universität wien

MASTER THESIS

Titel der Master Thesis / Title of the Master's Thesis

„Queering parenthood: Debates and prospects about reproductive medicine legislation relevant for LGBTIAQ+ persons“

verfasst von / submitted by

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angestrebter akademischer Grad / in partial fulfilment of the requirements for the degree of

Master of Arts (MA)

Wien, 2018 / Vienna 2018

Studienkennzahl lt. Studienblatt / Postgraduate programme code as it appears on the student record sheet:	A 992 884
Universitätslehrgang lt. Studienblatt / Postgraduate programme as it appears on the student record sheet:	Master of Arts in Human Rights
Betreut von / Supervisor	Dr.in Brigitte Holzner MA

Acknowledgements

I would like to thank my friends, my boyfriend and some family members, who have all shown me that sexuality and identity are not always black and white. Through you, I realized how diverse we humans are and you made me who I am today.

Thanks to my parents, without whose support I would not have been able to spend so much time on my studies and on this paper.

Thanks to my supervisor, Dr.in Brigitte Holzner MA, who has not only spent way more time than required on supervising my work, but who has also given me a lot of mental support whenever I did not know how to go on and helped me with her expertise and knowledge in conceptualising, structuring, and improving this thesis.

Thanks to Julia Wolf BA for proofreading this thesis and helping me write in proper English.

Without you all, this thesis would not exist in the way it does now. Thank you all for your great support, your knowledge, and for sharing your convictions.

List of Abbreviations and Acronyms

art.	article
CoE	Council of Europe
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
ECHR	European Convention on Human Rights
ESHRE	European Society of Human Reproduction and Embryology
EU	European Union
e.g.	example given
FRA	European Union Agency for Fundamental Rights
HFEA	Human Fertilisation and Embryology Act
HR	human rights
ICMART	International Committee for Monitoring Assisted Reproductive Technology
ICD	International Classification of Diseases
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICSI	intracytoplasmic sperm injection
iss.	issue
IVF	in-vitro-fertilization

LGBTIAQ+	lesbian, gay, bisexual, transgender, intersexual, asexual, queer and other not according to the social conceptions of gender and sexuality identified
MAR	medically assisted reproduction
MART	medically assisted reproduction technologies
no.	number
nos.	numbers
org.	Organisation
p.	page
para.	paragraph
pp.	pages
RepMedA	Austrian Reproductive Medicine Act
CC	Civil Code of Ukraine
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
vol.	volume
WHO	World Health Organisation
§	section
§§	sections

Table of Content

1. Terminology

Unlike scientific papers are usually structured, this paper does not start with the introduction, but with the terminology. The reason for this is the great amount of terms and definitions that are indispensable for writing this work. The terms and acronyms are an essential part of this study, as can already be seen by looking at the title of this paper. As it is important to use these terms already in the introduction, they need to be explained first.

As this master's thesis is about *queer* parenthood, the meaning of the term *queer* has to be clarified first. The word *queer* first appeared in the 1980s when it was used as a slogan by activists, who fought for 'sexual and gender freedom' during the AIDS crisis. Scholars and activists drew attention to the violence against and the stigmatization of people who do not meet the gender ideals of society. In order to understand what *queer* means, the perception of society relating gender conformity and the social concept of men and women have to be explained first.[1]

According to Connell, who is one of the most prominent sociologists in the field of gender theory[2], societies' understanding of men and women is based on biologically determined factors. The author tries to explain this by saying about sex roles:

> 'In sex role theory, action (the role enactment) is linked to a structure defined by biological difference, the dichotomy of male and female—not a structure defined by social relations. This leads to categoricalism, the reduction of gender to two homogenous categories, betrayed by the persistent blurring of sex differences with sex roles. Sex roles are defined as reciprocal; polarization is a necessary part of the concept. This leads to a misperception of social reality, exaggerating differences between men and women, while obscuring the structures of race, class and sexuality. It is telling that discussions of the 'male sex role' have mostly ignored gay men.'[3]

It is not just the understanding of sex roles, but also the gender relations between the different sexes that are influenced by this binary system. *Queer* family relations are therefore non-normative family relations between persons who do not fit these binary conceptions of men and women. As a consequence, *queer* parents are parents who do not fit the social norms linked to

[1] H. Love, 'Queer', *Transgender Studies Quarterly*, vol. 1, no. 1-2, 2014, p. 172. Available from Duke University Press (accessed 21 June 2018).
[2] The University of Sidney, *Professor Raewyn Connell*, [website], 11 April 2013, http://sydney.edu.au/education_social_work/about/staff/profiles/raewyn.connell.php, (accessed 1 July 2018).
[3] R. W. Connell, *Masculinities*, Cambridge, Polity Press, 2005, p. 26.

gender and sexuality. *Queer* parents include not only same-sex parents, but also those who practice their sexuality in ways that do not conform to the expectations of society.[4]

However, not all persons outside the binary system of gender and sexuality define themselves as being *queer*.[5] Therefore, this term would not do justice to all the persons I write about in this study. To address the persons who are outside the binary social conceptions of men and women and who are particularly affected by impediments of access to medically assisted reproduction technologies (MART), the umbrella term LGBTIAQ+ is used throughout this master's thesis. LGBTIAQ stands for 'lesbian, gay, bisexual,' transgender, intersex, asexual and queer persons.[6]

The following Table represents an overview of the definitions of the respective sexual orientations and gender identities included in the acronym LGBTIAQ. Due to the extensive amount of definitions, many different sources and explanations exist. For example, while bisexuality is often defined as the sexual and emotional attraction of both sexes, I follow the definition of purely sexual, but not emotional, attraction, as it is more widely accepted. The definitions I used are the most common, consistent, and appropriate ones.

Table 1: Explanation of the acronym LGBTIAQ

Lesbian	Lesbians are women, who feel primarily attracted to other women.[7]
Gay	Gay people are sexually attracted to persons from the same sex.[8]
Bisexual	Bisexual individuals feel sexually attracted to both, men and women. This does not necessarily mean that bisexuals are attracted to males and females in the same way.[9]
Transgender	Transgender persons do not identify with the sex they were born with and the female or male genitals, that society typically connects to their gender, were not assigned to them at birth.[10]

[4] Love, p. 172.
[5] See: A. Obinwanne, 'Why I'm a Lesbian (Not Queer)', *Lesbians Over Everything*, [web blog], 18 April 2016, http://lesbiansovereverything.com/why-im-a-lesbian-not-queer/, (accessed 21 June 2018); J. Kirchick, 'Young, Out, and Gay – Not Queer', *Independent Gay Forum CultureWatch*, [web blog], 14 February 2006, https://igfculturewatch.com/2006/02/14/young-out-and-gaynot-queer/, (accessed 21 June 2018).
[6] N. J. Mulé, 'LGBTQI-identified human rights defenders: courage in the face of adversity at the United Nations' *Gender & Development*, vol. 26, no. 1, 2018, pp. 89-101. Available from Taylor & Francis Online (accessed 17 April 2018).
[7] The Regents of the University of California, *Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual Resource Center* [website], 2 May 2018, https://lgbtqia.ucdavis.edu/educated/glossary.html, (accessed 10 May 2018).
[8] Ibid..
[9] R. A. Sprott and B. Benoit Hadcok, 'Bisexuality, pansexuality, queer identity, and kink identity', *Sexual and Relationship Therapy*, vol. 33, nos. 1-2, 2018, pp. 214. Available from Taylor and Francis Journals Complete (accessed 10 May 2018).
[10] B. Aultman, 'Cisgender', *Transgender Studies Quarterly'*, vol. 1, no. 1-2, 2014, p. 61. Available from Duke University Press (accessed 17 April 2018).

Intersex	Intersex people define themselves as male and female or neither nor. Both interpretations of the term are correct. The gonadal, genital, or chromosomal characteristics they are assigned at birth, do not clearly fit into the social construction of one gender.[11]
Asexual	Asexual individuals do not feel sexually attracted to or are sexually interested in other persons.[12]
Queer	Queer persons refuse the classification of sexual orientation and gender identity into categories such as lesbian or gay, for example. Instead, queer individuals define themselves as non-heteronormatively gendered and/or sexual orientated.[13]

Source: This Table was created by the author. The information contained is a compilation from various references, which are cited directly in the Table itself.

However, the definitions of gender and sexuality change over time, as new kinds of sexual and gender diversities are added, and also because persons may change the way they define their identities. This issue of gender varieties was also tackled by Judith Butler. She became known through her prominent books 'Gender Trouble' (1990) and 'Bodies That Matter' (1993) and is one of the most famous scholars[14] associated with the investigation of gender diversity and departure from a socially created and binary construct of gender and sex.[15]

> 'Gender is the mechanism by which notions of masculine and feminine are produced and naturalized, but gender might very well be the apparatus by which such terms are deconstructed and denaturalized. […] the alternative to the binary system of gender is a multiplication of genders. Such an approach invariably provokes the question: how many genders can there be and what will they be called?'[16]

Gender and sexuality are so diverse that it is impossible to summarize all types of sexual orientation and gender identity under one term.[17] People who are attracted to both sexes will not always call themselves bisexual. Some of them identify as pansexual[18], because they are not attracted to a certain sex, but to the nature of a human being. Others identify themselves as bi*sexual*, but hetero*romantic*, because they are physically attracted to both sexes, but can only

[11] J. A. Greenberg, *Intersexuality and the Law : Why sex matters*, New York, New York University Press, 2012, p. 1. Available from EBSCOhost Ebooks (accessed 17 April 2018).
[12] A. F. Bogaert, 'Asexuality: What It Is and Why It Matters', *The Journal of Sex Research*, vol. 52, no. 4, iss. 4: Annual Review of Sex Research Special Issue, 2015, p. 363. Available from Taylor & Francis Online (accessed 17 April 2018).
[13] Love, p. 172.
[14] B. Duignan, 'Judith Butler. American Philosopher', *Encyclopaedia Britannica* [website], https://www.britannica.com/biography/Judith-Butler, (accessed 24 May 2018).
[15] J. Butler, *Gender Trouble: Tenth Anniversary Edition*, New York, Routledge Publishing, 1999, p. 84-85. Available from: EBSCOhost eBooks, (accessed 14 May 2018).
[16] J. Butler, *Undoing Gender*, New York, Routledge Publishing, 2004, pp. 42-43.
[17] P. Oosterhoff and C. Sweetman, 'Introduction: Sexualities' *Gender & Development*, vol. 26, no. 1, 2018, p. 13. Available from Taylor & Francis Online (accessed 17 April 2018).
[18] Sprott and Hadcok, pp. 214-215.

fall in love with people from the opposite sex.[19] These are just a few examples that seek to demonstrate how broad the subject of sexual and gender identity is.

Therefore, a plus (+) follows the earlier mentioned letters that stand for the identified sexual and gender diversities used in this study. The plus contains all other forms of sexual and gender identities, which are not yet included in the letters used before. It illustrates how diverse the concepts of sexuality and gender are. The chosen acronym LGBTIAQ+ is an attempt to address all various kinds of sexualities and gender identities.[20]

Table 2: Explanation of further terms on gender and sexuality that will be used throughout this study

Aromantic	Aromantic persons do not have romantic feelings for anybody, regardless of their sexual orientation .[21]
Cisgender	Contrary to transgender persons, cisgender persons identify with the gender they were born with and society typically connects their gender to the female or male genitals they were assigned at birth.[22]
Heteronormativity	Heteronormativity is the conviction, that heterosexuality and the binary conception of gender are the natural norm. The binary construct of sex, gender identity and gender expression is promoted through set living norms and practices. Monogamous, committed, heterosexual, opposite-sex relationships are emphasized.[23]
Heteroromantic	Heteroromantic persons only fall in love with persons of the opposite sex.[24]
Heterosexual	Heterosexual individuals feel exclusively and consistently sexually attracted to persons of the opposite sex.[25]
Homoromantic	Homoromantic individuals are emotionally attracted to persons of the same sex only.[26]
Homosexual	Homosexual people feel sexual attraction only for persons of the same sex.[27]
Pansexual	Pansexual people feel attracted to persons regardless of their genders or sexes. They are not only attracted to cisgender males and/or females, but also to intersex, transgender persons, or other individuals outside conventional gender identities.[28]

Source: This Table was composed by the author on the basis of various references. The choice of references for the creation of this Table was made by the same criteria that were used for the compilation of Table 1. The definitions are listed in alphabetical order.

[19] C. Pulliam-Moore, 'The Beef with Bisexuals', *Thought Catalog*, 22 April 2014, https://thoughtcatalog.com/charles-pulliam-moore/2014/04/the-beef-with-bisexuals/ (accessed 17 April 2018).
[20] Oosterhoff and Sweetman, p. 13
[21] Bogaert, p. 365.
[22] Aultman, p. 61.
[23] The Regents of the University of California, ibid..
[24] E. M. Lund, 'Examining Concordant and Discordant Sexual and Romantic Attraction in American Adults: Implications for Counselors', *Journal of LGBT Issues in Counseling*, vol. 10, no. 4, 2016, p. 212. Available from Taylor & Francis Online, (accessed 10 May 2018).
[25] R. L. Crooks and K. Baur, *Our Sexuality*, Wadsworth, Cengage Learning Publisher, 2010, p. 250.
[26] Lund, p. 212.
[27] Crooks and Baur, p. 250.
[28] Sprott and Hadcok, pp. 214-215.

2. Introduction

Queer parenthood is nothing new, as there already are non-heteronormative couples who are able to raise children due to the possibilities of adoption, foster care, or because the children from a previous opposite-sex cisgender partnership were brought into the current one.[29] However, people who do not live in opposite-sex cisgender relationships might have difficulties in accessing the possibilities of raising children. It is easier for opposite-sex cisgender couples to conceive a child, because of the rather natural way of achieving a pregnancy by having sexual intercourse. When a pregnancy is not attainable for them due to infertility reasons, or when there is a risk of infecting the partner with a serious disease during intercourse, access to medically assisted reproduction (MAR) is easier for them to obtain as it is for non-heteronormative couples. For the latter, it is usually not possible to raise children through any way other than adoption or MAR. Furthermore, if they wish to have their own genetic child, adoption is not the path to achieve the goal.[30]

In order to achieve it, they rely upon MART, which are a means to get children for persons, who are not able to or do not want to conceive children naturally[31], and furthermore, this is sometimes the only reasonable way to have biologically related children.[32] While a couple of two cisgender men depends on an embryo donation to produce a child that is at least biologically related to one of them, two cisgender women, or transgender couples, would even be able to produce a child that is biologically related to both of them by using the oocytes from one partner and donate them to fertilize the other. In that case, one person would be the genetic (whose ovum will be donated) and the other the placental (who will give birth to the child) parent.[33]

However, MART are not accessible everywhere for persons regardless of their sexual orientation and gender identity. LGBTIAQ+ communities are still being discriminated against

[29] D. A. Greenfeld and E. Seli, 'Same-sex reproduction: medical treatment options and psychosocial considerations', *Current Opinion in Obstetrics and Gynecology*, vol. 28, no. 3, 2016, pp. 202-205. Available from Wolters Kluwer Health (accessed 17 April 2018).
[30] Greenfeld and Seli, 2016, ibid.; V. Mitchell, 'Medically Assisted Reproduction', in T. K. Shackelford and V. A. Weekes-Shackelford (eds.), *Encyclopedia of Evolutionary Psychological Science*, Springer International Publishing, 2017, p. 1.
[31] Mitchell, p. 1.
[32] Greenfeld and Seli, 2016, ibid.; Mitchell, p. 1.
[33] C. Müller-Götzmann, *Artifizielle Reproduktion und gleichgeschlechtliche Elternschaft. Eine arztrechtliche Untersuchung zur Zulassung fortpflanzungsmedizinischer Maßnahmen bei gleichgeschlechtlichen Partnerschaften*, Berlin Heidelberg, Springer-Verlag, 2009, p. 228.

all over the world in different kinds of ways. These include access restrictions to MAR. The states' arguments to justify their national legal regulations vary.[34]

Particularly by using the example of surrogate motherhood, the different attitudes of states can be demonstrated. While in Belgium, Denmark, Ireland, and the United Kingdom (UK), surrogacy may be carried out free of charge only, other countries, such as Russia, India, Ukraine[35], Laos, Bangladesh, Cambodia, and some states of the United States, commercialize them. In Israel, surrogacy is partially subsidized by the state under certain conditions, while in many countries, such as Austria, Germany[36], Bulgaria, Italy, and Spain, this type of reproduction is completely prohibited.[37] Those distinct regulations affect the life of individuals who want to access MAR.[38]

Also, internationally, a recognized right to MAR is not granted to LGBTIAQ+ and therefore, they are forced to move within the legal opportunities granted to them by the national legislation of the respective countries.[39] One way to bypass this is to go to other countries and access the legally permitted MART there.[40] Nonetheless, LGBTIAQ+ individuals lack an explicit and enforceable right to MAR.

The purpose of this study is to find out whether LGBTIAQ+ persons hold such a right by calling upon other human rights (HR) than the right to MAR. Sexual and reproductive rights, women's rights, children's rights and equality and non-discrimination law matter and the tensions between those HR instruments will be scrutinized to either see if they contradict each other, or if a reconciliation between them is achievable.

This study is locally limited to Europe, as a global discussion of the topic would go beyond the scope of this thesis. For this purpose, six European countries, namely the Czech Republic, Ukraine, Austria, Spain, the Netherlands and the UK, are/were selected and categorised into

[34] Müller-Götzmann, pp. 11-12.
[35] H. Cheung, 'Surrogate babies: Where can you have them, and is it legal?', *BBC News*, 6 August 2014. Available from http://www.bbc.com/news/world-28679020 (accessed 5 April 2018).
[36] C. Calla, 'Leihmutterschaft. Kinderkriegenlassen ist okay', *Zeit Online*, 20 February 2017. Available from http://www.zeit.de/kultur/2017-02/leihmutterschaft-tabu-koerper-schwangerschaft-reproduktionsmedizin (accessed 5 April 2018).
[37] Cheung, ibid.
[38] Müller-Götzmann, pp. 11-12.
[39] European Court of Human Rights, X and Others vs. Austria, no. 57813/00, 3 November 2011, para. 93.
[40] P. Präg and M. C. Mills, 'Assisted Reproductive Technology in Europe: Usage and Regulation in the Context of Cross-Border Reproductive Care', in M. Kreyenfeld and D. Konietzka (eds.), *Childlessness in Europe: Contexts, Causes, and Consequences*, Cham, Springer International Publishing, 2017, p. 303. Available from: SpringerLink Open Access eBooks, (accessed 12 May 2018).

three different clusters of state legislation. Their legal regulations were categorised, closely examined, and then compared.

The paper is structured as follows: First, the medical possibilities of achieving a pregnancy in general are discussed. Then, the partner constellations of couples, who depend on the help of MART in order to get a child, are examined and contrasted with each other. Subsequently, the relevant HR documents, which are important for fulfilling the desire to have a child, are explained. They build the HR framework of this paper. Afterwards, an analysis and comparison of selected European countries' legislation seek to show the diverse ways in which Europe is regulating the access to MAR for LGBTIAQ+ persons. Then, these European legislation are analysed within the HR framework mentioned before. Finally, this study will clarify whether the respective HR support or contradict each other in the access to MAR, and whether a reconciliation of legislation on the European level is possible.

3. Literature Review

This literature review concerns the complexity of the HR of LGBTIAQ+ persons regarding their access to MAR and will identify gaps. First, it touches the issue of queer parenting and shows how scholars have dealt with that subject. The distinct discourses that already refer to this topic are medical, legal, and ethical discourses. As medicine is concerned with the potential opportunities for persons to procreate, morals and ethics want to narrow these possibilities down. Then, law is building the framework for which technologies can actually be used. Especially religion is a powerful factor when it comes to determining whether medical possibilities are ethical or not. Psychology also plays a role in arguments for or against LGBTIAQ+ persons to be able to raise children. The religious and psychological perspectives on LGBTIAQ+ parenting are left out here, as the inclusion of all disciplines would go beyond the scope of this discussion.

First the literature review outlines relevant works on MAR for LGBTIAQ+ persons from a sociological perspective. Then, the medically possible ways of attaining a pregnancy and the different constellations of couples, who are in need of those methods in order to get pregnant, will be presented. Second, queer parenting will be shown from a legal perspective and the question as to how the different legislation of selected European countries regulate MAR and

its access for LGBTIAQ+ persons will be answered. Finally, gaps in the literature will be identified and the questions that arise due to these gaps will be presented.

One of the first authors (others: Müller-Götzmann, 2009; Greenfeld and Seli, 2016) to write about queer parenthood is Laura Mamo, who explicitly addresses this issue in her journal article 'Queering the Fertility Clinic'. She looks at queer parenting from a sociological perspective and specifically concentrates on non-heteronormative family formations with a particular focus on couples of two cisgender women who both participate to attain a pregnancy.[41]

Furthermore, there were numerous books and articles written on the various MART and their application.[42] The multiple perspectives regarding queer parenthood are shown by Condat et al.. The authors discuss the issue of trans parenthood in particular and look at it from a medical, psychological, and ethical perspective.[43]

However, what medicine is able to do is not always allowed by law. From a legal perspective, it can be said that national laws and guidelines determine which MART are permitted and who may have access to these methods.[44] In some countries, such as Austria, statements of the government and ethic commission on the legal background for the authorization or prohibition of certain methods, or for certain persons, are publicly available.[45] However, in many countries, the states' arguments on how they chose to regulate the access to MAR are not publicly available. Besides other reasons, such as the stand of a country's society on LGBTIAQ+ persons, this unavailability of information might be the result of a lack of cases regarding the right of LGBTIAQ+ persons to MAR.[46]

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[41] L. Mamo, 'Queering the Fertility Clinic', *Journal of Medical Humanities*, vol. 34, no. 2, 2013, p. 228. Available from Springer Standard Collection (accessed 23 May 2018).

[42] The literature mainly used in this study to explain the different MART are books and articles written by Mitchell, Müller-Götzmann, Greenfeld and Seli, Kamel and Barth and Erlebach.

[43] A. Condat et al., 'Biotechnologies that empower transgender persons to self-actualize as individuals, partners, spouses, and parents are defining new ways to conceive a child: psychological considerations and ethical issues', *Philosophy, Ethics, and Humanities in Medicine*, vol. 13, no. 1, 2018, pp. 1-11. Available from BioMed Central (accessed 17 April 2018).

[44] Präg and Mills, p. 295.

[45] E.g. Austrian Constitutional Court, G 16/2013 and others, 10 December 2013, VfSlg. 19824/2013. Available from: Rechtsinformationssystem des Bundes (RIS), https://www.ris.bka.gv.at/Dokument.wxe?Abfrage=Vfgh&Dokumentnummer=JFT_20131210_13G00016_00, (accessed 12 May 2018).

[46] I checked the national case law of the selected countries, as well as publications of the respective ethic commissions. If publications were only available in the national languages, online translation tools were used to gain information about the backgrounds. However, official publications of governments or ethic commissions in the respective countries do barely exist.

On the European and international level, European and international organizations deal with rights to reproduce on the one hand, and/or with LGBTIAQ+ rights on the other. However, the two subjects are rarely combined, but treated separately, and literature on their stance on LGBTIAQ+ persons' right to MAR does barely exist: The Fundamental Rights Agency of the European Union (FRA), which is the EU's highest authority on giving legislative advice to the EU member states concerning HR issues[47], has not dealt with a right to MAR for LGBTIAQ+ persons so far. In its publications, the FRA is either addressing the rights to reproduce, or LGBTIAQ+ rights. Both together are not considered,[48] except for a few single paragraphs, which address the issue of sterilisation as a requirement for the legal recognition of an individual's gender identity.[49] Also, the European Court of Human Rights (ECtHR) seldomly made decisions concerning this topic and when it did, the right to MAR was only dealt with in combination with the prohibition of discrimination.[50] A lack of the European legislative literature is the non-existence of a self-standing right of LGBTIAQ+ persons to MAR. In case law, the HR approach to this issue on the rights of LGBTIAQ+ persons to access MAR has always been addressed from the angle of equality and non-discrimination rights, but never from the perspective of a right to MAR as such.

Such an enforceable right to MAR for LGBTIAQ+ persons does not exist in any of the international documents and the existing HR do not provide enough specification to allow for MART to be accessible for LGBTIAQ+ persons. The reason for this is the margin of appreciation doctrine, which was developed by the ECtHR and which leaves it to the member states to determine legal regulations concerning moral and ethical issues.[51] At least some non-governmental organisations, such as the European Society of Human Reproduction and Embryology (ESHRE), tackled the issue of MAR access for LGBTIAQ+ persons and released

[47] European Union Agency for Fundamental Rights, [website], *About FRA*, 2007-2018, http://fra.europa.eu/en/about-fra, (accessed 21 June 2018).
[48] Additionally, I received two different e-mails from persons working for the FRA as a reply to my request for an interview, who both told me that the FRA has not dealt so far with reproductive rights of LGBTIAQ+ persons. FRA, e-mails, 30 April 2018 and 2 May 2018.
[49] Fundamental Rights Agency, *Being Trans in the European Union. Comparative analysis of EU LGBTI survey data*, Luxembourg, Publications Office of the European Union, 2014, p. 81.
[50] E.g. European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[51] Ibid., para. 93; D. Sperling, ''Male and Female He Created Them': Procreative liberty, its conceptual deficiencies and the legal right to access fertility care of males', *International Journal of Law in Context*, vol. 7, no. 3, 2011, p. 377. Available from: Cambridge University Press Journals Complete, (accessed 12 May 2018).

publications on that topic.[52] However, for LGBTIAQ+ individuals, a legally binding norm that allows them to access MAR does not exist.

Gunnarsson Payne (2013)[53] and Trimmings and Beaumont (2011)[54] address the issue of the so-called 'cross-border reproductive care'.[55] They all discuss the problem of having different national country legislation on MAR (Trimmings and Beaumont are focusing on surrogate motherhood) and the resulting issue of intended parents travelling to other countries, due to the easier access to such methods.[56] Trimmings and Beaumont even scrutinize a possible harmonization of surrogacy arrangements on the international level.[57] However, none of these scholars approaches this subject from a HR perspective.

Looking at the available literature on reproductive possibilities for LGBTIAQ+ persons, gaps can be identified. While comments on domestic legislation exist and literature on same-sex parenting can be found in every country, there are big deficiencies in literature on reproductive opportunities for transgender and intersex persons. Out of the six countries chosen for this study, Spain and the UK are the only ones for which literature on procreation for transgender persons can be discovered.[58] According to my research and investigation, nobody has ever written about the access to MAR for transgender persons in Ukraine, Czech Republic, and Austria. Comments on legal texts explain why the respective countries permit or prohibit access to same-sex couples, but transgender couples or individuals are not even mentioned. The fact that national legislation often lack clear regulations is nothing new, but the reality that there are not even expert comments by lawyers, as it is the case here, is rare. When transgender persons want to undergo MAR treatment, their access is not regulated and modern interpretations of existing legal norms do not exist either. The access is even more difficult for intersex persons, who

[52] E.g. De Wert et al., p. 1859-1865.
[53] J. Gunnarsson Payne, 'Europeanizing Reproductive Technologies in Europe and Scandinavia', *NORA – Nordic Journal of Feminist and Gender Research*, 2013, vol. 21, no. 3, pp. 236-242. Available from Taylor and Francis Online, (accessed 19 April 2018)
[54] K. Trimmings and P. Beaumont, 'International Surrogacy Arrangements: An urgent need for Legal Regulation at the International Level', *Journal of Private International Law*, vol. 7, no. 3, 2011, pp. 627-647. Available from Taylor and Francis Online (accessed: 17 April 2018).
[55] Gunnarsson Payne, p. 238;Trimmings and Beaumont, p. 629.
[56] Gunnarsson Payne, p. 236; Trimmings and Beaumont, p. 629.
[57] Trimmings and Beaumont, pp. 633-647.
[58] for example M. Boada et al., 'Transexualidad y reproducción: situación actual desde el punto de vista clínico y legal', *Revista Internacional de Andrología*, vol. 12, no. 1, 2014. Available from Elsevier, (accessed 31 May 2018); see also: S. Knapton, 'NHS must offer transgender men egg storage so they can be parents, says British Fertility Society guidance', *The Telegraph*, 4 January 2018, https://www.telegraph.co.uk/science/2018/01/04/nhs-must-offer-transgender-men-egg-storage-can-parents-says/, (accessed 1 June 2018).

possess different reproductive cells and organs.[59] Out of all studied countries, Austria is, as of very recently, the only one, which allows intersex persons to be legally recognized by their identified gender[60]. The reason for the non-regulation of the access to MAR for intersex persons in the national legislation might be that they are not officially recognized by their identified gender.

Summing up, there are considerable gaps and the reasons for their existence are the non-existence of a free-standing right of LGBTIAQ+ persons to MAR, the silence of international HR instruments on that issue, and the addressing of LGBTIAQ+ rights to MAR only from the angle of equality and non-discrimination in European case law. In order to find out if theses gaps can be filled, this study aims to show whether there are tensions between the existing HR instruments (women's rights, children's rights, sexual and reproductive rights) relevant for the access to MAR for LGBTIAQ+ persons, and to clarify to what extent they are interconnected. Subsequently, this study examines how the various HR interact with and contradict each other in the fulfilment of the desire of LGBTIAQ+ persons to have a child . The question arises whether LGBTIAQ+ individuals have a right to MAR. The problem that LGBTIAQ+ persons cannot rely on an enforceable free-standing right leads to the research questions explained in the next Chapter.

4. Research Questions

Main Research Question: Which HR are relevant for LGBTIAQ+ persons to fulfil their desire to have a child using MART and how do they support or contradict each other?

The aim of this study is to find out which HR play a key role in the debates about the fulfilment of the desire to have a child for LGBTIAQ+ persons. The emphasis of this study is put on individuals and couples who want to access MAR in order to get children themselves; it does not focus on the rights of gamete donors[61] or gestational mothers. Subsequently, this study examines which HR play an important role for LGBTIAQ+ persons on their path to get a child. The various HR are used to argue for or against the permission – in general or for LGBTIAQ+

[59] The Regents of the University of California, ibid..
[60] P. Aichinger, 'Richter erlauben drittes Geschlecht', *Die Presse*, 29 June 2018, https://diepresse.com/home/innenpolitik/5455833/Richter-erlauben-drittes-Geschlecht, (accessed 29 June 2018).
[61] The access of donors to MART can also be restricted due to their gender identity or sexual orientation. In Denmark, for example, the domestic law explicitly prohibits the donation of semen by men, who conduct sexual intercourse with other men (Gunnarsson Payne, p. 238)

persons – of such methods. Not only do sexual and reproductive rights play a crucial role in building up arguments, but also women's rights and children's rights. In order to answer this question, some sub-issues have to be solved too.

Sub-Question 1: Which medical methods would make it possible for LGBTIAQ+ persons to have children via MAR?

This study provides answers as to how it is medically possible to achieve a pregnancy without the two future parents having sexual intercourse, and even though one partner is infertile. For this purpose, different MART are scrutinized and explained in detail. The practically possible ways of attaining a pregnancy, excluding the legal possibilities, will be examined.

Sub-Question 2: How do new MAR possibilities influence country jurisdictions of selected countries?

Medicine is a constantly evolving discipline. The possibilities of technical and medically assisted procreation are continually expanding. Law, however, sets out the legal framework, within which these possibilities can actually be carried out. Often, the science of medicine is more advanced than the laws that govern it. New medical methods have evolved that have not yet been considered legally, creating a legal vacuum. In order to find out whether the newly developed methods are legal or not, the sub-question, namely how medicine and law interact and how medical issues affect legislation, needs to be answered.

Sub-Question 3: How do selected European states regulate the access for LGBTIAQ+ persons to MART?

A deeper look at the national legislation of selected European countries will show how these states regulate the access for LGBTIAQ+ persons to MAR. The ways in which European countries restrict or permit reproductive rights and the arguments they use to justify their choices are further examined. Subsequently, the consequences of these permissive or restrictive legislation for LGBTIAQ+ persons will be shown.

Sub-Question 4: How does the jurisdiction of the ECtHR support or weaken the right to MAR for LGBTIAQ+ persons?

The ECtHR is an important key player in the upholding of HR by the state parties of the European Convention on Human Rights (ECHR). It has the mandate to decide in cases of requests from individuals, states, or non-governmental organizations, who have concerns that a

state has violated the ECHR.[62] Its jurisdiction is binding and it not only has an impact on the state concerned, but also on the other state parties of the ECHR. This study will scrutinize how the ECtHR's jurisdiction supports or weakens the right to MAR for LGBTIAQ+ persons in the member states of the ECHR.

Sub-Question 5: What are the possibilities to reconcile national with international legislation and harmonize the access to MAR for LGBTIAQ+ persons on an European level?

Due to the different national country legislation on the access for LGBTIAQ+ persons to MAR, many people decide to go to other member states and undergo these medical treatments there.[63] Therefore, the question arises as to whether the distinct domestic legislation can be harmonized on an European level or not.

5. Methodology

The following Chapter describes the methodology and research methods used of for writing this thesis. The collection of the relevant data sources, their interpretation, and their analysis will be explained in detail.

5.1. Research Approach

This master's thesis is a multidisciplinary and comparative study. Multidisciplinary in the way that it combines medical and legal aspects of queer parenting. Current knowledge on the technical and medical possibilities to achieve pregnancies in an artificial way, is presented. Law is needed to analyse the diverse national legislation of the respective countries and to interpret international legal instruments.

