# CREATING A FAMILY FOR SAME-SEX COUPLES

PART OF THE PATHWAYS TO PARENTHOOD BOOKLET SERIES

# ABOUT THIS BOOKLET

Merck Healthcare thanks the many individuals, couples and Australian healthcare professionals, including fertility specialists, specialist nurses and psychologists who shared their knowledge and expertise during the production of these booklets.

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Prescription medicines have benefits and risks. Use all prescribed medicines strictly as directed by your doctor and raise any questions or concerns with them before, during or after using them. If you experience side effects consult your doctor.

Medication availability and funding criteria may differ between Australia and New Zealand.


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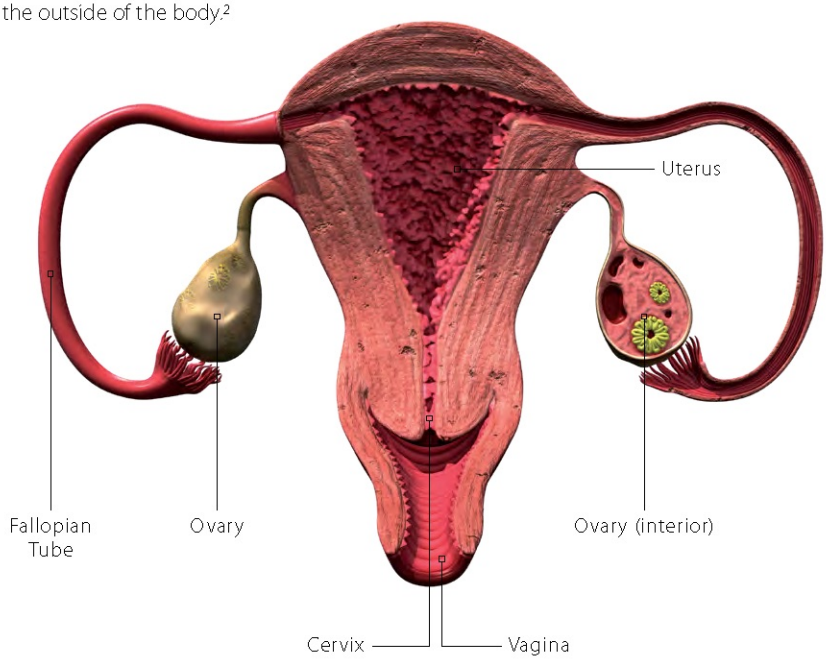
# BIO 101 – THE BIRDS AND THE BEES

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[1-3]

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.[1]

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.[2]

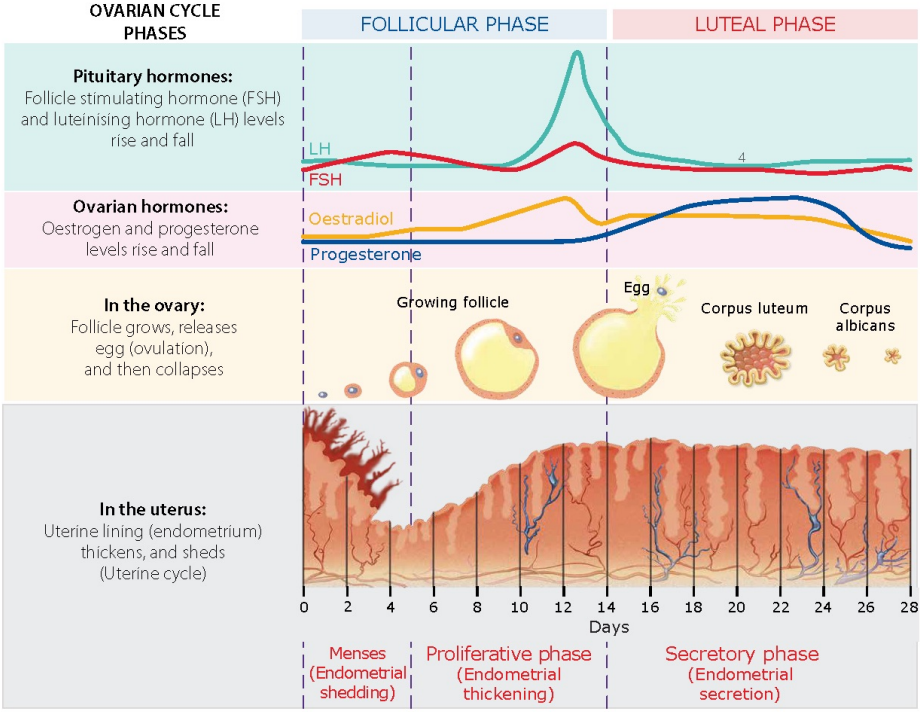



Adapted from Mayo Clinic.[3]

# 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:

1. Follicular phase
2. Ovulatory phase
3. Luteal Phase




Adapted from Boron WF et al 2017[4]

## 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 the endometrium, preparing it to receive an embryo if conception occurs. Oestrogen also causes mid-cycle changes to the cervical mucus. These changes help prepare the cervical mucus to receive and nourish sperm.

