The Path to Parenthood isn’t Always Straight: A Qualitative Exploration of the Experiences of Gestational Surrogacy for Gay Men in Canada – Perspectives of Gay Fathers and Surrogates

By

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

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Abstract

Background: Assisted reproductive technologies (ARTs) have facilitated novel family structures and, in turn, have yielded new opportunities to parent for gay men. Recently, Canada has witnessed an increased number of same-sex parent families and a growth of gay father-headed households. ARTs continue to be only ascribed as biomedical interventions to resolve infertility. With the progress of ARTs and the increasing prevalence of gay fathers, the aim of this dissertation is to explore gestational surrogacy for gay men in Canada.

Methods: From January 2015 to January 2016, gay fathers (n=16) and gestational surrogates (n=6) were recruited through advertisements distributed across same-sex parenting groups, surrogacy consulting services and social media. Using non-probability purposive sampling, three populations were targeted: (1) single or partnered gay fathers who completed gestational surrogacy; (2) gestational surrogates who bore a child for gay men; and (3) gay fathers and their paired surrogate. All participants had to be living in Canada at the time surrogacy was practiced. In-depth semi-structured interviews (~60-90 min) were conducted either in-person or over the phone; informed consent was reviewed and obtained prior to the interview. Textual
analysis was conducted by the researcher; emerging patterns were organized from the data manually to generate findings. Triangulation, member-checking and peer-debriefing supported validity.

**Results:** The three empirically-based chapters will report on: (1) the motivations of gay intended fathers and gestational surrogates to pursue surrogacy; (2) the interpersonal relationships between gay intended fathers and gestational surrogates before, during and post pregnancy; and (3) institutional supports and barriers encountered during surrogacy and post-birth, with respect to both the practice of surrogacy and gay fatherhood.

**Implications:** This dissertation has implications for social work practice, research and education, as well as policy, law and bioethics. The aim of this dissertation is to advance an understanding of non-normative families, resisting and challenging heteronormative discourses that have framed parenting and reproduction practice and scholarship. Encouraging dialogues with stakeholders, such as surrogates, intended parents, lawyers, fertility specialists and allied health professionals, is critical.
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Chapter 1
Introduction

Preamble

The purpose of this dissertation is to promote an understanding of the experiences of gay men and gestational surrogates who have pursued altruistic surrogacy in Canada. Utilizing an interpretive hermeneutic phenomenological approach, this dissertation project was designed with the aim to identify, describe and interpret the subjective experience of pursuing surrogacy for gay intended parents and gestational surrogates. The objectives of this study were to investigate: (1) the motivations to pursue surrogacy; (2) the relationships between gay intended parents and gestational surrogates; and (3) institutional supports and barriers of pursuing surrogacy. These three objectives reflect critical segments of the surrogacy process, and have influenced how intended parents and surrogates experience and make meaning of their procreative decisions. With limited empirical research on surrogacy, both in Canada and worldwide, and even less on gay parenthood, this dissertation was fulfilled with the intention to contribute to and enhance previous scholarship; and add a much needed perspective to conversations and discourses on third-party reproduction. The broad exploration of surrogacy in Canada may provide empirically-based research to inform the development of relevant, inclusive and informative practices and policies to help ease the path to gestational, genetic and/or social parenthood for both surrogates and gay men.

For the readers of this dissertation, it is important that I contextualize the organization of this document at the forefront. Herein, this thesis follows the guidelines of a three-paper dissertation. In turn, the proceeding chapters will look as follows: Chapter 1 reads as a general introduction of the thesis topic, and will cover a brief literature review of the relevant subject
matter, as well as an overview of the theoretical frameworks that supported this work and the methodological design that guided this project. The subsequent three chapters (chapters 2 to 4) should each be read as independent empirically-based manuscripts grounded in the data of this research project. Each chapter will contain distinct sections pertaining to the: (1) literature review, (2) methods, (3) results, and (4) discussion and implications. Each of these chapters reports on findings from this research study that are in line with the aforementioned research objectives. However, as scholarship on contemporary gestational surrogacy and gay parenthood is quite limited in scope, and the structure of surrogacy in the Canadian context is important to explicate for each separate manuscript, there may be some repetitive material within these chapters. Yet, each literature review will be shaped with specific relevancy to the objectives of each independent manuscript. The conclusion of this thesis (chapter 5) will integrate the analyses and interpretations from chapters’ 2 to 4 to present a newly developed conceptual framework that emerged from the findings of this dissertation project.

1 Introduction

The use of assisted reproductive technologies (ARTs) has disrupted normative constructs of reproduction, kinship and family (Franklin, 1993; Mamo & Alston-Stepnitz, 2015; Markens, 2007; Shannon, 1988). ARTs have facilitated novel family structures and, in turn, have yielded new opportunities to parent for sexual and gender minorities (Norton, Hudson, & Culley, 2013); heterosexuality, and specifically heterosexual sex, are no longer necessary for procreation (Corradi, 2008; Daar 2007; Mamo, 2007; Parry, 2005). Yet, in both research and practice,

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1 This dissertation will consistently use the abbreviation ‘ARTs’ as an umbrella term for medically-assisted reproduction. ARTs refer to procedures that require medical interventions in a clinic/laboratory (e.g., egg donation, in-vitro fertilization). Another common abbreviation is AHR (assisted human reproduction), which comprehensively includes procedures, such as donor insemination, that may not be medically invasive (Marvel, 2015). As gestational surrogacy is the focus of this research project, the abbreviation of ART will be utilized throughout to refer to activities facilitating reproduction (Health Canada, 2013).
ARTs continue to be ascribed as biomedical interventions to resolve infertility (Greil, Slauson-Blevins, & McQuillan, 2010; Franklin, 1993; Kissil & Davey, 2012; Mamo, 2007). The medical treatment model of ARTs ultimately limits fertility scholarship and, consequently, overlooks the unique reproductive needs of lesbian women and gay men.

Over the past decade, the trajectory of policy initiatives in Canada has importantly extended lesbian and gay parenting rights. In 2005, federal legislation enacted same-sex marriage (Rayside, 2008); currently, most provinces legally permit second parent adoptions, names of both partners on birth certificates and, most recently, British Columbia has sanctioned three-parent families (CBC, 2015; LGBTQ Parenting Network, 2017). The evolution of political and social inclusivity of sexual minorities has reshaped the landscape of queer parenthood in Canada. In 2011, Statistics Canada reported 64,575 same-sex couple families (21,015=married; 43,560=common law), a rise of 42.4% from 2006; 9,600 children aged 24 and under were living with same-sex parents (Statistics Canada, 2013). Data show that female same-sex couples were nearly five times more likely to have a child at home (n=7,700 children; 16.5%) than male same-sex couples (n=1,900 children; 3.4%). However, 2011 census results

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2 The clinical definition of infertility, as stated by the World Health Organization (WHO), is “a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.” This includes both male and female infertility. The epidemiological definition is: “women of reproductive age (15-49 years) at risk of becoming pregnant (not pregnant, sexually active, not using contraception and not lactating) who report trying unsuccessfully for a pregnancy for two years or more.”

3 Although ARTs have created opportunities for transgender individuals, the following dissertation is positioned from a cisgender perspective. Cisgender refers to an individual whose gender identity and expression aligns with their assigned sex at birth. I remain attuned to this limitation, with consideration of how the forthcoming literature review and theoretical framework address the experiences of cisgender sexual minorities, omitting the diversity of experiences across the LGBTQ+ spectrum. Although beyond the scope of this project, this is an important consideration for future research.

4 The act of a same-sex partner adopting their partner’s biological or adopted child(ren).

5 This is the most recent Canadian data available. The 2016 Census results will be publicly released subsequent to the submission of this dissertation; data on ‘families, households and marital status,’ will be available August 2, 2017.

6 This was the first year census data collected information on same-sex families.
indicate a larger increase of male same-sex parents since 2006, as compared to their female counterparts; in 2006, 16.3% of female same-sex couples had a child at home, compared to 2.9% of men (Statistics Canada, 2009). With the progress of ARTs and the increasing prevalence of gay fathers, the aim of this dissertation is to explore gestational surrogacy for gay men in Canada.

