel above also include a social worker or counsellor, and that there be capacity for more than one community representative.

We are sure the Commission is aware that there are a wide range of views in the community on issues around ART and parenting, and these must be broadly represented on any decision-making body. We support the principle of requiring at least 50 percent representation by women on the panel. FAR also argues that it is not only professional backgrounds/expertise of panel members that matters, but their values and approaches to critical issues around parenting, ART and family. Thus individuals should be selected for panel membership whose attitudes reflect the principles of the Act, in particular those of non-discrimination and openness to the diversity of families in society.

INTERIM RECOMMENDATIONS 11 – 13

11. The requirement that a woman who undergoes a treatment procedure be 'married and living with her husband on a genuine domestic basis', or 'living with a man in a de facto relationship' should be removed.
12. The Act should otherwise be amended to recognise that some people to whom the Act applies will be married or in a heterosexual de facto relationship, some will be in a same-sex relationship and others will not have a partner**.**
13. 'Partner' should be defined in section 3 to include a spouse or 'domestic partner'.57

FAR unequivocally supports Interim Recommendations 11, 12 and 13.

FAR supports the removal of all barriers to ART that are discriminatory. FAR argues that there should be equality under the law and that legislation regulating access to ART and adoption should apply equally to all groups and individuals in Victoria, regardless of sexuality, martial status, ability, race, ethnic background or belief system.

FAR supports the statements made by the commission in Section 2.65 and Section 2.68 (Pg 19) respectively that:

- after reviewing the social research on outcomes for children born to and raised in a diversity of family types, "this research does not support the view that martial status requirement should be retained to safeguard the health and welfare of children", and
- "…the marital status requirement is not only inconsistent with the principal of non-discrimination, but it also bears no relationship to the health and wellbeing of children…".

Further, FAR supports the Commission's statement in Section 2.66 (p 19) that "laws reinforcing social attitudes which stigmatise non-nuclear families may have a negative effect on children born to single women or women in lesbian relationships."

INTERIM RECOMMENDATION 14 and 15

14. Before a woman undergoes a treatment procedure a doctor must be satisfied that the woman is:

(a) in the circumstances in which she finds herself, unlikely to become pregnant other than by a treatment procedure; or

(b) unlikely to be able to carry a pregnancy or give birth to a child without a treatment procedure; or

(c) likely to transmit a genetic abnormality or a disease to a person born as a result of a pregnancy conceived other than by a treatment procedure (including where the woman's partner is the carrier of the genetic abnormality or disease which is likely to be passed on to a child conceived other than by a treatment procedure).

For the purpose of (a), the doctor may be satisfied that a woman is unlikely to become pregnant other than by a treatment procedure if she does not have a male partner.

For the purpose of (c), the doctor must seek advice from another doctor who has specialist qualifications in human genetics or infectious diseases.

15. Where a woman does not satisfy these requirements she may apply to the ITA review panel, which may authorise the clinic to provide the treatment procedure. In deciding such applications the review panel should have regard to the guiding principles of the Act.

FAR unequivocally supports Interim Recommendations 14 and 15. FAR agrees that the definition of "unlikely to become pregnant' should be broadened to include anyone who has need of ART to conceive and bear a child. This may be for medical reasons, such as unknown or known infertility, or

for any other reasons, such as being a single woman, or in a same-sex relationship. This should be a matter of self-definition.

FAR supports the statement made in Section 2.76 (Pg 21) that:

- "the Commission recommends that a women be eligible for treatment if she is unlikely to become pregnant, and that her inability to become pregnant…be assessed on the basis of the circumstances she finds herself (be it single, in a same sex relationship, psychologically averse to having sexual intercourse with a man, or otherwise)."

With regards to Recommendation 15, FAR acknowledges that the proposal of establishing the ITA review panel (as outlined in Section 2.61 (Pg 18)) may be necessary to arbitrate such decisions.

INTERIM RECOMMENDATION 16

Where an approved doctor, scientist, counsellor or the Infertility Treatment Authority considers that a new development in treatment or a new use of treatment raises ethical concerns, the matter must be referred to the ITA ethics committee for advice. In reaching a decision, the ITA ethics committee must consult with clinics and may choose to undertake further public consultation.

ISSUE

2.80 The commission has developed a tentative model for the composition of the ITA ethics committee. We seek your views and comments about these suggestions.

2.81 We suggest that the membership of the review panel comprise:

• the Chairperson of the ITA;
• a person with knowledge of the ethics of clinical practice;
• a person who has expertise in law;
• a person who has experience in public health;
• a person who has experience in social research;
• a person who has experience in the clinical medical practice of assisted reproduction;
• a person who has experience in nursing or allied health practices;
• a person with understanding of health consumer issues;
• a person with understanding of the concerns of people with a disability;
• a person with expertise in philosophy and applied ethics; and
• a layperson sitting in the capacity of a community representative.

