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Advancing Reproductive Justice in Canada:

A policy Brief on Improving Access to Reproductive Healthcare for 2SLGBTQI People

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Context

This brief is part of a series of policy briefs created for RainbowCanada.org, a tool that aims to improve understanding of the historical and contemporary landscape of laws and policies that affirm the identities, experiences, and health of 2SLGBTQI people in Canada. These briefs highlight opportunities for future policy advances in Canada, acknowledging the successes and limitations of policy-work to-date.

To help put this brief into context, you may want to explore the family policy category on RainbowCanada.org.

This brief includes an introduction to the policy domain, followed by a review of the current Canadian policy landscape and recommended policy actions.

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Introduction

Reproductive rights are basic human rights that enable people to make decisions about their own bodies and lives. These include the right to decide whether and when to have children, access to safe and legal abortion services, assisted human reproduction services, access to contraception and quality sexual and reproductive healthcare services.

2SLGBTQI people, particularly sexual minority women and TGD (trans and gender-diverse) people, face a number of barriers to accessing reproductive healthcare in Canada [1]. The existing medical systems are designed to serve the needs of cis straight people, as well as individuals in monogamous relationships. This has led to the neglect of the reproductive health needs and concerns of 2SLGBTQI populations [2].

Additionally, cisnormativity, or the privileging of cis bodies and identities, is prevalent in reproductive healthcare. For example, reproductive healthcare services are often designed to exclusively address the needs of cis men and women, which reinforces a gender binary, and marginalizes trans men and women, as well as non-binary people [3]. Experiences of stigma and discrimination are common among TGD people accessing sexual and reproductive healthcare services [4]. Furthermore, many in these groups face financial barriers related to the cost of reproductive healthcare such as accessing contraception, fertility preservation services, and abortion care [5]. For example, people who have changed their gender markers may face difficulties using their health cards for coverage of abortion pills and physician fees, depending on their location [6]. And because of high levels of poverty among 2SLGBTQI populations, people in these communities who cannot afford contraception are more likely to experience unplanned pregnancies and require abortion care. Furthermore, there is a lack of competence among healthcare providers in providing care to TGD patients [7]. As a result of these barriers, TGD people may face delays in seeking healthcare, obtaining diagnoses and may disproportionately experience unmet needs.

This policy brief provides an overview of the state of reproductive healthcare in Canada and highlights the importance of addressing barriers and challenges faced by 2SLGBTQI people accessing reproductive healthcare. This brief explores opportunities to better support 2SLGBTQI people who wish to become parents; however, it is important to note that there are significant gaps in access across many areas of reproductive health care (e.g., contraceptive access, abortion

services). The brief puts forth recommendations for policy and practice to guide stakeholders in implementing measures that promote equitable access to comprehensive reproductive healthcare for 2SLGBTQI people in Canada.

Rights and Realities of 2SLGBTQI people in accessing Reproductive Healthcare

The paths to family-making

The paths to family-making for 2SLGBTQI people are as varied as the individuals and partners themselves, reflecting their unique experiences, preferences, and the changing landscape of societal visibility and legal rights. For some, adoption or fostering provides an opportunity to provide a home to children in need [8]. Many 2SLGBTQI families are also reliant on reproductive technology such as artificial insemination, in vitro fertilization, and gamete intrafallopian transfer [1]. Some 2SLGBTQI people may avoid the clinical system entirely and first pursue home-based solutions with known donors due to a variety of reasons including stigma and discrimination [9]. Group parenting arrangements, where friends or cohabitating partners raise children together, are also a common non-traditional family structure among 2SLGBTQI people [10].

The acquisition of gametes is strictly regulated in Canada. Canada's Assisted Human Reproduction Act (AHRA) prohibits the private purchase of human reproductive materials [11]. Although the AHRA includes a non-discrimination clause barring discrimination based on sexual orientation or marital status, under the current Health Canada guidelines, a man who has had sex with another man in the preceding three months is deemed 'unsuitable' and excluded from donating to sperm banks [12]. However, they may still act as a known donor provided the recipient signs a waiver. This threshold for sperm donation prevents gay and bisexual men from donating. As a result, the supply of anonymous semen is reduced, making it more difficult for 2SLGBTQI families to start families.