The different HR approaches used by countries in order to build up arguments in favour of or against specific legal regulations, are analysed. Lawmakers often choose to explain their legislation by looking at impacts on the well-being of the child, the parental desires to fulfil

[62] International Justice Resource Center, *European Court of Human Rights*, [website], https://ijrcenter.org/european-court-of-human-rights/#, (accessed 21 June 2018).
[63] F. Shenfield, 'Implementing a good practice guide for CBRC: perspectives from the ESHRE Cross-Border Reproductive Care Taskforce', *Reproductive BioMedicine Online*, 2011, no. 23, iss. 5, p. 658. Available from Elsevier (accessed 21 June 2018).

their desire to have a child, or their right to self-determination. Women's rights, children's rights, and parental rights are then considered at to come to a final conclusion.

Additionally, this study is comparative, as three different categories of national legislation are analysed and finally compared. The countries are divided into countries with restrictive, partially restrictive, and liberal reproductive medicine legislation. The criteria to determine which country falls into which category are formulated by myself. As the comparison of countries from all over the world would go beyond the scope of this study due to their immense diversity, the examined countries for my master's thesis are all European ones from inside and outside the European Union. Access to information, the existence of ethics committees, language barriers, and national laws played a crucial role in my choosing of the examined countries. For each category, two countries were selected as examples for restrictive, partially restrictive, and liberal countries regarding reproductive medicine law. The criteria for categorizing the countries and the choices for selecting them will be explained in more detail in Chapter 10.

5.2. Research Methods

In order to collect and analyse the relevant data sources, the research strategy used in this study was to focus on 'words rather than quantification in the collection and analysis of data'.[64] Therefore, this study is considered to be a qualitative investigation.[65] The primary research methods used for writing this thesis were mainly 'the collection and qualitative analysis of texts and documents' and 'qualitative interviewing'.[66]

To gain relevant texts and documents and conduct a qualitative analysis of said literature, various kinds of data sources were looked at. The main literature used for conducting this study consists of books, journal articles, countries' legislation, and international legal texts. Books on MAR, domestic legal norms, and diverse HR data sources were used as well. The information needed for this study was obtained from a summary and a critical examination of /previous literature on MART and anti-discrimination and equality legislation.

[64] A. Bryman, *Social Research Methods*, 4th Edition, New York, Oxford University Press, 2012, p. 380.
[65] Ibid..
[66] Ibid., p. 383.

Additionally, I conducted a qualitative interview in order to get data sources. The type of interview I used was an expert interview.[67] It was carried out with an expert on reproductive medicine who works at the Council of Europe (CoE) Parliamentary Assembly. As the interviewee is also specialised in LGBTIAQ+ rights, this person could provide an expert opinion on the topic of LGBTIAQ+ access to MAR. The interview complements this thesis with knowledge on the happenings on the background of international HR players and clarifies practices of respective European states on MART.

The presentation of the collected relevant data starts with the presentation of MART. Literature on the various possible artificial ways to achieve a pregnancy are summarized and analysed as well. The analysis is made in the context of various constellations of couples, who are in need of MART in order to get a child, and for whom adoption and/or foster care are no options. Next, relevant HR for LGBTIAQ+ persons in regard to their right to MAR are identified. The important HR are women's rights, sexual and reproductive rights, children's rights, as well as the principles of equality and non-discrimination. The HR enshrined in international legal documents, such as the CEDAW, CRC, or ECHR, are first presented and then analysed.

Subsequently, the different national legal systems of the selected countries are explained and compared. Domestic national law of the European states regarding access to MAR for LGBTIAQ+ persons are interpreted and analysed. The legal consequences of prohibitions and permissions of MART for LGBTIAQ+ people are examined in addition to the analysis of jurisdiction and legal norms concerning queer parenting. The scrutinized legal norms are the domestic legislation of the selected countries.

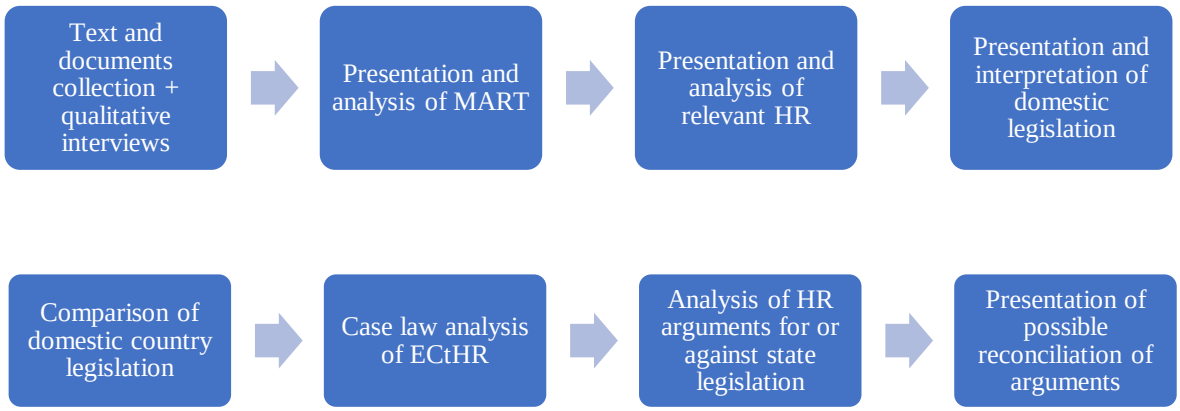
Afterwards, the domestic legal systems are analysed within the international HR framework presented before. The national country legislation is looked at from a HR perspective, as international documents, such as the CEDAW and ECHR, are also applicable in the respective countries. The analysis of jurisdiction is mainly focused on the ECtHR's case law, whose legal examination approach I follow. Its stance on whether respective domestic MAR legislation of the selected European countries violate the rights of LGBTIAQ+ persons and are thus

[67] A. Heistinger, *Qualitative Interviews – ein Leitfaden zur Vorbereitung und Durchführung inklusive einiger theoretischer Anmerkungen*, Universität Innsbruck, 2006, p. 6/13, https://www.uibk.ac.at/iezw/mitarbeiterinnen/senior-lecturer/bernd_lederer/downloads/durchfuehrung_von_qualitativen_interviews_uniwien.pdf, (accessed 5 June 2018).

discriminatory under international law, is scrutinized. Additionally, the changes of the ECtHR jurisdictions are investigated to analyse developments in the past and prospect changes in the future.

The representation and definition of the legal norms is carried out by using hermeneutic methods, whereby the material is also explained in more detail. The hermeneutic research method is used to promote a deep reflection on what texts really say and to help make interpretations of those texts. The aim is not to copy the texts as they are, but to analyse them from a different angle. Not only are textual statements considered in a linguistic context, but also in their concrete historical context. In the case of this study, the hermeneutic research method allows to examine international norms and principles from a different perspective, and also to interpret legal documents and look at the contemporary lifestyle of human beings at the same time.[68]

Figure 1: Research approach



Source: This Figure was created by the author.

5.3. Reflection on the Research Process

My interest in this topic kept me motivated and made it easier for me to write about it. In the end, I could answer my research questions and finish this work in time. However, I experienced some challenges in researching and writing.

[68] H. Burchert and S. Sohr, *Praxis des wissenschaftlichen Arbeitens: Eine anwendungsorientierte Einführung*, München, Oldenburg Verlag, 2005, p. 56.

One of the difficulties was finding a suitable interview partner. The FRA could not refer me to a specialist on that issue, as they have not tackled this subject up until then. I contacted individual experts and organisations that advocate for rights to MAR for LGBTIAQ+ persons, but they just referred me to other persons. Eventually, ESHRE recommended a professional expert in LGBTIAQ+ rights, who works for the CoE and was willing to help me.

Another difficulty was to find out the causes for the individual countries' legislation. Not all countries had data available, which explains why some MAR possibilities are permitted and some are not. Also, getting access to publications of the national ethic commissions was proving a problem. Unfortunately, the only one that I could use was from Austria and published on the ethic commissions' homepage.

Additionally, language barriers made it difficult to write this thesis. While it was easy to find English or German literature on the medically possible ways of attaining a pregnancy and on international HR law, data on national legislation of the scrutinized countries, and especially national legal texts, barely existed in the languages I am proficient in.[69] Therefore, I needed to use web-based translation tools to get the information I wanted. Potential misunderstandings were reduced by additionally looking through comments and articles on national legislation and taking more sources into account than just the one that had to be translated.

6. Methods of Artificial Reproduction

> *'Not all bodies have sperm, some do… Not all bodies have eggs, some do… And not all bodies have a uterus, some do… Who helped bring together the sperm and egg that made you?'*[70] – Cory Silverberg

MAR is a tool to cause a pregnancy by means other than through unprotected sexual activity between two persons of the opposite sex. It is an umbrella term for all different types of MART, regardless of whether the fertilization takes place outside or inside of the human body of the person, who will later give birth to the child, and also for all treatments regarding hormonal fertility. The reasons for using MART are very diverse. For one thing, MAR helps all those

[69] I am proficient in German and English, have working knowledge in Spanish and was able to understand a few basic words in Dutch, due to its similarity to the English and German language. To understand the Czech and Ukrainian text I needed translation tools.
[70] C. Silverberg, *What makes a Baby*, New York, Triangle Square Publishing, 2012, cited in Mamo, p. 227.

persons who cannot achieve a pregnancy due to fertility problems or because it would be unreasonable to have sexual intercourse with a person of the opposite sex.[71] According to the International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organisation (WHO), infertility is defined as the lack of success of two persons of the opposite sex to attain a pregnancy after one year of having sexual intercourse on a regular basis and not using contraception.[72] For another, people with serious infectious diseases, such as HIV or Hepatitis A or B, use MAR to be able to get children without potentially risking to infect their partner.[73]

Attempts to attain pregnancies in the unconventional way have been around already for several years. The first successful attempt in the field of MAR was the birth of Louise Brown on the 25th of July, 1978. She was the first human being to be born with the help of in-vitro-fertilisation (IVF)[74], which is, according to the ICMART and WHO, defined as a MAR method, in which fertilisation takes place outside of the woman's body.[75] Since then, across the world, already more than 5 million babies were given birth to with the help of this MAR technology.[76] In contrast to this method, when talking about in-vivo-fertilisation, one means the method used to fertilize the oocytes inside of the woman's body.[77]

6.1. Sperm Donation

The usage of donor sperm to establish a pregnancy is the oldest of all MART and practiced since the 1960s as a solution to male infertility.[78] The definition of the term sperm donation contains two different processes. The removal of the sperm cells from the donor's testicles constitutes the first process. The subsequent use of these spermatozoa to fertilise oocytes constitutes the second part of the definition. The sperm cells, which will later be used for the insemination, are

[71] Mitchell, p. 1.
[72] F. Zegers-Hochschild, G.D. Adamson, J. de Mouzon et al., 'The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary on ART Terminology, 2009†', *Fertility and Sterility*, vol. 92, no. 5, November 2009, p. 1522, http://www.who.int/reproductivehealth/publications/infertility/art_terminology2/en/ (accessed 6 April 2018).
[73] Mitchell, p. 1.
[74] R. M. Kamel, 'Assisted Reproductive Technology after the Birth of Louise Brown', *Journal of Reproduction & Infertility*, vol. 13, no. 3, 2013, pp. 96-109. Available from Avicenna Research Institute (accessed 17 April 2018).
[75] Zegers-Hochschild et al, p. 1522.
[76] Kamel, pp. 96-109.
[77] Zegers-Hochschild et al., p. 1522.
[78] D. Meirow and J. G. Schenker, 'The current status of sperm donation in assisted reproduction technology: Ethical and legal considerations', *Journal of Assisted Reproduction and Genetics*, vol. 13, no. 3, 1997, pp. 133-138. Available from Springer-Verlag (accessed 17 April 2018).

obtained by masturbation. If the spermatozoa of the partner are used for the MAR and he suffers from functional impotence, the sperm cells are removed artificially from the testicles.[79]

Sperm donation can be distinguished between homologous and heterologous sperm donation, depending on the receiving woman who will become pregnant. Homologous insemination is the usage of sperm cells from the future mother's husband or partner in order to fertilize her ovum. Almost every country in the world permits the practice of this kind of insemination technique. In any other case, in which the spermatozoa used for the fertilisation are not donated by the spouse or partner of the receiving woman, this process is referred to as heterologous or donor insemination. If the term 'sperm donation' is used in common language, people usually talk about heterologous insemination, which was described as the fertilization of the ovum with spermatozoa of a third person.[80]

6.2. Oocytes Donation

Also the term oocytes donation contains two definitions, namely the egg cell production of one woman and additionally, the subsequent use of these oocytes to implant them in the body of the mother-to-be.[81] This MAR technique is used when the uterus of the recipient is not working properly anymore and cannot produce viable ova sufficiently.[82] This is the case if no more follicles are produced by the ovaries of a woman, which usually happens at a certain age or can be caused by disease.[83]

If the method of egg donation is used, the ovaries of the donating woman are medically treated with stimulation. This stimulation leads to the maturation of several egg cells at the same time. After the removal of the produced ova by puncture, they are fertilized outside of the donor's body and subsequently implanted in the body of the birthing woman. In this case, the child born is not genetically related to the receiving future mother.[84]

The sperm cells, which are used for the fertilization do usually come from the partner or husband of the woman who will become pregnant. It might happen that the spermatozoa of the

[79] M. Erlebach, 'Die Samen- und Eizellspende im FMedG', in P. Barth and M. Erlebach (eds.), *Handbuch des neuen Fortpflanzungsmedizinrechts*, Wien, Linde Verlag, 2015, p. 215.
[80] Ibid..
[81] Ibid., p. 216.
[82] Müller-Götzmann, p. 224.
[83] Erlebach, p. 216.
[84] Ibid..

partner are not used, because he suffers from infertility problems too. In such cases, the usage of donor sperm, which comes from a third person, might be possible. This method is referred to as separate embryo donation.[85]

6.3. Embryo Donation

As the name already indicates, embryo donation is the establishment of a pregnancy by implanting an embryo in the uterus of the mother-to-be. Technically, the transfer of an embryo into the body of the recipient is the same method as the one used for IVF, as there is also an embryo transferred.[86] The particularity of this method is that the delivered embryo consists neither of the oocytes, nor the spermatozoa donated from one of the future parents.[87] The donated embryos are usually surpluses from previous IVFs of other couples, which were not used anymore because a pregnancy has already been achieved or because the plans to have a child have changed. These embryos are also called surplus embryos. As a result, the born child is not genetically related to its social[88] parents, but to the embryo donors. Other children from the donor couple have the same genetic material as the siblings of the child born through embryo donation.[89]

6.4. Particularity: Surrogate Motherhood

A surrogate mother is the woman who is carrying out a baby for another person or couple with the intention to give the child to them after having given birth to it. Already before conception, the surrogate mother and the social parents make an arrangement or contract that the surrogate mother must give away the child after birth and disclaim her rights as a mother. A distinction is made between traditional and gestational surrogate motherhood. Traditional surrogacy is the establishment of a pregnancy by using the surrogate mother's own ova. The pregnancy is caused by sexual intercourse, or more likely, through artificial insemination using semen of the

[85] Ibid..
[86] P. Czech, *Fortpflanzungsfreiheit*, Seekirchen, Jan Sramek Verlag, 2015, p. 204.
[87] Zegers-Hochschild et al., p. 1522.
[88] The purely social parents are defined to as the parents, who have no biological relation to their child. This is the case, for example, if a child is adopted, taken care of through foster parenting, or given birth to by a surrogate mother. The parents, who ultimately raise the child and take actually care of it are called social parents (Müller-Götzmann, p. 226).
[89] S. Goedeke and K. Daniels, 'The Discourse of Gifting in Embryo Donation: The Understandings of Donors, Recipients, and Counselors', *Qualitative Health Research*, vol. 27, no. 9, 2017, pp. 1402-1411. Available from Sagepub (accessed 17 April 2018).

intended father of the child or of a donor. As a result, the baby will be genetically related to the surrogate mother. By contrast, the child born through gestational surrogacy is not genetically related to the surrogate mother, as the embryo is a result of an IVF, for which the gametes of donors or the gametes of the intended parents, which are the ova from the future mother and the spermatozoa from the future father, were used. [90]

6.5. Cryopreservation

According to ICMART and the WHO, 'the freezing or vitrification and storage of gametes, zygotes, embryos, or gonadal tissue' is referred to as cryopreservation.[91] The first time when frozen spermatozoa were used to artificially inseminate a human being was in 1953. Within a few years, the interest in freezing, vitrifying, and storing sperm cells grew and sperm banks became popular. Artificial insemination using frozen semen started to become a big success in the 1960s, when numerous pregnancies were caused by this kind of insemination method.[92]

Cryopreservation is a tool used for various kinds of reasons. Mostly, it is used when there are fears of a future occurrence of infertility or subfertility. This might happen, for example, due to chemotherapies, radiation therapies, diseases, or surgical operations, such as vasectomies or infertility-related surgeries. Therefore, the sperm cells or egg cells of the affected person are frozen, vitrified, and stored before the treatments just mentioned in order to keep fertile spermatozoa or oocytes, which will later be used for MAR. Cryopreservation is a solution for couples to get children even though one of them has to undergo therapies or surgeries that could cause infertility.[93]

When the oocytes of a healthy woman are cryopreserved precautionarily with the intention to use these fertile egg cells when hers are not fertile anymore due to her advanced age, this type of cryopreservation is called social egg freezing. In that case, the woman does not have any medical reasons for the oocytes cryopreservation, such as upcoming therapies or surgeries that

[90] Trimmings and Beaumont, pp. 628-629.
[91] Zegers-Hochschild et al., p. 1521.
[92] Y. Shufaro and J. G. Schenker, 'Cryopreservation of human genetic material', *Annals of the New York Academy of Science*, vol. 1205, issue 1 Women's Health and Disease, 2010, p. 220. Available from Wiley, (accessed 17 April 2018).
[93] M. Di Santo et al., 'Human Sperm Cryopreservation: Update on Techniques, Effect on DNA Integrity, and Implications for ART', *Advances in Urology*, vol. 2012, 2012, p. 1. Available from Hindawi, (accessed 17 April 2018).

might affect her infertility. Rather, it is her intention to keep her fertile egg cells in order to be able to delay a pregnancy to a time when her ova would probably not be fertile anymore.[94]

6.6. Human Reproductive Cloning

Another way of reproducing is cloning. Cloning is defined as the genetic multiplication of molecules, cells, or whole creatures, which can be plants, animals, or even human individuals. The methods of cloning can be classified into reproductive cloning, therapeutic cloning, and DNA cloning. DNA cloning is the copying of genes to examine genomes scientifically. Therapeutic cloning is understood as the cloning of human cells in order to treat diseases and to study the human development. In therapeutic cloning, a human embryo is examined and, in most cases, destroyed at the end of the examination, which is why there are ethical objections to this technique. Reproductive cloning is defined as the genetic multiplication of animals or human beings.[95] The first animal cloned successfully was a sheep named Dolly in 1996 in Sweden. Back then, cloning was not efficient. Only 1% of all cloning attempts lead to the birth of a living clone. However, cloning methods were improved. Just recently, in January 2018, monkeys were cloned in China. Nevertheless, the two monkeys died soon after their birth, which shows that cloning technologies are not yet perfected.[96]

Even though animal reproductive cloning has been attempted several times, a human being has never been cloned till today.[97] Still, human reproductive cloning would make it possible to produce an individual who is genetically identical with another already existing human being. The clone would not be a genetic sibling or genetic child of the cloned individual, but a genetic replication.[98]

From a medical and technical point of view, it would even be possible to mix the genetic material of two persons, regardless of their gender identity or sexual orientation, and inject the commixture into an egg, which then develops into an embryo. The developed child would

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[94] Erlebach, p. 226.
[95] M. Agha-Mohammadi, 'A Study of Fourteen Interpretations for Human Reproductive Cloning and Violating Man's Dignity', *Kom: Časopis za Religijske Nauke*, vol. 6, no. 1, 2017, pp. 99-100. Available from DOAJ, (accessed 17 April 2018).
[96] A. Regalado for MIT Technology Review, 'Is it time to worry about human cloning again?', *The Guardian*, 20 April 2018, https://www.theguardian.com/lifeandstyle/2018/apr/20/pet-cloning-is-already-here-is-human-cloning-next, (accessed 21 April 2018).
[97] Ibid..
[98] I. Ştefan, 'Arguments for and against human cloning in terms of teleological and deontological theories', *Revista Romana de Bioetica*, vol. 13, no. 3, 2015, p. 6. Available from Free Medical Journals (accessed 17 April 2010).

ultimately be genetically related to both parents, even when they are of the same sex. This method and other similar futuristic techniques to potentially create a person by combining the genetic material of two persons will not be further scrutinized in this study, as this would go beyond the scope of this paper. Also, at this point, these methods still seem to be too far away from reality to apply them in practice.[99]

6.7. Concluding Paragraph: Medically Assisted Reproduction Technologies

MAR is carried out by using different methods. In the case of infertility, various cells can be replaced in order to establish a pregnancy. Fertilization of gametes might take place either outside of or inside of the body of a woman, depending on the method used. The donation of spermatozoa, oocytes, embryos, or uteruses makes it possible for persons to attain a pregnancy even when they are infertile or unable to conduct sexual intercourse. Another reason might be the danger to infect the partner with a serious disease that is transmissible through unprotected sexual activity.[100] The multifarious ways of causing a pregnancy artificially make it possible for persons to get children, who were not able to do so before.[101]

7. Specific Couples in Need of Medically Assisted Reproduction to get Children

> *'Brittlestar species exhibit great diversity in sexual behavior and reproduction: some species use broadcast spawning, some exhibit sexual dimorphism, some are hermaphroditic and self-fertilize, and some reproduce asexually by regenerating or cloning themselves out of the fragmented body parts.'*[102] – Karen Barad

As already mentioned in the introduction, some couples are particularly affected by access restrictions to MAR due to infertility reasons or the combination of the partners' sexes. Not all couples have the privilege to attain a pregnancy without taking the help of others. Some men, be it cis- or transgender, might lack sufficient spermatozoa and some women might not be able

[99] Müller-Götzmann, p. 232.
[100] Mitchell, p. 1.
[101] E. Navas et al., 'Assisted reproduction technology and inheritance: examining the laws of Spain and Mexico', *Trusts and Trustees*, vol. 20, no. 3, April 2014, p. 251. Available from Oxford University Press Journals, (accessed 30 May 2018).
[102] K. Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*, Durham & London, Duke University Press, 2007, p. 377.

to produce fertile oocytes.[103] In the following Chapter, different constellations of couples, which are in need of MART in order to fulfil their desire to have a child, will be scrutinized.

7.1. Infertility in Opposite-Sex Cisgender-Couples

In this study, the focus is put on the right of LGBTIAQ+ persons to MAR. However, in the following paragraph, two cisgender persons, who live in an opposite-sex relationship, and their reasons for using MART, will be discussed first. This examination is relevant for the following comparison of different constellations of couples that need MAR to fulfil their wish for a child.

I deliberately chose to describe this couple as an 'opposite-sex cisgender partnership' and not as a 'heterosexual couple'. The classification 'heterosexual couples' is vague and inadequate in regard to MAR access. The categorization 'cisgender couples of the opposite sex' is more suitable, as countries do not always distinguish between couples on the basis of their sexual orientation, but on the grounds of their sex when determining the legal standards regarding MAR access. However, not even this categorization is entirely suitable, considering the fact that prior to their sex change surgery, a transgender person, who is in a relationship with a person of the same gender identity, has, medically and technically speaking, the same access to MAR as a cisgender person. For example, a transman who lives in a partnership with a cisgender man, may, prior to his transition from female to male, use the same MART as a cisgender woman who is in a relationship with a cisgender man. The choice of the term 'two-cisgender-persons of the opposite sex' is therefore only an incomplete attempt to show how a person who is biologically and socially perceived as a woman, and who lives in a relationship with someone that is biologically and socially perceived as a man, is medical-technically treated in the access to MAR.

A couple of two cisgender persons of the opposite sex (consider: this couple does not necessarily consist of two hetero-*sexual* persons. They could, for example, also be bi- or pan-*sexual*, or queer. However, they probably will have a hetero-, or bi-*romantic* relationship) will usually have less problems in getting children, as in most cases, they can achieve a pregnancy by having unprotected sexual intercourse. Still, some couples suffer from infertility and thus rely on MART to attain a pregnancy.[104]

[103] Mitchell, p. 1.
[104] Mitchell, p. 1.

One reason why an opposite-sex cisgender couple can be infertile could be that the semen of the men show abnormalities. In that case, the combination of intracytoplasmic sperm injection (ICSI) and IVF can be a solution to attain a pregnancy and allow the couple to get a child that is genetically related to both partners. In the ICSI treatment, an individual sperm cell is being injected into the egg cells' cytoplasm. Spermatozoa may have structural problems that hinder it from fertilizing the ovum. The direct injection practised in the ICSI method can counteract such problems during fertilization. If the couple is completely infertile, which is when they have no possibility to cause a pregnancy using their gametes, or when one of them suffers from an infectious disease and does not want to pass it on to the partner, they depend on donors. This can be a semen donor for when the spermatozoa of the man are completely infertile, and when the woman is suffering from infertility, an oocyte donor can help them to conceive.[105] If the woman has fertile eggs, but suffers from inborn defects of the uterus, using the method of uterus transplantation is another medical and technical possibility. Here, a donor's healthy uterus is implanted in the recipient's body and an embryo, which was created before by IVF, is transferred into that uterus. The first successful uterus transplantation took place in Sweden in 2013. A particular aspect of this method is that the child born will be genetically related to its gestational mother, and not to the donor.[106]

If both persons are infertile, they depend on an embryo donation to attain a pregnancy. Surrogate motherhood can also be an option for the infertile couple, especially when the social mother-to-be cannot carry a baby due to health issues, a lack of required reproductive organs, or the infertility of her eggs.[107] Another theoretical option for at least one of the partners to have a genetic offspring would be human reproductive cloning. All these MART were already discussed in more detail in the sections above.[108]

7.2. Two-Cisgender-Women-Couples

Two cisgender women living in a partnership always depend on MART to get their own child when adoption and foster parenting are no options for them and having sexual intercourse with

[105] Ibid., pp. 2-3.
[106] M. Brännström et al., 'Livebith after uterus transplantation', *The Lancet*, vol. 385, iss. 9968, February 2015, pp. 607. Available from ProQuest (accessed 17 April 2018).
[107] Michell., p. 2.
[108] Ştefan, p. 6.

a man is unacceptable to them, which is mostly the case.[109] Usually, when MART are carried out, one woman becomes pregnant via insemination of donor sperm. If one of the women is infertile, a pregnancy of her fertile partner can still be achieved via insemination. The child will have a biological relation to the gestational mother, but not to her partner.[110]

This could be changed, however, by using the shared motherhood method. In this technique, the oocytes or the embryo from one woman are implanted in the uterus of her partner, which enables one woman to be the genetic mother and the other to be the placental mother. The woman, whose oocytes are fertilized with donor spermatozoa, is referred to as the genetic mother. The placental mother is defined as the gestational mother, who carries the pregnancy and bears the child. The child will be biologically related to both mothers.[111] The desire to pursue the treatment and share the motherhood can have various reasons. First of all, it makes it possible for a woman, who has a healthy uterus but defective or absent oocytes, to get pregnant with a child that is genetically related to her girlfriend. Furthermore, a woman who is suffering from the absence of a uterus, but can produce oocytes, is able to get a child she is genetically related to when her partner carries and bears this child. Moreover, it provides a two-cisgender-women-couple with the possibility to share the experience of biological motherhood, which can strengthen their relationship, or that to the child.[112] If both women possess fertile oocytes and an intact uterus, they could each even be both the recipient and the donor. The embryo formed from the egg of one women could be transferred into the uterus of her wife, while another embryo developed from the oocytes of the wife is implanted into the womb of the first woman.[113]

Other options would be to use a surrogate mother or to produce a child through human reproductive cloning. In the first case, both mothers can raise the child as social mothers who have no genetic relation to it, whereas the child will be genetically related to the surrogate mother, who acts as the gestational mother.[114] The possibility of human reproductive cloning

[109] E. Rosswood, *Journey to same-sex parenthood :: firsthand advice, tips and stories from lesbian and gay couples*, New Horizon Press, Far Hills, 2016, p. 115. Available from EBSCOhost (accessed 17 April 2018).
[110] K. Zeiler and A. Malmquist, 'Lesbian shared biological motherhood: the ethics of IVF with reception of oocytes from partner', Med Health Care and Philos, vol. 17, no. 3, 2014, p. 348. Available from Springer (accessed 17 April 2018).
[111] Müller-Götzmann, p. 226.
[112] Zeiler and Malmquist, p. 348.
[113] S. Marina et al., 'Sharing motherhood: biological lesbian co-mothers, a new IVF indication', *Human Reproduction*, vol. 25, no. 4, p. 940. Available from Oxford University Press Journals, (accessed 30 May 2018).
[114] Trimmings and Beaumont, pp. 628-629.

was also further explained under Chapter 5.6 and would be a medically and technically possible solution for a two-women partnership to be able to have a genetic offspring of one of them.[115]

7.3. Two-Cisgender-Men-Couples

When a couple of two cisgender men desires to get a child via MART, it depends on an oocyte donor and a woman who is willing to carry the baby for them.[116] Without the involvement of a woman who agrees to get pregnant and deliver the child for them, they would have no chance to get a child who is genetically related to at least one of the men. Assuming that it is unreasonable for both men to have unprotected vaginal sexual intercourse with the woman to impregnate her, the method of artificial insemination has to be used. In that scenario, various practices of MART are possible. One way is to inseminate the surrogate mother using the semen of one man. As a result, the child born will have genetic relations to the woman and the man whose semen was used to fertilize the oocytes of the woman.[117]

It is also possible to produce a mixture of the spermatozoa of both men, so that both have the chance to become the genetic father of the child. Indeed, only one man will be genetically related to the child, as the egg is usually fertilized with one sperm cell. The fertilization of the oocytes can also take place outside of the woman's body with the help of IVF. For this purpose, either her own egg cells, or the oocytes of another woman are fertilized with the semen of one man or the semen-mixture or both men, and the formed embryo is then transferred into the uterus of the surrogate mother.[118]

If both men want to fulfil their desire for a genetically related child, it is possible to develop two embryos by using the spermatozoa of one man one time and the sperm cells of the other another time to fertilize the oocytes of the gestational mother. For that to happen, the woman's egg cells are fertilized with the respective spermatozoa via IVF and then transferred into her

[115] Stefan, p. 6.
[116] D. A. Greenfeld and E. Seli, 'Gay men choosing parenthood through assisted reproduction: medical and psychosocial considerations', *Fertility and Sterility*, vol. 95, iss. 1, 2011, p. 225. Available from Elsevier (accessed 17 April 2018).
[117] Müller-Götzmann, p. 228.
[118] Ibid..

uterus. Subsequently, two children can be born and each of them is genetically related to one of the partners.[119]

The already formulated comments on human reproductive cloning in two-women relationships are also applicable here.

7.4. Transgender Persons Living in Relationships

In 2003, Thomas Beale got pregnant and became the worldwide first pregnant man who is legally recognized as male. He is a transgender person who identifies as a man but was born in a woman's body, and he is an example that shows how diverse relationships, bodies, and the achievement of pregnancies can be.[120] Looking at options for queer people in the area of MAR, various ways to achieve a pregnancy can be pursued.

When a transgender person is part of a couple that wants to attain a pregnancy via MAR, the situation becomes more complex. As this constellation is not as well-known, not much relevant information on this matter can be found. Another difficulty in the case of a transgender individual desiring to achieve a pregnancy with the help of MAR, is that the reproductive options are diverse. Since gender identity and sexual orientation are not the same, the kinds of relationships a transgender person can live in are very diverse. Although most transgender individuals live in heterosexual partnerships, this does not necessarily have to be the case.[121]

The female cisgender partner of a transgender person, for whom it does not matter if they underwent a transition from male to female or vice versa, can become pregnant using donor semen. Furthermore, it would be possible to get a biologically descended child if the cisgender woman is living in a partnership with a transman. The cisgender woman could receive cryopreserved oocytes from the transman before his transition to male and then be inseminated with donated sperm. In this case, the transman will be the genetic father, as his former egg cells were used. The cisgender woman will be the gestational mother, as she is giving birth to the child. Another relationship constellation, which makes it medically possible to get a child that is biological related to both parents, is a couple consisting of a transwoman (who changed sex from male to female) and a cisgender woman. The cisgender woman could be inseminated with

[119] G. Sylvestre-Margolis, V. Vallejo, E. Rauch, 'Gestational surrogacy / egg donor IVF: behavior of gay men intended parents with respect to numbers of embryos transferred', *Fertility and Sterility*, vol. 104, no. 3, 2015, pp. e57-e57. Available from Elsevier (accessed 17 April 2018).
[120] Mamo, pp. 227-228.
[121] De Wert et al., p. 1860.

the cryopreserved sperm of the transwoman, who froze her spermatozoa before her sex transition. Subsequently, the transwoman will become the genetic mother, as her sperm was used, and her girlfriend will be the genetic and gestational mother. The child will be genetically related to both parents.[122]

In all kinds of relationship constellations including a transgender person, the couple can get a child through the help of surrogate motherhood, either with or without the additional donation of oocytes, depending on whether or not the genetic and gestational mother should be different persons.[123] In the particular case of a couple consisting of a transman and a cisgender man, the child conceived via surrogate motherhood can be genetically related to both of them. This can be the case when the prior cryopreserved oocytes of the transman are inseminated with the spermatozoa of the cisgender man and the developed embryo is then implanted into the uterus of the surrogate mother, who will carry the pregnancy for them.[124]

Table 3: Overview of medical and technical possibilities of MAR for specific couples

<u>ciswoman + cisman</u> ICSI + IVF or sperm/oocytes/embryo/uterus donation or surrogacy or human reproductive cloning	<u>ciswoman + ciswoman</u> insemination with donor sperm or shared motherhood (embryo/oocytes donation from one woman to the other + sperm donation) or surrogacy or human reproductive cloning	<u>cisman + cisman</u> surrogacy or human reproductive cloning
<u>ciswoman + transwoman</u> insemination with donor sperm or insemination with the cryopreserved sperm of the transwoman or surrogacy or human reproductive cloning	<u>transman + ciswoman</u> insemination with donor sperm or shared parenthood (transfer of the transman's cryopreserved oocytes into the uterus of the ciswoman + sperm donation) or surrogacy or human reproductive cloning	<u>transwoman + transwoman</u> surrogacy or human reproductive cloning

[122] Ibid..
[123] Ibid..
[124] Condat et al., pp. 3-5.

transman + cisman surrogacy (genetic related child to both parents: fertilize cryopreserved oocytes of transman with spermatozoa of cisman and transfer it into the uterus of the gestational mother) or human reproductive cloning	transman + transman surrogacy (cryopreserved oocytes of one of the transmen could be fertilized and transferred into the uterus of the surrogate mother) or human reproductive cloning	transwoman + cisman surrogacy or human reproductive cloning

Source: Table 3 was created by the author with the information taken from the previous chapters number 6.1 – 6.4 and constitutes a short summary of what was already mentioned in those chapters.