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

The ovulatory phase begins with a surge in the level of luteinising hormone (LH). This hormone is released by the pituitary gland and it activates the final maturation of the egg.

During her reproductive years, a woman usually releases a single mature egg each month. This process is known as ovulation.

The ovulatory phase commences 14 days before the start of a woman's menstrual cycle, which may not be exactly 28 days. A cycle begins on the first day that a woman experiences a full day of bleeding. A women can determine the day of ovulation by subtracting 14 days from the first day of menstrual bleeding.

## 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 a fertilised egg. The luteal phase is fixed and always lasts 14 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]

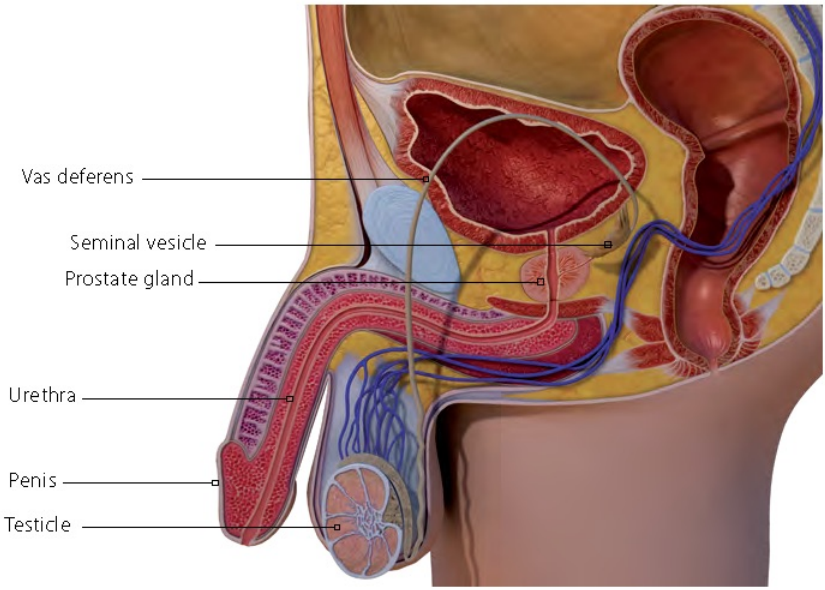
After fertilisation, the embryo travels through the fallopian tube toward the uterus. Inside the uterus, the embryo implants itself into the lining on about the 20th day of the cycle and continues to grow into an embryo and eventually a foetus. The corpus luteum continues to produce progesterone to preserve 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 et al 2017[4]

# FAMILY BUILDING OPTIONS

## Creating Your Family[5,6]

For couples, regardless of their gender identities, the choice of family planning methods depends on various factors. These factors include the age and health of each partner, as well as their individual desires and capacities when it comes to carrying a child. Additionally, couples may consider aspects such as sperm quality and the availability of surrogacy options as they navigate their path to starting or expanding their family.

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.[6]

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.[6]

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[7-9]

Personal circumstances, including any infertility and its potential cause, will guide 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. OI can be used in conjunction with intrauterine insemination (IUI) with donor sperm or with timed intercourse.[7-9]

**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.[8]

**Donor Insemination (DI)** – Clinic-based DI utilises sperm collected from a donor who has been screened for various health problems. This donor can be someone you have selected and know personally, who has provided sperm through a medical facility, or it may be a donor recruited by the clinic. The collected sperm undergoes a six-month freezing period for safety testing. Once it's cleared for use, it can be utilised through procedures similar to artificial insemination (AI). This method of conception is open to single individuals, same-sex couples, including lesbian couples, and non-binary couples. Some individuals or couples who choose a known donor might opt for home insemination. It's essential to note that certain clinics may offer stored, screened sperm from a known donor for home use if desired.[9]

## Assisted Reproductive Technologies (ART)[5,9-11]

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.[9]

***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.[9,10]

After collection of the eggs and sperm, ICSI involves a laboratory technician, using a microscope and 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.[9]

**Egg and Sperm Donation**[9]

For couples and individuals of diverse gender identities, including gay partners, lesbian couples, and non-binary individuals, who may encounter issues with egg quality or experience premature ovarian failure, egg donation is a viable option. Egg donation entails one individual (the donor) providing their eggs to another to create embryos. The egg donor undergoes an egg retrieval procedure, and IVF or ICSI is carried out using sperm from the intended parent(s) or a sperm donor. The resulting embryos may be transferred fresh into the individual who wishes to conceive, following the completion of necessary waivers and infection counseling.