1.1 The Problem

Research on the use of ARTs among sexual minorities has predominantly focused on investigating the experiences of lesbian women (Hayman, Wilkes, Halcomb, & Jackson, 2015; Ross, Steele, & Epstein, 2006; Wall, 2011). This is perhaps on account of: (1) the increased number of lesbian mothers, as compared to gay fathers (Statistics Canada, 2013); (2) the less invasive practice of donor insemination, as compared to *in-vitro fertilization* (IVF); and (3) hegemonic femininity that has associated women’s identity with reproduction and childcare (Greil, Slauson-Blevins, & McQuillan, 2010; Kissil & Davey, 2012; Purdy, 1996; Shalev, 1989, 2012). Accordingly, limited scholarship has explored gay men’s paths to parenthood and their decision to pursue surrogacy (Blake et al., 2017; Norton, Hudson, & Culley, 2013). One reason may be owing to the novelty of surrogacy, which may present unique challenges in recruiting and connecting with potential participants. However, far more significant explanations are perhaps indicative of heteronormative and sexist approaches in parenting and fertility scholarship.

Heteronormativity is a “set of ideas, norms, and practices that sustain heterosexuality and gender differentiation and hierarchy, including romantic love, monogamy, and reproductive sexuality” (Hopkins, Sorensen, & Taylor, 2013, p. 98). Early parent-child attachment research
implied that mother-infant relationships were the foremost contributing factor of children’s well-being and development (Fuchs et al., 2016; Lamb, 2000). As women entered the workforce and divorce rates rose, research shifted to demonstrate fathers’ effect on children’s self-esteem, peer relationships and academic success (Amato, 1994; Saracho & Spodek, 2008; Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2007; Wilson & Prior, 2011). Although the substantiated impact of fathers’ parenting involvement initially disrupted previous gender-role segregation (women as primary caretakers and men as authoritarian breadwinners), these findings are used to endorse ideologies that both mothers and fathers are necessary for childhood adjustment (Krueger et al., 2015; Saracho & Spodek, 2008; Silverstein & Auerbach, 1999). This research fosters gender essentialism, upholding the perception that mother and father parenting roles are uniquely distinct but equally important in children’s lives (Brewaeys et al., 1997; Crompton & Lyonette, 2005; Franklin, 1993; Malone & Cleary, 2002; Meyer, 2011).

Consequently, when gay men anticipate parenthood intentionally without a mother/woman present in the household, there may be doubt as to how they will be able to adequately parent and raise children (Berkowitz & Marsiglio, 2007; Folgerø, 2008; Goldberg & Smith, 2011; Mezey, 2013). Yet, recent empirical scholarship shows that children in same-sex parent households are as equally well-adjusted as to children with heterosexual parents (Hosking, Mulholland, & Baird, 2015; Manning, Fettro, & Lamidi, 2014; Miller, Kors, Macfie, 2017; Richards, Rothblum, Beauchaine, & Balsam, 2017). 7 Notwithstanding the importance of these

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7 Other studies, although methodologically flawed, have suggested that children with same-sex parents are worse off, reporting less developmental well-being and academic success than their peers with heterosexual parents. However, there are serious limitations to these studies’ methodological designs, sample sizes and survey instruments (as found in Allen, Pakaluk, & Price, 2013; Goldberg, Bos, & Gartrell 2011; Regnerus, 2012). Researchers have argued that these findings are perhaps driven by political controversy and negative biases regarding same-sex parenting. The consensus, as reached by Manning and colleagues (2014), shows that children “fare just as well when they are raised by same-sex parents when compared to children raised by
findings, repeated comparisons of gay fathers to their heterosexual counterparts promote the evaluation of gay men alongside a heterosexual norm. In turn, the nuclear family (married heterosexual biological parents)\(^8\) is presented as the framework for normative successful parenting (Biblarz & Stacey, 2010; Hicks, 2008; Nordqvist, 2008; Sullins, 2015). It is evident, therefore, that studies “privilege the nuclear family” and, in turn, make it difficult “to imagine other notions of family as equally viable” (Guzman & Sperling, 2009, p. 121). Accordingly, research that continues to draw comparisons to heterosexual households is problematic; it often disregards the unique political and social barriers that hinder gay men’s route to parenthood (Manning et al., 2014). Unsubstantiated allegations that perceive gay men as unsuitable fathers and inadequate role models may influence gay men’s involvement in the procreative realm and their considerations of parenthood (Bauermeister, 2014; Goldberg, Downing, & Moyer, 2012; Riskind, Patterson, & Nosek, 2013).

Moreover, sexist discourses have influenced scholarship on ARTs and experiences of infertility. Women are believed to naturally desire biological children and are to be singularly involved in fertility practices (Gimenez, 1983; Johansson & Andreasson, 2017; Morell, 2000; Shalev, 2012); procreation and childrearing are upheld as women’s responsibilities (Johnston & Swanson, 2006; McQuillan, Greil, White, & Jacob, 2003). Research on ART use has predominantly investigated heterosexual women’s psychosocial experiences with infertility and their decisions to use assisted reproduction (Andrews, Abbey, & Halman, 1991; Blake, Casey, Jadva, & Golombok, 2012; Cwikel, Gidron, & Sheiner, 2004; Lee, Sun, & Chao, 2001; Oddens, opposite-sex parents.” Thus, it is important to understand and, subsequently, challenge a priori biases that emerge within parenting scholarship.

\(^8\) This has also been referred to as the Standard North American Family (SNAF), which importantly explicates the value of having ‘natural’ children, through heterosexual sex and without the use of ARTs (Smith, 1993).
Tonkelaar, & Nieuwenhuysel, 1999; van Balen & Trimbos-Kemper, 1994). Consequently, there has been limited scholarship on heterosexual men’s experiences with ARTs (Martins et al., 2016). Empirical research has demonstrated that heterosexual men who are involuntarily childless may experience poor marital satisfaction, a result of the lack of intimacy associated with scheduled and highly pressurized intercourse (Monga et al., 2004). They may also struggle with humiliation, depression, guilt, shame and anger (Hadley & Hanley, 2011; Martins et al., 2016). This may lead to decreased self-esteem (Hadley & Hanley, 2011), masculine insecurity (Cwikel, Gidron, & Sheiner, 2004), and alienation from the ART process (Malik & Coulson, 2008).

Similarly, the paucity of empirical research on gay fatherhood may also be a reflection of sexist assumptions that have associated reproduction with motherhood (DiLapi, 1989; Dyer et al., 2002; Schacher, Auerbach, & Silverstein, 2005; Ulrich & Weatherall, 2000). Gay men are on the periphery of ART scholarship and practice when compared to their lesbian counterparts (Appleby, Jennings, & Statham, 2012; Johansson & Andreasson, 2017; Tasker & Patterson, 2008). However, the isolation of gay men from the procreative realm is further evidenced by negative sexist attitudes that have deleteriously impacted their access to reproductive care (Berkowitz, 2009; Daley & MacDonnell, 2011; Marvel et al., 2016; Mezey, 2013; Ross et al., 2014).

When compared to their lesbian counterparts, some research has shown that gay men may encounter increased barriers to fertility care (Appleby, Jennings, & Stratham, 2012; Bos, van Balen, & van den Boom, 2003). For instance, in a U.S.-based study, a significantly greater number of fertility clinics were very or extremely likely to turn away a gay couple as compared
to a lesbian couple (48% vs 17%). The physicians explained their reasoning by presuming that “it is wrong for them to help bring a child into the world to be cared for by a parent who would be unfit in some way” (Gurmankin, Caplan & Braverman, 2005, p. 65). Robertson (2005) similarly estimated that about 80% of fertility clinics in the U.S. would be willing to provide ART services to lesbian women, as compared to 20% for gay men. Although these studies were conducted over a decade ago, the disparity in accessible reproductive services importantly elucidates how sexism impacts gay men’s fertility care and parenting (Appelby, Jennings, & Statham, 2012; Hicks, 2006). For instance, negative perceptions of gay fathers may have implications for the availability and accessibility of resources and services that importantly facilitate the transition to parenthood; in turn, these practices result in exclusionary, irrelevant and unsupportive care for gay men interested in fathering (Andreasson & Johansson, 2017; Kelly, 2014; Zrenchik & Craft, 2016). This is not only a reflection of overt discriminatory practices that may impede upon gay men’s right to parent, but it is also symbolic of the deeply entrenched heteronormativity and sexism in distal structural, cultural and historical contexts (Johansson & Andreasson, 2017; Robertson, 2005).