7.5. Other Constellations

As gender identity, sexual orientation, and human beings as such are very diverse, not all persons, who are restricted from accessing MART, are covered by the previous constellations of couples. Unfortunately, people from the LGBTIAQ+ community, who are barely considered when talking about the possible ways of reproducing, are, among others, intersex and asexual people. The barriers to achieve a pregnancy in the conventional way for intersex and asexual persons will therefore be explained in the following paragraphs.

In general, the bodies of intersex people are not clearly categorized as female or male, because they might have genitals or chromosomes that are not clearly attributable to one sex. Therefore, their bodies can have an intact uterus, fertile egg cells, or viable spermatozoa.[125] Thus, these respective gametes could be used either to be fertilized or to fertilize gametes of the partner or a third person, for example a surrogate mother.[126]

[125] Greenberg, pp. 1-2.

[126] Unfortunately, I could neither find literature, nor internet documents regarding reproductive opportunities for intersex persons. While transgender individuals are sometimes considered when talking about MART (e.g. De Wert et al., p. 1860; Condat et al., pp. 3-5), nobody seems to think about MART for intersex people. I searched for literature in various university database, Google and Google Scholar, but unfortunately I found nothing suitable to that issue. The terms entered during my research included, among others, 'intersex*', 'reproduction', 'reproduced*' and 'reproductive' individually and in combination with each other. My assumption why so little is to be found is perhaps that people, who are not clearly born as female or male very often have to undergo gender adaptive surgeries as a child, which in sometimes lead to infertility (Greenberg, p. 108). Often, MART, to which they could later refer to, are limited to the inclusion of a surrogate mother or the controversial method of human reproductive cloning. Furthermore, the third gender is recognized in the least countries (Council of Europe Commissioner of Human Rights, *Human Rights and Intersex people*, Strasbourg, Council of Europe Publishing, 2015, p. 37. Available from https://rm.coe.int/16806da5d4, [accessed 18 April 2018]). So if we talk about reproductive rights of intersex people, they are in most cases not legally intersexual, but female or male. As a result, they reproduce as men or women, not as intersex individuals (C. G. Costello, 'Intersex Fertility', *The Intersex Roadshow*, [web blog], 7 September 2011, http://intersexroadshow.blogspot.co.at/2011/09/intersex-fertility.html, [accessed 18 April 2018]).

Asexual people might possess the necessary genitals, chromosomes, and fertile cells to produce a child. However, they may find it unreasonable to have sexual intercourse, due to their low or inexistent sexual desire for other persons.[127] In order to get a genetically related child, they thus depend on the MART.

A*sexual* people should not be mistaken with a*romantic* people, who may also have problems in reproducing. Sexuality always refers to the sexual attraction of people towards others. Heterosexual persons are sexually attracted to people of the opposite sex, bisexuals to men and women, and homosexuals to persons of the same sex. As already stated briefly in the introduction, a bisexual person does not necessarily have the ability to enter romantic relationships with both men and women. If a person only loves people of the same sex, they are referred to as homo*romantic*. Contrary to that, a hetero*romantic* person only has romantic relationships with persons of the opposite sex. Accordingly, a*romantic* people are persons who do not have romantic feelings for anybody, regardless of their sexual orientation. However, a*romantic* people may still have a strong sexual desire and can be hetero*sexual*, homo*sexual*, bi*sexual*, or pan*sexual*.[128] But, an a*romantic* person will most likely not want to have children within a romantic relationship. If there is no desire to raise a child within a platonic friendship, a*romantic* people depend on their own to get children. For this, all the various medical possibilities of MART could be thought of, depending on the gametes the a*romantic* person is assigned with and whether they are fertile or not.

Intersex, asexual, and aromantic people have, like all others, the potential option to arrange a surrogate mother in order to get a child. Or, from the perspective of a medical and technical possibility, they could also be cloned. Everything discussed so far regarding surrogate motherhood and human reproductive cloning also applies here.

7.6. Concluding Paragraph: Persons Dependent on Medically Assisted Reproduction in order to Achieve a Pregnancy

Summing up, MAR is a way to attain a pregnancy by ways other than unprotected sexual intercourse between a male and a fertile female cisgender person. MAR is used for various reasons. The two intended parents may access MART due to infertility issues concerning one

[127] Bogaert, p. 364.
[128] Bogaert, p. 365.

or both of the persons. Some others choose to attain a pregnancy in the artificial way because their sexual orientation hinders them to conduct sexual intercourse with a person of the opposite sex, or because their bodies do not possess the necessary genitals, organs, or gametes to produce a child. In a nutshell, MART are an important tool for people from all over the world to get children when they are unable to get children in other ways, due to various reasons, such as infertility, the unreasonableness to conduct sexual intercourse, or when there is a potential risk to infect their partner because of a serious disease.[129]

8. From the Desire to Have a Child to a Right to Medically Assisted Reproduction

> *'Reproductive freedom is not just the ability not to have a child through birth control. It's the ability to have one if and when you want'* – Pamela Madson

By some activists, the desire to have a child is considered as a fundamental human need that exists independently from the sexual orientation or gender identity of those affected.[130] However, the definition of human needs varies and not every person agrees with defining the desire to have a child as a fundamental human need. Some people classify infertility treatment as a basic health care need, while some others insist on the term fundamental human need.[131]

At this point, it should be mentioned that human needs have to be divided into needs that everybody has and needs that vary from person to person or from time to time.[132] Donald Evans explains these differences with the example of the need for oxygen. He states that while all persons need oxygen to breathe in order to survive, only some individuals need other people to supply them with oxygen . Some people's need for oxygen is more urgent than for others due to their medical conditions. In the narrower sense, only the latter one is a human need that calls for remedy. This remedy does not always lie in health treatment, but can also be produced through educational or environmental means. For example, the quality of oxygen could be worsened by pollution, which will damage people's lungs. The better treatment of the environment leads to a better health condition of individuals. This better treatment of the natural

[129] Mitchell, p. 1.
[130] Müller-Götzmann pp. 11-12.
[131] D. Evans, 'The clinical classification of infertility', in D. Evans (ed.), *Creating the Child. The Ethics, Law and Practice of Assisted Procreation*, Wales, Kluwer International Publishing, 1996, p. 47.
[132] Ibid., p. 55.

world can be achieved by protecting the environment, and people can live healthier through educating and informing them about the consequences of smoking. If we now transfer this statement to the problem of childlessness, the issue can be seen similarly. A man who inseminates his wife with spermatozoa and thus ends her childlessness, cannot be seen as treating her clinically. However, the pregnancy can also be caused by clinical means, which are not only used in cases of infertility.[133]

In order to answer the question of MAR being a human need, the understanding of the term from physicians' point of view must be considered first. In the UK, a gynaecologist is allowed to refuse medical treatment even without having to have medical reasons for this refusal. For example, the performance of an abortion or MART can be refused when it would go against the ethics of the particular physician.[134] This does not include the general refusal to employ MART when it is argued that interfering unnaturally in the process of achieving a pregnancy would be amoral. The issue gets more complicated when it comes to objections to the usage of MART due to a person's lifestyle. In the view of a clinician, a single woman, one with disabilities, or one who feels attracted to other women, might not be seen as a suitable patient to get infertility treatment. This inclusion of non-clinical criteria in deciding whether a woman is a suitable MAR patient, might constitute a problem.[135]

As Soren Holm explains, human needs should furthermore not be confused with human 'wants' or 'desires'. Not everything a person wants is something they really need. A need is referred to as something that a specific person lacks, whereas desires or wants are states of minds. She also connects human needs with human suffering. Both ethical concepts can go hand in hand with each other or be separated from each other. Disease is not treated solely because of its nature of being a disease, but even more so because of the suffering and the needs it might cause. Moreover, there might be situations, in which suffering is caused not because of a need, but because there is an unfulfillment of desires or wants. And there are situations, in which there exists a need that appears to not cause any kind of suffering.[136] Usually, infertility does not cause physical suffering, as there is no actual physical pain. However, childlessness might cause psychological or social suffering. The existence of children is in many societies the only way to

[133] Ibid., p. 58.
[134] Ibid., p. 59.
[135] Ibid., p. 60.
[136] S. Holm, 'Infertility, Childlessness and the need for treatment. Is childlessness a Social or a Medical Problem?', in D. Evans (ed.), p. 71.

be insured as an elderly person. Additionally, young persons want their expectations to have children to be met. To not be able to cope with this social pressure can cause tremendous suffering. Still, with the possibility of adoption, it is possible to get a child through other ways than MAR. At this point, it has to be shown that new MART satisfy the fundamental needs of somebody, which adoption cannot meet.[137] Therefore, the desire to have children has to be distinguished from the desire to have genetically related children. The unfulfillment of this desire can also lead to suffering. Here, the questions arise as to which functions will only be fulfilled through having a biologically descended offspring, and which will not be fulfilled through having a child with no genetic relation to its parents. Here, the spreading of genes plays an important role in arguing for or against the desire to have a genetically related child being a fundamental human need. If we come back to the societal pressure, it is not plausible why society would want individuals to spread their genes, as this is not to the advantage of other people. Furthermore, the argument that genetically descended children bond better with their parents is not proven and therefore an invalid statement.[138] From another point of view, already the sole desire to conceive and/or bear a child can be defined as a fundamental human need. The desire to bear a child could be seen as a wish for a specific experience. This experience includes a nine-month long pregnancy followed by the painful, yet inspiring process of giving birth to a human being. To argue in favour of a generic wish to bear a child being a human need is rather difficult, as this sole desire to experience a set of happenings usually does not constitute a human need.[139]

In conclusion, it can be said that although a desire to conceive, carry, or bear a genetically related child may exist, defining this desire as a human need could be rather problematic.[140] Still, the unfulfillment of the human desire to have children often leads to suffering. And this suffering can lie heavy on persons in non-heteronormative partnerships.[141] Therefore, societies should minimize this problem by allowing persons to access MAR.[142] In order to allow such an access to members of the LGBTIAQ+ community and evaluate a possible right to MAR for LGBTIAQ+ persons, in the following Chapter, the relevant HR for LGBTIAQ+ persons to fulfil this desire, will be scrutinized.

[137] Ibid., p. 72.
[138] Ibid., p. 73.
[139] Ibid., p. 74.
[140] Ibid., p. 75
[141] Müller-Götzmann, pp. 11-12.
[142] Holm, p. 75.

9. Human Rights Relevant for LGBTIAQ+ Persons to Access Medically Assisted Reproduction

> *'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood*.'[143] – Universal Declaration of Human Rights

In order to find out if a right to MAR exists for LGBTIAQ+ persons, the international legal documents and the further explanations of their respective bodies have to be looked at. International legal instruments already deal with certain rights that can be interpreted in a way so that they include the right to MAR. Additionally, discrimination clauses that prohibit discrimination against persons on the basis of their sexual orientation or gender identity are often found. This Chapter scrutinizes the content of important documents and their references, which are relevant for LGBTIAQ+ persons in order to access MAR.

9.1. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

The CEDAW is considered as the international bill of women's rights, adopted by the United Nations General Assembly (UNGA) on the 18 December 1979. The convention consists of a preamble and 30 articles[144] and has 189 state parties.[145] The CEDAW defines what is meant by discrimination against women and builds a legal framework for all state parties to combat such discrimination. Pursuant to the convention, discrimination of women is considered to be:[146]

> 'any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their material status, on a basis of equality of men and women, of human

[143] United Nations General Assembly, Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III), http://www.un.org/en/universal-declaration-human-rights/, (accessed 11 June 2018).
[144] United Nations Human Rights Office of the High Commissioner, *Convention on the Elimination of All Forms of Discrimination against Women. New York, 18 December 1979* [website], http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx, (accessed 11 June 2018).
[145] United Nations Human Rights Office of the High Commissioner, *Status of ratification. Interactive Dashboard*, [website], 4 June 2018, http://indicators.ohchr.org/, (accessed 25 June 2018).
[146] United Nations Human Rights Office of the High Commissioner, *Convention on the Elimination of All Forms of Discrimination against Women. New York, 18 December 1979* [website], http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx, (accessed 11 June 2018).

> rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.'[147]

The prohibition of discrimination in matters regarding family planning is regulated in art. 12 of the CEDAW, which regulates that

> 'all states parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.'[148]

A similar reference regarding the right to get children is enshrined in art. 16 para. 1 lit. e CEDAW. It states the right of all women to choose at what time and how many children they wish to get.[149] At this point, it is noteworthy that art. 16 concerns all women. Taking into account the explicit acceptance of women in same-sex relationships and the additional recognition of gender identity as protected ground against discrimination by the Committee on the Elimination of Discrimination against Women in 2010, art. 16 can be interpreted as including all women regardless of their sexual orientation and identified gender. The just mentioned recognition was made by the Committees General Recommendation 27 on elderly women and its General Recommendation 28 on the core duties of state parties regarding art. 2 of the CEDAW. Both recommendations explicitly include all women, regardless of their sexual orientation and/or identified gender. Hence, transwomen and women who feel attracted to persons of the same sex also fall under the scope of the CEDAW.[150]

Specific references to gender identity were made by the Committee on the Elimination of Discrimination against Women in its General Recommendations regarding lesbian, bisexual, and transgender issues. It is noteworthy that in the cases in which the Committee addresses sexual orientation and gender identity, transgender women are also included. In regard to

[147] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) UNTS vol. 1249, art. 1.
[148] Convention on the Elimination of All Forms of Discrimination against Women, art. 12.
[149] Convention on the Elimination of All Forms of Discrimination against Women, art. 16 para. 1 lit. e.
[150] A. M. Miller and M. J. Roseman, 'Sexual and reproductive rights at the United Nations: frustration or fulfilment?', *Reproductive Health Matters*, vol. 19, no. 38, 2011, p. 108. Available from Taylor and Francis Online, (accessed 23 April 2018).

intersex persons, the Committee addressed them already in its General Recommendation, as well as in terms of their access to have their identified gender legally recognized.[151]

Furthermore, the Committee on the Elimination of Discrimination against Women recommended Portugal, in its concluding observations in 2015, that MART should be accessible non-restrictively for all women.[152] The Committee did not mention LGBTIAQ+ persons explicitly but might have included them when addressing 'all women'.[153]

9.2. Convention on the Rights of the Child (CRC)

The CRC is an international convention with 196 states parties.[154] It was adopted in 1989 and entered into force in 1990.[155] The Committee on the Rights of the Child is the monitoring body of the CRC and the two Optional Protocols thereto. It consists of 18 independent experts who examine the country reports of the state parties and recommend the individual countries to improve the situation of children in their concluding observations.[156]

The Committee on the Rights of the Child is frequently addressing the situation of children living in LGBTIAQ+ families. In already more than half of its concluding country observations, it explicitly expressed recommendations on LGBTIAQ+ issues. Thus, it can be said that the Committee is actually keen on observing the situation of children in LGBTIAQ+ families on a regular basis. In its recommendations, it expresses its concerns on discrimination of non-heteronormative family models regularly and advises the countries to improve their awareness-raising campaigns. These recommendations can be an important tool to better inform civil societies on the situation of children living in LGBTIAQ+ families, or on how they are being cared for by members of the LGBTIAQ+ community. In this context, activists could also brief

[151] H. Nolan and K. DeMilio for ILGA, *United Nations Treaty Bodies: References to sexual orientation, gender identity, gender expression and sex characteristics*, Geneva, ILGA, 2015, p. 54. Available from ILGA [website], https://ilga.org/downloads/2015_UN_Treaty_Bodies_SOGIEI_References.pdf, (accessed 11 June 2018).
[152] Committee on the Elimination of Discrimination against Women, 'Concluding observations on the combined eighth and ninth periodic reports of Portugal*', 24 November 2015, CEDAW/C/PRT/CO/8-9, para. 45, http://plataformamulheres.org.pt/wp-content/ficheiros/2015/11/CEDAW_C_PRT_CO_8-9_20571_E.pdf, (accessed 19 June 2018).
[153] Nolan and DeMilio, p. 53.
[154] United Nations Human Rights Office of the High Commissioner, *Status of ratification. Interactive Dashboard*, [website], 4 June 2018, http://indicators.ohchr.org/, (accessed 25 June 2018).
[155] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) UNTS vol. 1577.
[156] United Nations Human Rights Office of the High Commissioner, *Committee on the Rights of the Child*, [website], https://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIntro.aspx, (accessed 25 June 2018).

societies on how the treatment of LGBTIAQ+ persons influences the children who live in a non-heteronormative family or are being raised by non-heteronormative family members.[157]

Political and moral objections to LGBTIAQ+ persons raising children, as well as arguments for restricting access to MART for different-sex couples, are often based on the argument of the child's need for a mother and a father. However, such an argument is untenable under the CRC. The Committee on the Rights of the Child never supported such a view in its jurisprudence. Pursuant to art. 7 para. 1 of the CRC, every child has the right to know who its parents are and the right to be cared for primarily by its parents. Furthermore, art. 18 para 1 declares that the parents are primarily responsible for the childcare and the child's development. Additionally, art. 27 para. 2 enshrines the parent's responsibility to provide the secure living conditions that best support the child's development. There is not one single reference in the entire CRC or in its drafts throughout history that states that parents are defined as consisting of a male and a female parent.[158] Rather, the Committee underlined the flexibility of the definition of the term 'parents' in its remarks on the discussions about the duties of families in promoting the children's rights in 1994:[159]

> 'When considering the family environment the Convention reflects different family structures arising from the various cultural patterns and emerging familial relationships. In this regard the Convention refers to the extended family and the community and applies to situations of nuclear family, separated parents, single parent family, common law family and adoptive family.'[160]

Due to the fact that there is no explicit declaration stating that the term parents is only understood as two persons who are a mother and a father, LGBTIAQ+ parents cannot be excluded.[161] To the contrary, art. 2 CRC explicitly prohibits any discrimination of the child, its parents, or legal guardians on the basis of their sex or other status:

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[157] Nolan and DeMilio, p. 70.
[158] J. Tobin and R. McNair, 'Public International Law and the Regulation of private spaces: Does the Convention on the Rights of the Child impose an obligation on states to allow gay and lesbian couples to adopt?', *International Journal of Law, Policy and the Family*, vol. 23, vol. 1, 2009, p. 112. Available from Oxford Journals, (accessed 12 June 2018).
[159] Ibid..
[160] Committee on the Rights of the Child, *Role of the Family in the Promotion of the Rights of the Child*, 7th session, 10 October 1994, CRC/C/24.
[161] Tobin and McNair, p. 113.

> 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.'[162]

In regard to transgender rights, the Committee on the Rights of the Child expressed its concern in its concluding observations in 2016 on how the Islamic Republic of Iran is conducting forced medical interventions on transgender individuals.[163]

9.3. Programme of Action of the International Conference on Population and Development (ICPD Programme of Action)

In 1994, a United Nations conference took place in Cairo. The conference was referred to as International Conference on Population and Development (ICPD) and for the first time, sexual and reproductive health were addressed as needs and rights of human beings.[164] The ICPD Programme of Action was the first international legal document that included sexual health as a protected human right.[165]

Pursuant to para. 7.2 of ICPD Programme of Action, reproductive health is defined as 'a state of complete physical, mental and social well-being […] in all matters related to the reproductive system', including the right to 'have a satisfying and safe sex life' and to 'have the capability to reproduce and the freedom to decide if, when and how often to do so.' It also mentions the 'right of men and women to […] have access to safe, effective, affordable and acceptable methods of family planning of their choice for regulation of fertility which are not against the law'. Thus, the definition of reproductive health care, incorporated in the ICPD Programme of Action, also includes sexual health.[166] A more precise definition of 'sexual health' cannot be found in the ICPD Programme of Action. Due to the need of a clearer definition, the WHO has taken the

[162] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) UNTS vol. 1577, art. 2.
[163] Committee on the Rights of the Child, *Concluding observations on the combined third and fourth periodic reports of the Islamic Republic of Iran*, 14 March 2016, CRC/C/IRN/CO/3-4, para. 71.
[164] J. Thukral, S. Koerber and A. J. Wang, 'Sexual Rights as Human Rights: Informing a Domestic Reproductive Justice Agenda', in Center for Women Policy Studies, *Reproductive Laws for the 21st century papers. Center for women policy studies*, May 2012, http://www.racialequitytools.org/resourcefiles/REPRO_SexualRights_OpptyAgenda.pdf, p. 3.
[165] Ibid., p. 4.
[166] Programme of Action of the International Conference on Population and Development (adopted 5-13 September 1994) International Conference on Population and Development (ICPD Programme of Action) para. 7.2.

initiative and adopted the current working definition of sexual health.[167] Sexual health is referred to as

> 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'[168]

The right to sexual and reproductive health was constantly developed. In the General Comment No. 22 of the Convention, the ICPD declared the states' duties to ensure that reproductive health services are available, accessible, acceptable, and qualitative. Therefore, the states have an obligation to ensure the maximum of possible legal and budgetary resources for the constant guaranteeing of the right to reproductive health.[169]

According to the ICPD, reproductive rights include all other internationally recognized HR, which were agreed upon in international documents, such as the ICESCR, the ICCPR, or the CEDAW. Reproductive rights are the rights of all persons, either as individuals or as a couple, to choose when they want to have children and how many they want. Reproductive rights embrace the freedom of choice regarding matters on reproduction without discrimination.[170] Consequently, the prohibition of discrimination constitutes a state obligation to abolish impediments that prevent same-sex couples, single persons, people with disabilities, and transgender persons from accessing MAR. The General Comment No. 22 calls the states to reform their national laws and policies insofar that everybody can realize their right to reproductive health.[171]

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[167] World Health Organisation, *Sexual Health and its linkage to reproductive health: an operational approach*, WHO Publications, Geneva, 2017, https://creativecommons.org/licenses/by-nc-sa/3.0/igo, p. 2.
[168] Ibid., p. 3.
[169] A. Exter, 'Access to reproductive health services under the European convention on human rights', *Reproductive System and Sexual Disorder International Journal*, vol. 2, iss. 2, 2018, p. 29. Available from MedCrave, (accessed 18 June 2018).
[170] C. Shalev, 'Rights to Sexual and Reproductive Health – the ICPD and the Convention on the Elimination of All Form of Discrimination Against Women', *UN* [website], 18 March 1998, http://www.un.org/womenwatch/daw/csw/shalev.htm, (accessed 25 April 2018).
[171] Exter, p. 29.

Art. 7.16 of the ICPD Programme of Action goes even further, as it states that the countries should aim to 'assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice'.[172] The right to attain a safe pregnancy and the right to be supported in reproductive issues fall under the scope of reproductive health.[173]

9.4. The Yogyakarta Principles

The Yogyakarta Principles are a document about different international principles, which were published as the outcome of an international meeting of distinct HR experts in 2006 in Yogyakarta, Indonesia. The principles are legally binding guidelines for states applicable in issues regarding sexual orientation and gender identity.[174] According to the Yogyakarta Principles

> 'all human beings are born free and equal in dignity and rights. All human rights are universal, interdependent, indivisible and interrelated. Sexual orientation and gender identity are integral to every person's dignity and humanity and must not be the basis for discrimination or abuse.'[175]

The right to found a family is enshrined in Yogyakarta Principle 24. It declares that

> 'Everyone has the right to found a family, regardless of sexual orientation and gender identity. Families exist in diverse forms. No family may be subjected to discrimination on the basis of the sexual orientation or gender identity of any of its members.'[176]

Since 2006, the Yogyakarta Principles were expanded and in 2017, an additional document was launched. Another nine principles and 111 state duties were included in the Yogyakarta Principles Plus 10, which is a supplement document to the original principles.[177]

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[172] Programme of Action ICPD, para. 7.16.
[173] Miller and Roseman, p. 104.
[174] T. Martsenyuk, 'Ukrainian societal attitudes towards the lesbian, gay, bisexual, and transgender communities', in O. Hankivsky and A. Salnykova (eds.), *Gender, Politics and Society in Ukraine*, Toronto Buffalo London, University of Toronto Press, 2012, p. 401. Available from EBSCOhost Ebooks, (accessed 15 May 2018).
[175] International Commission of Jurists (ICJ), *Yogyakarta Principles – Principles on the application of international human rights law in relation to sexual orientation and gender identity*, March 2007, http://www.refworld.org/docid/48244e602.html, (accessed 18 June 2018).
[176] Ibid., Yogyakarta Principle 27.
[177] ARC International, *Introduction (YP+10)*, [website], 2016, http://yogyakartaprinciples.org/introduction-yp10/, (accessed 18 June 2018).

9.5. European Convention on Human Rights and Fundamental Freedoms (ECHR)

The ECHR was adopted in 1950 and entered into force in 1953. The ECHR ensures the protection of the HR of persons in the 47 member states of the CoE, which all signed the ECHR. The rights incorporated in the ECHR are binding. The ECtHR upholds these HR enshrined in the ECHR in its jurisdiction.[178] Individuals, member states, and non-governmental organizations can send complains to the ECtHR if have concerns that a member state has violated a right enshrined in the ECHR.[179] Additionally, the ECtHR further explains the scope of the respective rights under the ECHR in its case law.[180]

Art. 8 ECHR ensures the right to 'respect for private and family life'.[181] According to the ECtHR, it includes 'the right to respect for both the decisions to have and not to have a child'[182]. According to the ECtHR's jurisdiction, the medical treatment of the desire to have children falls under the section of private life enshrined in art. 8 ECHR, even though the pregnancy can only be achieved with medical assistance. The classification of MAR into the protection area of art. 8 ECHR is based on the same general principles as its natural pendant. The desire to have children is always an expression of a fundamental aspect of the private life.[183]

According to recent ECtHR's jurisprudence, same-sex partnerships (as well as opposite-sex relationships) are also explicitly included by the term family, as long as they live in a stable, de-facto partnership and in a shared household. Therefore, the couple enjoys the protection of private and family life in accordance with art. 8 para. 1 ECHR.[184] The desire to have a child and the use of MART for this purpose falls under the protection of art. 8 para. 1 ECHR and is therefore part of the private life of a person.[185]

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[178] Equality and Human Rights Commission, *What is the European Convention on Human Rights?*, [website], 19 April 2017, https://www.equalityhumanrights.com/en/what-european-convention-human-rights, (accessed 12 June 2018).
[179] International Justice Resource Center, ibid..
[180] Fundamental Rights Agency and Council of Europe, *Handbook on European non-discrimination law*, Luxembourg, Publications Office of the European Union, 2018, p. 141.
[181] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (adopted 4 November 1950, entered into force 3 September 1953) ETS No. 005 (ECHR), art 8.
[182] European Court of Human Rights, E.B. vs. France, no. 43546/02, 22 January 2008, para. 43.
[183] Czech, p. 26.
[184] J. Hengstschläger and D. Leeb, *Grundrechte*[2], Wien, Manz Verlag, 2013, p. 171.
[185] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.

Furthermore, a for gender registration required sex change surgery that leads to infertility, is seen as a violation of art. 8 ECHR.[186] The ECtHR emphasized in 2015 that such a requirement to undergo medical interventions that lead to a person's infertility before their preferred gender is legally recognized, is violating the ECHR.[187] Furthermore, in 2017, the ECtHR decided that a medical surgery or sterilisation as a requirement for recognizing the identified sex of transgender individuals by state authorities constitutes a violation of art. 8 ECHR.[188]

The right to found a family is enshrined in art. 12. This right is explicitly guaranteed to 'men and women' and 'according to national laws governing the exercise of this right'[189]. According to Holzleithner, the requirement to found a family with a person of the opposite sex does not necessarily follow this wording. The fact that the right to found a family is granted to 'men and women' does not mean that they can only do so with persons of the opposite sex. It could be also interpreted in the way that 'men and women' are enshrined with the right to marry and found a family, regardless of the sex of the person they are going to marry.[190]

Art. 14 ECHR enshrines the prohibition of discrimination. However, art. 14 ECHR is only applicable if another right of the Convention is violated too.[191] Sexual orientation is not specifically mentioned as discrimination ground, but it does fall under the scope of other grounds.[192] However, in regard to LGBTIAQ+ rights, the ECtHR decided in 2012 that the refusal of the adoption of a child by the female civil partner of a woman in France was not seen as a violation of articles 8 and 14 ECHR. Under French law, the adoption of a child was restricted to individuals or spouses of the respective child's parent. As same-sex marriage was not legal and an unmarried partner of a person in an opposite-sex couple would not have the possibility to adopt the child as well, the refusal is not violating articles 8 and 14 ECHR.[193] However, when a similar case occurred one year later in Austria, the ECtHR ruled differently. The ECtHR found a violation of articles 8 and 14 ECHR in the refusal of the adoption of a child by the same-sex partner of the child's parent. The crucial difference in that case was that Austria

[186] Fundamental Rights Agency and Council of Europe, 2018, p. 175.
[187] European Court of Human Rights, Y.Y. vs. Turkey, no. 14793/08, 10 March 2015.
[188] European Court of Human Rights, Garcon and Nicot vs. France, no. 79885/12, 6 April 2017.
[189] European Convention on Human Rights and Fundamental Freedoms, art. 12.
[190] E. Holzleithner, 'Spannungsfeld: Sexualität, geschlechtliche Identität und Menschenrechte', in G. Heißl (ed.), *Handbuch Menschenrechte*, Wien, facultas Verlag, 2009, p. 275.
[191] European Convention on Human Rights and Fundamental Freedoms, art. 14.
[192] Fundamental Rights Agency and Council of Europe, 2018, p. 178.
[193] European Court of Human Rights, Gas and Dubois vs. France, no. 25951/07, 15 March 2012.

allowed the adoption of a partner's child by persons living in opposite-sex relationships. Therefore, the general exclusion of persons living in same-sex partnerships in the access to adoption was seen as an objectively unjustified, differential treatment and thus, discriminatory.[194] Furthermore, the ECtHR has explicitly mentioned several times that art. 14 ECHR prohibits the discrimination against same-sex partnerships in comparison with opposite-sex relationships with the same marital status.[195] According to the ECtHR, discrimination based on sexual orientation is particularly weighty and can therefore only be justified on very serious and limited grounds/ in very serious and limited amount of cases.[196]

Prot. No. 12, which is ratified by 20 member states,[197] includes in its art. a 'general prohibition of discrimination'.[198] The scope of Prot. No. 12 is even greater than the one of art. 14 ECHR, as it is applicable independently from the violation of other HR enshrined in the ECHR.[199] Instead, Prot. No. 12 prohibits every discrimination of persons in their 'enjoyment of any right set forth by law'.[200]

Although the right to MAR falls under the scope of art. 8 para. 1 ECHR[201], and discrimination is prohibited pursuant to art. 14 ECHR and Prot. No. 12 ECHR[202], the ECtHR grants the member states a wide margin of appreciation when it has to decide in MAR cases. The term margin of appreciation is neither defined, nor mentioned in the ECHR. However, the ECtHR uses this doctrine in order to decide in specific cases.[203] The margin of appreciation grants the member states a space for manoeuvre in fulfilling their obligations. The idea behind it is that the states should be able to make decisions in accordance with their national legislation in cases on which extent some HR should be implemented. Especially in cases, in which different HR have to be

[194] European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[195] European Court of Human Rights, J.M. vs. United Kingdom, no. 37060/06, 28 September 2010.
[196] European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[197] Council of Europe, *Chart of signatures and ratifications of Treaty 177*, [website] 18 June 2018, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/177/signatures?p_auth=2EGkdcNa, (accessed 18 June 2018).
[198] Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended), art.1.
[199] Fundamental Rights Agency and Council of E, *Handbook on European non-discrimination law*, Luxembourg, Publications Office of the European Union, 2018, p. 63.
[200] Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended), art.1.
[201] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[202] Fundamental Rights Agency and Council of Europe, 2018, p. 178.
[203] G. Wadlig, 'The margin of appreciation and medically assisted reproduction. A study on the Application of the European Court of Human Rights' Margin of Appreciation Doctrine in Cases Concerning Medically Assisted Reproduction', Diploma Thesis, University Graz, 2014, p. 83.

balanced in order to come to a decision, the ECtHR often leaves this particular freedom to the states.[204] Nevertheless, there are some certain rules that have to be met in order to find out if the margin of appreciation is applicable in a certain case or not. First, the HR and their restrictions have to be balanced with the state interests and the purpose of the restrictions. Additionally, the existence of an European consensus in that issue has to be scrutinized. In order to do that, the ECtHR looks at the different national legislation of its member states and compares them. If such a European consensus does not exist and an interference of the ECtHR is not necessary in a democratic society, the ECtHR will grant a certain margin of discretion to the concerned state.[205]

9.6. Istanbul Convention

The CoE 'Convention on preventing and combating violence against women and domestic violence', in the following referred to as Istanbul Convention, was adopted on 11 May 2011 and entered into force on 1 August 2014.[206] It is ratified by 31 countries, which are all member states of the CoE.[207]

Pursuant to art. 1 Istanbul Convention, one of its aims is 'the elimination of all forms of discrimination against women' and the promotion of gender equality.[208] Art. 4 of the Convention explicitly prohibits discrimination on sexual orientation and gender identity grounds[209] and the parties agreed to 'abolishing laws and practices which discriminate against women'[210]. The explicit inclusion of non-discrimination on grounds of sexual orientation and gender identity expands the scope of the Convention. The explanatory report to the Istanbul Convention expressly declared that transgender persons fall under the non-discrimination clause enshrined in art. 4 para. 3 Istanbul Convention. Furthermore, all other persons, who 'do not

[204] Ibid., p. 32.
[205] Ibid., p. 35.
[206] Council of Europe Convention on preventing and combating violence against women and domestic violence (adopted 11 May 2011, entered into force 1 August 2014) CETS No.210 (Istanbul Convention).
[207] Council of Europe, *Chart of signatures and ratifications of Treaty 210*, [website] 12 June 2018, https://coe.int/en/web/conventions/full-list/-/conventions/treaty/210/signatures, (accessed 12 June 2018).
[208] Istanbul Convention, art. 1.
[209] Istanbul Convention, art. 4, para. 3.
[210] Ibid., art. 4, para. 2.

correspond to what society has established as belonging to "male" or "female" categories' are protected by the rights enshrined in the Istanbul Convention.[211]

Moreover, the state parties agreed to prohibit forced sterilisation of women in their domestic legislation. Art. 39 of the Istanbul Convention states that every medical intervention which should lead to the prevention of a woman's possibility to reproduce naturally and is conducted without her consent, should be criminalized.[212]

9.7. Oviedo Convention and its Additional Protocol

The 'Convention on Human Rights and Biomedicine', which is also referred to as Oviedo Convention, is the first and only legally binding document aiming to protect the HR and freedoms in the field of biomedicine on the international level. It entered into force in 1999 and is ratified by 29 states, which are all member states of the CoE. The purpose of the Oviedo Convention is the protection of human dignity and identity. The Oviedo Convention developed basic principles and prohibitions, which should be applied in everyday medicine practice. Advantages gained through malpractices in medicine and biology should be prevented. Priority is given to the protection of the human beings instead of to gains for science or society. Research in biomedicine, matters regarding genetics, bioethics, rights to privacy, and organ and tissue transplantations are especially regulated in this convention.[213]

A right to MAR could be derived from art. 3 Oviedo Convention. Pursuant to art. 3 Oviedo Convention, the states have a duty to guarantee all persons an equal health care access, which also includes access to reproductive services. The health needs of the concerned person should be considered, as well as the available resources.[214]

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[211] Council of Europe, 'Explanatory Report to the Council of Europe Convention on preventing and combating violence against women and domestic violence', Council of Europe Treaty Series – No. 210. 2011, p. 10. Available from Council of Europe, [website], https://rm.coe.int/16800d383a, (accessed 18 June 2018).
[212] Ibid., Art. 39 para. b.
[213] Council of Europe, *The Oviedo Convention: protecting human rights in the biomedical field*, [website], 2018, https://www.coe.int/en/web/bioethics/oviedo-convention, (accessed 14 June 2018); Council of Europe, *Details of Treaty No. 164*, [website], 2018, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/164, (accessed 14 June 2018).
[214] Exter, p. 29.