For individuals and couples using a surrogate, the embryos can be frozen and quarantined, or if using a traditional surrogate (see below), the embryos may be transferred fresh. Different states/territories have varying legislation regarding the use of traditional surrogates, and IVF clinics have individual policies as well. When opting for a fresh embryo transfer, the recipient also receives medications to synchronize her cycle with the donor's, ensuring her body is prepared to receive the embryo(s).

For individuals and couples utilising donated sperm, it may be necessary to use the services of a fertility clinic. Sperm donors recruited by clinics undergo thorough health screening, which includes assessments for serious infections and genetic conditions. They also receive counseling. These donors provide informed consent for the use of their sperm, willingly relinquishing any parental rights over children conceived with their sperm. Additionally, they agree to the release of their identity to the child when they reach 18 years of age, or earlier under regulated circumstances.

Fertility clinics can also offer sperm screening and storage services for known donors, whether the semen is intended for clinic-based conception procedures or for at-home insemination procedures performed by individuals.

When it comes to gay male couples, selecting an egg donor can involve choosing a known donor or utilising the services of a fertility clinic. The age of the egg donor is a crucial factor that significantly impacts the success of in vitro fertilization (IVF). As fertility tends to decline with age, the ideal age range for an egg donor is typically between 21 and 34 years. Once a donor is chosen, they undergo a comprehensive screening process, which 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.[9] Most fertility clinics offer this option.

**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.[11]

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 person to carry the condition in oder 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.[11]

## Things to Consider[9]

It's important to know that advanced fertility treatment can be stressful . 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 your doctors' instructions and report any adverse events.[9]

## Surrogacy[9,12]

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).[9,12]

# Surrogacy and ART[9,12-14]

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.[12]

Legislation related to surrogacy varies across Australia and New Zealand. In Australia, surrogacy legislation is governed separately by each state and territory. Similarly, New Zealand has its own set of surrogacy laws. It is crucial to be well-informed about the specific legislation that pertains to your country, state, or territory to ensure compliance and understanding of the legal requirements. In general, altruistic (unpaid) surrogacy is legal in all Australian states and New Zealand. 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.[13,14]

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.[13,14]

# Considerations for HIV-Positive Prospective Parents[15]

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[16]

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

# Legal Parentage and Related Considerations

## Donor Sperm or Eggs[17]

When considering the use of donor eggs, sperm, or a surrogate, there are significant factors to take into account. When individuals or couples opt for fertility services, they can expect a comprehensive examination of the psychological, ethical, and legal dimensions involved in building a family through these methods. This scrutiny is a regulated and integral part of the process.

Legislation related to egg and sperm donation can vary from one Australian state or territory to another. Each state and territory in Australia has its own laws and regulations governing assisted reproductive technologies and donor conception. It's important to note that laws and regulations can change over time.

For individuals or couples who are using donated sperm outside of a clinical setting, it is advisable to seek guidance from their healthcare provider, legal counsel, and potentially a specialised counsellor. It's essential to navigate this process with expert advice.

Of utmost significance, regarding parental rights and responsibilities, Australian legislation uniformly establishes that donors of eggs, sperm, and embryos are not legally recognised as parents of children conceived through artificial means utilising their reproductive material.

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[14]

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 noncommercial. 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.

# Fertility Considerations[18]

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[18]

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[18,19]

The most common cause of female infertility is the result of ovulation disorders. 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[18.19]

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[19]

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[18]

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[18]

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[18]

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[18,21]

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[18,21]

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[18,20]

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[18,20]

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.[20]

# OTHER FACTORS TO CONSIDER

## Having Realistic Expectations about Getting Pregnant[22,23]

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[23]

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.

The expenses associated with IVF can vary significantly, influenced by factors such as your place of residence (country or state) and the specific fertility clinic you opt for. To gain a comprehensive understanding of the costs involved in the procedure, it is advisable to have a discussion with your chosen clinic or fertility specialist. They can provide detailed information about the expenses and any potential financial assistance or insurance coverage options available to you.

# GETTING HELP[20]

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[20]

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[24]

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.

## Possible questions you could discuss with your partner before your 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.

## Possible questions you could ask during your 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.**

# 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

**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/

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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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