Gay men pursue surrogacy in a social context that has constructed their procreative choices as immoral, unjust and wrong (Andreasson & Johansson, 2017; Brown, Smalling, Groze, & Ryan, 2009; Giesler, 2012). Thus, empirical research is necessary to inform and develop non-heterosexual approaches to ART, parenting and fertility scholarship. When the narratives of marginalized populations are repeatedly overlooked and ignored in both practice and research contexts, it is critical to introduce platforms to gain insight into their lived experiences; to identify and challenge the mechanisms in place that have resulted in the continued heteronormativity and sexism in considerations of reproduction and parenting. Innovative
scholarship can lead to better understanding in which to inform practice and policy recommendations.

1.2 Terminology

Surrogacy, a form of third-party reproduction, is a practice in which a woman elects to bear a child for another individual or couple (Kashmeri, 2008). Intended parent(s) refers to the individual or couple who, although may or may not be genetically related to the child, plans to legally and socially rear the offspring post-birth (Greenfeld, 2008). A surrogate may either be: (1) a genetic carrier,\(^9\) in which she supplies her own ovum/ova for fertilization through donor insemination; she has a genetic and gestational connection to the child; or (2) a gestational carrier, in which she is implanted with an embryo(s) from fertilized donor gametes (sperm and ova/ovum); she has only a gestational, as opposed to genetic, connection to the offspring.

Gestational surrogacy involves the process of \textit{in-vitro fertilization} (IVF) (Brinsden, 2003; Crawshaw, Blyth & van den Akker, 2012; Imrie & Jadva, 2014). An IVF cycle is a medically invasive procedure in which an embryo is created in a laboratory and subsequently implanted into the woman’s uterus (an embryo transfer) (DeCherney, 1986; Mayo Clinic, 2017).\(^10\) The gametes may be donated by the intended parents, a combination of an intended parent and donor, or be selected from anonymous or known donors. Egg (oocyte) donation is a procedure that consists of ovarian stimulation to retrieve one (or several) egg(s) of a woman (the intended mother or egg donor) for the purposes of assisted reproduction (Sauer & Klein, 2011).

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\(^9\) Some scholarly work has referred to surrogates as ‘surrogate mothers;’ the use of ‘mother’ is purposefully omitted from this dissertation on account of recognizing gay men’s desire to intentionally parent without a mother present in their household.

\(^10\) Gestational surrogates, in order to ready their bodies for the embryo transfer, must also take a range of fertility therapies: a two-week regimen of Estrogen and Progesterone is administered pre-transfer and then continued for 8 or 9 weeks after a successful transfer (pregnancy). A self-administered injection, known as Lupron, is occasionally used in addition to Estrogen and Progesterone.
The practice of genetic surrogacy, in particular, has fueled ethical concern that the surrogate’s genetic connection will enhance her attachment to the fetus, and lead to difficulty relinquishing the child post-birth (Appleton, 2001; Sanabria, 2013; Suzuki et al., 2006). Consequently, this has resulted in the preferred and more frequent use of gestational surrogacy among intended parents (Dar et al., 2015; Grover et al., 2015). Removing a surrogate’s genetic relationship to the fetus is perceived as a way in which to mitigate bonding and prevent the desire for social motherhood post-birth (O’Neill & Blackmer, 2015; Sanbria, 2013). Social motherhood, distinct from genetic and gestational motherhood, refers to an individual who is not biologically related to the child, but plans to rear, care and nurture the child from birth (Ber, 2000).

1.3 Political Structure of Surrogacy in Canada

The legal regulations of gestational and/or genetic surrogacy differ across countries; policies may: (1) prohibit surrogacy altogether, (2) commercialize surrogacy through the provision of monetary compensation to genetic or gestational surrogates, or (3) sanction altruistic genetic or gestational surrogacy. In altruistic surrogacy, there is no financial compensation beyond reimbursements for out-of-pocket medical expenditures incurred as a result of the surrogate pregnancy (Reilly, 2007).

11 Although gestational surrogacy has been thought to mitigate emotional ties to the fetus, there are two considerations that should be mentioned. The first is that research has not shown a remarkable difference regarding the surrogate-fetus attachment between gestational and genetic surrogates. The second is that although gestational surrogacy is seen as a perhaps more ethically justifiable practice, there are ongoing ethical debates regarding the practice of gestational surrogacy. For instance, the “harm debate” stipulates that it is harmful to separate a child from a gestational surrogate post-birth (Agnafors, 2014). As the impact of surrogacy on the offspring is beyond the scope of this research project, this debate will not be examined in further detail. In Canada, most fertility clinics advocate against the practice of genetic surrogacy.

12 There are also countries (and parts of the U.S.) that forbid surrogacy for unmarried couples (whether heterosexual or gay).
Prior to delineating the legal regulations of surrogacy in Canada, it is important to first understand why some policies permit altruistic surrogacy as opposed to commercial surrogacy. The prohibition of commercial surrogacy is rooted in fears of the coercion and exploitation of economically-disadvantaged and racially-marginalized women (Baker, 1996; Inhorn & Birenbaum-Carmeli, 2008; O’Neill & Blackmer, 2015). Financial compensation is associated with the objectification of women’s reproductive bodies and the commodification of children (Braverman, Casey, & Jadva, 2012; van Niekerk & van Zyl, 1995; Pennings, Vayena, & Ahuja, 2012). Altruistic surrogacy is consequently perceived as a way in which to alleviate these concerns; albeit, these emerging ethical issues are not necessarily resolved through this practice (Narayan, 1995; O’Neill & Blackmer, 2015; Ruparelia, 2007; Tong, 1997; Walker & van Zyl, 2016). For instance, theorists have queried whether familial obligations may appear, in some respects, more coercive to surrogates than compensation (Anleu, 1990; Banerjee, 2013; Ruparelia, 2007). Emotional pressure from family members and female relatives may influence a woman’s decision to act as a surrogate, stemming from feelings of responsibility and guilt surrounding her functioning fertility and capacity to reproduce.

In Canada, surrogacy is regulated by the Assisted Human Reproduction Act (AHRA), under the auspices of Health Canada. It is a criminal offense to pay or offer to pay surrogates and/or egg

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13 Although beyond the scope of this dissertation, some feminist perspectives assert that monetary compensation may advance women’s position in society, as forbidding payment undermines women’s reproductive capacity and excludes their contributions to the economic realm (Shanley, 1995).