According to art. 5 Oviedo Convention, a person has to agree to medical interventions on their health before they are conducted.[215] Therefore, conducting medical treatments without consent of the concerned person are prohibited under art. 5 Oviedo Convention. An exception is made if the concerned person's health would otherwise be harmed or when the recovering process would be endangered.[216]

According to art. 14, MART should not be used for the purpose of deciding which sex the child should have. The only exception to this prohibition concerns cases in which serious diseases of the future child can be avoided.[217] This means that sex selection is only permitted if a genetic disease can occur when the child has a specific sex.[218]

Art. 21 Oviedo Convention forbids any financial benefit gained from one's body or parts of it.[219] Consequently, in states which ratified the Convention, the payment of gamete donors or surrogate mothers is not allowed. The providing of the uterus falls under the providing of elements of the human body, just as the donation of gametes does.[220]

The Oviedo Convention itself does not make any reference to cloning.[221] However, its Additional Protocol prohibits human reproductive cloning.[222] Art. 1 and 2 of the Additional Protocol to the Oviedo Convention prohibit the production of a genetic offspring of a human being. According to its art. 1 no. 1, 'any intervention seeking to create a human being genetically identical to another human being, whether living or dead' is prohibited. This is further explained in art. 1 no. 2, which states: 'for the purpose of this article, the term human being "genetically

[215] Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (adopted 4 April 1997, entered into force 1 December 1999) ETS No.164, art. 5.
[216] V. L. Raposo, 'The convention of human rights and biomedicine revisited: Critical assessment' *The International Journal of Human Rights*, vol. 20, iss. 8, 2016, p. 1280. Available from Taylor & Francis Online, (accessed 18 June 2018).
[217] Convention on Human Rights and Biomedicine, art. 14.
[218] Raposo, p. 1286.
[219] Ibid., p. 1289.
[220] G. Druzenko, 'Ukraine', in K. Trimmings and P. R. Beaumont (eds.), *International Surrogacy Arrangements :: Legal Regulation at the International Level*, Portland, Oregon, Hart Publishing, 2013, p. 357. Available from EBSCOhost, (accessed 31 May 2018).
[221] Raposo, p. 1287.
[222] Ibid., p. 1288.

identical" to another human being means a human being sharing with another the same nuclear gene set'.[223]

> 'The term "nuclear" means that only genes of the nucleus – not the mitochondrial genes – are looked at with respect to identity, which is why the prohibition of cloning human beings also covers all nuclear transfer methods seeking to create identical human beings. The term "the same nuclear gene set" takes into account the fact that during development some genes may undergo somatic mutation. Thus monozygotic twins developed from a single fertilized egg will share the same nuclear gene set, but may not be 100% identical with respect to all their genes. It is important to note that the Protocol does not intend to discriminate in any fashion against natural monozygotic twins.'[224]

The specification of the terms 'genetically identical' and 'same nuclear gene set' was important, as the offspring created through human reproductive cloning is not always genetically identical to the cloned person. This is only the case if the donated nucleus coincides come from the same individual as the donated enucleated cells. If they come from different persons, the cloned offspring will have no genetical relation to any of them. The specifications in art. 1 number 2 and point 7 make sure that also this kind of cloning is prohibited.[225]

At this point, it is noteworthy that although the Oviedo Convention incorporates a legally binding ban on human reproductive cloning, it is only ratified by 29 states and therefore, only applicable in those states. There do exist other HR documents that abolish human reproductive cloning, such as the UNESCO's 1997 Universal Declaration on the Human Genome and Human Rights or the EU Charter of Fundamental Human Rights (EU Charter). However, the UNESCO's declaration is not binding and the EU Charter only so if member states or EU institutions apply EU law. Consequently, an absolute prohibition of human reproductive cloning does not exist.[226]

[223] Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings (opened to signatures 12 January 1998) ETS No. 168, art. 1-2.
[224] Ibid., point 7.
[225] Raposo, p. 1288.
[226] A. Langlois, 'The global governance of human cloning: the case of UNESCO', *Palgrave Communications*, 21 March 2017, p. 3. Available from Palgrave Journals, http://www-nature-com.uaccess.univie.ac.at/articles/palcomms201719.pdf, (accessed 19 June 2018).

9.8. Concluding Paragraph: Overview of HR Relevant for LGBTIAQ+ Procreation

There are various international HR documents that make references to MAR rights on the one side, and non-discrimination of LGBTIAQ+ persons on the other side. The following Table is an overview of the most important references scrutinized in Chapter 9 of this study.

Table 4: International documents on a right to MAR for LGBTIAQ+ persons

Legal documents	Rights to MAR of LGBTIAQ+ persons
CEDAW	States have the duty to 'eliminate discrimination against women in the field of health care in order to ensure […] access to health care services, including […] family planning.'[227] Women have the right 'to decide freely and responsibly on the number and spacing of their children'.[228] Furthermore, 'access to assisted reproductive services, including in vitro fertilization' should be ensured 'for all women without any restrictions.'[229]
CRC	'State Parties shall respect and ensure the rights set forth in the present Convention […] without discrimination […], irrespective of the child's or his or her parent's or legal guardian's […] sex […] other status.'[230]
ICPD Programme of Action	The ICPD Programme of Action enures the right to 'have the capability to reproduce and the freedom to decide if, when and how often to do so' and the 'right of men and women to […] have access to safe, effective, affordable and acceptable methods of family planning of their choice for regulation of fertility which are not against the law'.[231] The purpose of the countries should be to 'assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.[232]
Yogyakarta Principles	Everyone has the right to found a family, regardless of sexual orientation and gender identity.[233]
ECHR	Art. 8 ECHR ensures the right to 'respect for private and family life'.[234] It includes 'the right to respect for both the decisions to have and not to have a child'[235]. The desire to have a child and the right to MAR for this purpose fall under the protection of art. 8 para. 1 ECHR.[236]

[227] Convention on the Elimination of All Forms of Discrimination against Women, art. 12.
[228] Convention on the Elimination of All Forms of Discrimination against Women, art. 16, para. 1, lit. e.
[229] Committee on the Elimination of Discrimination against Women, 'Concluding observations on the combined eighth and ninth periodic reports of Portugal*', 24 November 2015, CEDAW/C/PRT/CO/8-9, para. 45, http://plataformamulheres.org.pt/wp-content/ficheiros/2015/11/CEDAW_C_PRT_CO_8-9_20571_E.pdf, (accessed 19 June 2018).
[230] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) UNTS vol. 1577, art. 2.
[231] ICPD Programme of Action, para. 7.2.
[232] ICPD Programme of Action, para. 7.16.
[233] Ibid., Yogyakarta Principle 27.
[234] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (adopted 4 November 1950, entered into force 3 September 1953) ETS No. 005 (ECHR), art 8.
[235] European Court of Human Rights, E.B. vs. France, no. 43546/02, 22 January 2008, para. 43.
[236] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.

	Sex change surgery leading to infertility as a requirement for gender registration is a violation of art. 8 ECHR.[237] Discrimination against same-sex partnerships in comparison with opposite-sex relationships with the same marital status is prohibited.[238]
Istanbul Convention	The purpose is to eliminate 'all forms of discrimination against women' and to promote 'gender equality'.[239] Every medical intervention which should lead to the prevention of a woman's possibility to reproduce naturally and is conducted without her consent should be criminalized.[240]
Oviedo Convention	All persons should have an equal health care access, including access to reproductive services.[241] To gain a financial benefit from one's body or parts of it is forbidden.[242] Human reproductive cloning is prohibited.[243]

Source: This Table was created by the author. The contained information is gained from Chapter 9 and is an overview of the distinct references made in various international HR documents in regard to a right to MAR for LGBTIAQ+ persons.

10. National Regulations on the Access of LGBTIAQ+ Persons to Medically Assisted Reproduction

> *'The task […] seems to me to be about distinguishing among the norms and conventions that permit people to breathe, to desire, to love, and to live, and those norms and conventions that restrict or eviscerate the conditions of life itself [...] what is most important is to cease legislating for all lives what is livable only for some, and similarly, to refrain from proscribing for all lives what is unlivable for some'*[244]. – Judith Butler

The CoE member states are autonomous in regulating ethical and bioethical issues, such as same-sex marriage and reproductive possibilities.[245] Therefore, the access to MAR is regulated differently in domestic laws all over the world and within Europe.[246] For example, while three European countries, namely Germany, Norway, and Switzerland, decided to ban oocytes donation in general[247], others, such as the UK or Ukraine, even open up to domestic legal

[237] Fundamental Rights Agency and Council of Europe, 2018, p. 175.
[238] European Court of Human Rights, J.M. vs. United Kingdom, no. 37060/06, 28 September 2010.
[239] Istanbul Convention, art. 1.
[240] Ibid., Art. 39 para. b.
[241] Exter, p. 29.
[242] Ibid., p. 1289.
[243] Ibid., p. 1288.
[244] Butler, 2004, p. 8.
[245] Petra De Sutter, interviewed by Barbara Treichl, 4 July 2018, via skype, Vienna / Brussels.
[246] Trimmings and Beaumont, p. 629.
[247] Embryo Protection Law 1990 (Germany) s. 1 (1-3); Reproductive Medicine Act 1998 (Switzerland) s. 4; Biotechnology Act 2003 (Norway) s. 2-18.

possibilities like using a surrogate mother to fulfil a couple's desire to have children.[248] Therefore, the conditions to the access vary. In the UK, all couples regardless of their gender identity and sexual orientation can arrange a surrogate mother[249], but in the Ukraine, this is only allowed for married persons.[250] The national legislation on the access to MART are as diverse as the countries themselves.

Due to the plurality of different national legal systems, it would not be enough to compare only two or three countries, since such a comparison would not lead to a meaningful conclusion on the European level. The differences in the various countries require that at least five or six different legal systems are examined in order to cope with the European diversity. Indeed, the more countries are scrutinized, the more accurate this study will be. However, due to the scope of this study and the timeframe available to do it, it is not possible to compare more than six nation states. The countries are put into different categories and thus, each category will be compared. The criteria I have set for each category will be explained in the next paragraph.

10.1. Criteria of Classification of Countries

There are different ways of categorizing countries when conducting a comparative legal analysis. I have chosen to group the legal systems into three classifications of nation states, namely *restrictive*, *partially restrictive*, and *liberal* countries.

The legal regulations of the access to MART are very diverse and no domestic legal system corresponds to the other. While in some countries the general access to MART can be easily obtained, others fill their reproductive legislation with prohibitions and restrictions.[251] Since this study does not refer to the general access to MART, but to the access of members for the LGBTIAQ+ community, the word *restriction* is not seen as a general restriction to MAR, but rather as *access restrictions to MART for LGBTIAQ+ persons*. Ukraine, for example, is widely seen as one of the most liberal countries on the global level in regard to surrogacy issues. It is one of the few countries worldwide where it is even possible to obtain a surrogate mother by

[248] C. Fenton-Glynn, 'International surrogacy before the European Court of Human Rights', *Journal of Private International Law*, December 2017, vol. 13, no. 3, p. 546. Available from Taylor and Francis Online, (accessed 19 April 2018).
[249] M. Crawshaw, E. Blyth and O. Van den Akker, 'The changing profile of surrogacy in the UK – Implications for national and international policy and practice', *Journal of Social Welfare and Family Law*, vol. 34, no. 3, 2012, p. 272. Available from Taylor and Francis Online, (accessed 20 April 2018).
[250] Gunnarsson Payne, p. 239.
[251] Trimmings and Beaumont, p. 629.

commercial means. The general approach to surrogacy is therefore undoubtedly liberal in Ukraine.[252] Nevertheless, Ukraine is extremely conservative in regard to the rights of LGBTIAQ+ individuals and explicitly prevents them from appointing a surrogate mother because of their sexual orientation and gender identity.[253] Consequently, Ukraine will be categorized as a restrictive country. Other states that deny access for persons, whose gender identity or sexual orientation differs from the majority, are, among others, Albania, Belarus, the Czech Republic, France, and Turkey.[254] By contrast, the UK, Belgium, and the Netherlands are examples for nation states, which allow full access to the available MART, regardless of the sexual orientation or gender identity of the respective persons. In those countries, LGBTIAQ+ individuals have the same access to the prevalent MART as persons living in conventional heteronormative relationships, and can even arrange a surrogate mother.[255] Therefore, they will be further discussed within the category of *liberal* countries.

The national legal systems of some other countries are not clearly classifiable as *liberal* or *restrictive*. Norway and Germany are examples for nation states, which prohibit the use of specific MART, such as surrogacy or oocyte donation.[256] On the one hand, this general denial also constitutes a restriction for LGBTIAQ+ persons. On the other hand, in those countries, there do exist domestic legal regulations that allow access to MART for two cisgender women living in a partnership in some cases.[257] The legally accessible MART in these countries are therefore also available for some members of the LGBTIAQ+ community and not only restricted to conventional heteronormative couples under national law.[258] As a result, these nation states have to be ranked somewhere between *restrictive* and *liberal* countries. Therefore, they will be examined more closely under the heading of *partially restrictive* countries.

[252] Druzenko, p. 357.
[253] Gunnarsson Payne, p. 239.
[254] Rainbow Europe, *Rainbow Map* [website], 2018, https://rainbow-europe.org/#0/8682/0, (accessed 23 May 2018).
[255] J. Cohen, 'Jean Cohen's corner. Procreative tourism and reproductive freedom', Reproductive BioMedicine Online, vol. 13, iss. 1, 2006, p. 145. Available from Elsevier, (accessed 20 April 2018).
[256] ESHRE, *Regulation and legislation in assisted reproduction* [website], January 2017, p. 2, https://www.eshre.eu/Press-Room/Resources.aspx, (accessed 20 April 2018).
[257] Council of Euorpe, *Discrimination on grounds of sexual orientation and gender identity in Europe*, Council of Europe Publishing, Strasbourg, 2011, p. 99. Available from http://www.refworld.org/docid/4eb8f53f2.html, (accessed 21 April 2018); Mitteldeutscher Rundfunk AKTUELL Nachrichten, 'Lesbische Frauen können künstliche Befruchtung steuerlich absetzen', *Mitteldeutscher Rundfunk* [website], 18 January 2018, https://www.mdr.de/nachrichten/politik/inland/urteil-lesbische-frauenkoennen-kuenstliche-befruchtung-steuer-absetzbar-100.html, (accessed 21 April 2018).
[258] Rainbow Europe, ibid..

To sum up, due to the plurality of different national legal norms, the countries are divided into different categories. However, a mere classification into *restrictive* and *liberal* nation states would not be satisfactory, since the respective country legislation are not always clearly restrictive or liberal. Sometimes, some MART are also available for LGBTIAQ+ persons, while some others are not. Therefore, it is necessary to create a third category that covers all countries that are in this grey area, so to speak. *Liberal* countries are thus the countries in which LGBTIAQ+ people have access to MART, regardless of their sexual orientation, gender identity, or civil status. *Partially restrictive countries*, by contrast, are those which regulate the access to MART irrespective of gender and sexual orientation and which have corresponding anti-discrimination provisions in their legal systems. However, members of the LGBTIAQ+ community are partially excluded due to general impediments to access. For example, in partially restrictive countries, surrogacy is not allowed by law, which is why two-cisgender-male-couples have no way of fulfilling their desire to conceive by using MAR. *Restrictive* countries are those countries that may be liberal concerning the general access to MART, but that limit access to persons with certain gender identities and/or sexual orientations, which results in a marginalization of LGBTIAQ+ persons.

Table 5: Criteria of Classification of Countries

Categories	**Explicit access to MAR for singles with female reproductive systems regardless of sexual orientation and gender identity**	**Access to surrogacy for same-sex couples**	**Legal possibility to establish a shared biological motherhood**
Restrictive countries	No	No	No
Partially restrictive countries	Partially	Partially	Partially
Liberal countries	Yes	Yes	Yes

Source: This Table was created by the author.

10.2. Choice of Countries

As already mentioned in the beginning, this analysis is focused on European countries, as not all nation states worldwide can be scrutinized within the scope of this study. However, Europe is big and the national legislation systems of the countries are very diverse.[259] As already mentioned before, not all domestic legal systems of the European states can be examined in this study. Therefore, this study is limited to six countries, which will be discussed in more detail.

[259] Trimmings and Beaumont, p. 629.

These have been chosen so that two countries of each of the chosen categories can be discussed as example states. In order to decide which countries are best suited for this study, criteria of choice had to be established. Several factors played a role in selecting these criteria of choice of the respective nation states.

First of all, the chosen countries are all member states of the CoE. This is important, since the CoE, as an international organization, offers a set of international legal regulations, which are applicable in all discussed countries. Furthermore, all the selected countries have ethic commissions. To select countries by looking for existing ethic commissions is important, as their publications on MAR legislation and LGBTIAQ+ rights constitute one of the most important data sources of this study. In addition to publications of the individual ethic commissions, other accessible information sources are essential to write a good academic paper on this issue. Without reliable sources and literature, this goal cannot be achieved. Therefore, the access to trustworthy, scientific publications and to legal analyses of the separate countries plays an important role. Not only the access to information itself, but also the comprehensibility of these sources is essential. Language barriers stand in the way of understanding data sources, which are often only available in the national languages of the respective states. Therefore, countries, for which English, German, and Spanish literature and on-topic research results can be found, were preferred in this study. The legal texts themselves were partially translated by using web-based translation tools, so that text comprehensibility could be achieved.

The examined countries were thus selected according to multiple criteria. The restriction to six European countries allows a more detailed analysis than a superficial, general discussion on the global level. Access to information on this matter, such as publications of ethic commissions, and the linguistic comprehensibility of this information are an indispensable requirement for conducting such a country analysis.

10.3. Restrictive Countries: Ukraine and Czech Republic

Restrictive countries are those countries, which deny access to MART for LGBTIAQ+ persons either because of a general restriction, or explicitly because of their sexual orientation or gender identity.[260] The two selected countries, which will be discussed for the purpose of analysing the individual legal systems, are Ukraine and the Czech Republic. The two chosen countries differ

[260] Rainbow Europe, ibid..

from each other in the way that the Ukrainian law formally allows surrogate motherhood[261], while the Czech law does not allow it explicitly.[262] Nevertheless, surrogacy is practiced in both countries.[263] While the Czech Republic specifically limits the access to MART to two persons of the opposite sex[264], surrogacy is only available for spouses under Ukrainian law.[265] In this chapter, the access to MART for LGBTIAQ+ individuals in those two restrictive countries will be scrutinized.

10.3.1. Ukraine

Ukraine is one of the most liberal countries when it comes to the general access to MART. Most applied MART are legally regulated and permitted. Family planning and reproductive health care are important issues in Ukraine, especially because of unwanted developments concerning the population there.[266] MAR has become a political issue due to the very low birth rates of the post-communist country. The government decided to impose a pro-natalist policy in order to increase childbirths.[267]

According to the right to life, established under art. 281, para. 7 of the Ukrainian Civil Code (UCC), men and women of adult age are entitled to a right to MAR, whose procedures are regulated by law:[268]

> 'An adult woman or a man has the right to medical indications for the provision of auxiliary reproductive technologies in accordance with the procedure and conditions established by law.'[269]

[261] Druzenko, p. 357.
[262] D. Císařová, J. Brojáč and N. Roubíčková, 'Parenthood and Homosexuality within the context of assisted Reproduction – are we ready for homoparental families?', *International Journal for Legal Research*, vol. 5, no. 4, 2015, p. 298. Available from The Lawyer Quarterly, (accessed 21 April 2018).
[263] Fenton-Glynn, p. 546.
[264] Císařová, Brojáč and Roubíčková, p. 299.
[265] Druzenko, p. 359.
[266] S. Lysytsia, '26 Law regulation of ART in Ukraine', *Reproductive BioMedicine Online*, vol. 22, supplement 2, March 2011, p. S104. Available from: Elsevier, (accessed 15 May 2018).
[267] T. Zhurzhenko, 'Ukraine. Mothering the Nation. Demographic Politics, Gender and Parenting in Ukraine' in K. Daskalova et al. (eds.), *Gendering Post-Socialist Transition. Studies of Changing Gender Perspectives*, Vienna, Lit Publishing, 2012, p. 300.
[268] Druzenko, p. 357.
[269] The Civil Code of Ukraine, Law No. 435-IV of 16 January 2003 (entered into force 1 January 2004), art. 281 para. 7. Available from http://www.wipo.int/wipolex/en/text.jsp?file_id=436135, (accessed 19 June 2018), translated through web-based translation tools.

It is important to note that all natural persons can rely on art. 281, regardless of their nationality.[270] Embryo, oocyte, and spermatozoa donations are permitted under Ukrainian law.[271] However, when carried out, these gamete and embryo donations are legislated to protect the donors' anonymity and the medical professionals are subject to confidentiality obligations.[272] Every male and female adult is allowed to access MART. As a requirement for the use of such methods, the person concerned has to prove their infertility or subfertility. This proof can be submitted by getting a confirmation from a physician, who signs the appropriate certificate. Regardless of their marital status, couples and individuals have thus access to MART as long as the need for fertility treatment is proven.[273] The access to MAR is denied to same-sex couples. They can only make use of these methods as single persons.[274] However, in the special case of surrogacy, only spouses can access this type of MAR as a couple.[275]

Surrogacy is regulated by law and its provisions are primarily based on the rights of the child and its genetically related parents.[276] The legal relations of the child perceived through surrogate motherhood to its parents is regulated under art. 123, para. 2 of the Ukrainian Family Code. It declares that the legal parents of the child will be the spouses that made use of surrogacy in order to fulfil their desire to have a child and whose gametes were used to create the embryo. The intended parents will only be legally registered as parents when no germ cells of the surrogate mother were used and when the child is at least 50% genetically related to one or both of the spouses.[277] This means that the intended parents will also be registered officially as parents when the gametes of only one of them were used in the fertilization process, and thus, when only one of the parents is genetically related to the child.[278] Furthermore, the spouses are explicitly prescribed as a man and a woman. Additionally, art. 139, para. 2 of the Ukrainian Family Code declares that a surrogate mother has no possibility to rely on her relation to the

[270] Druzenko, p. 357.
[271] Lysytsia, p. S104.
[272] Ibid..
[273] Sandra F. for invitra, *Regulations governing egg and sperm donation in Ukraine*, [website], 16 August 2016, https://www.invitra.com/regulations-governing-egg-and-sperm-donation-in-ukraine/, (accessed 17 May 2018).
[274] C. Phillips for Fertility Clinics Abroad, *IVF Ukraine* [website], 3 January 2017, https://www.fertilityclinicsabroad.com/ivf-abroad/ivf-ukraine/, (accessed 17 May 2018).
[275] Sandra F. for invitra, *Regulations governing egg and sperm donation in Ukraine*, [website], 16 August 2016, https://www.invitra.com/regulations-governing-egg-and-sperm-donation-in-ukraine/, (accessed 17 May 2018).
[276] Lysytsia, p. S104.
[277] P. Frati et al., 'Surrogate motherhood: Where Italy is now and where Europe is going. Can the genetic mother be considered the legal mother?', *Journal of Forensic and Legal Medicine*, vol. 30, 2015. p. 5. Available from: Elvesier, (accessed 15 May 2018).
[278] Ibid., p. 6.

child when the embryo was conceived by the gamete cells of the intended parents and then transferred into her uterus.[279]

The surrogate mother has to affirm, by means of a notarial certificate, that the intended parents will be legally registered as the parents of the child she was carrying. If the surrogate mother does not consent to the legal recognition of the parents by a notary, the intended parents have to go to court. The court, in turn, would require an authority office to register the parents legally as such.[280]

Commercial surrogacy is not regulated explicitly under Ukrainian law. Nevertheless, art. 6, para. 1 of the UCC regulates the principle of freedom of contract, which constitutes a basic element of the Ukrainian contract law. It declares the right to conclude any contract, even if it is not explicitly regulated by law. The contract, however, must be consistent with the fundamental elements of Ukrainian civil law. Additionally, art. 627, para. 1 of the UCC allows free contract entering, free choice of contract parties, and free decision about the content and conditions, as long as it is rational and just and in accordance with the civil law and common practice in business affairs.[281] Taking into account the above-mentioned principle of freedom of contract, commercial surrogacy is not illegal under Ukrainian law and therefore, permitted.[282]

At this point, it is important to note that since 22 March 2002, Ukraine is one of the signatories of the Oviedo Convention and has not made any reservations to it.[283] The Convention prohibits under art. 21 that 'the human body and its parts shall not, as such, give rise to financial gain'[284]. The ratification of this Convention would lead to its entry into force and integration into the national Ukrainian law. Consequently, the payment of surrogate mothers would become illegal, as providing a uterus for the purpose of carrying a child for third persons and giving birth to it would fall under providing a part of the human body and this would not be allowed if it involves a financial gain.[285]

[279] Druzenko, p. 358.
[280] Ibid..
[281] Ibid..
[282] Ibid., p. 359.
[283] Ibid..
[284] Council of Europe, Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (adopted 4 April 1997, entered into force 1 December 1999) ETS No.164, art. 21.
[285] Druzenko, p. 359.

Ukrainian law does not regulate traditional surrogacy, which is the insemination of the oocyte of the surrogate mother with spermatozoa of the intended father. In this scenario, the surrogate mother would also be genetically related to the child. The Ukrainian legislation requires the embryo, which will be transferred to the uterus of the surrogate mother, to be conceived by gamete cells of the intended parents. Consequently, there is no chance for another person to be legally recognized as the child's mother, but the surrogate mother.[286]

Some persons are not allowed to hire a surrogate mother. The Ukrainian law only allows spouses to arrange a surrogate mother in order to conceive a child. If the couple is not married, it has no legal entitlement to be registered as parents of the child born by the surrogate mother, even though it is genetically related to both of them.[287] As only two cisgender persons of the opposite sex are allowed to marry in Ukraine, LGBTIAQ+ couples and individuals are prevented from arranging a surrogate mother under domestic law.[288] The Ukrainian legal framework makes it clear that married same-sex couples, who got married in a country that allows same-sex marriage, are not permitted to be registered as parents of a child born through surrogacy. The provision 'a man and a woman' in art. 139, para. 2 of the UCC specifies that the term 'spouses' does not include same-sex spouses.[289]

Access to MART requires for the intended parents to be unable to attain a pregnancy and carry and bear a child naturally.[290] Surrogacy can only be used as an MAR method when the married couple is infertile, or when the health of the intended mother and/or the child are at risk. This is especially the case when the body of the intended mother lacks a uterus, when the uterus is deformed due to prior diseases or congenital defects, when the future mother suffers from intrauterine adhesions, or when the married couple already tried to conceive a child via other MART four times or more and all of them were not successful.[291]

[286] Ibid., p. 360.
[287] Ibid., p. 359; Rules of Civil Registration in Ukraine, Chapter III, s. 1 para 11.
[288] Druzenko, p. 359.
[289] Ibid., p. 360.
[290] Ibid., p. 360-361.
[291] Ibid., p. 361.

Until 2016, transgender people were obliged to undergo sterilisation before they could legally change their gender.[292] With decree No. 1041[293] issued on 30 December 2016, a new procedure was adopted which now even made it possible for transgender individuals to have their gender identity legally recognize without having to undergo mandatory sterilisation processes first.[294] The Unified Clinical Protocol, which was approved in 2016, now even contains a chapter in which trans people are being encouraged to use MART. Unfortunately, there are in fact still some limitations for transgender persons in their access to MART.[295] The limitations can be found in Order No. 579[296] of the Ministry of Health in Ukraine, which was issued on 29 November 2004. It bans persons with female reproductive systems from using MART in case they have received any of the diagnoses listed, including the F64 diagnoses.[297] The F64 diagnoses, also known as 'Gender identity disorders', are listed under the category of 'Mental, Behavioral and Neurodevelopment disorders' in the ICM-10-CM list.[298] The International classification of Diseases (ICD) is a standardized tool provided by the WHO and used to classify diseases and other health issues. The ICD is available in 117 countries and 43 different languages.[299] This means that every individual who has female reproductive cells or organs and who suffers from any of the F64 'diagnoses', which is the case when the person concerned is trans or intersex, is not allowed to access MART under Ukrainian law.[300]

At this point, it is worth mentioning that the WHO released a revised version of the ICM-10-CM list just recently on 18 June 2018.[301] The new classified list of diseases, ICM-11-CM, will be presented in May 2019 to finally get approved by the World Health Assembly. Then, the member states have time to adopt the changes in their national legislation until June 2022. It is

[292] Insight public organization, *International Conference. Transgender issues: challenges and perspectives in modern Ukraine and world* [website], 2018, http://transconf.org.ua/en/, (accessed 16 May 2018).
[293] Ministry of Health in Ukraine, Decree No. 1041, 5 October 2016, http://zakon0.rada.gov.ua/laws/show/z1589-16, (accessed 16 May 2018).
[294] N. Husakouskaya, 'Transgender, Transition, and Dilemma of Choice in Contemporary Ukraine', in L. Attwood, E. Schimpfössl and M. Yusupova (eds.), *Gender and Choice after Socialism*, Cham, Palgrave Macmillan, 2018, p. 27. Available from Google Books, (accessed 16 May 2018).
[295] Iryskina I., e-mail, 26 May 2018.
[296] Ministry of Health in Ukraine, Order No. 579, 29 November 2004, http://zakon3.rada.gov.ua/laws/show/z0224-05, (accessed 28 May 2018).
[297] Iryskina, ibid..
[298] World Health Organisation, *ICD-10 Version:2016* [website], 2016, http://apps.who.int/classifications/icd10/browse/2016/en#/F60-F69, (accessed 28 May 2018).
[299] World Health Organisation, *International Classification of Diseases* [website], 23 February 2018, http://www.who.int/classifications/icd/en/, (accessed 28 May 2018).
[300] Iryskina, ibid..
[301] World Health Organisation, *ICD-11: Classifying disease to map the way we live and die*, [website], http://www.who.int/health-topics/international-classification-of-diseases, (accessed 22 June 2018).

noteworthy that trans persons are no longer regarded as being mentally disordered in the new ICD list.[302] However, this does not count for intersex persons. Individuals, whose sex characteristics vary, fall under the category of 'Disorder of Sex Development' in the ICD-11-CM.[303]

In conclusion, the legal framework of Ukraine includes regulations on spermatozoa, oocyte, and embryo donation. Also, surrogacy is regulated and legally permitted in Ukraine. Compared to other European countries, Ukraine is therefore a more liberal country in terms of permitting various MART in general.[304] To access MART in Ukraine, couples and individuals are required to prove their infertility.[305] LGBTIAQ+ persons, who are living in a same-sex relationship, are never allowed to access surrogacy in Ukraine, neither as couples nor as individuals.[306] Trans and intersex persons, who fall under F64 diagnoses of the WHO, are prohibited from accessing MAR, if they provide a female reproductive system.[307] Lesbian, bisexual, pansexual, and queer women, who live in a relationship with another woman, can make use of MAR as long as they access it as single persons. Within a relationship, a two-women-couple is not allowed to employ those medical possibilities.[308] Due to all the limitations mentioned above, Ukraine falls under the category of *restrictive country* in the sense as access to MAR is mostly only granted to non-LGBTIAQ+ persons.