Discrimination and stigma against 2SLGBTQI people persist in primary care settings in Canada [13, 14]. For example, TGD individuals in Canada still face numerous obstacles to accessing gender-affirming primary healthcare, including stigma and discrimination [15]. They are frequently mistreated, neglected, or exposed to violence by healthcare professionals [16, 17]. These challenges and barriers also make it difficult for sexual and gender minorities to access the support they need to

start their families. For example, they are also more likely to face discrimination and stigma when seeking fertility preservation services [18]. A Canada wide study showed that sexual and gender minority women living with HIV reported feeling uncomfortable discussing both sexual health and reproductive health and pregnancy needs due to stigma and discrimination [19]. Some clinics may require single women or same-sex partners to undergo additional screening or counseling. A recent study has revealed that lesbian patients face additional challenges while navigating a system not designed for them, leading to higher costs and potential ethical concerns in a publicly funded healthcare system [20]. Further research has shown that some fertility clinics may: refuse to provide services to trans people, make assumptions about a trans person's sexual orientation or gender identity, or have forms that do not allow for correct gender identification [11, 21].

A significant gap in medical training regarding family planning and fertility options for 2SLGBTQI exacerbates these difficulties. The lack of education and training on 2SLGBTQI affirming services for assisted reproductive technology (ART) providers has led to further barriers for 2SLGBTQI people [1, 11]. This includes people who are trans, non-binary, or intersex, as well as people who are single or in queer relationships. For example, trans people who were female-assigned at birth can face discrimination and stigmatization should they become pregnant [22].

In addition to ensuring access, there is a need for intersectional approaches that recognize the structural components that shape the diverse experiences of these populations by addressing the various forms of discrimination they face. 2SLGBTQI Black, Indigenous, and people of colour (BIPOC) particularly face compounded forms of oppression in the context of ART due to the influence of various forms of stigma and discrimination in their lives, including racism, homophobia, and heterosexism [2, 11]. This discrimination is harmful to 2SLGBTQI people who are seeking fertility assistance, making it more difficult for them, particularly for 2SLGBTQI BIPOC to access the services they need to build families.

Surrogacy

2SLGBTQI people in Canada face barriers to access surrogacy due to the legal framework surrounding surrogacy in the country. The AHRA prohibits commercial surrogacy limiting it to altruistic surrogacy (except for Quebec where it is not allowed), where surrogates cannot receive any financial compensation[1] for their services. Instead, they can only be reimbursed for specific expenses related to the surrogacy, such as medical bills, travel costs, and loss of work-related income incurred during pregnancy [11, 23]. Surrogacy agencies are also prohibited from charging fees for coordinating surrogacy services.

This can make it more difficult for 2SLGBTQI people to find surrogates and limits their reproductive options, as they may not have the same networks or resources as cis straightl people. For example, a 2SLGBTQI family may have difficulty finding a surrogate and navigating the legalities of paying for surrogacy without violating the prohibitions of the AHRA which can be a complex and time-consuming process. Furthermore, the limited availability of surrogates in Canada can lead to waiting lists, and the costs associated with surrogacy can be high creating financial challenges for 2SLGBTQI families seeking to start a family through surrogacy [11]. These challenges and lack of access to surrogates and gametes in Canada due to restrictive laws encourages 2SLGBTQI individuals to travel to other countries with more relaxed rules to pursue surrogacy and obtain gametes.

Recognition of Parentage

The legal status of sperm donors, surrogates and intended parents in Canada varies by province and territory [24]. Legal recognition of legal parentage can be a challenging issue for 2SLGBTQI+ families. 2SLGBTQI+ parents often face unique challenges that are not experienced by cis straight parents. For example, in some jurisdictions, only married or civil union partners are automatically recognized as legal parents, while in others, only biological parents have automatic recognition. In these cases, a non-biological parent may need to adopt the child in order to be legally recognized as in this case of a queer family from Nova Scotia[2] [25].