14 The 1993 final report of the Royal Commission of New Reproductive Technologies advocated for federal legislation on assisted reproductive technologies. AHRA was introduced and passed in 2004 and fully enforced in 2007. In 2010, the Supreme Court of Canada declared some sections of AHRA as unconstitutional. Certain stipulations have been retained at the federal level (such as regulations monitoring surrogacy) while others are upheld at provincial levels (healthcare regulation). The AHRA regulates many aspects of ART use “from sperm and egg donation to stem cell research and cloning;” (Cameron, 2008, p. 108). In 2013, Assisted Human Reproduction Canada was eliminated due to budgetary concerns and organizational challenges. This has led to decreased federal oversight, including guidelines and directives for fertility clinics and surrogacy consulting services (Health Canada, 2014). This legal historical framework shows how surrogacy is highly contentious and ambiguous in Canada.
donors, as well as to advertise or arrange payment beyond what is considered a legitimate financial reimbursement (Busby & Vun, 2010; Reilly, 2007; Snow, Baylis, & Downie, 2015). Consequences may include incarceration (~10 years) or fines possibly exceeding $500,000; notably, the provision of payment, rather than the acceptance of payment, is considered illegal (Nelson, 2016; Snow, 2014). Accordingly, under AHRA, altruistic surrogacy is permissible if the surrogate is 21 years of age or older.\textsuperscript{15} However, federal stipulations as to what constitutes legitimate reimbursements have remained vague and subject to periodic amendments. Expenses incurred as a result of surrogacy have included items such as maternity clothing, food, travel and accommodation costs for doctor’s appointments and fertility clinic visits; and expenses for lost wages, medications and unanticipated time off work (Nelson, 2016; Surrogacy in Canada Online, 2017). Lost wages are only permissible with a physician’s recommendation that continuing to work would be a risk to the future offspring (Marvel et al., 2016). Further incidentals may also include costs associated with C-sections, multiple births or bed rest

Although the law is currently under review and subject to change,\textsuperscript{16} a lack of legal clarity has caused tremendous ambiguity for both service users and service providers in how to adhere to federal surrogacy regulations.

\textsuperscript{15} In Canada (excluding British Columbia), post-birth orders are signed by intended parents and surrogates to obtain a court order declaring the intended parents as the legal parents. Before a post-birth order is signed, the surrogate (and her spouse) is the legal parent. The province of Ontario currently covers part of the cost of one round of IVF treatment (regardless of sexual orientation) and has recently (Jan 1, 2017) introduced the All Families Are Equal Act. This act aims to create a more streamlined process for legal parenthood. For example, up to 4 intended parents of a child born to a surrogate can be recognized without a court order, provided that: (1) this is written into the contract, and (2) the surrogate provides written consent before conception and 7 days post-birth. Data collection and analysis were completed before this law was enacted; all surrogacies (in Ontario) were conducted before IVF coverage was introduced into provincial law.

\textsuperscript{16} Bill C-38 (entitled: The Jobs, Growth and Long-Term Prosperity Act or, more colloquially, the Omnibus Bill), introduced in 2012, removed the license requirement and legal precedent for medical expenditures incurred during surrogacy. There are currently no official mandates of how to monitor and legislate medical reimbursements associated with surrogacy pregnancies (Cattapan & Cohen, 2013; Marvel, 2015). A press release dated September 30, 2016 by Health Canada announced that they were looking to make several adaptations to the regulations of AHRA.
Consequently, the law in Canada has hindered the provision of clear and transparent information to surrogates and intended parents. Owing to fears of legal ramifications, formal surrogacy programs and consultants are unlicensed and unregulated in Canada (Scotti, 2016; Surrogacy in Canada Online, 2017). Online surrogacy consulting services are registered businesses that are established to help connect intended parents and surrogates, but without assistance in the negotiation of financial reimbursements or monetary expenses between parties. Accordingly, online surrogacy consulting services are legal in Canada, so long as they do not facilitate payment between matched surrogates and intended parents (Motluk, 2014). These organizations provide referrals to fertility clinics and reproductive lawyers, and offer access to legal information regarding surrogacy (Motluk, 2014). For the most part, they are run and managed by former surrogates who offer added facilitation, which may include mediation, advice and online support for both intended parents and surrogates.

However, there are a lack of national oversight and standardized practices guiding the organization of surrogacy consulting services. With no structured regulations in place, all online surrogacy consulting services operate a little differently; yet, all have associated membership costs for intended parents. As it is considered illegal to pay these businesses to match intended parents and surrogates, services associate membership costs with access to consultations, information, referrals and support (Cribb & Jarratt, 2016). Membership fees support the coordination between intended parents, surrogates, and professional teams of lawyers, counselors and fertility staff. In Canada, the cost of joining a surrogacy consulting service for intended parents may range from $5,000-$10,000 (CAD) for one or two years of membership. Accordingly, conservative estimates suggest that intended parents have at least $60,000-$80,000 (CAD) budgeted to pursue gestational surrogacy in Canada (Surrogacy in Canada
Online, 2017), with additional costs reflecting independent legal counsel for both the surrogate and intended parents, medical and fertility interventions, as well as reimbursement expenses and other treatment plans.

Although there has never been a reported court case with regard to a surrogate not relinquishing the baby post-birth in Canada, one surrogacy consulting service faced accusations of enabling payment for surrogates and egg donors (Blackwell, 2013). In 2012, Leia Swanberg, now CEO of Canadian Fertility Consulting, was charged with allegations of brokering payments for surrogates and egg donors; she did not have sufficient medical receipts and paperwork that was requested by Health Canada (Cribb & Jarratt, 2016). She paid a $60,000 fine and is, currently, the only person to have ever reportedly been charged under the AHRA (Nelson, 2016). Most contracts and medical reimbursements are therefore managed by reproductive lawyers who specialize in assisting surrogates and intended parents negotiate their financial expectations. It is often recommended by surrogacy consulting services that both parties maintain their own (separate) legal counsel to protect their best interests, expectations and needs.

Notwithstanding these legal intricacies, the use of gestational surrogacy in Canada has continued to steadily rise over the past decade. The Canadian Assisted Reproductive Technologies Register (CARTR), voluntarily created by Canada’s fertility clinic directors, reported that, in 2015, there were 533 total IVF cycles for gestational carriers (CARTR, 2015) as compared to 103 cycles in 2005 (Gunby, 2010). The cycles do not represent live births, and are thus inclusive of those that resulted in termination, miscarriage or stillbirth (Gunby, 2010).

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17 There is no legal requirement to report ART data in Canada. The medical directors of Canada’s fertility clinics entered an agreement to collect, analyze and report clinics’ data on IVF cycles, pregnancy rates and birth outcomes (Born Ontario, 2017).
Importantly, there are limitations to the data available on surrogacy in Canada. Information from CARTR is only collected by fertility clinic directors who have voluntarily offered to publicly document their client data. As a result, fertility clinics may decline to have their data incorporated into this federal report.

Moreover, there are no official data related to surrogates’ demographic information or even the estimated number of gestational surrogates in Canada (CARTR, 2015). Notably, the above data specify the number of IVF cycles and not the number of surrogates; within a year, it is likely that one surrogate may go through more than one round of IVF in order to conceive. Not only are the numbers of gestational surrogates omitted from such reports but demographic information, such as ethnicity, socioeconomic status, geographical location and age, are unknown. This information can be important when concerns over exploitation and coercion of marginalized women are being used to sustain federal regulations governing surrogacy in Canada. Additionally, there is entirely no information on women who have elected to act as traditional (genetic) surrogates.

Although no demographic information on surrogates is available, there are certain qualities that are considered more acceptable for those wishing to act as surrogates under Canadian practice guidelines. The Canadian Fertility and Andrology Society clarifies that a surrogate must be at least 21 years of age (and optimally under the age of 35), understands the risks of surrogacy, and undergoes a complete medical/physical and obstetrical exam and psychosocial history (Havelock et al., 2016). Guidelines indicate that a surrogate should have a body mass index (BMI) between 18.5 and 24.9 and have had at least one uncomplicated term pregnancy, have a stable living arrangement and support network, and be a non-smoker (Havelock et al., 2016).
However, these practice recommendations are not mandated by any provincial or federal policies.

Accordingly, a surrogate is typically required to undergo an initial psychosocial assessment and complete diagnostic tests to ensure that she is a suitable candidate for surrogacy. The initial psychosocial assessment may include medical counseling, as well as discussions regarding intent, motivations and suitability to be a surrogate (Dar et al., 2015). This conversation may include the evaluation of a surrogate’s background and support system, including an assessment of her attachment style and attitudes towards reproductive issues such as abortion, multiple pregnancies and selective reduction. Counselors may also discuss a surrogate’s desired birth plan and expectations regarding her relationship with the intended parents (Dar et al., 2015). A surrogate will grant consent to all medical/fertility procedures, and show understanding of potential risks and side effects. Surrogates and intended parents are often counseled independently and, subsequently, hold a joint session in which both parties may discuss expectations to facilitate communication and trust (Dar et al., 2015). However, after this initial assessment, there may be no counseling or support for the duration of the surrogacy pregnancy or even post-birth (Dar et al., 2015).