A reason for this restrictive access might be that still today, non-heteronormative sexual activities and relationships are viewed as abnormal and preposterous by the majority of the Ukrainian population.[309] Additionally, homophobia is openly supported by the state, its officials, and the media.[310] When it comes to the right of LGBTIAQ+ persons to raise children, such a right is rejected by more than 80% of the Ukrainian citizens.[311] Not only are LGBTIAQ+ persons accepted by a minority of Ukrainians, but also the level of acceptance is continuously

[302] The European Parliament's Intergroup on LGBT Rights, 'Trans identities no longer considered a mental disorder in WHO's ICD-11', 19 June 2018, http://www.lgbt-ep.eu/press-releases/6901/, (accessed 22 June 2018).
[303] Irene, 'WHO publishes ICD-11 – and no end in sight for pathologisation of intersex people', *Organisation Intersex International Europe*, 19 June 2018, https://oiieurope.org/who-publishes-icd-11-and-no-end-in-sight-for-pathologisation-of-intersex-people/, (accessed 22 June 2018).
[304] Lysytsia, p. S104.
[305] Sandra F. for invitra, *Regulations governing egg and sperm donation in Ukraine*, [website], 16 August 2016, https://www.invitra.com/regulations-governing-egg-and-sperm-donation-in-ukraine/, (accessed 17 May 2018).
[306] Druzenko, p. 359.
[307] Iryskina, ibid..
[308] Phillips, ibid..
[309] Martsenyuk, 386.
[310] Ibid..
[311] Ibid., p. 391.

decreasing.[312] In addition to the open non-LGBTIAQ+ attitude in politics, religion promotes discrimination on grounds of sexual orientation and gender identity too.[313] The predominant Greek Catholic Church and other religious groups explicitly express their opinion against same-sex marriage in Ukraine, which is one of the most controversial issues being discussed between LGBTIAQ+ activists, the government, and the Churches right now. Religion plays an important role for the Ukrainian population and its anti-LGBTIAQ+ views are shared by its majority.[314]

10.3.2. The Czech Republic

The majority of the Czech population views parenthood as an indispensable factor in one's life. Most Czech citizens believe that becoming a mother or father is the main goal to reach in a marriage. Due to low birth rates in the last years, infertility treatment has become an important issue in the Czech Republic.[315]

The requirements for artificial insemination are regulated in the Czech Specific Health Services Act, more precisely under § 6:[316]

> 'Artificial insemination can be carried out on a woman of childbearing age if her age does not exceed 49 years, at the written request of the woman and the man who intend to undertake this health service together (hereinafter referred to as "infertile couple").'[317]

This means that in order to attain a pregnancy through artificial insemination, an opposite-sex couple has to request it in written form. Whether the couple is married or not is not relevant and neither is whether they are in a relationship or not,[318] as long as their marriage would be legal

[312] R. Bränström and A. Van Der Star, 'More knowledge and research concerning the health of lesbian, gay, bisexual and transgender individuals is needed', *The European Journal of Public Health*, vol. 26, iss. 2, 2016, p. 208. Available from Oxford University Press Journals, (accessed 16 May 2018).
[313] Martsenyuk, p. 397.
[314] Ibid..
[315] L. Slepičková, 'Couples undergoing infertility treatment in the Czech Republic: Broad range of possibilities in a traditional milieu', *Social Theory & Health*, vol. 8, iss. 2, May 2010, p. 152. Available from ProQuest Sociology Database, (accessed 29 May 2018).
[316] Císařová, Brojáč and Roubíčková, p. 293.
[317] Czech Specific Health Services Act, Act No. 373/2011 of 8 December 2011 (entered into force 1 April 2011) in the version from 1 June 2018, § 6, para. 1. Available from https://www.zakonyprolidi.cz/cs/2011-373, (accessed 17 July 2018), translated through web-based translation tools.
[318] Czech Specific Health Services Act, § 6, para. 2; Císařová, Brojáč and Roubíčková, p. 293.

under Czech law.[319] Furthermore, the woman applying has to be infertile.[320] According to the Czech New Civil Code, the father of the child conceived through artificial insemination will be the man who made the application. This is not the case if the woman who applied is married. Then, her husband will automatically be assumed to be the father of the newborn, unless it is proven that another man took part in applying for the use of MART.[321] As the request has to be made by a couple, single persons are consequently denied access to the method of artificial insemination. Access is also prohibited for people living in same-sex relationships, as different-sex partners and the infertile couple to be a 'woman' and a 'man' are explicitly declared a requirement for making use of this method.[322]

Sperm and egg donation are regulated by law in the Czech Republic, more precisely through Legislative Act No. 227/2006 Col., which entered into force in 2006. This legislation act permits the donation of spermatozoa and oocytes, provided that it is being carried out on a voluntary basis, anonymously, and with no financial gain for the donor. Even though donations may only be performed free of charge, the donors get high compensation for their discomfort before and during the donation process.[323]

Other MART still remain unregulated under the Czech legislation.[324] Due to the non-existence of legal regulations regarding other MART than artificial insemination, the general principle, stating that everything that is not prohibited is allowed, applies.[325] Also, surrogacy is not explicitly regulated under Czech law and neither explicitly prohibited nor permitted. The

[319] At present, same-sex couples are not permitted to enter into marriage in the Czech Republic. They are only granted to become registered partners with many same rights as spouses. However, just recently the Czech government proposed a law which would allow same-sex marriage, which make it the first post-communist EU country to legalise marriage between same-sex couples. To the contrary, the opposition calls for a precise formulation in the Czech Constitution that explicitly defines marriage as a legal bond between a man and a woman (S. Shah, 'Czech Republic Set to Become First Post-Communist State to Legalise Same-Sex Marriage', *Emerging Europe*, 28 June 2018, https://emerging-europe.com/in-brief/czech-republic-set-to-become-first-post-communist-state-to-legalise-same-sex-marriage/, [accessed 20 July 2018]); Czech Specific Health Services Act, § 6, para. 2; Císařová, Brojáč and Roubíčková, p. 293.

[320] Centrum Lèčby Neplodnosti, *Methods of Assisted Reproduction* [website], www.fertimed.cz/en/methods-of-assisted-reproduction/, (accessed 18 May 2018).

[321] Císařová, Brojáč and Roubíčková, p. 293.

[322] Ibid., p. 294; Czech Specific Health Services Act, § 6, para. 1.

[323] A. Whittaker and A. Speier, '"Cycling overseas": Care, commodification, and stratification in cross-border reproductive travel', *Medical Anthropology: Cross Cultural Studies in Health and Illness*, vol. 26, no. 4, 2010, p. 369. Available from Taylor and Francis Journal Complete, (accessed 17 May 2018).

[324] Císařová, Brojáč and Roubíčková, p. 294.

[325] M. Pauknerová, 'Czech Republic', in K. Trimmings and P. R. Beaumont (eds.), *International Surrogacy Arrangements :: Legal Regulation at the International Level*, Portland, Oregon, Hart Publishing, 2013, p. 106. Available from EBSCOhost, (accessed 28 May 2018).

Czech New Civil Code only mentions it very shortly under § 804, which declares that persons are prohibited from adopting their lineal relatives or their siblings, but that surrogacy is an exception to this rule.[326] Surrogate motherhood is common practice in the Czech Republic and there are several cases, in which a pregnancy of a woman was caused by using the oocytes of the intended mother. In this case, the woman who will give birth to the child, is the gestational mother. It is assumed that per year, approximately fifteen surrogate mothers give birth to a child in the Czech Republic.[327]

The legal regulations of MAR are really vague in the Czech Republic. Still, it is assumed that the regulations regarding artificial insemination also apply to cases of surrogate motherhood. Therefore, also in cases of surrogacy, a woman and a man, who intend to become parents, have to make a written request by mutual consent. In order to receive medical treatment, a certain requirement has to be met. Either the couple has to be infertile, or there has to be a risk that the child is born with genetic defects, or there has to be a risk that the child or the partner can be infected with a serious disease. The man applying has to agree to the fertilization of the woman. The relationship of the commissioning parents has to be one that would allow the couple to enter legally into marriage under Czech law. Furthermore, lineal relatives and siblings are excluded, as are adopted persons and their respective adoptive parents. According to §§ 11 and 12 of the Czech Family Act, registered partners are not permitted to access this MAR technology.[328]

As the gamete donors are to be anonymous and unknown to the gamete recipient under Czech law, it is not possible to use the oocytes of the surrogate mother. The donor of the oocytes has to be the intended mother, according to the 'Clinic for Reproductive Medicine and Gynaecology in Zlin', which is the only Czech medical centre that openly admits the medical treatment of surrogacy. Furthermore, the oocytes donation of a third woman, who is neither the surrogate mother nor the intended mother, is prohibited. If the gestational mother is married, her husband has to agree to the surrogacy.[329]

When the surrogate mother bears the child, the applying man automatically becomes the father of the child and gets custody. At the same time, the surrogate mother has to hand over the

[326] Císařová, Brojáč and Roubíčková, p. 294.
[327] Pauknerová, p. 108.
[328] Ibid..
[329] Ibid., p. 109.

newborn. The intended father has to appear before Czech authorities and acknowledge parenthood officially, such as the giving up and delivering of the child to the intended father by the surrogate mother. After the birth of the child, the woman applying adopts the child and subsequently becomes its legal mother.[330] Before the adoption, the surrogate mother is the legal mother. The intended mother can only file a suit to gain parenthood when the surrogate agreed to the adoption and when the child already lived with the intended woman for a minimum duration of three months.[331]

Commercial surrogacy is seen as unmoral and is therefore not tolerated.[332] The Czech Republic has ratified the Oviedo Convention. Its art. 21 prohibits financial gain from the human body and its parts. If a surrogate mother would accept payments for providing her uterus, this act would fall under § 168 of the Criminal Code. Consequently, she could be accused of child trafficking or prosecuted for delivering the child to another person and thus, for paid adoption, which is prohibited under § 169 of the Criminal Code.[333]

Under Czech law, the usage of MART is only allowed for a woman who requests it together with the intended father. Single persons and same-sex couples are prohibited from accessing it.[334] However, as the intended parents have to be a man and a woman, but not explicitly a couple, the Czech legal framework would make it possible for LGBTIAQ+ persons to request MAR together with a person other than their partner and of the opposite sex.[335] The Czech legal framework does not explicitly say anything about the right of same-sex persons to access MART, neither as a couple nor as single persons. This non-regulation is not an issue in current politics and this will probably not change in the near future. The consequence of such a non-regulated situation of queer parenthood is that for LGBTIAQ+ persons, it will indeed be nearly impossible to find a legal way to bear or raise a child and form a family in a same-sex relationship.[336] Currently, single women and women living in same-sex relationships often ask

[330] Ibid..
[331] Ibid., p. 110.
[332] Ibid..
[333] Ibid., p. 111.
[334] Císařová, Brojáč and Roubíčková, p. 297.
[335] Pauknerová, p. 108.
[336] Ibid., p. 295.

male friends or acquaintances for help and fake a relationship with them. Consequently, they are allowed to access MART, because they obtained the consent of their 'partner'.[337]

The raising of a child by persons living in a same-sex relationship is a very controversial issue in the Czech Republic and permanently questioned by the Czech population.[338] § 855 of the New Czech Civil Code and its following §§ regulate the relationship between a child and its parents. According to it, the welfare of the child is best guaranteed when both parents, who are explicitly stated to be its mother and its father, actively participate in the raising of the child. This mutual contribution of mother and father is necessary for a child's good upbringing on the one hand and its health status on the other. Following the argumentation that a child needs a woman and a man as parents, which is the prevalent view in the Czech Republic, there is no doubt that same-sex couples are not seen as proper parents and prohibited from accessing MAR.[339] However, in cases where only one parent is raising the child, this parent's partner is obliged to take care of it too if he or she is living in the same household as the child. Thus, same-sex partners also have the duty to take care of the child of their partner.[340]

The Act on Specific Health Services 2012 regulates the recognition of one's desired gender identity in the Czech Republic. In order to change one's sex, an experts committee has to approve the recognition. There are seven experts sitting in the committee, one of them is representing the Czech Ministry of Health. Without undergoing a gender reassignment surgery, it is not possible for trans persons to have their desired sex legally recognized. Personal data in official documents, such as the name of a person, will only be changed if the concerned person can prove that they underwent a medical sex-change treatment by means of a certificate. Furthermore, as a consequence of the official sex-change of a person, their marriage or registered partnership will automatically be annulled.[341] Additionally, sterilisation is a requirement for trans persons in order to get their identified gender legally recognized.[342]

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[337] D. Lazarová, 'Czech lawmakers reject proposal to enable unmarried women to undergo artificial fertilization', *Radio Praha*, 27 April 2017, http://www.radio.cz/en/section/curraffrs/czech-lawmakers-reject-proposal-to-enable-unmarried-women-to-undergo-artificial-fertilization, (accessed 7 June 2018).
[338] Pauknerová, p. 295.
[339] Ibid., p. 297.
[340] Ibid., p. 298.
[341] European Commission against Racism and Intolerance (ECRI), *ECRI report on the Czech Republic (fifth monitoring cycle)*, CRI(2015)35, Strasbourg, adopted 16 June 2015, published 13 October 2015, https://www.coe.int/t/dghl/monitoring/ecri/Country-by-country/Czech_Republic/CZE-CbC-V-2015-035-ENG.pdf, pp. 32-33.
[342] M. Childs, 'Between genders in Prague', *Politico*, 16 February 2017, https://www.politico.eu/article/between-genders-in-prague-transgender-czech-republic-id-card/, (accessed 29 May 2018).

Although the ECtHR decided in April 2017 that compulsory gender reassignment surgeries violate the ECHR, this decision does not force the member states to automatically change their legislation.[343] Therefore, having to undergo a medical sex-change treatment is still a prerequisite for trans people in the Czech Republic in order to get their identified sex officially recognized.[344] Due to prior sterilisation, it is thus not possible for transgender persons to get children via MAR after their sex transition.

To sum up, the requirement of the different sexes, which has to be met in order to request the application of MAR, makes it hard for same-sex couples to build a family and raise a child. Also, there is no possibility for transgender persons to access MAR, as sterilisation is mandatory in order to get their identified sex legally recognized. As the access to MAR is neither permitted to LGBTIAQ+ persons living in a same-sex relationship, nor to singles and transgender persons after their sex change, the Czech Republic constitutes a really good example for a *restrictive country* for the purpose of this study.

10.4. Partially Restrictive Countries: Austria and Spain

Partially restrictive countries are understood as those countries, which generally do not restrict reproductive rights in their legislation for specific sexes, gender identities, or sexual orientations. Still, the existence of general limitations to specific MART, such as the possibility to arrange a surrogate mother, does not allow all LGBTIAQ+ couples to reproduce artificially. The two countries, which will be discussed as examples for partially restrictive countries, are Spain and Austria.

10.4.1. Austria

In Austria, MAR is regulated in the Reproductive Medicine Act (RepMedA).[345] The federal law entered into force on 1 July 1992 and was amended two times in 2004 and 2015. The most

[343] M. H., 'Why transgender people are being sterilised in some European countries', *The Economist*, 1 September 2017, https://www.economist.com/the-economist-explains/2017/09/01/why-transgender-people-are-being-sterilised-in-some-european-countries, (accessed 29 May 2018).
[344] Transgender Europe, *Trans Rights Europe Map & Index 2017* [website], 18 May 2017, https://tgeu.org/trans-rights-map-2017/, (accessed 29 May 2018).
[345] Austrian Reproductive Medicine Act, BGBl 1992/275, current version: BGBl I 2015/35. Available from Rechtsinformationssystem des Bundes, https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10003046, (accessed 19 June 2018).

important alterations to the amendment in 2015 are the implementation of insemination and IVF for two-cisgender-women-couples, the legalisation of sperm and egg donation under certain circumstances, and the permission of preimplantation genetic diagnosis.[346]

According to § 2 para. 1, 'medically assisted reproduction is only permitted in a marriage, registered partnership or cohabitation'.[347] The term civil relationship covers every relationship between two persons that is permanent and intense.[348] Since the amendment in 2015, it does not matter anymore if the relationship is a same-sex or opposite-sex one. Due to the requirement of a partnership, individuals cannot profit from the usage of MAR.[349] The argument used for limiting the access to MART to couples only is that a child should not only have one parent already from the very beginning on.[350]

In addition to having to live in an existing civil relationship, marriage, or registered partnership, one out of four additional prerequisites has to be fulfilled in order to carry out MAR. According to § 2 para. 2 item 1 of the RepMedA, all other possibilities to achieve a pregnancy by having sexual intercourse need to have been unsuccessful or unreasonable.[351] This means that priority is given to those medical treatments, which allow or facilitate reproduction through sexual intercourse. Hence, the use of MART should always be "ultima ratio", so a last resort.[352] This prevalent principle in the MAR law, which allows the use of MART only due to medical indications and as last resort, is referred to as 'principle of subsidiarity'.[353]

According to § 2 para. 2 item 2 RepMedA, MART can also be used for the purpose of causing a pregnancy when sexual intercourse would lead to a potential risk of infection. Thus, MAR is

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[346] B. Hadolt, *Reproduktionstechnologiepolitik in Österreich: Die Genese des Fortpflanzungsmedizingesetzes 1992 und die Rolle von ExpertInnen*, Wien, Sociological Series Verlag, 2015, p. 1; Kinderwunschzentrum Goldenes Kreuz, *The Austrian Reproductive Medicine Act* [website], 2015, http://kinderwunschzentrum.at/en/patient-info/reproductive-medicine-act/, (accessed 29 May 2018).
[347] Austrian Reproductive Medicine Act, art. 2 para. 1, own translation.
[348] M. Mayrhofer, 'Fortpflanzungsmedizingesetz (FMedG)', in M. Neumayr, F. Wallner, and R. Resch (eds.), *Gmundner Kommentar zum Gesundheitsrecht (GmundKomm)*, Wien, Manz Verlag, 2016, p. 2173.
[349] M. A. Steinhuber, *Das Fortpflanzungsmedizinrecht: Verfassungsrechtliche und zivilrechtliche Aspekte des Fortpflanzungsmedizingesetzes (FMedG) sowie des Fortpflanzungsmedizinrechts-Änderungsgesetzes 2015 (FMedRÄG 2015)*, Dissertation, Innsbruck, Universität Innsbruck, 2016, p. 76; P. Barth, 'Zur Zulässigkeit medizinisch unterstützter Fortpflanzung aus rechtlicher Sicht', in P. Barth and M. Erlebach (eds.), *Handbuch des neuen Fortpflanzungsmedizinrechts*, Wien, Linde Verlag, 2015, p. 3; Mayrhofer, p. 2173;
[350] 445 der Beilagen XXV. GP - Regierungsvorlage – Erläuterungen, in parlament.gv.at, parlament.gv.at/PAKT/VHG/XXV/I/I_00445/fname_377350.pdf, (accessed 29 May 2018).
[351] Steinhuber, p. 77.
[352] Barth, p. 12.
[353] E. Bernat, 'Das österreichische Fortpflanzungsmedizingesetz wurde liberalisiert', *Der Gynäkologe*, vol. 48, iss. 9, 2015, p. 689. Available from Springer Standard Collection, (accessed 29 May 2018).

also permitted when it is unacceptable that the spouses or civil partners have sexual intercourse due to a serious danger of transmitting a severe infection. Registered partners are not mentioned here, as the risk of transmitting a disease in same-sex relationships is no obstacle to reproduction.[354]

Furthermore, achieving a pregnancy artificially is explicitly permitted in same-sex relationships.[355] This arises from the general principle of equality laid down in art. 2 'Austrian Basic Law on the General Rights of Nationals'[356] and art. 7 Austrian Federal Constitutional Law[357]. The principle of equality states that 'all citizens are equal before the law'[358]. This means that all nationals have to be treated equally. Any unobjective privileging and discrimination on the basis of birth, sex, class, religion, skin color, nationality, or ethnicity is prohibited.[359] According to § 2 para. 3 item 3 RepMedA, MAR can be used if a two-women-couple wants to get a child. Whether these women are living in a registered partnership or just a civil relationship is irrelevant. The argument that was used to achieve this legal change to the amendment in 2015 was that two women cannot produce a pregnancy through sexual intercourse and therefore, only MAR, as a last resort, can help to reach the desired goal.[360]

If one of the two cisgender women is infertile, the case gets more complicated. Since the amendment to the RepMedA in 2015, the usage of egg cells of a third person may now be allowed, pursuant to § 3 para. 3 of the RepMedA. The general principle of para. 1 RepMedA is that one's own oocytes have to be used primarily. In § 3 para. 3 RepMedA, a new exception to this general principle was formulated: Donor oocytes may now be used if the oocytes of the woman who wants to get pregnant are infertile. Other motives, such as the desire to create a shared biological motherhood in a two-cisgender-woman-partnership through the egg donation from one woman to the other, are inadmissible.[361] Here, however, the question arises as to how

[354] Barth, p. 13.
[355] Barth, p. 14.
[356] Austrian Basic Law on General Rights of Nationals of 21 December 1867, RGBl. No. 142/1867, last amendment: BGBl. No. 684/1988. Available from https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10000006, (accessed 17 July 2018).
[357] Austrian Federal Constitutional Law, BGBl. Nr. 1/1930 in the version of BGBl. I Nr. 194/1999, last amendment: BGBl. I Nr. 22/2018. Available from https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10000138, (accessed 17 July 2018).
[358] Austrian Basic Law on General Rights of Nationals, art. 2; Austrian Federal Constitutional Law, art. 7, para. 1, own translation.
[359] Hengstschläger and Leeb, p. 98.
[360] Barth, p. 14.
[361] Erlebach, p. 219.

the exception of § 3 para. 3 RepMedA has to be understood in connection with the basic principle of § 3 para. 1 RepMedA. Does the female cisgender partner of another cisgender woman have to give birth to the child through artificial insemination if the woman, who was supposed to get pregnant, is infertile? Or is it sufficient if her egg cells are used for the MAR? According to Erlebach, § 3 para. 1 RepMedA applies also in this constellation and therefore, the ova of the couple have to be used primarily. For the MAR, only the oocytes and the spermatozoa of the spouses, civil partners, and life companions may be used, if there is no exception according to para. 2 and 3. As 'partners' are explicitly mentioned in the law, two-(cisgender)-women couples are obliged to use their own germ cells primarily, just like opposite-sex-couples. This means that the use of ova from a third person is only permissible if neither the oocytes of the one partner nor those of the other are fertile. Moreover, a two-women-couple is not allowed to freely choose which one of the women will become pregnant, if one of them is fertile. The reason behind such a desire could be that the women want a child that is biological related to both of them, as mentioned above.[362] The Austrian legislator wants to avoid such a shared biological motherhood.[363]

The prohibition of surrogate motherhood is not explicitly mentioned in the RepMedA. However, its illegality follows from the above-mentioned principle of subsidiarity. As a surrogate mother has to be able to attain a pregnancy and carry and bear a child, delivering an embryo that was conceived by germ cells of the intended parents would violate § 2 para. 2 item 1 RepMedA.[364] Additionally, § 3 para. 3 RepMedA stipulates that an oocytes donation is only permissible if the ova of the woman, in whose uterus the pregnancy should be caused, is infertile.[365] As surrogate motherhood is not permitted in Austria, two cisgender men living in a relationship can never profit from the usage of MAR.[366]

§ 2b of the RepMedA regulates the permissibility of the cryopreservation of sperm, ova, testicular, and ovary tissue. These gametes may be removed and stored for MAR in the future if a physical condition or a medical treatment, corresponding to the current state of medical science and experience, is so dangerous that future reproduction through natural sexual

[362] Erlebach, p. 221.
[363] Erlebach, p. 219.
[364] Bernat, p. 690.
[365] Erlebach, p. 221.
[366] Steinhuber, p. 76; Mayrhofer, p. 2173; Barth, p. 3.

intercourse is no longer possible as a result of physical suffering or its treatment.[367] This physical suffering does not have to reach a particular degree of severity. It is only required that the treatment could lead to permanent infertility. However, the predicted probability of infertility must be high. Examples for diseases in women would be cancer, infections or inflammations of the uterus, fallopian tubes, or ovaries. Diseases in men include infections or inflammations of the prostate or testis. Treatment of such diseases may also have lasting effects on fertility, such as chemotherapy, radiotherapy, or administration of medicine (e.g. genotoxic potential of ingredients in the treatment of multiple sclerosis), just as surgical interventions may affect the sexual organs (e.g. removal of the uterus).[368] The precautionary freezing of ova only because of social indications is not possible in Austria.[369]

Intersexuality or transgender identity can be understood as a physical affliction in the sense of art. 2b RepMedA if the person concerned is perceived to be suffering. If the hormonal or surgical treatment of this affliction (sex change) is linked to the loss of infertility, it will be permissible to remove sperm cells (before converting from male to female) or egg cells (before converting from female to male) and cryopreserve them.[370] The cryopreserved spermatozoa of a transwoman could later be used to fertilize her female cisgender partner. However, if the transwoman is in a relationship with a cisgender man, they have no possibility to get a child through MAR due to the prohibition of surrogate motherhood. The same applies for a transman who is in a relationship with another cisgender man. Using a woman to carry a child conceived through the transman's prior cryopreserved oocytes and the spermatozoa of his male cisgender partner, would constitute surrogacy and is therefore not possible in Austria. If the transman is in a partnership with a cisgender woman, it is questionable whether the usage of his oocytes would be possible, as this is not clearly regulated under Austrian law. Taking into account the aforementioned principle of subsidiarity and § 3 para. 3 RepMedA, which states that donor oocytes may only be used if the gestational mother's egg cells are infertile, this means that the transplantation of cryopreserved oocytes into the uterus of the transman's partner is not legal under Austrian law. The only exception to this rule is when the transman's female cisgender

[367] P. Barth, 'Die Entnahme von Zellen für Zwecke medizinisch unterstützter Fortpflanzung', in P. Barth and M. Erlebach (eds.), *Handbuch des neuen Fortpflanzungsmedizinrechts*, Wien, Linde Verlag, 2015, p. 200; Bernat, p. 689.
[368] Barth, p. 202.
[369] Steinhuber, p. 171.
[370] Barth, p. 202.

partner is infertile. Therefore, the later use of frozen germ cells depends on the fertility of the woman.[371]

Nevertheless, medical treatment, such as sterilisation, gender reassignment surgeries, or hormone treatment is no more a requirement for transgender persons to have their identified gender legally recognized in Austria.[372] Therefore, if a transgender person did not undergo any of those treatments, they have the same access and legal possibilities to conceive a child via MART as a cisgender person who possesses the same fertile gametes.

Regarding intersex persons, the Austrian Constitutional Court declared just recently, on 29 June 2018, that intersex persons have a right to be legally recognized as such. This judgement leads to the question of how their access to MART will look like. Art. 2 para. 1 RepMedA does not require the concerned person to be a woman.[373] Therefore, intersex persons with female reproductive systems also fall under the scope of the RepMedA and are thus able to make use of the same MART as women.

It is assumed that the underlying reasons for the way Austria regulates MAR are mainly its history and dominant religion. Austria is a Catholic country and the Catholic traditions played an important role in the past. According to the Catholic Church, same-sex marriage, abortion, and MAR are seen as obstacles to Catholic values. Still today, the Catholic Church has a good relationship with the governing political parties and participates in political dialogues.[374]

However, the Austrian population's attitude to LGBTIAQ+ persons changed remarkably in the last 20 years. Persons outside of the heteronormative binaries are persistently becoming more accepted and with this increasing acceptance, their family rights are being more promoted as well. This could also be seen in the amendment to the RepMedA in 2015.[375] Both the Austrian Supreme Court and the Austrian Constitutional Court considered the prohibition of the use of MAR for a two-cisgender-women-couple to be unconstitutional. Therefore, the legal regulations regarding the prohibited use of MAR for two-cisgender-women-couples were

[371] See: Steinhuber, p. 76; Mayrhofer, p. 2176; Bernat, p. 690; Erlebach, p. 221.
[372] W. Wilhelm, *Personenstandsänderung*, [website], https://www.wien.gv.at/menschen/queer/transgender/geschlechtswechsel/rechtlich/personenstand.html, (accessed 29 May 2018).
[373] Austrian Reproductive Medicine Act, art. 2 para. 1.
[374] E. Griessler and M. Hager, 'Changing direction: the struggle of regulating assisted reproductive technology in Austria', *Reproductive BioMedicine and Society Online*, vol. 3, 2016, p. 70. Available from Elvesier, (accessed 30 May 2018).
[375] Ibid., p. 71.

abolished on 10 December 2013. It was argued that the reason for abolishing those provisions lied in the violation of art. 8 in combination with art. 14 of the ECHR. In addition, the Austrian Supreme Court also infringed the principle of equality laid down in art. 7 B-VG.[376]

Today, Austria's society is divided, which can be seen best in the voting habits of the Austrian citizens. The political parties are split into conservative ones, which still uphold the values of the Catholic Church, and more liberal ones regarding LGBTIAQ+ rights, including their family rights.[377] This fragmentation might be a reason why Austria is classed as a *partially restrictive country* when it comes to the reproductive rights of LGBTIAQ+ persons, as its population does not clearly represent one opinion.

The categorisation of Austria as a *partially restrictive country* can be seen in its position of being somewhere in the middle between a restrictive and permissive country. On the one side, it appears to be open regarding reproductive rights of LGBTIAQ+ persons, as it allows two cisgender women explicitly to access MART and tries to get rid of sexual orientation requirements. On the other side, certain medical possibilities, such as getting a biologically related child to both partners, is not legally possible for them.[378] Single persons and two-cisgender-men-couples are generally excluded from accessing MART.[379] For transgender and intersex persons, it gets more complicated, as their access is not clearly regulated under Austrian law. In my point of view, their access depends on the sex and fertility of their partner and in case transgender persons want to make use of MART after their transition, also the type of their cryopreserved gametes is a relevant factor.