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[1] According to regulations in Canada surrogates may only be reimbursed for reasonable out of pocket expenses related to the surrogacy process. Compensation or an offer of compensation to a surrogate is prohibited.
[2] Nova Scotia only allows two parents on a birth registration. Same-sex parents who use assisted conception with an anonymous sperm donor can be listed as parents on the birth registration, but if the donor is known, only one parent can be listed on the birth certificate. In this case, one parent is unable to be named as a mother on the birth certificate, and their only recourse is to adopt their own child.

If a 2SLGBTQI+ family has a child through assisted reproduction and only one parent is automatically recognized, the other intended parents may not have the same rights, such as the right to make medical decisions for the child [24, 26]. The lack of parentage laws in some provinces further leaves 2SLGBTQI+ families who often use sperm and ova donations or other methods to conceive a child at risk for stigma and discrimination. The language we use to talk about partnerships and parenting can be also limiting for 2SLGBTQI+ people. For example, it may seem simple to say that a trans man is a father, and a trans woman is a mother, but this is not always the case. Some TGD people may identify with both mother and father roles, or they may not identify with any traditional parenting roles at all [27]. Furthermore, group parenting structures and polyamorous families are becoming more common among 2SLGBTQI+ families. In a group parenting structure, more than two adults may be involved in raising a child and the relationships between the parents and children may not be traditional. Even in provinces with parentage law reforms, 2SLGBTQI+ parents who deviate from the nuclear family norm face risks and discriminations [28].

Table 1. Legislative landscape defining parentage across Canada.

Province	Donor/Provider	Surrogate	Intended parents	# of parents can be registered for a child.
Alberta (Family Law Act, RSA 2003, Chapter F-4.5)	Not considered a parent	Application can be made that a surrogate is not a parent of a child.	Must have a genetic connection to the child	Up to 2, with one having a genetic link to the child
British Columbia (Family Law Act [SBC 2011] chapter 25)	Not considered a parent	Not considered a parent if there is a written preconception agreement	Allows more than 2[3]	No express reference[4]
Manitoba (Family Maintenance Act, R.S.M. 1987, c. F20)	Not considered a parent (18)	The surrogate need to agree not to be a parent of the child in a surrogacy agreement (22(4))	The spouse or other person in marriage-like relationship is	A child has no more than two parents. (16(1))

[3] https://www.canlii.org/en/bc/bcsc/doc/2021/2021bcsc767/2021bcsc767.html

[4] The BC Family Law Act recognizes that a child may have three or more legal parents if conceived through assisted reproduction but does not contemplate a child having more than two parents when a child is conceived through sexual intercourse.

			also the child's parent.[5]	
New Brunswick (Family Services Act, S.N.B. 1980, c. F-2.2)	No legislation	No legislation	Must apply to the court to be declared parents	No express reference
Newfoundland and Labrador (Children's Law Act, R.S.N.L. 1990, c. C-13 and Vital Statistics Act, S.N.L. 2009, c. V-6.01)	Not a parent if not married to or cohabiting with carrying parent.[6]	No legislation	With the written consent of the carrying parent the spouse or cohabiting partner can be a parent (5).	No Legislation
Northwest Territories (Vital Statistics Act, RSNWT 1988, c V-3)	Not considered a parent	No legislation	Child is presumed to be Child of Birth mother	Registering up to four parents on the birth registration statement was recommended in 2022[7].
Nova Scotia (Vital Statistics Act, RSNS 1989, c 494)	Not considered a parent	Not considered a parent if there is a written preconception agreement (2)	Must apply to the court to be declared parents[8]	One of the parents must have a genetic link to the child (Section 51)
Nunavut (Children's Law Act, CSNu, c C-70)	No legislation	No express reference in the statute to surrogacies.	Must apply to the court to be declared parents	No express reference
Ontario (Children's Law Reform Acts.10)	Not considered a parent	Not considered a parent if there is a written	-Can have up to 4 with a written agreement signed before	-Up to 4 when there is pre-