Fertility clinics uphold responsibility in carrying out psychosocial assessments and medical evaluations. As is currently stands, there are no provincial or federal guidelines monitoring the practices and procedures of private fertility clinics; yet, many private fertility clinics in Canada adhere to Accreditation Canada’s standards for laboratory services and working with third party donors (Accreditation Canada, 2017). However, all accreditations are voluntary and there are no national standards for training practices, counseling or research activities with respect to
surrogacy (Marvel et al., 2016). Importantly, there are no formal qualifications for staff working in fertility clinics. For instance, counselors primarily include those affiliated with social work, psychology and education (professionals who are not covered under provincial healthcare plans); their professional conduct is held accountable to their corresponding affiliated body, as fertility clinics do not have their own regulating association. Thus, individual private fertility clinics set their own costs, service provision and practice standards. This has resulted in often arbitrary and inconsistent care in the practice of surrogacy (O’Neill & Blackmer, 2015). It is important to stipulate that due to the legal ambiguities, fertility clinics will not assist in matching surrogates and intended parents, often wanting contracts and negotiations to be handled prior to any fertility interventions.

Although the exact number of gestational surrogates in Canada is unknown, reports suggest that even amid the ambiguity of legislation, surrogacy has continued to rapidly increase. Nevertheless, legal and ethical implications likely account for the paucity of empirical research in Canada. Accordingly, scholarship is necessary to recognize how ART practices and policies have influenced experiences of gestational surrogacy.

1.4 Literature Review

The following literature review will be divided into two sub-sections: (1) experiences of surrogates, and (2) gay men who have pursued fatherhood. My intention is not to present a comprehensive review of scholarship on surrogacy and gay parenthood. Rather, I aim to establish a focused overview on: (1) surrogates who have gestated a child for heterosexual couples experiencing infertility; and (2) gay fathers who have decided to parent in the context
of a pre-existing same-sex relationship. Accordingly, I demonstrate the gaps in scholarship that attest to the significance and originality of this dissertation.

1.4.1 Surrogacy

Research on gestational surrogacy has predominantly been conducted in the United States (U.S.) and the United Kingdom (U.K.) with women who have gestated a child for heterosexual couples (Blyth, 1994; Bromfield, 2016; Ciccarelli & Beckman, 2005; Covington & Patrizio, 2013; Edelmann, 2004; Jacobson, 2016; van den Akker, 2003, 2007). Although commercial surrogacy is legal in some parts of the U.S. (yet not in the U.K.), surrogates have consistently expressed that monetary compensation is not the only motivating factor in pursuing surrogacy. More common are reflections of altruism and empathy; a wish to help women who are unable to conceive a child or who have faced previous difficulties with pregnancy (Blyth, 1994; Edelmann, 2004; Kanefield, 1999; Ragoné, 1996). Nevertheless, there is debate among researchers, ethicists and policy makers as to whether these are genuine motivations or socially desirable scripts to advocate for surrogacy (Ciccarelli & Beckman, 2005; Ragoné, 1994; Tieu, 2009).

Overall, surrogates have indicated positive experiences (Imrie & Jadva, 2014). They have refuted encounters of psychological or emotional distress, and contested difficulties relinquishing the child post-birth (Hanafin, 2006; Hohman & Hagan, 2001; Imrie & Jadva, 2014; Jadva, Blake, Casey, Golombok, 2012; Jadva, Imrie & Golombok, 2015; Teman, 2008). Surrogates’ positive experiences are typically a reflection of their relationship with the intended mother (Berend, 2012; Blyth, 1994; Ciccarelli & Beckman, 2005; Ragoné, 1996; van den Akker, 2003); they initiate surrogacy with anticipation of developing close and intimate bonds.
Surrogates have generally expressed harmonious and successful relationships. Yet, some follow-up studies have demonstrated surrogates’ distress, regret or remorse when relationships with their intended parents unwillingly terminate post-birth; these reactions, however, are largely transient and tend to diminish in the months following the birth (Brinsden, 2003; Jadva, Murray, Lycett, MacCallum, & Golombok, 2003; Jadva et al., 2015; Ragoné, 1994).

There is a lack of scholarly work investigating the experiences of surrogates for gay men; generally, anecdotes from the perspectives of gay fathers have described surrogates’ positive experiences (Bellafante, 2005; Lev, 2006; Stacey, 2006). Conversely, surrogates’ narratives are predominantly accessed through news articles and media messaging: “gay couples have developed a reputation as especially grateful clients, willing to meet a surrogate’s often intense demands for emotional connection” (Bellafante, 2005). Thus, exploring gestational surrogates’ perspectives is necessary to understand their experiences bearing a child for gay men.

1.4.2 Gay Fatherhood

Earlier scholarship investigated the practices of gay fathers who had children in previous heterosexual relationships (Barrett & Tasker, 2002; Bigner, 1999) to explore the ‘coming out’ process and its impact on wives and children. As legal and social reforms have afforded gay men with alternative family planning options, research has shifted over the past decade to explore ‘planned gay parenthood’ (Biblarz & Savci, 2010; Mallon, 2004; Murphy, 2013); this refers to gay men who reflect on and intentionally consider parenthood after assuming a non-heterosexual identity and, oftentimes, in the context of a pre-existing same-sex relationship (Murphy, 2015).
Empirical research on planned gay parenthood has predominantly focused on experiences of adoption and/or co-parenting practices. Recently, surrogacy has started to be included as an added route to parenthood, used in these studies as a comparison to adoption and/or co-parenting (Bergstrom-Lynch, 2016; Berkowitz & Marsiglio, 2007; Kruczkowski, 2012). Participants who have pursued surrogacy, however, comprise a much smaller sample; fewer gay men have elected surrogacy in relation to those who have adopted and/or co-parented. This disparity in sample size detracts from a more nuanced understanding of third-party reproduction among gay men, as focus is allocated to the sample of gay men who have chosen to adopt and/or co-parent. As the use of surrogacy is not differentiated from adoption and/or co-parenting, this may have critical implications for practice and policy. For instance, some fertility clinics and surrogacy screening tools have been shown to use adoption data to enhance their practice; this is problematic, as “surrogacy is exceedingly more complex than adoption and has fewer government laws and regulations structuring it” (Ciccarelli & Beckman, 2005, p. 23).

Empirical qualitative research conducted exclusively on surrogacy among gay men has largely been carried out in the U.S., the U.K. and Australia (Bergman, Rubio, Green & Padron., 2010; Dempsey, 2013; Greenfeld & Seli, 2011; Lev, 2006; May & Tenzek, 2016; Mitchell & Green, 2007; Murphy, 2013; Tuazon-McCheyne, 2010). Across these studies, researchers have

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18 Although co-parenting among heterosexuals often refers to two separated or divorced parents who have planned to socially rear their children together, sexual minorities may intentionally seek co-parenting family formations when deciding to have children. Some gay men, for instance, may actively seek women (whether lesbian or heterosexual) with whom they have entered into an arrangement to jointly raise a child either through adoption or through the collaborative use of assisted reproduction (the mutual provision of gametes).

19 Moreover, as Jacobson (2016) suggests, the concept of ‘intent’ is an important factor in delineating adoption from surrogacy. In contrast to women who unintentionally become pregnant and, subsequently, make the decision to carry the baby to term and then relinquish the offspring to adoptive parents, surrogacy is a process in which “children are created from the outset with the intent of being raised by someone other than the gestating woman.” (p. 18).
explored the motivations for biological paternity among gay men (Blake et al., 2017; Dempsey, 2013; Murphy, 2013), and the political and social inequalities that impede upon gay men’s paths to parenthood (Berkowitz, 2013; Greenfeld & Seli, 2011; Norton et al., 2013; Tuzon-McCheyne, 2010). Access to surrogacy has been hindered by prejudicial legislation, organizational regulations, or limited availability of community resources and support (Donovan, Heaphy, & Weeks, 2004; Kazyak & Woodell, 2016; Mezey, 2013). Although there is limited empirical research on gay men’s use of surrogacy, scholarship has shown that reproductive decision-making for gay parents is an extensively planned, difficult and time-consuming process (Bergman et al., 2010; Greenfeld & Seli, 2011; May & Tenzek, 2016; Tuazon-McCheyne, 2010). Further studies that have explored surrogacy for gay men have primarily been conducted across European countries with participants who have intentionally chosen to pursue transnational, or cross-border, surrogacy. These experiences may be different from domestic surrogacy and, as such, are beyond the scope of this dissertation (Carone, Baiocco, & Lingiardi, 2016; Riggs, Due & Power, 2015; Ziv & Freund-Eschar, 2015).