10.4.2. Spain

Spain was one of the first countries in Europe, which regulated MAR in its legislation. Law 35/1988 was the first legal basis in Spain to regulate infertility treatments and scientific research

[376] Austrian Constitutional Court, G 16/2013 and others, 10 December 2013, VfSlg. 19824/2013.
[377] Griessler and Hager, p. 72.
[378] Barth, p. 14; Erlebach, p. 219.
[379] Steinhuber, p. 76; Mayrhofer, p. 2173; Barth, p. 3.

on MART.[380] Currently, Law 14/2006[381] is the main legal document regulating MAR in Spain and constitutes an important document for the 800.000 infertile couples in the country.[382]

In Spain, access for LGBTIAQ+ persons to MART is regulated under the Equal Marriage Act 2005 and the Law 14/2006. The Equal Marriage Act is grounded on the principle that same-sex and opposite-sex marriages should enjoy the same rights, including rights regarding parenthood. Pursuant to Law 14/2006, all

> 'women older than 18 years and with full capacity to act may be the recipient or user of the techniques regulated in this law, as long that they have given their written consent to its use freely, consciously and expressly.'[383]

This means that all mentally sound women older than 18 years are permitted to access IVF and artificial insemination in order to conceive a child.[384] This access is permitted without distinction as to their sexual orientation or civil status.[385] The woman has to agree to the application of the MAR method in written form. If the woman is married to a man, her husband has to agree as well.[386] This does not apply for the wife of a woman.[387] Furthermore, consent is not needed if the spouses are separated. In the case that the woman is divorced, single, or lives separately, the born child will not have a father.[388]

Oocytes and spermatozoa donation are only permitted under Spanish law when the requirement of anonymity and gratuity is fulfilled. The donation of gametes outside of a medical centre is not allowed, neither is the selling of sperm or egg cells. In one specific case, namely when a woman receives donated germ cells of her married partner, the donation does not need to be anonymous. This regulation allows the creation of a shared biological motherhood between two cisgender women. The pregnancy is attained by transferring an embryo, conceived through

[380] Navas et al., p. 253.
[381] Spanish Parliament, Law 14/2006 of 26 May, sobre técnicas de Reproduccion human asistida, Boletín Oficial del Estado no. 126, 27 May 2006, https://www.boe.es/buscar/act.php?id=BOE-A-2006-9292, (accessed 1 June 2018).
[382] Merck Global, 'A policy audit on Fertility. Analysis of 9 EU Countries', Darmstadt, 2017, p. 40, https://www.professionalsinfertility.com/en/news/policy-audit-on-fertility.html, (accessed 1 June 2018).
[383] Law 14/2006, art. 6, para. 1, own translation.
[384] Ibid.; E. Imaz, 'Same-sex parenting, assisted reproduction and gender asymmetry: reflecting on the differential effects of legislation on gay and lesbian family formation in Spain', *Reproductive BioMedicine and Society Online*, vol. 5, 2017, p. 7. Available from Elsevier, (accessed 30 May 2018); Navas et al., p. 253.
[385] Law 14/2006, art. 6, para. 1.
[386] Law 14/2006, art 6, para. 3; Navas et al., p. 253.
[387] Navas et al., p. 253.
[388] Ibid., p. 255.

donated spermatozoa and the oocytes of a woman, into the uterus of her wife. In Spain, motherhood is achieved through giving birth to a child. If the oocytes of a woman were donated to her wife, the motherhood of the donating woman is not determined by her genetic bonds to the newborn. Instead, her motherhood is established through her marital status. The fact that she is married to the birth-giving woman is turns her into a mother. It is required that the spouse of the pregnant woman declares her motherhood before the child is born.[389] If the women are not married, the spouse of the pregnant woman has no possibility to make such a request. In that case, her maternity can only be determined if she adopts the child.[390] The legal possibility of the establishment of a biologically shared motherhood allows two-cisgender-women-couples to conceive a child that is biologically related to both women. Both of them have the opportunity to participate in the procreation of the child if they decide to use the oocytes of one woman, fertilize them with donor spermatozoa, and transfer the resulting embryo into the uterus of the other woman.[391]

According to art. 10 of Law 14/2006, surrogate motherhood is not permitted in Spain.[392] Para. 1 declares that it is not allowed to arrange a woman to carry and bear a child, which will then be delivered to another woman or a man, whose spermatozoa were not used for the fertilization. Therefore, attaining a pregnancy by using oocytes of the intended mother, who is not able to carry a baby herself, is also unlawful.[393] According to para. 2 of Law 14/2006, the legal motherhood will automatically be conferred to the gestational mother of the child, as she was the person who bore it. According to para. 3 of Law 14/2006, the fatherhood of the child can be established by legal means. Thus, the legal parents of a child born through surrogacy will always be the woman who gave birth to the child and her male or female spouse or the genetic father, if he officially requested for the fatherhood.[394] Due to the prohibition of surrogate motherhood, two-cisgender-men-couples are denied access to MART in Spain.[395]

[389] Imaz, p. 7.
[390] Navas et al., p. 256.
[391] Marina et al., p. 940.
[392] Ibid..
[393] Imaz, p. 7.
[394] P. Orejudo Prieto de los Mozos, 'Spain', in Trimmings, K., and Beaumont, P. R., (eds.), *International Surrogacy Arrangements :: Legal Regulation at the International Level*, Portland, Oregon, Hart Publishing, 2013, p. 348. Available from EBSCOhost, (accessed 30 May 2018).
[395] Imaz, p. 9.

The anti-surrogacy approach in Spain results from a report drafted by a parliamentary commission, before the current Assisted Human Reproductive Act was adopted. The report is referred to as 'Palacios Report' and expresses the concern that women could be exploited and children commercialized in case surrogacy becomes legal. However, it is noteworthy that even though surrogate motherhood arrangements are not permitted, the Spanish law lacks explicit prohibitions. Criminal and administrative sanctions against violations of art. 10 Law 14/2006 are not contained in the law. Consequently, when surrogacy is actually practised in Spain, the participants will not be sanctioned if the persons included in the practice do it openly.[396] The non-existence of legal consequences to the practice of surrogacy points to a somewhat semi-liberal attitude on surrogate motherhood. Surrogacy might not be legal, but in fact, it is possible. If the genetic father has its relationship officially confirmed, the surrogate mother can transfer the motherhood and hence, the female or male spouse of the father can adopt it.[397] The openness regarding surrogacy can also be seen in the current attitudes of the Spanish society, as various persons in Spain advocate for an amendment of the Law 14/2006 and for a change that would make surrogate motherhood become legal.[398]

With the adoption of the Gender Identity Law 2007 (Law 3/2007), Spain afforded its citizens to recognize their sex changes officially.[399] According to the current law there is no need to undergo gender reassignment surgeries in order to have the identified gender of a person legally recognized.[400] Art. 4 of Law 3/2007 requires the concerned person to be diagnosed with 'gender dysphoria' in order to change their sex. Additionally, the person needs to undergo medical treatment for a minimum duration of two years.[401] Furthermore, the concerned individual has to be a Spanish citizen and become 18 years old before the official gender recognition.[402]

Regarding the access of transgender persons to MART, there is no specific regulation under Spanish law. The cryopreservation of gametes is regulated under art. 11 of Law 14/2006, which permits the freezing of spermatozoa during a man's whole life, but the cryopreservation of

[396] Orejudo Prieto de los Mozos, p. 348.
[397] Ibid., p. 349.
[398] Navas et al., p. 257.
[399] M. V. Carrera et al., 'Pathologizing gender identity: An analysis of Spanish law and the regulation of gender recognition', *Journal of Gender Studies*, vol. 22, iss. 2, 2013, p. 206. Available from Taylor & Francis Online, (accessed 30 May 2018).
[400] Ibid., p. 207.
[401] Ibid., p. 208.
[402] A. Moraleda, 'More than 2,000 Spaniards have changed sex on ID cards since 2007', *El País*, 5 July 2017, https://elpais.com/elpais/2017/07/04/inenglish/1499190280_976300.html, (accessed 30 May 2018).

oocytes and pre-embryos only until the recipient does not meet the clinically appropriate requirements anymore.[403] Taking into account Law 3/2007[404] and its specification that transgender persons should be entitled to all rights inherent in their new condition without having to change the ownership of the legal rights and obligations that may correspond to the person prior to their official sex change, the right to its use should be maintained even after their sex change.[405]

However, the National Commission for Assisted Human Reproduction represented another view in 2010. It was discussed whether a transman, who was going to undergo sex change, could cryopreserve oocytes preventively and eventually use them after his sex change. The National Commission for Assisted Human Reproduction found the desire to preserve oocytes to stand in contrast with the desire to change one's sex. It argued that both demands had medical and surgical effects contrary to itself due to the necessity of having to use female hormones to obtain and preserve the oocytes, and male hormones to achieve the sex change. The National Commission for Assisted Human Reproduction considered that the request was not covered by the law of MAR, because it was not a clinically indicated request. Furthermore, it argued that due to the fact that transgender individuals identify with the opposite sex, they should not want to cryopreserve their gametes, since those are linked with the sex the transgender individuals reject. According to Montserrat Boada et al., the question regarding transgender persons should be posed as a desire to preserve fertility with the gametes they have, regardless of whether those are oocytes or spermatozoa. The petition should be understood only as a request for technical assistance to preserve their future fertility, which is something many other people do who fear that their reproductive capacity is compromised due to social reasons and who decide to have their gametes cryopreserved as a preventive action. The law only refers to the regulation of MART as a treatment of fertility problems and/or a preimplantation genetic diagnosis to avoid transmission of genetic diseases. But, throughout the Spanish legislation regarding MAR, no reference is made to the preservation of fertility for transgender persons, an emerging issue in the years following the enactment of the law and which, at present, would probably require a specific regulatory development.[406]

[403] Boada et al., p. 28.
[404] Spanish Parliament, Law Orgánica 3/2007 of 22 March, para la igualidad efectiva de mujeres y hombres, BOE-A-2007-6115, 24 March 2007, https://www.boe.es/buscar/act.php?id=BOE-A-2007-6115, (accessed 1 June 2018).
[405] Boada et al., p. 28.
[406] Boada et al., p. 30.

However, the stance on reproductive rights of transgender persons seemed to change recently. In September 2017, the Valencian Supreme Court of Justice decided against the Spanish government for discriminating a cisgender woman and her male transgender spouse. The Valencian Supreme Court of Justice recognized the right of a married cisgender woman and a transgender man to receive MAR treatment with public funds through the General Mutual Fund of Civil Servants of the State (Muface[407]). It decided that the government violated the concerned couple's fundamental right to not be discriminated against on the basis of their sexual orientation. Said transman had cryopreserved nine oocytes before he underwent hormone treatment, which was financed by Social Security. After the hormone therapy, he could legally change his sex due to his diagnosed gender dysphoria. The oocytes were frozen with the intention to be later fertilized with donor sperm and then implanted into the uterus of his wife. This procedure, referred to as shared biological motherhood, was already explained before and is usually chosen by two cisgender women to get a child with biological bonds to both parents. Nevertheless, the particular couple had to face impediments to access the MAR procedure. When the husband asked Muface to finance the wife's treatment due to the cause of primary infertility, the health services providing company denied the funding of the treatment due to the 'absence of a gynaecological cause that prevents a gestation by natural means'. The medical centres that the couple requested to conduct the MAR technology, refused to undertake those. The persons in the medical centres were unsure about the legality of the treatment and wanted to wait for a favourable report of the National Commission of Assisted Reproduction. Finally, the Valencian Supreme Court of Justice clarified that the legislator's obligation is to facilitate the same treatment to those who are in an equal legal situation. To not facilitate such a treatment is clearly discriminatory and violating the concerned couple's right to equality. The Valencian Supreme Court of Justice determined that the legislation on MAR were misinterpreted by the administrations. By insisting on the literal meaning of the norms, they impose inapplicable conditions on the intended parents. The Court found that the couple is entitled to receive MAR treatment due to the infertility of the transman and regardless of whether or not the ciswoman has gynaecological impediments to gestate naturally.[408]

[407] In Spanish: Mutualidad General de Funcionarios de Funcionariios Civiles del Estado (Muface).

[408] M. C. Sánchez, 'La Justicia reconoce el derecho a la reproducción asistsida a una pareja con un cónyuge transexual', *El País*, 19 October 2017, https://politica.elpais.com/politica/2017/10/19/diario_de_espana/1508401642_897282.html, (accessed 1 June 2018).

To sum up, Spain is a country that has very liberal elements in its regulations regarding access to MART. Access is not only granted to individuals, but also to couples, regardless of their marital status.[409] The permission for two-cisgender-women-couples to establish a shared biological motherhood and participate both in the creation of their child is regulated under Spanish law and constitutes a particularity under European legislation.[410] However, some parts of MAR are not regulated yet and even public institutions are unsure about the application of MART in some case. For example, in the case of transgender persons, there do not exist any regulations on their access to MART, which makes it in practice hard for them to make use of such methods.[411] Furthermore, surrogacy is prohibited under Spanish law, which results in the legal impossibility for two persons, who possess male reproductive organs, to access MART.[412] Taking into account all these mentioned factors, Spain can be classified as a *partially liberal country*.

10.5. Liberal Countries: Netherlands and United Kingdom

Liberal countries allow full access to the dominant MART used by LGBTIAQ+ persons. Within their legislation, they do not limit the access to those technologies to couples in heteronormative relationships. People can make use of the legally allowed MART regardless of their sexual orientation and gender identity. Individual cisgender women as well as two-cisgender-women-couples are permitted to make use of MART in order to have children.[413] Even the establishment of a shared biological motherhood is allowed.[414] Furthermore, surrogate motherhood is legal in the Netherlands and the UK, which makes it possible for two-cisgender-men-couples to have children via MAR.[415]

[409] Imaz, p. 7; Navas et al., p. 253.
[410] Imaz, p. 7.
[411] Boada et al., p. 30; Sánchez, ibid..
[412] Marina et al., p. 940.
[413] Cohen, p. 145.
[414] D. Bodri et al., 'Shared motherhood IVF: high delivery rates in a large study of treatments for lesbian couples using partner-donated eggs', *Reproductive BioMedicine Online*, vol. 36, iss. 2, 2018, p. 135. Available from Elsevier, (accessed 4 June 2018).
[415] Cohen, p. 145.

10.5.1. The Netherlands

Fertility treatment is an important issue in the Netherlands and constantly on the political agenda. Thirteen licensed medical centres deal with infertility issues. The centres are well organized and research on that topic is conducted on a regular basis.[416]

In the Netherlands, it is not allowed to exclude a woman from accessing artificial insemination on the basis of her relationship status. Therefore, single women are also permitted to access MAR. However, some medical centres refuse to apply MART on single women. The reason for the refusal of providing infertility treatment to single women is mainly that some gynaecologists believe single parenthood would not be the right choice. The Dutch Association for Obstetrics and Gynaecology has published a guideline, which allows the refusal of providing MART in cases in which the welfare of the future child could be in danger. This might be the case if the intended parents have been found guilty of abuse or are addicted to drugs. However, the sole relationship status of a women is not enough to refuse her treatment.[417]

Due to the prohibition of excluding a woman only because of her maternal status, two-cisgender-women-couples are also allowed to make use of MART. However, in the Netherlands, the determination of maternity is regulated very complexly. The woman who gives birth to the child will automatically become the legal mother of the newborn, no matter her relationship status and regardless of whether she has genetic bonds to the child.[418] If the two women are married and one of them is inseminated with donor sperm, her wife will automatically be the other parent as long as the man who donated the sperm remains unknown.[419] If the man is not anonymous or the women are not married (i.e. they live in a registered partnership or relationship), the partner of the birth-giving woman can recognize her maternity as long as the other woman agrees. If the birth-giving woman refuses the recognition of maternity of her female partner, there is no possibility to achieve the recognition in another

[416] J. van Kammen et al., ‚Technology assessment and knowledge brokering: The case of assisted reproduction in The Netherlands', *International Journal of Technology Assessment in Health Care*, vol. 22, no. 3, 2006, pp. 302.-306. p. 303. Available from Cambridge University Press Journals Complete, (accessed 31 May 2018).
[417] A. Stoffelen, 'Helft ziekenhuizen weigert single vrouwen ivf', *deVolkskrant*, 22 July 2015, https://www.volkskrant.nl/nieuws-achtergrond/helft-ziekenhuizen-weigert-single-vrouwen-ivf~b9f1e6b6/, (accessed 8 June 2018).
[418] M. Vonk, 'Parent-Child Relationships in Dutch Family Law' in I. Schwenzer (ed.), *Tensions between legal, biological and social conceptions of parentage*, Intersentia Publishing, 2007, p. 281. Available from Utrecht University Repository, (accessed 8 June 2018).
[419] M. Vonk, 'Same-sex parents in the Netherlands', in E. Bouvier de Rubia and A. Voinnesson (eds.), *Collection Colloques Société de législation compare*, Société de législation comparée, 2012, p 21. Available from Leiden University Repository, (accessed 31 May 2018).

way. If the partner of the birth-giving woman refuses the recognition, the gestational mother or the child can request a court to recognize the maternity. The court will determine the maternity if the woman has agreed to the procedure that led to the pregnancy of her partner.[420]

Although the establishment of a shared motherhood is permitted with no restrictions under Dutch law, its actual access is not that easy.[421] In comparison to Spain and the UK, the Netherlands have not reported as many cases of shared motherhood thus far.[422] Some Dutch medical centres refuse two women the access to the MAR method that enables the creation of a child that is biologically related to both women. The arguments used for restricting the access are mostly that the women have no medical reason for undergoing the oocytes donation and the following fertilization and transplantation process. The possibility to get a child within the relationship through donor insemination, which is the less complicated method, is a reason for some gynaecologists to not conduct the shared biological motherhood method.[423]

Surrogate motherhood is legal under Dutch law. The contracts between the surrogate mother and the intended parents are very diverse and include clauses such as that the gestational mother is not allowed to smoke or that she will undergo an abortion in case the child suffers from a serious disease. The main clause in surrogate contracts is that the surrogate mother is obliged to hand over the child to the intended parents after giving birth to it. Although most conditions will be seen as enforceable by lawyers, prevalent doctrine says that the main clause is neither valid nor enforceable. The reason for that is that such contract clauses are seen as unmoral. Currently, it is not possible to legally enter into such contracts, which determine that the legal parents are others than those determined by Dutch law.[424] As agreed determinations on parenthood are not valid, the surrogate mother has no legal obligation to hand over the child after giving birth to it, just as the commissioning parents are obliged to accept the newborn. The Child Protection Board has to give their consent should the child already live in the household of the

[420] A. Nuytinck, 'New law on lesbian parenthood and transgender individuals', *Radboud University*, [website], 2018, https://www.ru.nl/english/research/radboud/top-research-areas/business-law/more-info/new-law-lesbian-parenthood-transgender-individuals/, (accessed 31 May 2018); Vonk, 2012, p. 30.
[421] Bodri et al., p. 131.
[422] Ibid., 135.
[423] W. J. Dondorp, G. M. De Wert and P. M. W. Janssens, 'Shared lesbian motherhood: a challenge of established concepts and frameworks', *Human Reproduction*, vol. 25, no. 4, 2010, p. 813. Available from Oxford University Press, (accessed 11 June 2018).
[424] I. Curry-Sumner and M. Vonk, 'The Netherlands', in K. Trimmings and P. R. Beaumont (eds.), *International Surrogacy Arrangements :: Legal Regulation at the International Level*, Portland, Oregon, Hart Publishing, 2013, p. 275. Available from EBSCOhost, (accessed 31 May 2018).

commissioning parents before it gets six months old. Maternity is determined by the giving birth to the child. Therefore, the gestational mother will automatically be the legal mother of the newborn. It is irrelevant whether the child is genetically related to the gestational mother or not.[425] If the surrogate mother is married to a man, her husband will be the other legal parent.[426] If she is married to a woman, her wife will only become the other legal parent automatically when the origin of the spermatozoa used for the MAR is unknown, or when both women and the known donor agree to her recognition as the legal mother.[427] In both cases, the parenthood can be challenged if the spouse did not agree to the surrogacy. The commissioning parents will gain parenthood through adopting the child.[428] The ordinary rules regarding adoption will apply here, as the Dutch law does not provide any special adoption procedures for cases regarding surrogacy.[429] If the surrogate mother is in a registered partnership, she will become the only legal parent of the child. However, she and her partner will have the mutual parental responsibility for the child. In the case that the surrogate mother is neither married nor in a registered partnership, the child will not have another legal parent and the woman alone holds the parental responsibility.[430] However, the commissioning father can recognize the child as his if the surrogate agrees to it. Afterwards, the father can request to be the only one parentally responsible for the child. Then, the commissioning mother can adopt the child.[431]

According to articles 151b and 151c Criminal Code, the promotion of commercial surrogacy is illegal. Neither the announcement of parents, who want to get a child through surrogacy, nor the offering of one's own body for matters concerning surrogacy, is allowed. However, the commissioning parents are permitted to privately arrange a person they know in order to gestate a child for them. Also, the payment of compensation fees for the gestation and delivery of the child is not unlawful.[432]

Two different kinds of surrogate motherhood can be accessed in the Netherlands. If the oocytes of the gestational mother are fertilized via MAR, this method is referred to as 'low-

[425] Ibid., p. 276.
[426] Ibid., p. 278.
[427] Vonk, 2012, pp. 21 and 31.
[428] Curry-Sumner and Vonk, p. 278.
[429] Ibid., p. 279
[430] Vonk, 2012, p. 15.
[431] Curry-Sumner and Vonk, p. 279.
[432] Government of the Netherlands, *Legal and illegal aspects of surrogacy*, [website], https://www.government.nl/topics/surrogate-mothers/surrogacy-legal-aspects, (accessed 31 May 2018).

tech-surrogacy'. In that case, the gestational mother will be the genetic mother. Another option is to choose 'high-tech surrogacy'. In high-tech-surrogacy, an embryo is conceived in-vitro with the gametes of the intended parents and then transferred into the uterus of the gestational mother. In that case, the surrogate mother will not have any genetic bounds to the child. A woman is only entitled to arrange a surrogate mother if she suffers from such serious health problems, so that carrying or bearing a child herself would be a risk to her life, or if the pregnancy is not advisable for any other reason.[433] Furthermore, two-cisgender-men-couples are allowed to arrange a gestational mother in order to get a child through artificial insemination (low-tech-surrogacy). Conceiving a child in-vitro with the spermatozoa of one man and donor oocytes, and then transplanting the embryo into the uterus of the gestational mother will not be permitted for a two-cisgender-men-couple, as this type of surrogacy (high-tech-surrogacy) requires the use of the gametes of both intended parents.[434]

In the Netherlands, transgender persons may change their sex officially without having to undergo prior sex change surgeries.[435] The cryopreservation of gametes to use them later for MAR is permitted under Dutch law. However, a transwoman, whose spermatozoa were frozen before her transition from male to female, will be referred to as the father and not the mother of the child conceived with her sperm cells and her female partner's egg cells.[436]

Taking into account the various legal possibilities of LGBTIAQ+ persons in the Netherlands to access MAR, such as artificial insemination for two-cisgender-women-couples, the access to MAR for single persons, the establishment of a shared biological motherhood, and the access to surrogacy, the Netherlands clearly fall under the category of *liberal countries* in terms of this study. The Dutch lawmakers' liberal stance on LGBTIAQ+ communities started already in 2001. The Netherlands was the first country worldwide to allow same-sex marriage. On 1 April 2001, the first same-sex couple got married.[437] Still today, LGBTIAQ+ persons are widely

[433] Government of the Netherlands, *Forms of surrogacy*, [website], https://www.government.nl/topics/surrogate-mothers/forms-of-surrogacy, (accessed 31 May 2018).
[434] L. Brunet et al. for the European Parliament, *Comparative study on the regime of surrogacy in the EU member states*, Brussels, 2012, p. 303. Available from The London School of Economics and Political Science, (accessed 1 June 2018).
[435] Nuytinck, ibid..
[436] Sexual Rights Initiative and Rutgers WPF, *UPR Submission on sexual and reproductive health and rights in the Netherlands*, 13th session of the Universal Periodic Report, 2012, The Netherlands, p. 5, http://www.sexualrightsinitiative.com/wp-content/uploads/Netherlands-UPR-13-WPF.pdf, (accessed 8 June 2018).
[437] T. Lundberg, 'The Netherlands: 15 years of gay marriage', , *I am Expat*, 15 April 2016, https://www.iamexpat.nl/expat-info/dutch-expat-news/netherlands-15-years-gay-marriage, (accessed 19 June 2018).

accepted in the Netherlands. The Dutch attitude to the LGBTIAQ+ community is very positive in comparison with other European countries and it even is constantly getting more and more positive. The Dutch population gets increasingly more supportive of LGBTIAQ+ issues in general, as well as of the promotion of equal rights, and the public visibility of their sexuality and/or gender identity.[438]

10.5.2. The United Kingdom

In the UK, the Human Fertilisation and Embryology Act 2008 (HFEA)[439] sets the legal framework, which is an important law for the estimated 3.5 million infertile couples there. Additionally, the National Institute for Clinical Excellence established guidelines, which are constantly updated and recommend the funding of some treatments in England, Scotland, Wales, and Northern Ireland. However, to comply with these guidelines is not compulsory.[440]

Access to MAR is granted to everybody in the UK, regardless of their marital status or sexual orientation. This means that single persons as well as couples, regardless of their sexual orientation, are permitted to make use of MART. The women in the UK can either use their own oocytes for insemination or donated ones. It is also possible for two-cisgender-women to fertilize the oocytes of one woman and implant them into the uterus of the other. In this way, a shared motherhood is established.[441] The gestating mother will ex lege become the legal mother after giving birth to the child. In the moment of giving birth to the child, her civil partner will automatically achieve legal paternity too.[442] In the case that the women are not in a civil partnership, the birth-giving woman can designate her partner as the other legal parent.[443]

The establishment of a shared "mother"hood is also possible for a transman that lives in relationship with a cisgender woman. The cryopreservation of gametes from transgender persons is not only allowed, but also current practice in the UK. Transmen, who are 16 years or

[438] L. Kuyper for Sociaal en Cultureel Planbureau, *Opvattingen over seksuele en genderdiversiteit in Nederland en Europa*, Den Haag, May 2018, p. 8, translated using online translation tools.
[439] Parliamentary Assembly of the United Kingdom, *Human Fertilisation and Embryology Act 2008*, 2008 Chapter 22, 13 November 2008.
[440] Merck, ibid..
[441] CoParents, *Donor conception, surrogacy, adoption and co-parenting laws in the UK*, [website], 2008-2018, https://www.coparents.co.uk/sperm-donors-laws-in-UK.php, (accessed 1 June 2018).
[442] M. Wells-Greco, 'United Kingdom', in K. Trimmings and P. R. Beaumont (eds.), *International Surrogacy Arrangements :: Legal Regulation at the International Level*, Portland, Oregon, Hart Publishing, 2013, p. 369. Available from EBSCOhost, (accessed 1 June 2018).
[443] CoParents, ibid..

older, are permitted to freeze their oocytes before they change their sex from female to male. Through the cryopreservation of the transgender person's gametes, they gain the opportunity to get genetically related children in the future, even though the hormonal treatment has damaged their reproductive system. After fertilizing them with spermatozoa, the prior cryopreserved oocytes of the transman can be transplanted into the uterus of his female cisgender partner, who gives birth to the child. The cryopreservation of gametes is also permitted for transwomen. They are allowed to freeze their spermatozoa before their sex change if they are at least 12 years old.[444] Just recently, on 4 January 2018, the British Fertility Society has published a guideline, stating that the National Health Service is obliged to offer oocytes cryopreservation to transmen prior to their sex transition.[445]

Regulations regarding surrogate motherhood are found in various UK legislation, which are mainly the Surrogacy Arrangements Act 1985[446], the Adoption and Children Act 2002[447], the Human Fertilisation and Embryology (Deceased Fathers) Act 2003[448] and the HFEA 2008. That a surrogate mother has to consent to hand over the child after giving birth to it is not enforceable under UK law, even though consent is given by means of a contract. Neither are the intended parents bound by a contractual agreement to accept the child. None of the contract parties can be obliged to follow the agreed clauses in a surrogacy arrangement. The promotion of surrogacy is prohibited by UK law. Neither the advertisement one's own body in order to become a surrogate mother, nor the public search for a gestational mother by the commissioning parents is permitted. Although commercial surrogacy is prohibited, it is allowed to pay reasonable compensation fees to the gestating woman.[449]

Legal maternity is determined by giving birth to a child:

[444] S. Manning, 'NHS saves sperm of transgender teenagers aged 12 so they can be fathers after changing sex', *Mail Online*, 1 October 2017, http://www.dailymail.co.uk/sciencetech/article-4937288/NHS-saves-sperm-transgender-teenagers.html, (accessed 1 June 2018).
[445] Knapton, ibid..
[446] Parliamentary Assembly of the United Kingdom, *Surrogacy Arrangements Act 1985*, 1985 Chapter 49, 16 July 1985.
[447] Parliamentary Assembly of the United Kingdom, *Adoption and Children Act 2002*, 2002 Chapter 38, 7 November 2002.
[448] Parliamentary Assembly of the United Kingdom, *Human Fertilisation and Embryology (Deceased Fathers) Act 2003*, 2003 Chapter 24, 18 September 2003.
[449] Wells-Greco, p. 367.

> ‘The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child.’[450]

Therefore, the gestational mother will automatically be the legal mother of the newborn. It is irrelevant whether the woman is genetically related to the child. The subsequent adoption or determination of parenthood by court can change the parental status of the child. If a married woman got pregnant through the use of donor spermatozoa, her husband will automatically be the legal father in case it is not proven that he did not agree to the MAR performed on his wife. The civil partner of a woman will automatically get the paternal status if not proven that she did not agree to the MAR.[451] In the case that the woman is not married or not in a civil partnership, or when her spouse/partner did not agree to the treatment, the intended father will be the legal father, as long as he is also the biological one.[452] The woman can also decide to designate another person as the second parent, which might be her unmarried partner.[453] By use of a so-called ‘parental order’, the legal parenthood of the child can be transferred to the intended parents. They will get all parental rights to the child. To get parental order has the same legal effects as adoption. The intended parents can apply to the court for a parental order. The requirements for getting the parental order are listed in § 54 HFEA 2008. Both of the intended parents need to apply and at least one of them has to have a genetic relation to the child. Furthermore, the intended parents have to be married, in civil partnership, or living together in an enduring family partnership, which is not illegal under UK law. Moreover, the parental order has to be requested from when the child is six weeks old, which is the earliest possible time, and up until it is six months old, which is the latest possible time.[454] This means that access to surrogacy is also allowed to LGBTIAQ+ couples. It does not matter in which kind of relationship they live in, as long as their relationship is legal under UK law and the child has genetic relations to at least one of them.[455] However, individual persons, regardless of their gender identity or sexual orientation, are not permitted to apply for a parental order.[456]

[450] Human Fertilisation and Embryology Act 1990, § 27, para. 1.
[451] Ibid., p. 369.
[452] Ibid., p. 370.
[453] CoParents, ibid..
[454] Wells-Greco, p. 371.
[455] CoParents, ibid.; Wells-Greco, p. 373.
[456] Wells-Greco, p. 373.

The UK law about MAR is particular in this matter, as it explicitly mentions that the welfare of the child is considered as a prerequisite to access MART.[457] According to § 13 para. 5 of the HFEA 2008 'a woman shall not be provided treatment services […] unless account has been taken of the welfare of any child who may be born as a result of treatment (including the need of that child for a supportive parent), and of any other child who may be affected by the birth'.[458]

Taking into account the multifarious possibilities LGBTIAQ+ persons have in the UK to access MAR, it is clearly the most *liberal* one from the scrutinized countries in this study. LGBTIAQ+ persons are permitted to make use of MAR either as single persons or as couples.[459] The only exception forms surrogacy, which is only allowed for two persons who are in a legal relationship.[460] Surprisingly, even though the UK is the most liberal country regarding the access of LGBTIAQ+ persons to MART, it is the only country among the partially restrictive and liberal countries that has not allowed same-sex marriage throughout the whole country yet, as it is still not permitted in Northern Ireland.[461]

10.6. Consistent Regulations on Medically Assisted Reproduction Access of LGBTIAQ+ Persons

The scrutinized countries regulate their national legislation regarding access to MART differently. However, there are some issues regulated in the same way. For example, none of the selected countries prohibits human reproductive cloning.[462] Also, intersex persons have no possibility to be recognized as such officially in those states. An exception to this is Austria, where has just recently, on 29 June 2018, the Constitutional Court decided that intersex persons should have the possibility to be legally recognized as such.[463] The following paragraph explains the consistent regulations in all six countries.

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[457] Sperling, p. 387.
[458] Human Fertilisation and Embryology Act 2008, § 13, para. 5.
[459] CoParents, ibid..
[460] Wells-Greco, p. 373.
[461] C. McGinn, 'It's time to make Northern Ireland allow same-sex marriage', *The Guardian*, 27 March 2018, https://www.theguardian.com/commentisfree/2018/mar/27/northern-ireland-same-sex-marriage-equality, (accessed 1 June 2018).
[462] Center for Genetics and Society, *Human Cloning Policies*, [website], 2018, https://www.geneticsandsociety.org/internal-content/human-cloning-policies, (accessed 19 June 2018).
[463] J. L. Hale, *Germany Will Officially Give Nonbinary People Legal Recognition After A Court Ruling, & They'll Be The First Country In Europe To Do So*, [website], 9 November 2017, https://www.bustle.com/p/germany-will-officially-give-nonbinary-people-legal-recognition-after-a-court-ruling-theyll-be-the-first-country-in-europe-to-do-so-3265680, (accessed 19 June 2018); Aichinger, ibid..

Human reproductive cloning is prohibited in all of the six selected countries. As already mentioned, the Additional Protocol to the Oviedo Convention is the only legally binding international document that prohibits the cloning of human beings.[464] However, only 24 states have ratified it so far and 9 more signed it without ratifying it. Among the countries scrutinized in this study, the Czech Republic and Spain have ratified the Additional Protocol of the Oviedo Convention. The Netherlands and Ukraine signed it, but did not ratify it. Austria and the UK neither signed nor ratified it.[465] Nevertheless, all six selected states ban human reproductive cloning in their national legislation.[466]

Germany and Austria are the only countries in all of Europe that officially called for the legal recognition of non-binary persons who do not identify as just male or female.[467] All other European states, including Ukraine, Czech Republic, Spain, Netherlands, and the UK, do not recognize intersex persons officially as such. Moreover, intersex persons are officially recognized as either male or female.[468]

10.7. Access Requirements to Medically Assisted Reproduction

The required relationship status in order to access MAR is different from country to country. While the Czech Republic and Austria do not permit single persons to access MAR, the other four scrutinized states allow such an access.[469] While Spain, the Netherlands, and the UK do not require a specific relationship status for the general access to MAR[470], the domestic laws of the Czech Republic, Ukraine, and Austria are built on such prerequisites.[471] In the special case of surrogate motherhood, the differences are even more apparent. Whereas in the Czech Republic

[464] Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings (opened to signatures 12 January 1998) ETS No. 168, art. 1-2.
[465] Council of Europe, *Chart of signatures and ratifications of Treaty 168*, [website] 19 June 2018, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/168/signatures?p_auth=VadhHyPI, (accessed 19 June 2018).
[466] Center for Genetics and Society, ibid..
[467] The German lawmakers need to decide until the end of December on how they will incorporate this recognition of a third gender in their national legislation. There are possibilities to introduce a third gender besides the already existing 'male' and 'female' as 'intersex', 'diverse', or 'undefined'. Another option would be to get rid of gender makers completely (Hale, ibid.); Aichinger, ibid..
[468] An exception is Malta, where children are not determined obligatory as female or male until their gender identity is clear (Gender Identity, Gender Expression, and Sex Characteristics Act of Malta, ACT No. XI of 2015, 14 April 2015. Available from https://tgeu.org/wp-content/uploads/2015/04/Malta_GIGESC_trans_law_2015.pdf, [accessed 16 July 2018]); ibid..
[469] Rainbow Europe, ibid..
[470] Navas et al., p. 253; Imaz, p. 7; Stoffelen, ibid.; CoParents, ibid..
[471] Císařová, Brojáč and Roubíčková, p. 293; Phillips, ibid.; RepMedA, art. 2 para. 1.

mere opposite-sex couples can access surrogate motherhood[472], the commissioning opposite-sex couple in the Ukraine has to be married to arrange a gestational mother.[473] While in the Netherlands, everybody, regardless of their marital status, can access surrogate motherhood[474], the UK only allows this access for couples.[475] In Austria and Spain, surrogate motherhood is generally prohibited.[476] The following Table shows an overview of the different national legislation on the access to MART with regard to the marital status of the intended parent(s).