FAR welcomes the Commission's recognition that a process is needed to deal with future changes in both reproductive technologies and use of them in the community. We would argue for an open and strongly consultative approach. Even more strongly than in the case of hospital committees or treatment review panels (see above) we argue that the above proposed panel should have capacity for more than one community representative. We are sure the Commission is aware that there are a wide range of views in the community on issues around ART and parenting, particularly when it comes to new and emerging issues around changes in technology and uses of technology. We believe all such views must be broadly represented on such a panel.

FAR supports the principle of requiring at least 50 percent representation by women on the panel. FAR argues that it is not only professional backgrounds/expertise of panel members that matters, but their values and approaches to critical issues around parenting, ART and family. Thus individuals should be selected for panel membership whose attitudes reflect the principles of the Act, in particular those of non-discrimination and openness to the diversity of families in society.

INTERIM RECOMMENDATIONS 17 and 18

17. If access to artificial insemination is extended to single women and women in same-sex relationships, clinics should no longer store sperm from screened donors for the purposes of providing it to women to self-inseminate.

18. Section 7(1) of the Act should be amended to read:

1) A person may only carry out artificial insemination of another woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed for the carrying out of donor insemination if he or she:

a) is a doctor approved under Part 8 to carry out donor insemination; and

b) is satisfied that the requirements of Divisions 2, 3 and 4 and section 36 (ie the counselling, consent and information provisions of the Act) have been met.

2) It is not an offence for a woman or her spouse or domestic partner (if any) to carry out artificial insemination of that woman.

FAR does not support Interim Recommendation 17. We know from our contact with large number of prospective and current lesbian parents in the community that even if donor insemination is made available within clinics to all women who need it to conceive, many women will continue to at least begin their attempt to conceive through self-insemination. This is for the very simple reason that, like heterosexual couples, many lesbian couples would prefer that their attempts to create a family stay within the intimate, private realm, and not be unnecessarily medicalised. It is simply unrealistic to think that women will no longer choose to self-inseminate if clinic donor insemination is made widely available, as is implicitly acknowledged by the Commission's recommendation that self-insemination be decriminalised.

If the Commission is to be consistent with its own principles outlined in Interim Recommendation 1, that the Act must prioritise the best interests (including health) of children born through ART, and the health and wellbeing of all parties involved, it should endeavour to ensure that risk is minimised and safety maximised for all forms of ART, including home self-insemination. We believe that this should include the provision of information and support (including counselling) to enable the arrangements made for and the practices of self-insemination to be safe, stable and effective. At present this kind of information is primarily provided by volunteer community self-help groups such as Prospective Lesbian Parents, Maybe Baby (a mixed gay and lesbian group) and Gay Dads Victoria (a new group); and by some community-based health care providers and counsellors.

Thus FAR supports the current practice to allow storage and screening of known donor sperm for the purpose of self-insemination as allowed under ITA guidelines '*Storage of sperm by women using known donors for the purpose of self-insemination : Interim conditions imposed under s106 Infertility Act 1995.'*

It is very unclear from the information provided by the Commission as to what it means that a doctor 'approved under Part 8 to carry out donor insemination' may do so provided they are satisfied that the counselling, consent and information provisions of the Act have been met. Does this mean that support with insemination will be able to be provided by doctors other than through the clinics or hospital where such services are currently offered?

As outlined above, FAR argues that the law should recognise the reality that some women will continue to choose self-insemination as a way to attempt conception. Thus all efforts must be made to maximise safety for those making such a choice. For example, clinics should still, under the Act, be available for people to access for counselling and medical care, even if they do not want to store or screen sperm. Self-insemination should not be treated as a criminal offence, regardless of who

performs the insemination, as this potentially increases the health risk to birth mother and child by discouraging GPs and other health providers from providing support or referral.

FAR supports the following:

- That health service providers be encouraged to support women who are self-inseminating with appropriate testing, and referral for services including counselling, donor insemination, investigation of possible fertility issues, instruction on correct techniques for self-insemination, storage and screening of donor sperm.
- That ART services offered be broadened to include providing women with screened donor sperm (from their own known donor or from the clinic) for self-insemination, counselling and instructions for correct techniques for self-insemination.
- That access to ART, including self-insemination with clinic-screened sperm, including consent requirements and supportive counselling be undertaken prior to having access to ART. Such counselling would be with all parties involved: the prospective birth mother, her partner if she has one, their known donor (if they have one) and his partner – if this is appropriate and desired by the parties.
- That counselling be given by counsellors trained in and sensitive to all the issues relevant to our diverse families, aimed at establishing that all parties had explored the issues involved not only with the outcome (i.e. the child and their roles in her/his life) but also the likely process.