Limited research has explored gay men pursuing surrogacy in Canada. A 2005 mixed-method study investigated gay, bisexual and queer men who had children in heterosexual relationships, same-sex relationships and those who were childless (Epstein, 2005, 2009). Participants (n=40) responded to questions on access to services, and social, legal and cultural barriers. However, much has changed in the last decade with respect to same-sex parent families and ART development, including the: (1) legalization of same-sex marriage and second-parent adoption, (2) the enactment of the AHRA, and (3) the increasing visibility of same-sex parent households. The absence of transparent surrogacy legislation may yield even further obstacles for gay men in Canada. As surrogacy continues to steadily increase and fatherhood becomes an added
possibility in gay men’s life course trajectory, empirical research is necessary to understand the experiences of gay fathers pursuing surrogacy.

1.4 Theoretical Frameworks

This dissertation is supported by: (1) equity theory, (2) feminist ethics, and (3) queer theory. These frameworks each comprise diverse perspectives, issues and epistemologies that are important to delineate. However, the intention here is not to comprehensively explore the range and depth of each theory. Rather, each are applied in this dissertation to elicit a distinct theoretical position that can assist in interpreting the practice of gestational surrogacy for gay men. For instance, equity theory examines how fairness emerges in personal relationships (Hatfield & Sprecher, 1983), while feminist ethics and queer theory provide more critical analyses of gender and sexuality (Watson, 2005).

Although each theory has its limitations, they intersect to support an analysis of the interpersonal and individual experiences of surrogacy. This fits into an understanding of surrogacy as an intimate social-relational process while, at the same time, recognizing that individuals pursue surrogacy from distinct historical backgrounds and sociocultural contexts. Thus, (1) equity theory supports an analysis of the surrogacy relationship between gay men and gestational surrogates; (2) feminist ethics supports a critical framing of gestational surrogates’ relational autonomy; and (3) queer theory supports an exploration of gay men’s considerations of parenthood.

Equity theory has been utilized in previous scholarship to explore how fairness is maintained in intimate relationships; however, rules of fairness differ cross-culturally and have been the topic
of debate among theorists (Clayton & Opotow, 2003; Walster, Walster, & Berscheid, 1978). Consequently, the four principles of biomedical ethics, developed by Beauchamp and Childress, provide a context to delineate notions of fairness. In this approach, principles are norms that encompass a type of common morality (Beauchamp, 2007). Each of the four principles (autonomy, beneficence, non-maleficence and justice) will be described in more detail in the corresponding sub-sections to follow (Beauchamp & Childress, 2001). The four principles are employed as a practical approach or guideline to help guide ethical decision-making; the “four-principles approach has universal applicability…that different cultures can draw on it for moral reasoning and decision making” (Gordon, 2011, p. 256). The principles encompass a common language (or norm) to consider moral issues that arise in bioethics.

Principlism is not without its limitations, particularly when considering the issue of surrogacy in Canada. In connection to the objectives of this dissertation project, an important restriction of principlism is its normative approach (Beauchamp, 2007). Normative claims distinguish how to assess whether certain actions or right or wrong, often without regard for how larger sociopolitical contexts influence such decisions (Beauchamp & Childress, 2011). For instance, autonomy (the principle of self-determination) is conceptualized as a purely individualistic, androcentric and authoritarian approach (Gillon, 1994; Gordon, 2011). In order to broaden principlism’s approach to understand the use of surrogacy for both women and gay men, feminist ethics and queer theory support a more critical framework in which to interpret and guide principlism. Feminist ethics comprise a broad range of approaches and theoretical outlooks (Braverman, Casey, & Jadva, 2012; Silverstein, 1996). More specifically, relational (feminist) theory of autonomy will be utilized to critically understand how social relationships, and systemic practices and policies may inhibit or promote a woman’s reproductive autonomy.
In turn, queer theory elucidates how heteronormativity has influenced gay men’s procreative choices; gay fathers simultaneously mimic and challenge heteronormative family systems (Hopkins, Sorensen, & Taylor, 2013; Folegrø, 2008).

Feminist ethics and queer theory emerged as a rebuttal to the androcentric and universal approach of principlism (Held, 1990; Jaggar, 1992). It may, therefore, seem contradictory in this dissertation to employ the principles of biomedical ethics alongside more critical theoretical frameworks. The four principles are employed to understand the interpersonal collaborative relationships between gay intended parents and surrogates. Principlism is a practical approach in which to frame universally-held values to resolve conflict, and it is only applicable when those in a relationship can equally contribute (Taylor, 2013). As gay men and women have both been historically marginalized, principlism examines surrogacy without partiality (or hierarchy) to any one population’s experiences with systemic inequality and injustice (Levi, 1996; Taylor, 2013). In this way, principlism defines notions of justice and fairness, without consideration of sociohistorical contexts or the particular experiences of communities (Beauchamp, 2003; Gordon, 2011). Feminist ethics and queer theory are subsequently utilized to interpret and deepen this analysis. As Beauchamp himself suggests, “this [the four principles] general framework is abstract and spare until it has been further specified, that is, interpreted and adapted for particular circumstances” (Beauchamp, 2007, p. 6). Principles of autonomy and

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20 ‘Care ethics’ was purposefully omitted from this theoretical framework due to the critique of it subscribing to gender essentialism— that women have a natural tendency to nurture, reproduce and value social relationships and interdependency (Keller, 1997). For this dissertation, this limitation was critical when intersected with the sexism and heteronormativity of parenting scholarship, as well as negative attitudes against gay fathers that are perpetuated, in part, by gender essentialism. Thus, it seemed an important limitation that would not align with my epistemological position of this dissertation.

21 As Beauchamp (1995) explains, “neither rules nor judgments can be deduced directly from the principles, because additional interpretation, specification, and balancing of the principles is needed in order to formulate policies and decide about cases” (p. 182). This dissertation employs feminist relational theory of autonomy and queer theory to enhance the interpretation of these normative principles.
justice are specifically examined with consideration of patriarchal and heteronormative
discourses to represent the distinct experiences of surrogates (women) and gay men in third-
party reproduction.

1.4.1 Equity Theory and the Four Principles of Biomedical Ethics

Exchange relationships are determined by perceptions of justice, fairness and equity (Skitka &
Crosby, 2003). An exchange relationship is when perceived benefits are comparably
reciprocated between parties (Cook & Hegtvedt, 1983; Sage, 2007). Two elements define an
equitable exchange relationship: (1) how rewarding is the person’s relationship; and (2) how
fair and equitable the relationship appears to the person (Opotow, 1990). Thus, an equitable
relationship is determined when an “individual perceives relative gains to be equal for self and
partner” (Davidson, 1984, p. 37), consisting of mutual benefit, justice and reciprocity.