Table 6: Relationship status requirement to access MAR

Classification of Country	Countries	Access for individuals	Required relationship status	Special case: surrogacy
Restrictive Countries	Czech Republic	No	Opposite-sex couples	Opposite-sex couples
	Ukraine	Yes	Singles or opposite-sex couples	Spouses (opposite-sex)
Partially restrictive Countries	Austria	No	Spouses, registered partners, civil partners	Not allowed
	Spain	Yes	None	Not allowed
Liberal Countries	Netherlands	Yes	None	None
	United Kingdom	Yes	None	Couples

Source: Table 6 was created by the author with the information taken from the previous chapters number 9.3 – 9.5 and constitutes an overview of the required relationship status in order to access MART.

In regard to access of LGBTIAQ+ to MART, the national legislation differ from each other in terms of the access permission and prohibition on the basis of the sexual orientation or gender identity of the persons concerned. Whereas two-cisgender-women are allowed to make use of artificial insemination as a couple in Austria, Spain, the Netherlands, and the UK, they are not allowed to do so in the Czech Republic, and Ukraine.[477] The establishment of a shared biological motherhood is possible in Spain, the Netherlands, and the UK[478], but forbidden in Austria, the Czech Republic, and Ukraine.[479] For same-sex couples, the arrangement of a surrogate mother is only allowed in the Netherlands and the UK.[480] Furthermore, the Netherlands and the UK

[472] Císařová, Brojáč and Roubíčková, p. 293.
[473] Sandra F., ibid..
[474] Stoffelen, ibid.
[475] CoParents, ibid.; Wells-Greco, p. 373.
[476] Bernat, p. 690; Marina et al., p. 940.
[477] Rainbow Europe, ibid..
[478] Imaz, p. 7; Bodri et al., p. 131; CoParents, ibid..
[479] Erlebach, p. 219; Císařová, Brojáč and Roubíčková, p. 293; Phillips, ibid.;
[480] Stoffelen, ibid.; CoParents, ibid.; Wells-Greco, p. 373.

permit access to all MART, including shared "mother"hood and surrogate motherhood for trans persons[481], whereas in the other countries, this access is prohibited either partially or completely.[482] The following table represents an overview of access possibilities to MART for LGBTIAQ+ persons.

Table 7: Permission of access to MAR for LGBTIAQ+ persons

Classification of Country	**Countries**	**Permission of access for a two cisgender women couple to artificial insemination**	**Permission of a shared biological motherhood**	**Permission of access to surrogacy for same-sex couples**	**Permission of access for trans persons**
Restrictive Countries	Czech Republic	No	No	No	No
	Ukraine	No	No	No	Partially
Partially restrictive Countries	Austria	Yes	No	No	Partially
	Spain	Yes, but adoption required	Yes	No	Partially
Liberal Countries	Netherlands	Yes	Yes	Yes	Yes
	United Kingdom	Yes	Yes	Yes	Yes

Source: Table 7 was created by the author with the information taken from the previous chapters number 9.3 – 9.5 and constitutes an overview of the access to MART for LGBTIAQ+ persons.

Furthermore, all selected countries ban human reproductive cloning in their national legislation and partially also by ratifying the Additional Protocol to the Oviedo Convention.[483] The creation of a genetically identical offspring by means of reproductive cloning methods is therefore not legally possible for any person in the scrutinized countries, regardless of their sexual orientation or gender identity.

Among all examined countries in this study, Austria is the only state which grants intersex persons the possibility to have their identified gender legally recognized.[484] In the other countries, their access to MART therefore depends on their legal recognition as either woman or man on the one hand, and the domestic legislation of the country they live in on the other

[481] Sexual Rights Initiative and Rutgers WPF, p. 5; Knapton, ibid..
[482] Iryskina, ibid.; Childs, ibid.; Bernat, p. 690; Sánchez, ibid.; Marina et al., p. 940.
[483] Council of Europe, *Chart of signatures and ratifications of Treaty 168*, [website] 19 June 2018, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/168/signatures?p_auth=VadhHyPI, (accessed 19 June 2018); Center for Genetics and Society, ibid..
[484] Aichinger, ibid..

hand. Under Ukrainian law, a specific reference relating to intersex persons is made in Order No. 579 of the Ministry of Health in Ukraine. According to it, persons, who possess female reproductive systems, are prohibited from accessing MART if they are F64 diagnosed.[485] This means that every person who is diagnosed with 'Gender Identity Disorder', which includes intersex persons, and who provides female reproductive organs is not allowed to access MART.[486]

Infertility is explicitly mentioned as a requirement to access MART under Czech and Ukrainian law.[487] By contrast, the UK and Spain do not mention infertility as a prerequisite in order to use MART in their domestic legislation regulating MAR.[488] Although the same applies to the Netherlands, physicians in Dutch medical centres often refuse specific persons the application of MART. This is regularly the case when two-women-couples want to establish a shared biological motherhood.[489] In Austria, infertility is not mentioned as such, but § 2 para 2 item 1 of the RepMedA specifies that all other possibilities to create a pregnancy through sexual intercourse need to have been unsuccessful or unreasonable.[490]

The infertility requirement has not just an impact on fertile LGBTIAQ+ persons, who live in same-sex relationships and wish to make use of MAR in order to fulfil their desire to get a child. Also asexual persons are not considered when infertility is required to make use of MART. ICMART and WHO define infertility for when an opposite-sex couple is not successful in establishing a pregnancy through frequently conducted, unprotected sexual intercourse within one year.[491] However, some asexual persons might find it unreasonable to have sexual intercourse regularly, due to their low or inexistent sexual desire for other persons.[492] The formulation in the Austrian RepMedA, which requires either unsuccessfulness or unreasonableness of sexual intercourse, is more friendly towards asexual persons.[493]

[485] Iryskina, ibid..
[486] Ibid..
[487] Centrum Lèčby Neplodnosti, ibid.; Sandra F., ibid..
[488] Navas et al., p. 253; Imaz, p.7; CoParents, ibid..
[489] Dondorp, De Wert and Janssens, p. 813.
[490] Steinhuber, p. 77.
[491] Zegers-Hochschild, Adamson, de Mouzon et al., p. 1522.
[492] Bogaert, p. 364.
[493] Steinhuber, p. 77.

11. Comparison of National Legislation on Medically Assisted Reproduction in the Selected Countries

As the previous Chapter has shown, LGBTIAQ+ persons do not have the same opportunities to reproduce via MAR in the respective European countries. While LGBTIAQ+ individuals are completely restricted from accessing MAR in some parts of Europe, they are able to fully access all prevalent MART in the liberal countries. The access is restricted, prohibited, or permitted through national legal norms and interpretations of these norms. As medicine and law interacts differently in the particular states and not all MART are considered by domestic laws, the legal possibilities of MAR access for LGBTIAQ+ persons vary. Furthermore, the existing legal regulations are formulated differently, and the arguments used to either permit or prohibit certain MART are not the same. Additionally, the HR behind these arguments weigh differently in the respective states. In this Chapter, the selected countries' national legislation on MAR are compared. The chapter explains the interactions between medicine and law, scrutinizes the different formulations of laws and the relation of HR arguments used to either permit or prohibit certain MART.

11.1. Interactions between Medicine and Law in Various Countries

Medicine is a permanently evolving discipline. New medical ways for human reproduction emerge constantly. However, not every medical option is also permitted by law. Law sets a framework of permissions and impediments, which makes it possible for persons to access MART or not. However, often the legal norms and their lawmakers do not consider all medical possibilities. In case that new or non-considered medical possibilities to achieve a pregnancy appear, new legal norms have to be established or the existing law has to be interpreted.

This can be shown when it comes to MAR options for trans and intersex persons. For example, the domestic legislation of Austria and Spain both lack a concrete regulation that either allows or forbids intersex or trans persons to access MART. Therefore, the question arises as to whether the particular application of these technologies is permitted or not. While both countries allow the cryopreservation of spermatozoa or oocytes of trans individuals,[494] the possibility of using them later for MART is not always clearly regulated.

[494] Boada et al., p. 28.

In Austria, a transman is allowed to cryopreserve his oocytes before his transition from male to female.[495] However, the possibility of a later use of these germ cells is more complicated. If the person concerned is in a relationship with a person with intact female reproductive organs, the law has to be interpreted according to § 3 para. 3, which states that the donation of oocytes is only allowed if the woman, who will bear the child, is infertile.[496] Therefore, except for this exceptional case, the frozen oocytes are useless. The same applies for when the transman is living in a relationship with a person possessing male reproductive organs, as surrogate motherhood is not permitted.[497] The permission of cryopreserving reproductive organs on the one hand, and the prohibition of their later use on the other represents a legal contradiction.

In Spain, the situation is similar. Cryopreservation of organs of trans persons is permitted under Spanish law.[498] However, the National Commission for Assisted Human Reproduction refused the application of MART on transgender persons in 2010.[499] A contrary opinion was shared by the Valencian Supreme Court in 2017, when it decided that refusing a trans person access to MART was unlawful.[500] This uncertainty concerning the access to MART for transgender persons stems from the non-existence of a clear reference on the cryopreservation of fertility of transgender individuals.[501] The access of trans individuals represents a legal vacuum in some European countries as it is not clearly regulated. The reason for this is probably that the lawmakers did not think about these possibilities. As a consequence, medical centres are not sure about whether they should apply MART in these cases or not.

Although infertility is not mentioned as a requirement for accessing MART in the Dutch law, medical centres in the Netherlands often refuse specific persons access to these methods. Physicians refuse the application of MART in cases where two women want to create a shared biological motherhood.[502] However, the establishment of such a shared motherhood is permitted under Dutch law and infertility does not constitute a requirement for the access of MAR.

[495] Barth, p. 202.
[496] Erlebach, p. 221.
[497] Bernat, p. 690.
[498] Boada et al., p. 28.
[499] Ibid., p. 30.
[500] Sánchez, ibid..
[501] Boada et al., p. 30.
[502] Dondorp, De Wert and Janssens, p. 813.

However, the lack of a precise regulation on the requirements to gain oocytes and sperm donations results in physicians' refusal to perform MART in this case.[503]

Furthermore, international changes in medical determinations can influence country jurisdictions. In the Ukraine, for example, persons with female reproductive systems who are F64 diagnosed, are not permitted to access MART.[504] However, the WHO revised its ICD-10-CM list and the new ICD-11-CM will not classify transgender identity as a disorder anymore.[505]

> 'Gender incongruence […] has […] been moved out of mental disorders in the ICD, into sexual health conditions. The rationale being that while evidence is now clear that it is not a mental disorder, and indeed classifying it in this can cause enormous stigma for people who are transgender, there remain significant health care needs that can be best met if the condition is coded under the ICD.'[506]

However, this is not the case for intersex persons. Individuals, whose sex characteristics vary, fall under the category of 'Disorder of Sex Development' in the ICD-11-CM.[507] The new standardized list of ICDs will get its final approval in May 2019 and will be effective by 2022. Until then, the Ukraine would have to change its law.[508] Whether a Ukrainian law will be adopted so that transgender persons with female reproductive systems also get access to MART, or whether they will ban their access by new legislative rules, remains to be seen.

A similar problem arises in Spain. Persons who want to have their identified gender legally recognized have to be diagnosed with 'gender dysphoria'. This is regulated in art. 4 of Law 3/2007.[509] However, this diagnosis will be abolished if the ICD-11-CM list will be approved by the World Health Assembly. Then, like the Ukraine, Spain will also have to adopt their legislation.[510]

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[503] Dondorp, De Wert and Janssens, p. 813.
[504] Iryskina, ibid..
[505] The European Parliament's Intergroup on LGBT Rights, 'Trans identities no longer considered a mental disorder in WHO's ICD-11', 19 June 2018, http://www.lgbt-ep.eu/press-releases/6901/, (accessed 22 June 2018).
[506] World Health Organisation, *ICD-11: Classifying disease to map the way we live and die*, [website], http://www.who.int/health-topics/international-classification-of-diseases, (accessed 22 June 2018).
[507] Irene, 'WHO publishes ICD-11 – and no end in sight for pathologisation of intersex people', *Organisation Intersex International Europe*, 19 June 2018, https://oiieurope.org/who-publishes-icd-11-and-no-end-in-sight-for-pathologisation-of-intersex-people/, (accessed 22 June 2018).
[508] The European Parliament's Intergroup on LGBT Rights, ibid..
[509] Ibid., p. 208.
[510] The European Parliament's Intergroup on LGBT Rights, ibid..

11.2. The Way of Regulating Medically Assisted Reproduction Access for LGBTIAQ+ Persons in the Selected Countries

None of the national legislation of the selected countries is like the other. On the contrary, the domestic laws regarding the access to MAR are very diverse. The way European states allow or forbid certain persons or couples to access MART and the arguments used for the justifications of their decisions differ from each other.

11.2.1. The Formulation of Legal Norms

The individual legislation are formulated differently and due to these formulations, impediments or permissions for LGBTIAQ+ persons develop. The language that the scrutinized states use is a crucial factor when it comes to permitting LGBTIAQ+ person access MAR or not.

Both restrictive countries, Ukraine and the Czech Republic, depend the access to artificial insemination on the difference of the sexes of the concerned persons.[511] While art. 287 para. 7 UCC explicitly stipulates that a 'woman or a man' have a right to MAR[512], § 6, para. 1 of the Czech Specific Health Acts expressly allows the access to MAR to women 'of childbearing age' and only 'at the written request of the woman and the man' who want to be the future parents.[513] In other words, the couple has to consist of two persons of different sexes to make use of those methods.[514] Surprisingly, Ukraine encourages transgender persons to make use of MART. However, persons, who are F64 diagnosed and possess female reproductive systems, are excluded.[515] Transgender persons are not allowed to access MAR as their identified gender in the Czech Republic, due to the requirement of having to undergo sterilisation before their gender identity is legally recognized.[516] This shows that both countries determine the access to MAR on the basis of the persons' sexes and the combination of their sexes. Same-sex couples are excluded from using MART in both states.[517]

In Austria, the requirements for being able to undergo MAR are listed in § 2 para. 1 RepMedA. There is no reference made to the requirement of specific sexes of the intended

[511] Phillips, ibid.; Císařová, Brojáč and Roubíčková, p. 293.
[512] The Civil Code of Ukraine, art. 281 para. 7.
[513] Czech Specific Health Act, § 6, para. 1.
[514] Císařová, Brojáč and Roubíčková, p. 293.
[515] Iryskina, ibid..
[516] European Commission against Racism and Intolerance, pp. 32-33.
[517] Phillips, ibid.; Císařová, Brojáč and Roubíčková, p. 293.

parents.[518] § 2 para. 3 item 3 RepMedA explicitly permits 'two women' to make use of MART.[519] This way of argumentation shows that in this case, 'two women' means two cisgender women. Otherwise, the argument that the couple cannot establish a pregnancy through sexual intercourse would be vague. That is to say because if one of the women is transgendered, they would have the possibility to achieve a pregnancy by means of sexual intercourse as long as the transgender person did not undergo sex change surgery, which is not a requirement for legal gender recognition in Austria.[520]

Similarly, Law 14/2006 allows 'all women older than 18 years and with full capacity to act'[521] to access artificial insemination technologies with no distinction made concerning their sexual orientation.[522] By using the formulation of restricting access literally to 'women', transgender men, who might possess the same reproductive systems as cisgender women and may thus have the same medical possibilities to access artificial insemination, are excluded. However, Law 3/2007 stipulates that transgender persons keep all rights from their prior condition that correspond with their new one.[523]

Through the way Austria and Spain formulate their legal texts it can be seen that the countries try to stop excluding women due to their sexual orientation. This is done through the explicit addressing of two-women-couples[524] (Austria) or the specific declaration that sexual orientation should not constitute a factor to make a distinction in a woman's access to artificial insemination[525] (Spain). However, the diversity of genders is not considered in the formulations. Both legal norms consider persons of different orientations not to be excluded, yet assume at the same time that every person is cisgender. Consequently, the regulations are interpreted in line with other principles and legal norms and finally lead to a uncertainty when it comes to MAR access for non-binary gender identified persons.

The Dutch and UK law do not address certain persons or groups of persons concerning the access to MAR in their legislation. In the Netherlands as well as in the UK, singles, same-sex

[518] See: Austrian Reproductive Medicine Act, § 2 para 1.
[519] Austrian Reproductive Medicine Act, § 2 para. 3 item 3.
[520] Wilhelm, ibid..
[521] Law 14/2006, art. 6, para. 1.
[522] Imaz, p. 7; Navas et al., p. 253.
[523] Boada et al., p. 28.
[524] Reproductive Medicine Act, § 2 para. 3 item 3.
[525] Imaz, p. 7; Navas et al., p. 253.

couples, and transgender persons are actually allowed to access MART.[526] However, a certain norm regarding the group of people permitted to make use of MAR is not explicitly addressed by the countries' domestic legislation.

11.2.2. The Arguments Used to Justify Certain Access Regulations to Medically Assisted Reproduction

The arguments used for prohibiting or permitting LGBTIAQ+ persons to access MAR vary and the HR emphasis is put/placed differently. While some countries base their legislation on the rights of the child and its genetic parents, others also emphasize the rights of the woman who gives birth to the child.

The Ukrainian MAR law puts the focus on the rights of the child and its genetic parents.[527] This can best be seen on the determination of motherhood. Art. 123 para 2 of the Ukrainian Family Code stipulates that the legal parents of a child born through a surrogate mother will always be its genetic parents[528]. If, in surrogate motherhood, no germ cells of the gestational mother were used, and the commissioning parents have used at least 50% of their gametes, they will be the legal parents.[529] The gestational mother has no possibility to insist on the motherhood when the gametes of the commissioning parents were used. This shows the Ukrainian MAR law's strong focus on the rights of the child and the rights of the genetic parents. By contrast, the maternity rights of the surrogate mother are not considered by the Ukrainian law, unless she is genetically related to the child.[530]

Just as Ukraine, also the Czech Republic puts its HR focus on the welfare of the child. § 855 of the New Czech Civil Code determines the child-parents relationship. It stipulates that the welfare of the child is best guaranteed when the parents mutually participate in the upbringing of the child. It further explicitly specifies that the parents are a mother and a father. The adequate raising and health status of the child require this mutual participation of a mother and a father.[531]

[526] CoParents, ibid.; Manning, ibid.; Knapton, ibid.; Stoffelen, ibid.; Sexual Rights Initiative and Rutgers WPF, p. 5.
[527] Lysytsia, p. S104.
[528] Ukrainian Family Code, art. 132, para. 2.
[529] Frati et al., p. 5.
[530] Druzenko, p. 358.
[531] Pauknerová, p. 295.

Also in Austria, the well-being of the child is considered to be the basic value of the legal regulation of MAR. Nevertheless, the legislature emphasizes the significance of a case-by-case decision.[532] Access to MAR is only granted to couples and not to individuals.[533] This limitation results from the conviction of Austrian lawmakers that a newborn should not begin life living with only one parent.[534] A reference to the well-being of the child is also made in art. 2 para. 3 sentence 2 RepMedA. Here, it is expressed that the child has to be considered. If, in accordance with the current state of medical science and experience, there are a number of promising and reasonable methods, then the one method, which is associated with the least health risks for the child, should be chosen.[535] Furthermore, the ethic commission of the Federal Chancellery of the Republic of Austria argues that two-cisgender-women-couples also have reproductive rights and should therefore be granted access to MAR. However, this does not apply to two-cisgender-men-couples, as surrogate motherhood is not allowed.[536] The prohibition of surrogate motherhood in Austria is based on the protection of women. There are concerns that if surrogate motherhood is approved, women would feel compelled to deliver their child as a result of financial distress or external psychological pressure.[537]

Just like the Austrian law, the Spanish law prohibits surrogate motherhood due to the danger that women could be exploited and children commercialized. This fear was expressed in the 'Palacios Report' of the Parliamentary Commission.[538] This means that in Spain, the HR aspect concerning the prohibition of surrogate motherhood lies in the protection of women and children. Furthermore, the Equal Marriage Act 2005 is based on equal reproductive rights, as it stipulates that same-sex and opposite-sex marriages should enjoy the same rights regarding parenthood. Moreover, the women's rights aspect is visible in Law 14/2006. According to it,

[532] Barth, p. 16.
[533] Steinhuber; p. 76; Barth, p. 3; Mayrhofer, p. 2173.
[534] 445 der Beilagen XXV. GP - Regierungsvorlage – Erläuterungen, in parlament.gv.at, parlament.gv.at/PAKT/VHG/XXV/I/I_00445/fname_377350.pdf, (accessed 29 May 2018).
[535] Barth, p.16.
[536] Bundeskanzleramt Bioethikkommission, *Gesetzesprüfungsverfahren G 47/11 betreffend die Beschränkung des Anwendungsbereiches des Fortpflanzungsmedizingesetzes auf verschiedengeschlechtliche Paare*, e-mail, Wien, 16 April 2012, p. 2, http://archiv.bundeskanzleramt.at/DocView.axd?CobId=47392, (accessed 23 June 2018).
[537] Bundeskanzleramt Bioethikkommission, *Stellungnahme der Bioethikkommission beim Bundeskanzleramt zum Entwurf eines Bundesgesetzes, mit dem das Fortpflanzungsmedizingesetz, das Allgemeine bürgerliche Gesetzbuch und das Gentechnikgesetz geändert werden (Fortpflanzungsmedizinrechts-Änderungsgesetz 2015 – FMedRÄG 2015)*, e-mail, Wien, 28 November 2014, p. 3, http://archiv.bundeskanzleramt.at/DocView.axd?CobId=57878, (accessed 23 June 2018).
[538] Orejudo Prieto de los Mozos, p. 348.

'all adult mentally sound women' are entitled to access IVF and artificial insemination technologies regardless of their sexual orientation or civil status.[539]

The Dutch law does not stipulate any specific restrictions in the access to MAR. Rather, according to the 'Dutch Association for Obstetrics and Gynaecology', the refusal to apply MART is permitted if the welfare of the child could be endangered. The sole relationship status of a person cannot be regarded as such an endangering aspect,[540] which represents an underlying equality and non-discrimination aspect.

Whereas under Dutch law, the refusal of MAR treatment is allowed in case the child's welfare is not guaranteed, the UK law, by contrast, declares the ensuring of the welfare of the child to be a requirement for accessing MAR.[541] As long as the child's welfare is not safeguarded, the woman cannot make use of MAR.[542] Thus, the HR perspective of the UK law emphasizes the rights of the child.

11.2.3. Concluding Paragraph: Regulating and Justifying Medically Assisted Reproduction Access

Some countries restrict the access to MAR by formulating in a way that persons of specific gender identities or sexual orientations are excluded and justify these impediments with the protection of the best interest of the child (Ukraine, Czech Republic).[543] Other countries explicitly allow LGBTIAQ+ persons to make use of MART by addressing them directly[544] (Austria) or in clauses within their MAR legislation that ensure equal treatment[545] (Spain). Others do not stipulate certain requirements at all (UK, Netherlands) and only deny access if the welfare of the child is endangered[546] (Netherlands), or they even condition the access on the specific case, proofing the welfare of the child beforehand[547] (UK).

[539] Imaz, p. 7; Navas et al., p. 253.
[540] Stoffelen, ibid..
[541] Sperling, p. 387.
[542] Human Fertilisation and Embryology Act 2008, s. 13, para. 5.
[543] See: Lysytsia, p. S104; Pauknerová, p. 295.
[544] Reproductive Medicine Act, § 2 para. 3 item 3.
[545] Imaz, p. 7; Navas et al., p. 253.
[546] Stoffelen, ibid..
[547] Human Fertilisation and Embryology Act 2008, s. 13, para. 5.

The following Table represents an overview of how the selected countries regulate the access to MAR and which HR they use for justifying their choices.

Table 8: The formulations used to regulate the MAR access and the HR used to justify these regulations

Classification of Country	Countries	Formulation of persons allowed to access MAR	HR emphasis of MAR legislation
Restrictive Countries	Czech Republic	'a woman of childbearing age […] at the written request of the woman and the man'[548]	Welfare of the child
	Ukraine	'An adult woman or a man'[549]	Rights of the child Rights of genetic parents
Partially restrictive Countries	Austria	No general sex requirement, but addressing two women couples	Well-being of the child Protection of women Equality and non-discrimination Limited reproductive rights
	Spain	'All women older than 18 years and with full capacity to act'[550]	Protection of women Protection of children Women's rights Equality and non-discrimination Reproductive rights
Liberal Countries	Netherlands	No specific access regulation	Women's rights Reproductive rights Welfare of the child Equality and non-discrimination
	United Kingdom	No specific access regulation	Welfare of the child

Source: This Table was created by the author. The information was gained from the previous Chapters no. 10.7.2. and 10.7.3..

The HR emphases of the selected countries vary and so do their interpretations of these HR. The individual HR, especially the welfare of the child, are used differently. Therefore, the following Chapter analyses the relation between the HR relevant for MAR for LGBTIAQ+ persons and how they support or contradict each other.

11.3. The Relation between the Human Rights relevant for Medically Assisted Reproduction of LGBTIAQ+ persons

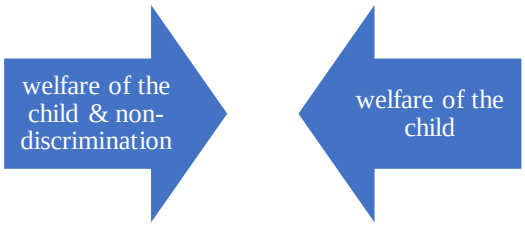
All of the scrutinized European countries justify their domestic MAR legislation by considering the welfare of the future child. Surprisingly, even though they put their focuses on the same human right, the national legislation differ completely. Other HR principles, such as the

[548] Czech Specific Health Act, § 6, para. 1.
[549] The Civil Code of Ukraine, art. 281 para. 7.
[550] Law 14/2006, art. 6, para. 1.

principle of equality and non-discrimination, or other HR, like women's rights or reproductive rights, are additionally considered by some of the countries.

Whereas the lawmakers in Ukraine and the Czech Republic argue that the welfare of the child is only guaranteed if the parents are a man and a woman[551], Spain, Austria, the Netherlands, and the UK do not follow this conviction.[552] Also, in the whole CRC, which is ratified by all six chosen countries[553], there is no reference made that the welfare of the child would be best guaranteed by a female and a male parent.[554] On the contrary, art. 2 CRC encourages states to not discriminate the chid on the basis of its parents' sex or status.[555] This shows a contradiction of argumentation, which is solely build on the principle of the child's welfare on the one hand, and the child's welfare in combination with equality and non-discrimination principles on the other.

Figure 2: The interpretation of the welfare of the child contradicts the interpretation of the child in combination with the principle of equality and non-discrimination.

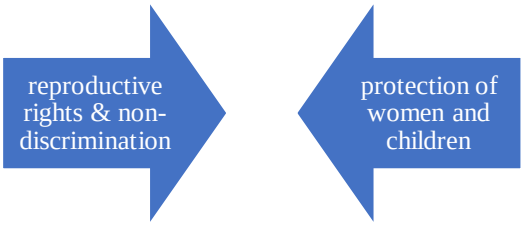


source: Figure created by the author.

In the partially restrictive countries, women's and children's protection rights and reproductive and non-discrimination freedoms stand in the way of each other when it comes to arguing for the prohibition of surrogate motherhood. The reproductive rights of two-men-couples and their rights to not be discriminated against in the access to MAR are restricted by arguing for the protection of the women[556] (Austria, Spain) and the protection of the future child [557] (Spain). In this case, reproductive rights are supported by the principle of non-discrimination and conflict with the protection of women and children, which also support each other in arguing against the permission of surrogate motherhood.

[551] The Civil Code of Ukraine, art. 281 para. 7; Císařová, Brojáč and Roubíčková, p. 293.
[552] See: Austrian Reproductive Medicine Act, § 2 para 1; Imaz, p. 7; Navas et al., p. 253; Stoffelen, ibid.; CoParents, ibid..
[553] United Nations Human Rights Office of the High Commissioner, *Status of ratification. Interactive Dashboard*, [website], 4 June 2018, http://indicators.ohchr.org/, (accessed 25 June 2018).
[554] Tobin and McNair, p. 112.
[555] Convention on the Rights of the Child, art. 2.
[556] Bundeskanzleramt Bioethikkommission, 2014, p. 3; Orejudo Prieto de los Mozos, p. 348.
[557] Orejudo Prieto de los Mozos, p. 348.

Figure 3: HR contradictions in deciding about the access of two-men-couples to surrogate motherhood.



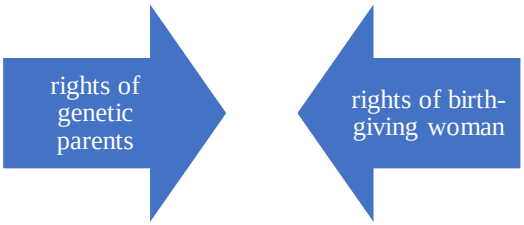
source: Figure created by the author.

In regard to women's rights, it can be said that by determining the legal maternity in surrogate motherhood, the HR focus is put differently in the selected countries. Ukraine puts its emphasis on the rights of the genetic parents, as the spouses, who arrange a surrogate mother, will automatically be the legal parents if at least 50% of their germ cells were used for the fertilization.[558] The gestational mother cannot claim the motherhood, unless her gametes were used as well.[559] In the Czech Republic, the woman who gives birth has no more chance to claim the motherhood if she agreed to the adoption and if the child already lived more than three months with the intended parents.[560] However, in the Netherlands and the UK, the gestational woman will automatically be the mother-in-law.[561]

This shows that in determining motherhood, the rights of the gestational mother contradict with the rights of the intended parents in the case of surrogacy. While Ukraine emphasises the rights of the genetic parents[562], the UK and the Netherlands focus on the rights of the gestational mother. The Czech Republic stands somewhere between those two ways of regulating it, as the gestational woman will automatically get legal maternity, but it can also happen that she will lose her maternity (see before).[563] This shows that the Czech Republic is granting both, the gestational mother and the intended parents, some rights to maternity to a certain extent.

[558] Frati et al., p. 5.
[559] Druzenko, p. 358.
[560] Pauknerová, p. 108.
[561] Vonk, 2007, p. 281; Wells-Greco, p. 369.
[562] Frati et al., p. 5.
[563] Pauknerová, p. 108.

Figure 4: Contradictions between the rights to maternity of the genetic parents and the gestational mother in surrogate motherhood.



source: Figure created by the author.

As this study has shown, the child's welfare is the mostly considered HR principle to lead states to either permit or restrict the access to MAR for certain persons or groups of persons, such as members of the LGBTIAQ+ community. This HR principle can be used in both cases of arguing for and against the access for certain persons or groups of persons, or when discussing the general permission of certain methods.

However, the argumentation of the scrutinized states does not match with the positions of the prevalent international HR bodies to the respective HR documents. For example, the argumentation that a child would need a father and a mother as parents is untenable under international HR law. As already mentioned before, the CRC and the Committee on the Rights of the Child do not define parents as a man and a woman.[564] Furthermore, the CEDAW, which was ratified by all chosen countries[565] stipulates that in relation to family planning, all women should have the same access and be free from discrimination.[566] This includes all women regardless of their gender identity and sexual orientation.[567] The non-discrimination of women in terms of their sexual orientation or identified gender is also supported by the ICPD Programme of Action, which stipulates this principle in its art. 1.[568]

Single parents are also directly addressed by the Committee on the Rights of the Child and should not be excluded due to their relationship status.[569] According to the ICPD Programme of Action, also individual persons should have the right to decide about when they have children and how many they want to have.[570] This shows that all prevalent HR documents relevant for

[564] Tobin and McNair, p. 112.
[565] United Nations Human Rights Office of the High Commissioner, *Status of ratification. Interactive Dashboard*, [website], 4 June 2018, http://indicators.ohchr.org/, (accessed 25 June 2018).
[566] Convention on the Elimination of All Forms of Discrimination against Women, art. 12.
[567] Miller and Roseman, p. 108.
[568] Istanbul Convention, art. 1.
[569] Committee on the Rights of the Child, *Role of the Family in the Promotion of the Rights of the Child*, 7th session, 10 October 1994, CRC/C/24.
[570] Shalev, ibid..

LGBTIAQ+ persons to make use of MAR, which are the CEDAW, CRC ,and ICPD Programme of Action, support queer parenthood as well as single parenthood. Therefore, from an international HR perspective, it is not understandable why persons that do not fit the binary social conceptions of men and women should be excluded from accessing MAR, regardless of whether they want to access it as couples or single persons.

12. The Impact of the ECtHR's Jurisdiction on the Right of LGBTIAQ+ Persons to Medically Assisted Reproduction

As all of the scrutinized countries are member states of the CoE and have ratified the ECHR, they fall under the jurisdiction of the ECtHR. Its case decisions are therefore important for the rights of LGBTIAQ+ persons to make use of MART or not. This Chapter will analyse to what extent the ECtHR is influencing the rights of LGBTIAQ+ persons to access MAR and how it would rule in cases regarding the examined countries.