INTERIM RECOMMENDATION 19

Donors should not be allowed to specify qualities or characteristics of the unknown recipients of their donated gametes and embryos.

FAR unequivocally supports Interim Recommendation 19 and also supports the recommendations made in Section 4.22 and Section 4.23 (Pg 34).

FAR argues it is discriminatory to allow people who are donating semen to an unknown recipient to stipulate qualities or characteristics of the recipient, and that this practice should stop. We offer the ongoing practice of allowing sperm donors to discriminate against single women or lesbians who may be potential anonymous recipients of their donation as evidence of institutionalised homophobia within fertility services, even those which have historically been as supportive of lesbian access to services as possible within current legislation. The institutionalisation of such discrimination would never have been contemplated or supported by fertility services on any other basis (e.g. race) – its continuing practice is of great concern to FAR, particularly in light of those recommendations which might increase the power given to practitioners to exclude people from treatment, and anecdotal evidence of practitioners in other jurisdictions effectively circumventing anti-discrimination regulations based on their own personal value systems.

ISSUE

Regarding the exclusion of certain groups from donating to clinics, in particular gay men.

4.21 Changes in clinic practices appear to have met these concerns. The ITA advised clinics on 20 September 2001 that the recruitment of homosexual men is not automatically excluded under Victorian legislation. The ITA received advice from the Director of Public Health, Professor John Catford, that the Health Act 1958 does not indicate that a 'yes' answer to the question on the Tissue/Semen Donation Statement requires the person to refrain from donating until their health status is ascertained. Professor Catford advised the ITA that this 'is a matter for risk assessment by the medical practitioner or other person dealing with tissue donation'. It is therefore at the discretion of the doctor to accept donors even if they say yes to some aspects of the Tissue/Semen Donation Statement. The directive also leaves to the discretion of the doctor a decision about any person who admits to having injected non-prescribed drugs.

4.22 It has not been clear to people wishing to access clinical services that a clinic may accept donors who answer 'yes' to some questions on the Lifestyle Declaration. In light of the confusion regarding the criteria for eligibility to donate, particularly in relation to gay men but also to people who have ever injected non-prescribed drugs, the commission recommends the Tissue/Semen Donation Statement be reviewed and clinics provide information to people seeking to donate about the way clinics use answers to questions in the statement.

Sperm donors should be screened out on the basis of high-risk activities. High-risk activities could be initially ascertained using a statement of risk behaviours, rather than the existing lifestyle declaration.

ISSUE

4.23 The commission has received advice that the current state of knowledge of HIV and HCV detection supports the reduction of the six-month quarantine period prescribed in the Health Act.101 The commission therefore recommends the Department of Human Services and the Infertility Treatment Authority seek advice on the quarantine period which should apply to donated gametes.

FAR supports that the requirement for a six-month quarantine of donor gametes be reduced to a period that is medically justified.

INTERIM RECOMMENDATIONS 20 - 26

20. Where people have expressly consented to the use of their gametes to treat their partner or an unknown recipient after their death, the clinic should be able to use those gametes in a treatment procedure after the person has died.

21. Where a person has died leaving express written instructions that his/her gametes are not to be used in a reproductive treatment procedure, then the clinic may not use those gametes.

22. Clinics should ensure that people's wishes about posthumous use of their gametes are recorded. This should apply to donors and to people who are involved in treatment programs.

23. Clinics should contact all people whose gametes are already in storage to ascertain their wishes with respect to posthumous use.

24. Donors who do not consent to posthumous use of gametes should be advised to make arrangements for the clinic to be notified if they die.

25. Where a person involved in a treatment procedure has expressly consented to his/her partner using an embryo created from his/her gametes and the gametes of another person, or to the donation of the embryo to another person after his/her death, the clinic may use that embryo after the person has died in the ways stipulated in the consent.

26. Where an embryo has been created from donated gametes, with the consent of the donor, the clinic may use that embryo in a treatment procedure after the donor's death.

Yes, FAR supports recommendation 20 where express consent exists. Unknown recipients of gametes donate by donors who have since died should be advised of this, and encouraged to explore any issues which may arise from this in counseling, e.g. what the implications may be for potential children born from such donated gametes.

We also support recommendations 21 to 26, and also recommend that issues which may arise from such decisions be explored in counseling with potential recipients of such gametes, whether they are the partner of someone who has died, or an unknown recipient. It should be noted that FAR have not specifically discussed these issues.