To structure equity theory as an applicable framework to support an analysis of surrogacy, the
four principles of biomedical ethics will be employed to define what constitutes mutual benefit,
justice and reciprocity (Beauchamp & Childress, 2001). These principles have been previously
utilized to discern the ethics of surrogacy and access for singles, lesbian and gay couples, and
transsexual [sic] people; practice guidelines were distributed by the European Society of
Human Reproduction and Embryology’s Task Force Ethics and Law (Wert et al., 2014). In this
section, the four principles of biomedical ethics will be applied to discern the equitability of the
surrogacy relationship.22

22 There is debate on the hierarchy of the four biomedical ethical principles (Page, 2012). Gillon (2003) writes that autonomy is
“the ability and tendency to think for oneself, to make decisions for oneself about the way one wishes to lead one’s life based
on that thinking, and then enact those decisions- is what makes morality- any sort of morality- possible.” (p. 310). He posits that
the principles of beneficence, non-maleficence and justice cannot be met without the fulfilment of autonomy.
The four principles of biomedical ethics comprise a framework to help guide moral decision-making in bioethics, consisting of: (1) autonomy, (2) beneficence, (3) non-maleficence, and (4) justice. How these principles are defined and then applied to the surrogacy relationship will be discussed in the sub-sections to follow.

1.4.1.1 Principle 1: Autonomy

Autonomy is “to acknowledge that persons’ right to hold views, to make choices, and to take actions based on personal values and beliefs,” free from coercion and intrusion (Beauchamp & Childress, 1994, p. 125). Autonomy is motivated by independency and self-determination.

Gestational surrogacy entails a complex social relationship, as the needs of the parents often prevail over the expectations and interests of the surrogate. It is common, for instance, that contracts forbid and monitor behavior; a surrogate is often mandated not to drink, smoke, eat specific foods or partake in certain activities (Busby & Vun, 2010; Greenfeld, 2014; Hanafin, 2006; Koert & Daniluk, 2016). This is based on the decisions of intended parents, but may also include restrictions from an extended network of health practitioners and lawyers; friends and family members, of either the surrogate or the intended parents, may also voice opinions on certain lifestyle choices.

Limiting a surrogate’s autonomy, no matter how trivial it seems, creates inherent power differences that place the surrogate’s interests as secondary to those of the intended parents.

The following argument does not mean to imply that surrogates are always considered non-autonomous; surrogates consent prior to any medical procedures or decisions (Daar, 2007). The principle of autonomy, however, supports the following ethical question: should a surrogate have full control over her reproductive body or does the fact that she consented to bear a child
for a third party essentially relinquish her individual procreative decision-making (Braverman, Casey, & Jadva, 2012)? This follows the contentious debate between “my baby, your body” and “my body, your baby” (Hanafin, 2006; Koert & Daniluk, 2016). Thus, self-determination and the individualism of autonomy (as opposed to feminist relational autonomy) is purposefully considered to understand whether (and how) the surrogate is able to independently deliberate on, and make choices regarding her own bodily autonomy.

1.4.1.2 Principles 2 and 3: Beneficence and Non-Maleficence

Beneficence and non-maleficence are respectively defined as the obligation to “uphold forms of action intended to benefit other persons” and “avoiding the causation of harm” (Beauchamp & Childress, 2001, p. 166, p. 12).

In equity theory, individuals in exchange relationships are valued based on the benefit they are able to provide (Hafer & Olson, 2003). An equitable relationship exists when the same level of benefits are reciprocated between parties. An ‘underbenefited’ relationship may emerge when an individual has received fewer gains in comparison to others; an ‘overbenefited’ relationship occurs when more gains are received (Davidson, 1984). The more an individual considers a relationship to be inequitable, the more distress that individual will feel (Sprecher, 1986). In turn, to restore equity, individuals either: a) balance the level of benefits; or b) terminate the relationship (Davidson, 1984). The principles of beneficence and non-maleficence are addressed in altruistic surrogacy.

Surrogates are promoting beneficence through their decision to gestate and bear a child for another individual or couple (Walters, 1989). In particular, surrogates endow gay men with a
biological child they would not otherwise be able to have; surrogacy is the only option for gay men wishing to pursue biological parenthood. Thus, a surrogate’s actions benefit gay men and afford them extensive opportunities to parent. In turn, a surrogate’s behaviors may also prevent harm. The surrogate promises to maintain a healthy pregnancy and relinquish the child post-birth. The surrogate’s ability to detach from her pregnancy and mitigate maternal-fetal bonding is important to alleviate intended parents’ concerns and anxieties during surrogacy (Baslington, 2002; Fischer & Gillman, 1991; Markens, 2007; Ragoné, 1994, 1996; Teman, 2008). Thus, a surrogate intends to prevent harm in two ways: (1) she prevents harm to the unborn offspring by caring for her pregnancy; and (2) she prevents potential emotional and psychological harm to the intended parents by relinquishing the child post-birth (Edelmann, 2004; MacCallum et al., 2003; Ruiz-Robledillio & Moya-Albiol, 2016). Thus, the surrogate’s actions are a cyclical pattern of enacting beneficence and non-maleficence.

Accordingly, intended parents’ behaviors are equally important to consider. For surrogates, the relationship with the intended parents is often the determining factor of a positive surrogacy experience (Berend, 2012; Busby & Vun, 2010; Hohman & Hagan, 2001; van den Akker, 2003). Surrogates’ motivations are, to some extent, reliant upon intended parents’ intimacy, closeness and gratitude; there is hope for a longstanding relationship post-birth (Ciccarelli & Beckman, 2005; Edelmann, 2004; Imrie & Jadva, 2014). In Ragoné’s (1994) study, surrogate participants expressed benefits of being protected, shielded and rewarded by the intended parents. However, intended parents also assume responsibility to prevent harm. For instance, intended mothers may experience shame, failure and anger as a result of their infertility.

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23 This may also be connected to the principle of ‘procreative beneficence,’ the moral obligation to bear a child who will have the most advantages in life (e.g., well-being). Although an important ethical issue that has emerged with advancements in genetic technologies, it is beyond the scope of this dissertation (Savulescu & Kahane, 2009).
(MacCallum et al., 2003; van den Akker, 2007). These feelings of loss may lead to discomfort and distress for the surrogate, yielding a tense, distant and unsatisfactory relationship. Surrogates’ disappointment may have a profound impact on their mental health post-birth (Berkowitz, 2013; Stacey, 2006).

Thus, gay intended parents are obligated to promote well-being through mutual respect, appreciation and care; simultaneously, they avoid deleterious consequences by maintaining a longstanding relationship, and preventing surrogates’ psychological and emotional distress through continued gratitude and admiration. Consequently, the interpersonal relationships between surrogates and intended parents rely on the obligations of beneficence and non-maleficence to uphold a positive and satisfactory surrogacy experience.

1.4.1.3 Principle 4: Justice

The principle of justice is described as the obligation to treat others equitability.

According to equity theory, there are three frames of justice: (1) distributive justice (goods, resources, psychological factors); (2) procedural justice (decision-making process); and (3) the moral community (Clayton & Opotow, 2003). In this section, focus will be placed on the ‘moral community,’ suggesting that justice and fairness are only applied to those situated within one’s scope of justice (Skitka & Crosby, 2003). The moral community creates a psychological boundary, granting only members a sense of self-worth, value and respect (Skitka & Crosby, 2003). Moral exclusion occurs when individuals or groups are perceived as outside the boundary in which moral values, rules, and considerations of fairness apply. Those who are morally excluded are
perceived as nonentities, expendable, or undeserving. Consequently, harming or exploiting them appears to be appropriate, acceptable, or just. (Skitka & Crosby, 2003, p. 1)

Exchange relationships in the moral community are grounded in the belief that individuals deserve valued treatment based on what they may offer (Huseman, Hatfield, & Miles, 1987). Thus, the model of ‘justice as reciprocity’ posits that equitability may only be considered when there is shared gain and mutual benefit (Buchanan, 1990). As individuals only comply with rules of justice when there is certainty that others will act in similar ways, this engenders ‘justice as self-interested reciprocity;’ individuals invest in reciprocal relationships when it fosters a self-interested advantage (Buchanan, 1990; Lister, 2011).

The model of ‘justice as self-interested reciprocity’ is applicable to surrogacy. Intended parents invest in surrogacy to have a child. Accordingly, it is to the intended parents’ advantage to treat the surrogate with fairness; this yields greater likelihood that she will be inclined to maintain a healthy pregnancy and relinquish the child post-birth (Teman, 2009; Toledano & Zeiler, 2017). In turn, surrogates may also treat the intended parents with mutual respect and equity based on their own self-interest to be appreciated and rewarded (Berend, 2012). Some theorists have described altruistic surrogacy as a narcissistic drive to feel unique and special (Braverman & Corson, 1992; Hanafin, 2006; Ragoné, 1994).