[5] "If the birth parent of a child conceived through assisted reproduction was married to or in a marriage-like relationship with another person when the child was conceived, the spouse or other person is also the child's parent."
[6] "(5) The birth registration of a child born as a result of artificial insemination shall be completed showing, with the written consent of the woman and her spouse or cohabiting partner, the particulars of the spouse or cohabiting partner as being the father or other parent of the child."
[7] The government is working to develop amendments to update and modernize two pieces of legislation: Vital Statistics Act and the Change of Name Act.
[8] (2) Despite Section 4 of the Act, if the mother of a child who was conceived as the result of assisted conception is unmarried and the person whom the child's mother acknowledges as the child's other parent files a statutory declaration with the Registrar or the division registrar acknowledging that that person intends to assume the role of parent of the child, the birth of the child must be registered showing that person as the child's other parent.

		preconception agreement[9]	the child was conceived[10]	conception agreement [11] -5 or more parents with a court order[12]
Prince Edward Island (Children's Law Act, RSPEI 1988 c. C-6.1)	Donor not automatically parent (19(3))	Considered the birth mother of the child, regardless of genetic relationship to the child with a surrogacy agreement [13]	Must apply to the court to be declared parents	No more than 2, in addition to the birth mother
Quebec (Civil Code of Québec, CQLR c CCQ-1991)	Not considered a parent	Surrogacy agreement is required [14]	Must go to court to adopt the child	No more than 2
Saskatchewan (Children's Law Act, 2020, SS 2020, c 2)	Not considered parent (4) [15]	Surrogate is listed as birth mother on an initial Birth Certificate	Can have up to 4	Up to 4[16]
Yukon (Children's Law Act, RSY 2002, c 31)	Not a parent if not married to or cohabiting with carrying parent.[17]	No legislation	Definition of parents is limited to “natural” parents.	No express legislative restrictions

[9] (a) the surrogate agrees to not be a parent of the child,
[10] (b) each of the other parties to the agreement agrees to be a parent of the child. (“convention de gestation pour autrui”) 2016, c. 23, s. 1 (1).
[11] (2) This section applies with respect to a pre-conception parentage agreement only if, (a) there are no more than four parties to the agreement;
[12] (1) If the conditions set out in subsection 10 (2) are met other than the condition set out in paragraph 3 of that subsection, any party to the surrogacy agreement may apply to the court for a declaration of parentage respecting a child contemplated by the agreement. 2016, c. 23, s. 1 (1).
[13] (b) the agreement provides that the potential surrogate will be the birth mother of a child conceived through assisted reproduction and that, on the child's birth, (i) the surrogate will not be a parent of the child, …
[14] 541.4. For the parental project involving surrogacy to be carried to completion, the woman or the person who gave birth to the child shall, after the birth, consent to the filiation of the child being established exclusively with regard to the person alone or both spouses who formed the parental project.
[15] (4) The person whose sperm is used to conceive a child through insemination by a sperm donor is not, and shall not be recognized in law to be, a parent of the child.
[16] 61(1) In this section, “parentage agreement” means a written agreement between 2 or more parties in which they establish, together, who will be the parents of a child yet to be conceived. (2) This section applies with respect to a parentage agreement only if: (a) there are not more than 4 parties to the agreement;
[17] (2) A man whose semen was used to artificially inseminate a woman is deemed in law to be the father of the resulting child if he was married to or cohabiting with the woman at the time she is inseminated even if his semen were mixed with the semen of another man.

Recommendations

1. We urge the federal government to **update the '**[Health Canada Guidance Document - Safety of Sperm and Ova Regulations'] to enable greater and more inclusive access to family-making through assisted reproductive technology (ART) clinics by:
    - Allowing people to use known sperm donors without lengthy waits, expensive screenings, or discriminatory double standards.
    - Allowing men over 40 and people living with HIV to be known donors/partners.
    - Removing the three-month abstinence requirement for men who have had sex with other men to become sperm donors.

2. We recommend that all levels of government **extend public funding** for assisted reproduction services for 2SLGBTQI people, and remove other financial barriers related to the cost of reproductive healthcare such as accessing contraception, fertility preservation services, and abortion care that many 2SLGBTQI people face when seeking assisted fertility services.