12.1. The ECtHR's Opinion on Medically Assisted Reproduction Access of LGBTIAQ+ Persons

Concerning family rights, the ECtHR already noted in the case X and Others vs. Austria that a differential treatment of unmarried same-sex couples and unmarried opposite-sex couples in the possibility to adopt a partner's biological child constitutes a violation of art. 8 ECHR in conjunction with art. 14 ECHR (see Chapter 9.4).[571]

Regarding MAR, it can be said that Ukraine and the Czech Republic postulate that couples have to be opposite-sex ones in order to access MAR with donor spermatozoa (the establishment of a shared motherhood and surrogacy are scrutinized later).[572] Due to the fact that unmarried different-sex couples are allowed to access MAR, but unmarried two-women-couples are excluded, this constitutes a differential treatment. The legal situation of two-women-couples and opposite-sex couples regarding access to MART is comparable. An objective or reasonable justification for this differential treatment cannot be found, as the difference in treatment is directly based on the sex of the concerned persons and indirectly on their sexual orientation.

[571] European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[572] The Civil Code of Ukraine, art. 281 para. 7; Císařová, Brojáč and Roubíčková, p. 293.

Therefore, the access limitation to MAR to only different-sex-couples constitutes a violation of art. 8 in conjunction with art. 14 ECHR.[573] In analogy to the case X and Others vs. Austria, it can be assumed that the ECtHR would in all probability decide in a case submitted by a two-women-couple from Ukraine or the Czech Republic, who were denied access to MART, that this restriction is violating the rights guaranteed by the ECHR.

As for arranging a surrogate mother in the Czech Republic, the same argumentation can be used. The legal norms regulating the access to artificial insemination also apply in the case of surrogate motherhood. Different-sex couples are allowed to arrange a surrogate mother in the Czech Republic, whereas same-sex couples are not permitted to do so.[574] Therefore, it can be argued that the same-sex couples are legally in the same position as different-sex couples. As the differential treatment is purely based on the sexual orientation of the concerned persons, it cannot be justified. Therefore, it is assumed that also in such a case, the ECtHR would identify a violation of art. 8 ECHR in conjunction with art 14 ECHR.[575]

However, the outcome would be different if the same case happens in Ukraine. The Ukrainian law determines that only spouses, who are a man and a woman, are allowed to arrange a surrogate mother.[576] In other words, it is not only same-sex couples that are banned from entrusting a woman to carry and bear a child for them, but also unmarried different-sex couples. The legal situation of unmarried same-sex couples and married different-sex couples is not comparable here. Such an argumentation could be found in the ECtHR's decision in the case Gas and Dubois vs. France (see Chapter 9.4). The ECtHR noted that through marriage, a couple gains a special status. The ECtHR does not interpret the ECHR so that countries have to allow same-sex marriage due to the right to marriage enshrined in art. 12 ECHR. As unmarried different-sex couples do not have the possibility to arrange a surrogate mother, the ECtHR would argue in this case that unmarried same-sex couples should not be granted this possibility either.[577]

[573] see argumentation of ECtHR in the case European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[574] Pauknerová, p. 108.
[575] See argumentation of ECtHR in the case European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[576] Druzenko, p. 360.
[577] See argumentation of ECtHR in the case European Court of Human Rights, Gas and Dubois vs. France, no. 25951/07, 15 March 2012.

Due to the general prohibition of surrogate motherhood in Austria and Spain[578], a same-sex couple, which would be refused to arrange a surrogate mother, would in the view of the ECtHR be in a comparable legal situation as an opposite-sex couple, which would get the same refusal. This opinion can be found in the Court's decision in the case S. H. and Others vs. Austria, in which the ECtHR applied its margin of appreciation doctrine. In that case, the ECtHR declared that the countries are granted a certain leeway in deciding whether they want to permit or prohibit oocytes donations.[579] While oocytes donation is currently allowed in both countries, this does not lead to an obligation of the states to also permit surrogate motherhood. On the contrary, the ECtHR stresses that a 'wide margin of appreciation' has 'to be left to States in making decisions relating to surrogacy, in view of the difficult ethical issues involved and the lack of consensus on these matters in Europe.'[580]

The case gets more difficult when it comes to the access of two cisgender women or a transman (after his transition) and a cisgender woman. In that case, a shared "mother"hood could be established when the oocytes of one woman (or the cryopreserved oocytes of the transman) are fertilized with donor spermatozoa before the created embryo is transferred into the uterus of the other woman.[581] This establishment of a shared biological "mother"hood is forbidden in Ukraine, the Czech Republic, and Austria.[582] All three countries require couples to be infertile (or in Austria unsuccessfulness or unreasonableness of achieving a pregnancy through sexual activity) in order to access MAR.[583] Therefore, the ECtHR could argue that a couple of two persons, from whom one possesses fertile oocytes and the other fertile spermatozoa, is not allowed to make use of MART either. A two-cisgender-women couple (or a transman after sex change surgery and a cisgender woman), who is fertile, is from this perspective in a comparable legal situation and therefore treated equally.[584]

However, this is not the only thinkable argumentation. Unlike a fertile couple, which is able to achieve a pregnancy through sexual intercourse, a two-women-couple (or a transman and a cisgender woman) is not able to do so. Thus, a two-women-couple (or a transman and a

[578] Bernat, p. 690; Marina et al., p. 940.
[579] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[580] European Court of Human Rights, *Factsheet - Gestational surrogacy*, Press Unit, June 2018, p. 2, https://www.echr.coe.int/Documents/FS_Surrogacy_ENG.pdf, (accessed 26 June 2018).
[581] Müller-Götzmann, p. 226.
[582] Erlebach, p. 219; Císařová, Brojáč and Roubíčková, p. 293; Phillips, ibid..
[583] Centrum Lèčby Neplodnosti, ibid.; Sandra F., ibid., Steinhuber, p. 77.
[584] See argumentation of ECtHR in the case European Court of Human Rights, Gas and Dubois vs. France, no. 25951/07, 15 March 2012.

cisgender woman) is excluded from the possibility to get a child with a biological relation to both of the persons. From this point of view, there would exist a differential treatment of two-women-couples (or a transman and a cisgender woman) on the one side, and couples of two persons, from whom one possesses fertile oocytes and the other fertile spermatozoa, on the other side. However, this differential treatment could be justified due to the Court's margin of appreciation doctrine and because an European consensus on the creation of a shared "mother"hood does not exist.[585]

In the case S. H. and Others vs. Austria, the ECtHR underlined that the

> 'Austrian legislature had not completely ruled out artificial procreation as it had allowed the use of homologous techniques. Austrian law was based on the idea that medically assisted procreation had to remain as close as possible to natural conception in order to avoid possible conflicts between biological and genetic mothers in the wider sense. In doing so, the legislature had tried to reconcile the wish to make medically assisted procreation available and the existing unease among large sections of society as to the role and possibilities of modern reproductive medicine.'[586]

Interestingly, this statement was made in regard to the general prohibition of oocytes donation.[587] Since currently, the donation of oocytes is allowed in Austria, the Czech Republic, and Ukraine [588], the case would look different. However, as there has not been a case before the ECtHR yet in which a two-women couple (or a transman and a cisgender woman) felt discriminated against in the access to MAR due to the prohibition of establishing a shared biological "mother"hood, it is not clear how the ECtHR would decide in such a case.

In order to access MART as a single person, it can be said that if the general access of individual persons to MAR is permitted under the domestic law, this access has to be granted with no discrimination on the grounds of sex or other status (which includes sexual orientation).[589] For example, if an individual heterosexual cisgender woman is allowed to be inseminated with donor spermatozoa under a domestic legislation, the same access has to be

[585] See argumentation of the ECtHR in the case European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[586] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[587] Ibid..
[588] Lysytsia, p. S104; Whittaker and Speier, p. 368; Hadolt, p. 1; Kinderwunschzentrum Goldenes Kreuz, ibid..
[589] Fundamental Rights Agency and Council of Europe, 2018, p. 178.

granted to every person, who possesses a comparable reproductive system and makes use of the same reproductive method, which, in this case, is sperm donation.

However, permitting access to MAR only to couples and not to individual persons has a big impact on aromantic persons, who might enjoy sexual intercourse, but lack the ability to fall in love with another person. Aromantic persons might wish for a genetically related child, but not within a relationship. Access restrictions that prohibit single persons from accessing MAR exclude aromantic persons from the possibility to get a genetically related child. Therefore, they are treated differently due to their inability to fall in love.

12.2. The Strengthening and Weakening Powers of the ECtHR

As the ECtHR's decisions are binding and the member states have to adapt their national legislation in order that a HR violation is identified[590], the Court has undoubtedly a great impact with its jurisdiction on the HR of persons living in the respective CoE member states. Indeed, the ECtHR is an important key player in strengthening family rights of LGBTIAQ+ persons and has ensured their equal treatment already with his jurisdiction.[591]

Noteworthy is the ECtHR's decision in the case Garcon and Nicot vs. France in 2017 concerning the requirement of sterilisation treatments and sex-change surgeries for transgender persons in order to have their identified gender officially recognized. The ECtHR identified a violation of art. 8 ECHR.[592] Not only has the case has an impact on the country, in which the HR violation was identified (i.e. France), but also on some other ECHR state parties, which subsequently adopted their national laws according to the ECtHR's decision (e.g. Ukraine).[593] However, the ECHR state parties are not forced to reform their domestic legislation automatically.[594]

The Court's margin of appreciation doctrine allows the state parties to the ECHR to decide about the admission of specific MART.[595] As this study could show, this leeway leads to access

[590] Council of Europe, *Accession by the European Union to the European Convention on Human Rights. Answers to frequently asked questions*, 1 June 2010, p. 1, https://www.echr.coe.int/Documents/UE_FAQ_ENG.pdf, (accessed 27 June 2018).
[591] See: European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[592] European Court of Human Rights, Garcon and Nicot vs. France, no. 79885/12, 6 April 2017.
[593] Husakouskaya, p. 27.
[594] M. H., ibid..
[595] See: European Court of Human Rights, *Factsheet - Gestational surrogacy*, Press Unit, June 2018, p. 2, https://www.echr.coe.int/Documents/FS_Surrogacy_ENG.pdf, (accessed 26 June 2018).

regulations that have a legal impact on LGBTIAQ+ couples and individuals. As the margin of appreciation principle does not state explicitly whether a certain MAR method should be allowed or prohibited, it is up to the ECHR state parties to decide on this issue.[596] If the ECtHR would not make use of this doctrine and had to come to a clear decision in such cases, the outcome could be different. An example how a case decision could look like without the provision of this leeway to the respective countries is shown here:

Due to the general prohibition of surrogate motherhood in Austria and Spain[597], some LGBTIAQ+ couples (among others: two cisgender men, two transwomen, a transwoman and a cisgender man…) have no possibility to conceive a child, which is genetically related to at least one of the partners. By contrast, opposite-sex-cisgender-couples (other constellations of couples are also thinkable here, for example: a transman, who did not undergo sex change surgeries or hormonal treatments that led to infertility and a cisgender man, or two transmen before transitioning…) can make use of MART if unprotected sexual intercourse between them does not result in a pregnancy.[598] The first mentioned constellations of couples are not equipped with the possibility to access to those MART, which would make it possible for them to conceive a child that is at least genetically related to one of them.[599] As the constellations of couples are in a comparable legal situation, this constitutes a differential treatment of couples who have the general ability to conceive a child through unprotected sexual intercourse and couples, which are not equipped with this ability. The differential treatment is made on the grounds of sex and other grounds (which includes sexual orientation[600]). The reasons for this differential treatment lies in the protection of others (i.e. the gestational mother).[601] Therefore, the HR of the intended parents and those of the gestational mother have to be balanced. However, as could be seen in other European states, the protection of women per se cannot justify a general ban, as their protection could also be guaranteed by other means than a complete prohibition. Thus, the differential treatment cannot be objectively justified and is therefore discriminatory.

Indeed, this is just a hypothetic example of how the ECtHR's jurisdiction could support LGBTIAQ+ rights. But it also shows the tremendous impact its decisions have on the rights of

[596] Wadlig, p. 83.
[597] Bernat, p. 690; Marina et al., p. 940.
[598] Steinhuber, p. 77; Merck Global, p. 40.
[599] Due to the prohibition of surrogate motherhood (see Bernat, p. 690; Marina et al., p. 940).
[600] Fundamental Rights Agency and Council of Europe, 2018, p. 178.
[601] Bundeskanzleramt Bioethikkommission, 2014, p. 3; Orejudo Prieto de los Mozos, p. 348.

LGBTIAQ+ persons to access MART and how the margin of appreciation doctrine can contribute to a weakening of such rights.

Another habit of the ECtHR that affects LGBTIAQ+ persons is the consistent application of art. 14 ECHR when it decides in cases on HR violations of LGBTIAQ+ persons. As could be seen in the cases mentioned in Chapters 9.4. and 14.1., the ECtHR proved in every of the scrutinized cases regarding family rights of LGBTIAQ+ persons if they were discriminated against or not.[602] The ECtHR states that a right to MAR exists in general and falls under the protection of art. 8 ECHR.[603] Thus, the ECtHR proves if this right is also granted to LGBTIAQ+ persons. More precisely, the ECtHR evaluates whether LGBTIAQ+ persons are discriminated against because they are in a non-objectively justified comparable legal situation as non-LGBTIAQ+ persons or not. However, instead of evaluating a right of LGBTIAQ+ persons to access MART by using art. 14 ECHR, the ECtHR could argue the other way round. Namely that just because LGBTIAQ+ persons do not have another possibility to cause a pregnancy in their relationships, they should still be entitled to have a right to MAR.[604] In this case, the sole application of art. 8 ECHR would be enough to identify a violation of LGBTIAQ+ persons to MAR, without even needing to prove a difference in treatment of non-LGBTIAQ+ persons.

12.3. Concluding Paragraph: The ECtHR on LGBTIAQ+ Rights to Medically Assisted Reproduction

Regarding the ECtHR's opinion on LGBTIAQ+ rights to MAR, it can be said that the ECtHR has a strong strengthening power on LGBTIAQ+ rights when it comes to discrimination cases. It proves potential unequal treatment and its justifications under the ECHR and identifies HR violations. Regarding MAR for LGBTIAQ+ individuals, its jurisdiction in the case Garcon and Nicot vs. France in 2017 had big success for the rights of transgender and intersex persons. The ECtHR ruled that the requirement of undergoing medical surgeries or sterilisation treatments in order to have one's identified gender recognized by state authorities constitutes a violation of art. 8 ECHR.[605]

[602] See European Court of Human Rights, Gas and Dubois vs. France, no. 25951/07, 15 March 2012; European Court of Human Rights, X and Others vs. Austria, no. 19010/07, 19 February 2013.
[603] Wadlig, p. 83.
[604] Boucai, p. 1066.
[605] European Court of Human Rights, Garcon and Nicot vs. France, no. 79885/12, 6 April 2017.

However, the ECtHR jurisdictions in respective cases do not force other ECHR state parties, but the concerned country, to reform their domestic laws, which is weakening the HR of LGBTIAQ+ persons from other states.[606] Furthermore, the ECtHR often allows the countries a broad discretion within its margin of appreciation doctrine in MAR issues. Due to inconsistent national attitudes, the countries command a huge latitude in the limitation of the right to MAR.[607] Furthermore, in its decisions, it identifies HR violations of LGBTIAQ+ persons always in conjunction with the prohibition of discrimination enshrined in art. 14 ECHR, instead of guaranteeing a self-standing right to MAR for LGBTIAQ+ persons without the need to additionally prove a discrimination. These habits constitute a weakening of LGBTIAQ+ rights.

13. Room for an European Harmonisation?

As this study has shown, European countries regulate the access to MAR for LGBTIAQ+ persons differently and use various arguments for or against these access regulations. However, the question remains whether the incompatibilities between the different national legislation and HR arguments could be reconciled to achieve an overarching European solution. As the ECHR provides the respective states with a mutual HR framework and the ECtHR contributes to the creation of commonalities between the states with its jurisdiction, this Chapter will analyse such a possible harmonisation of the MAR legislation relevant for LGBTIAQ+ persons on the European level.

A possible legally binding convention on MAR, which would permit the access of LGBTIAQ+ to MART, would have to be built on mutual agreed regulations and requires consensus of the respective states. Therefore, the commonalities and disparities have to be scrutinized.[608]

An immediate commonality is visible in the countries' stance on human reproductive cloning. Even though all of the scrutinized countries prohibit human reproductive cloning, only the Czech Republic and Spain have ratified the Additional Protocol of the Oviedo

[606] M. H., ibid..
[607] Wadlig, p. 83.
[608] L. Nielsen, 'Legal consensus and divergence in Europe in the area of assisted conception – room for harmonisation?', in D. Evans (ed.), *Creating the Child. The Ethics, Law and Practice of Assisted Procreation*, Wales, Kluwer International Publishing, 1996, p. 305.

Convention[609], which aims to uniform the European legislations on cloning. Not only is reproductive cloning of human beings illegal, but also seen as inefficient (the creating of two monkey clones in 2017 required 417 ova and 63 monkeys as surrogate mothers) and socially not accepted. However, this is the current stance. In the future, technology is likely to improve and human reproductive cloning could become an actual possibility.[610]

Besides human reproductive cloning, the selected European states apply different legislative and HR approaches in the regulation of MAR.[611] The different legal approaches are characterised as restrictive, partially restrictive and liberal in regards to MAR access of LGBTIAQ+ persons and were explained in more detail in Chapter 10. It is not just only the access that is regulated differently (on grounds of material status or sexual orientation), but also certain MART and the rights to maternity and paternity. The different legal approaches are characterised as restrictive, partially restrictive, and liberal in regard to MAR access of LGBTIAQ+ persons and were explained in more detail in Chapter 10. Not only the access is regulated differently (on grounds of marital status or sexual orientation), but also certain MART and the rights to maternity and paternity. The differences in LGBTIAQ+ possibilities to MAR are tremendous between the selected states and therefore, 'no uniform approach among the Contracting States of the ECHR' can be identified.[612] The conflict of legislations reflects the countries' diverse attitudes and currently leads to an almost impossible reconciliation of MART for LGBTIAQ+ on the European level.

However, the domestic laws are permanently changing and developing as the states' attitudes on LGBTIAQ+ issues change and their acceptance increases (e.g. Netherlands, Spain)[613], and in some countries, even decreases (e.g. Ukraine)[614]. All in all, a more liberal attitude of European states towards LGBTIAQ+ family rights can be observed. International and European law are evolving in a similar way. When looking at the development of the ECtHR's jurisdiction, its stance on MAR and LGBTIAQ+ family rights changed positively in line with the developments of the ECHR member states.

[609] Council of Europe, *Chart of signatures and ratifications of Treaty 168*, [website] 19 June 2018, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/168/signatures?p_auth=VadhHyPI, (accessed 19 June 2018).
[610] Regalado, ibid..
[611] Ibid., p. 306.
[612] Wadlig, p. 83.
[613] Kuyper, p. 8; Navas, p. 257.
[614] Bränström and Van Der Star, p. 208.

Regarding MAR rights, the ECtHR found in the case S. H. and others vs. Austria that the general prohibition of oocytes donation does not constitute a violation of art. 8 EMRK, as the decision to permit or prohibit this MAR method falls under the margin of appreciation of the respective state.[615] Furthermore, among all European states, currently only Norway, Germany, and Switzerland completely ban the donation of oocytes.[616] However, in Norway and Germany, the attitude towards the prohibition of egg donation is controversial and this type of MAR method might be permitted in the very near future.[617]

Regarding LGBTIAQ+ family rights, the ECtHR decided in the case Oliari and Others vs. Italy that Italy has violated art. 8 ECHR by not legally acknowledging stable same-sex relationships.[618] By arguing for Italy's obligation to provide for civil unions, the ECtHR 'pointed out, in particular, that there was a trend among Council of Europe member States towards legal recognition of same-sex couples'.[619]

A further contribution to the strengthening of LGBTIAQ+ rights to MAR was the already mentioned case Garcon and Nicot vs. France (see Chapter 14.2.), as the requirement of having to undergo medical treatments that lead to infertility in order to get one's identified gender officially recognized, constitutes a violation of art. 8 in conjunction with art. 14 ECHR.[620] This judgement is a step into the direction of acknowledging the rights to reproduce for non-heteronormative persons.

Taking into account the attitude changes of the respective European states and the development of their national legislation on the one side, and the dynamic jurisdiction of the ECtHR into the direction towards a greater acceptance of LGBTIAQ+ and MAR rights on the other side, the overall European stance on a right to MAR of LGBTIAQ+ persons might change

[615] European Court of Human Rights, S. H. and Others vs. Austria, no. 57813/00, 3 November 2011.
[616] K. Lee and L. Gotti Tedeschi for Core, *Worldwide Human Eggs Laws. Comment on Reproductive Ethics*, 2015, pp. 2-7, http://corethics.org/wp-content/uploads/Human-Eggs-Laws.pdf, (accessed 28 June 2018); R. Scammell, 'First Italian pregnant after egg donor ban lift', *The Local*, 22 July 2014, https://www.thelocal.it/20140722/first-egg-donation-pregnancy-after-ban-lifted, (accessed 28 June 2018); Republic of Lithuania, Law on Donation and Transplantation of Human Tissues, Cells and Organs, (adopted 19 November 1996, last amended 12 May 2016), No. XII-2344.
[617] P. Wijnen, 'Split Conservative party might vote in favour of egg donation', *Norway Today*, 1 April 2018, http://norwaytoday.info/everyday/conservatives-egg-donation/, (accessed 28 June 2018); M. Spiewak, 'Eizellspenden. Ein überholtes Gesetz', *Zeit Online*, 6 September 2017, https://www.zeit.de/2017/37/eizellspenden-gesetz-haftstrafe-prozess, (accessed 28 June 2018).
[618] European Court of Human Rights, Oliari and Others vs. Italy, nos. 18766/11 and 36030/11, 21 October 2015.
[619] Council of Europe, *Italy should introduce possibility of legal recognition for same-sex couples*, 2015, p. 1, https://www.ilga-europe.org/sites/default/files/Attachments/judgment_oliari_and_others_v._italy_-_impossibility_of_legal_recognition_for_same-sex_relationships.pdf, (accessed 28 June 2018).
[620] European Court of Human Rights, Garcon and Nicot vs. France, no. 79885/12, 6 April 2017.

in the future. Thus, if the European countries gain consensus in the matters regarding LGBTIAQ+ rights to MAR, a potential European unification of MAR law, which allows the access to MAR regardless of the concerned person's sexual orientation, relationship status, or gender identity, becomes realistic. However, one should always be aware of the fact that not all European countries move in the same direction and that the situation of LGBTIAQ+ persons in their access to MAR could also get worse.

14. Conclusion

As this study has shown, an internationally recognized and enforceable right of LGBTIAQ+ persons to access medically assisted reproduction (MAR) does not exist. Rather, the access to MAR for members of the LGBTIAQ+ community depends on the national legal regulations of the countries they live in. This study examined the prevalent medically assisted reproduction technologies (MART) that lead to queer parenthood, as well as the domestic legal possibilities for LGBTIAQ+ persons to access MAR in the selected European states. The human rights (HR) relevant for the establishment of queer parenthood via MAR and their relation to each other were scrutinized. Additionally, the interactions between medicine and law regarding MAR were investigated, the ways how the respective CoE member states regulate MAR access for LGBITAQ+ persons were explained, and the arguments the countries use to either permit, restrict or prohibit the application of MART on LGBTIAQ+ individuals were presented.

The information gained through research made it possible to answer the initial research questions, which are here summarized:

Main Research Question: Which HR are relevant for LGBTIAQ+ persons to fulfil their desire to have a child using MART and how do they support or contradict each other?

The HR relevant for the access to MAR for LGBTIAQ+ persons are reproductive rights, children's rights, women's rights, and the principle of equality and non-discrimination. According to the international HR documents and the references of their respective HR bodies, a restriction of MAR access to couples which do not comply with the binary social conceptions of men and women, cannot be pursued. By taking into account the statements of the international HR bodies, it can be said that all HR instruments support each other and work together towards a right of LGBTIAQ+ persons to MAR.

However, the HR documents are interpreted differently by the scrutinized states. Different HR are used to either permit access or to prohibit LGBTIAQ+ persons from accessing MAR. However, all of the selected countries put their focus on the same HR principle, which is the welfare of the child. Although the scrutinized states use this same principle in order to justify their national legislation, the domestic laws are completely different, as the countries use the principle of the welfare of the child contradictorily. While some states apply this principle in order to permit access to MAR for LGBTIAQ+ persons, others use it to refuse access to those persons. Thus, the access to MAR for LGBTIAQ+ persons is entirely restrictive in some countries, while in some others, it is completely liberal.

Sub-Question 1: Which medical methods would make it possible for LGBTIAQ+ persons to have children via MAR?

The medical and technical possibilities to achieve a pregnancy in the artificial way are multifarious. The usage of spermatozoa, oocytes, uterus, or embryo donation facilitates the establishment of a pregnancy in cases in which the person concerned is not living in a fertile opposite-sex cisgender couple that conducts sexual intercourse on a regular basis. Also the fertilization of oocytes inside or outside the human body using cryopreserved or donated gametes makes it possible for LGBTIAQ+ persons to get children via MAR. The establishment of a shared "mother"hood even enables two-cisgender-women-couples and some transgender couples to get a child that is biologically related to both parents. Furthermore, human reproductive cloning constitutes a medical and technical possibility to get a genetically identical child.

Sub-Question 2: How do new MAR possibilities influence country jurisdictions of selected countries?

The continually expanding technical and medical possibilities to achieve a pregnancy are not yet always considered by national and international legislation. An example for this is the access to MAR for trans and intersex persons in Austria or Spain, as both domestic laws lack a precise regulation on their access. In order to find out whether the newly developed technologies are legal or not, new legal norms have to be established, or the existing law has to be interpreted. As a consequence of unclear or non-existent regulations on MAR access for LGBTIAQ+ persons, physicians, medical centres, national commissions, and domestic courts are often

disagreeing with each other and also the concerned persons, who wish to make use of MART, are uncertain in terms of their legal options to reproduce by using MART.

Sub-Question 3: How do selected European states regulate the access for LGBTIAQ+ persons to MART?

The chosen European countries permit, restrict and prohibit the access to MAR for LGBTIAQ+ persons by formulating their national legislation in a way so that those persons are either explicitly addressed and thus included or excluded from using MART, or in a way that the legality of their access is explained through making use of general anti-discrimination and equality clauses. The regulations regarding the access to MAR for LGBTIAQ+ persons are justified by interpretations of HR, such as the safeguarding of the best interest of the child.

Sub-Question 4: How does the jurisdiction of the ECtHR support or weaken the right to MAR for LGBTIAQ+ persons?

The ECtHR has a strong power to strengthen LGBTIAQ+ rights when it rules in cases regarding discrimination. It has the mandate to identify HR violations of LGBTIAQ+ persons and already had success cases relevant for MAR of LGBTIAQ+ persons. However, the Court's judgements in specific cases do not force other CoE member states to adapt their national legislation. This constitutes a weakening power of the ECtHR. Furthermore, the different laws of the European states and their respective argumentations of HR law make it difficult for the ECtHR to pass concrete case judgements and to comment clearly on a right to MAR for LGBTIAQ+ persons. In order to not interfere too much in the national affairs of the ECHR member states, the ECtHR uses principles such as its margin of appreciation doctrine and provides European countries with an enormous leeway in regulating the domestic MAR laws.

Sub-Question 5: What are the possibilities to reconcile national with international legislation and harmonize the access to MAR for LGBTIAQ+ persons on an European level?

A reconciliation of MAR law on the European level through consistent jurisdictions of the ECtHR, or the development of a new convention would only be possible, if the CoE member states gain consensus on that topic. Due to the different attitudes of European countries and the granting of discretion to the ECHR member states and their different domestic MAR attitudes, a harmonisation of MAR laws is currently not realistic. However, even though such a unification

on the European level seems utopian at the moment, this could be changed in the future. Such a positive change towards a uniform right to MAR for LGBTIAQ+ persons on the European level is not unachievable. This can be said due to the fact that the European countries are generally moving forward into the direction towards a greater acceptance of LGBTIAQ+ family rights and some national legislation change consistently.

When looking at the way the European states regulate their respective legislation and at the language used in the domestic legal texts, it would be highly endorsed if in the future, a more liberal approach towards LGBTIAQ+ rights to MAR leads to formulations that allow MAR access to all persons, regardless of their gender identity or sexual orientation. Instead of enacting legal texts that consider cisgender bodies as the norm and using formulations that are constructed on the binary social conceptions of men and women and assume all persons to be cisgender, the access to MAR should rather be based on the possession of reproductive organs, and not on sex or sexual orientation.

If we come from the HR discussion on MAR to a pluriform gender approach to MAR that is not binary, then the access to artificial insemination should not be granted to women only, but rather to all persons, who possess intact uteruses and/or oocytes. And not only men should be allowed to donate their spermatozoa, but also persons who possess fertile sperm cells, such as intersex and transgender persons. Such regulations would not only open a large range of actual MAR possibilities for same-sex couples, but also for transgender, intersex, asexual persons, and all other human beings that do not fit into the binary social concepts of gender.

The following quote summarizes the argumentation of my position mentioned above:

> '*Bodies are not only biological phenomena but also complex social creations onto which meanings have been variously composed and imposed according to time and space*.'[621] – Katrina Karkazis

[621] K. Karkazis, *Fixing Sex: Intersex, Medical Authority, and Lived Experience*, Duke University Press, Durham and London, 2008, p. 287.

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16. List of Legislation and Jurisdictions

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17. List of Figures and Tables

English Abstract

Queer parenthood is the raising of children through parents, who do not meet the ideals of society regarding gender identity and sexual orientation. Those children were brought from a previous relationship into the actual one, are raised through adoption, foster care, or medically assisted reproduction (MAR). MAR is a means to achieve a pregnancy on an artificial way, and used especially in those cases, in which sexual intercourse between the two future persons is unreasonable or unsuccessful. The access to MAR is regulated differently in the European countries. Especially lesbian, gay, bisexual, transgender, intersex, asexual, queer, and other persons, who do not conform to heteronormative concepts of sexual orientation and gender identity (LGBTIAQ+ persons) are affected by access impediments and limited in their right to MAR. This study highlights the medical and technical possibilities of achieving a pregnancy for LGBTIAQ+ individuals and couples and examines international human rights documents and their relevance on the access to MAR for LGBTIAQ+ persons. This comparative study of six European countries explains the different national legal regulations on MAR in Ukraine, the Czech Republic, Austria, Spain, Netherlands and United Kingdom. It shows how the respective countries regulate the access to MAR for LGBTIAQ+ persons and which arguments they use to justify their legal provisions. This master's thesis illustrates the relation between the human rights instruments, it is women's rights, children's rights, reproductive rights, parental rights and the principle of equality and non-discrimination, and how they support or weaken each other. The case law of the European Court of Human Rights regarding MAR and LGBTIAQ+ rights is scrutinized and, the potential of an European harmonization of MAR law is outlined.

key words: queer parenthood, medically assisted reproduction, LGBTIAQ+ rights, reproductive rights, reproductive medicine law

German Abstract

Unter queerer Elternschaft versteht man das Aufziehen von Kindern durch Eltern, die die Ideale der Gesellschaft bezüglich Geschlechtsidentität und sexueller Orientierung nicht erfüllen. Diese Kinder stammen entweder aus früheren Beziehungen oder gelangen durch Adoption, Pflege oder medizinisch unterstützte Fortpflanzung (MUF) in die Familien. Der Zugang zur ist in den europäischen Ländern unterschiedlich geregelt. Insbesondere Lesben, Schwule, Bisexuelle, Transgender, Intersexuelle, Asexuelle, Queere und alle weiteren nicht der heteronormativen Auffassung von Geschlechtsidentität und sexueller Orientierung entsprechenden (LSBTIAQ+) Personen sind von Zugangsbeschränkungen betroffen und in ihrem Recht auf MUF eingeschränkt. Diese Studie beleuchtet die medizin-technischen Möglichkeiten, eine Schwangerschaft in den unterschiedlichsten Konstellationen von Paarbeziehungen herbeizuführen und untersucht internationale Menschenrechtsdokumente und deren Relevanz für den Zugang von LSBTIAQ+ Personen zur MUF. Diese Vergleichsstudie erklärt die unterschiedlichen nationalen gesetzlichen Regelungen der Reproduktionsmedizin in der Ukraine, der Tschechischen Republik, Österreich, Spanien, den Niederlanden und dem Vereinigten Königreich. Es wird aufgezeigt, wie die jeweiligen Länder den Zugang von LSBTIAQ+ Personen zur den Methoden der MUF regeln und welche Argumente sie zur Rechtfertigung ihrer Rechtsvorschriften verwenden. Diese Masterarbeit veranschaulicht die Beziehung zwischen den diversen Menschenrechtskomplexen (Frauenrechte, Kinderrechte, Reproduktionsrechte, Elternrechten, sowie das Prinzip der Gleichheit und Nichtdiskriminierung) und ihre gegenseitige Unterstützung beziehungsweise Schwächung. Die Rechtsprechung des Europäischen Gerichtshofs für Menschenrechte zur MUF und zu LSBTIAQ+ Rechten wird erklärt und eine potentielle europäische Harmonisierung des Reproduktionsmedizinrechts dargelegt.

Schlagwörter: Queere Elternschaft, LSBTIAQ+ Rechte, medizinisch unterstützte Fortpflanzung, Reproduktionsrechte, künstliche Befruchtung