3. We call on provincial and territorial governments to **enforce anti-discrimination laws** to ensure that 2SLGBTQI people are not denied fertility preservation services or treated with discrimination by fertility clinic staff. Ensure that 2SLGBTQI people have the same access to fertility preservation services as cis straight people.

4. We recommend that all levels of government **increase training for fertility clinic staff** about the reproductive health needs of 2SLGBTQI people. Implement comprehensive training programs for healthcare professionals to enhance their knowledge and understanding of gender diversity. Efforts should be made to recruit and retain healthcare providers with expertise in 2SLGBTQI health care, particularly in underserved areas. Medical education should include the sexual and reproductive health needs of 2SLGBTQI people so that these individuals can receive effective, affordable care through the public healthcare system. These would help to reduce the stigma and discrimination that SGM people often face in healthcare settings and ensure that they are treated with respect and dignity when seeking reproductive health services."

5. We urge provincial and territorial health authorities to **standardize the recognition of 2SLGBTQI people as legal parents across Canada**, regardless of the means of conception, biological relationship, marital status, sexual orientation, or gender identity. For example, Ontario's All Families Are Equal Act recognizes the legal status of all parents, regardless of their sexual orientation or gender identity, and can be seen as a progressive law in that sense. This would ensure that all parents, regardless of their sexual orientation or gender identity, have the same legal rights and responsibilities for their children. The language used in these laws should be inclusive of all families, including queer and trans families. For example, the terms "mother" and "father" should not be used exclusively, and there should be a way for parents to self-identify their gender and parenting role in medical forms and other contexts.

6. We recommend that all levels of government **increase funding for research on 2SLGBTQI reproductive health** to improve understanding of the specific challenges faced by 2SLGBTQI people who are trying to access reproductive care which will lead to the development of new and more inclusive services.

7. We urge provinces and territories to **establish specialized 2SLGBTQI health clinics or dedicated support centers** in regions with limited access to reproductive options, providing affordable and culturally competent care to 2SLGBTQI individuals, particularly focusing on the needs of TGD people and sexual and/or gender minority women.

8. We recommend that all levels of government **legalize and regulate commercial surrogacy** (See New York as an example where commercial surrogacy is allowed). Amend AHRA to permit regulated commercial surrogacy alongside altruistic surrogacy. This would ensure 2SLGBTQI families have increased access to surrogates and broaden their reproductive options and reducing waiting lists for surrogacy services.

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References

1. Ross, L.E., et al., *Sexual and Gender Minority Peoples' Recommendations for Assisted Human Reproduction Services*. Journal of Obstetrics and Gynaecology Canada, 2014. **36**(2): p. 146-153.
2. Tam, M.W., *Queering reproductive access: reproductive justice in assisted reproductive technologies*. Reprod Health, 2021. **18**(1): p. 164.
3. Lowik, A.J., *Betwixt, Between, Besides: Reflections on Moving Beyond the Binary in Reproductive Health Care*. Creat Nurs, 2020(2): p. 105-108.
4. Lampe, N.M. and A.C.H. Nowakowski, *New horizons in trans and non-binary health care: Bridging identity affirmation with chronicity management in sexual and reproductive services*. Int J Transgend Health, 2021. **22**(1-2): p. 141-153.
5. Rodriguez-Wallberg, K., et al., *Reproductive health in transgender and gender diverse individuals: A narrative review to guide clinical care and international guidelines*. International Journal of Transgender Health, 2023. **24**(1): p. 7-25.
6. Action Canada for Sexual Health and Rights. *Trends in barriers to abortion care*. 2022; Available from: https://www.actioncanadashr.org/resources/reports-analysis/2022-12-14-trends-barriers-abortion-care.
7. Lunde, C.E., et al., *Beyond the Binary: Sexual and Reproductive Health Considerations for Transgender and Gender Expansive Adolescents*. Front Reprod Health, 2021. **3**: p. 670919.
8. Gibson, M.F., *Adopting Difference: Thinking through Adoption by Gay Men in Ontario, Canada*. Signs: Journal of Women in Culture and Society, 2014. **39**(2): p. 407-432.
9. Eyler, A.E., S.C. Pang, and A. Clark, *LGBT Assisted Reproduction: Current Practice and Future Possibilities*. LGBT Health, 2014. **1**(3): p. 151-156.
10. Klesse, C., *Polyamorous Parenting: Stigma, Social Regulation, and Queer Bonds of Resistance*. Sociological Research Online, 2019. **24**(4): p. 625-643.
11. Marvel, S., et al., *Listening to LGBTQ People on Assisted Human Reproduction: Access to Reproductive Material, Services, and Facilities*, in *Regulating Creation*, L. Trudo, et al., Editors. 2017, University of Toronto Press: Toronto. p. 325-358.
12. Health Canada. *Health Canada Directive: Technical Requirements for Conducting the Suitability Assessment of Sperm and Ova Donors*. 2021; Available from: https://www.canada.ca/en/health-canada/services/publications/drugs-health-products/technical-directive-sperm-ova-donors.html.
13. Campbell, J., et al., *Lesbian, gay, bisexual, transgender and or queer patient experiences in Canadian primary care and emergency departments: a literature review*. Culture, Health & Sexuality: p. 1-18.

14. Schwab, A., et al., *"Expectation is Always that the Practitioner Might Not Be Okay with Queerness": Experiences of LGBTQ+ with the Healthcare System in Saskatchewan, Canada*. Journal of Homosexuality: p. 1-16.
15. Hébert, W., et al., *A Qualitative Look at Serious Legal Problems: Trans, Two-spirit, and Non-binary People in Canada*. 2022: Department of Justice Canada= Ministère de la Justice Canada.
16. Eisenberg, M.E., et al., *"It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States*. Health & Social Care in the Community, 2020. **28**(3): p. 1082-1089.
17. Reisner, S.L., et al., *Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health*. Journal of Urban Health, 2015. **92**(3): p. 584-592.
18. Tishelman, A.C., et al., *Health care provider perceptions of fertility preservation barriers and challenges with transgender patients and families: qualitative responses to an international survey*. J Assist Reprod Genet, 2019. **36**(3): p. 579-588.
19. Zhang, L.J., et al., *Prevalence and correlates of having sexual and reproductive health priorities met by HIV providers among women living with HIV in a Canadian setting*. Sex Reprod Healthc, 2021. **30**: p. 100666.
20. Gregory, K.B., J.G. Mielke, and E. Neiterman, *Building Families Through Healthcare: Experiences of Lesbians Using Reproductive Services*. J Patient Exp, 2022. **9**: p. 23743735221089459.
21. James-Abra, S., et al., *Trans people's experiences with assisted reproduction services: a qualitative study*. Human Reproduction, 2015. **30**(6): p. 1365-1374.
22. Kukura, E., *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*. J Law Med Ethics, 2022. **50**(3): p. 471-488.
23. Carkner, C. *Fair Compensation, Queer Families, and Bodily Autonomy: Legalizing Commercial Surrogacy*. 2021; Available from: https://mcgillpolicyassociation.com/latest-articles/2021/1/13/fair-compensation-queer-families-and-bodily-autonomy-legalizing-commercial-surrogacy#:~:text=A%20principle%20of%20the%20AHRA,sexual%20orientation%20or%20marital%20status%E2%80%9D.
24. CLEO Legal Rights. *Family law issues for LGBTQ families*. 2020; Available from: https://vimeo.com/423298165.
25. Lam, A. *Advocates, parents say N.S. needs new, more inclusive, parentage laws*. 2023; Available from: https://www.cbc.ca/news/canada/nova-scotia/ns-lacks-parentage-legislation-1.6948483.
26. Kelly, F.J., *Transforming law's family: the legal recognition of planned lesbian families*. 2007.
27. Lowik, A.J. *Trans-Inclusive Abortion Services: A Manual for Operationalizing Trans-Inclusive Policies and Practices in an Abortion Setting, Canada*. 2018;

Available from: https://www.ajlowik.com/publications#/transinclusive-abortion.

28. Kelly, F., *One of These Families is Not Like the Others: The Legal Response to Non-Normative Queer Parenting in Canada.* Alberta Law Review, 2013. **51**(1): p. 1.