‘Justice as self-interested reciprocity,’ however, is only sustained when all parties remain in the scope of justice (e.g., moral community); only when both parties are capable of receiving and contributing to this shared benefit can fairness ensue (Buchanan, 1990). During surrogacy, both surrogates and intended parents are involved in the creation of the unborn offspring; there is a
shared goal. Yet, upon completion of surrogacy, when the surrogate may no longer be asked to contribute to or share in the offspring’s life, the surrogate may no longer remain in the intended parent’s scope of justice. Research has shown that contact typically does dissipate after a child is born and is, more frequently, instigated by the intended parents rather than the surrogate (Berend, 2012; Jadva et al., 2012). Surrogates may feel used or exploited when they expect to have ongoing communication post-birth and are then denied visitation rights or future contact (Hohman & Hagan, 2001).

Thus, “the problem posed by the circumstances of justice is not simply to stabilize mutually beneficial cooperation, but to establish a relationship of mutual recognition as equals in a context of conflicts of interests and ideas” (Lister, 2011, p. 106). Surrogates may be perceived as somewhat dispensable post-birth, which may engender perceptions of exploitation and objectification (Davidson, 1984; Shannon, 1988). There is overarching concern that surrogates may simply be a means to an end, substantiating fears of vulnerability and powerlessness.

1.4.2 Feminist Ethics: Relational Theory of Autonomy

Butler (1988) posits that feminist theory explores how “systemic or pervasive political and cultural structures are enacted and reproduced through individual acts and practices…situating issues in a broader and shared cultural context” (p. 522). Feminist relational theory of autonomy does not associate individualism with self-determination. Rather, autonomy is constructed through a sociohistorical framework, attained through social relationships, emotions and gender hierarchies (Ball, 2005; Keller, 1997; Sherwin, 2002). Relational theory of autonomy will be situated across two premises that discern surrogates either: (1) uphold their reproductive autonomy; or (2) adopt normative femininity that questions the legitimacy of their authentic
autonomy. This theoretical approach suggests that autonomy is either fostered or hindered by social relationships.

The first premise develops from ‘procedural causal’ conceptions of relational autonomy (Ball, 2005; Friedman, 1997; Stoljar, 2015). Procedural theories surmise that women have the internal and intellectual capacity to deliberate upon their motivations and needs to make informed decisions (Stoljar, 2015). This is described as ‘content-neutral’ autonomy (Stoljar, 2015). The decision reached is grounded in critical self-reflection, and a woman’s own values, beliefs and attitudes (regardless of the content of the decision). Causality posits that women’s decision-making is promoted by positive social relationships, interpersonal connections and the emotional needs of others (Christman, 2014; Friedman, 2003). In this premise, a surrogate’s autonomy is influenced by her relationships. This reflects previous scholarship that has demonstrated surrogates’ expressions of altruism, empathy and compassion (Berend, 2012; Held, 2005; Lennon, 2010; Parks, 2010; Tong & Williams, 2009). Surrogates dispute vulnerability; social relationships promote their relational autonomy, and foster their reproductive freedom (Markens, 2007; Strong, 1997) and procreative liberties (Purdy, 1996; Weiss, 1992). For example, in Toledano and Zeiler’s (2017) work on relational labor in altruistic surrogacy, they argue that surrogacy is reciprocal relational work, in that surrogates and intended parents care for each other “by making and giving space to each other in their lives and thoughtfully diminishing the burdens and demands that come with surrogacy” (p. 12).

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24 This dichotomy is not meant to be representative of the entirety of positions encompassed in feminist ethics. Feminist ethics is not monolithic. For instance, there are feminist deliberations that are beyond the scope of this dissertation project that reflect issues regarding enforceable contracts, commercialization and commodification of surrogates, and transnational surrogacy. As well, issues including egg donation, genetic engineering, sex selection and prenatal screening are often explored. With that in mind, the aim of this section is not to comprehensively explore or represent all feminist perspectives.

25 “Emotions can be reflections of a person’s wants, values, concerns, and commitments and can therefore constitute the bases for coherent choices and actions that are consistent with those wants, values, concerns, and commitments” (Ball, 2005, p. 364).
The second premise stems from ‘substantive constitutive’ conceptions of autonomy (Benson, 2005; Jaggar, 1985; Stolfjar, 2015). Substantive theory suggests that autonomy is ‘value-laden’, as opposed to ‘content-neutral.’ Constitutive approaches suggest that interpersonal relationships or social circumstances influence a woman’s autonomy (Christman, 2014; Stolfjar, 2015; Westlund, 2003). Women’s marginalization, vulnerability and subordination to men remove the inherent authority and control that is symbolic of autonomy: “to talk about the freedom of the self-possessing individual to do what she will with her own body while ignoring gender structures in her society distances such arguments from the world of lived experience” (Shanley, 1995, p. 628). This consequently limits a woman’s decision-making capacity.

In turn, ‘autonomy competency’ is the distinction between: (1) a perceived autonomous decision, and (2) an authentic decision aligned with one’s ‘true self’ (Friedman, 2003; Keller, 1997; Meyers, 1987; Stoljar, 2015). Accordingly, practices and policies may impede upon a surrogate’s autonomy, and restrict her ability to enact her true or authentic procreative decision-making capacity (Christman, 2014); women may only think they are demonstrating autonomy: “authentic caring cannot occur under conditions characterized by male domination and female subordination” (Tong & Williams, 2009). In turn, surrogates’ decisions are a socialized reflection of a context that has depreciated women’s value with their ability to reproduce (Ruparelia, 2007).

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26 The ‘Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE)’ is an international network of feminists who are concerned with the impact of ARTs on women: “women are also used as ‘vessels’ in so called surrogacy arrangement which is an assault on their dignity, a risk to their health and a modern form of slavery.” Retrieved from: http://www.finrrage.org/ (as seen referenced in Marvel, 2015).
1.4.3 Queer Theory

According to Foucault, socially constructed dichotomies of gender and sexuality are “dividing practices” (Foucault, 1982, p. 77), and are employed to facilitate patterns of exclusion based on social perceptions of difference (Jenkins, 2000). Consequently, queer theory provides a framework to question, challenge and resist practices that have dictated normative attitudes and behaviors (Oswald, Kuvalanka, Blume, & Berkowitz, 2009). Scholarship on gay fatherhood has resulted in a queering of the family that has resisted “the holy trinity of heterosexuality, biological reproduction, and the nuclear family” (Marcus, 2005, p. 206). As gay men elect surrogacy, their decisions extend the family unit beyond the two-parent biological paradigm of family and kinship. Employing queer theory deconstructs assumptions and knowledge systems that have endorsed definitions of ARTs as medical interventions for heterosexual couples’ infertility; gay fathers are “disrupting heteronormativity” (Goldberg, 2012, p. 10).

In contrast, some queer theorists have interpreted surrogacy as a type of assimilative practice. Applying a similar argument espoused in feminist ethics, the position here is that gay men who desire children are mirroring heteronormative hegemonic family norms. Gay fatherhood may be perceived as a type of normalizing practice (Folgerø, 2008; Warner, 2000); non-heterosexual couples are depicted as adopting socially accepted standards of living, and ascribing to normative biogenetic (biological and genetic connections; blood ties) and relational (marital) patterns of kinship and families (Donovan et al., 2004; Schneider, 1980; Warner, 2000). Queer theory will be employed to understand how gay men challenge, accept or oscillate between expanding and mirroring heterosexuality.
Applying queer theory to feminist ethics, the behaviors of surrogates to bear a child for gay men may also, in part, queer reproduction. Through their actions, surrogates are not only assisting in broadening constructs of family, but they are also contesting heterosexual notions of parenthood (Marvel, 2015; Oswald, Kuvalanka, Blume & Berkowitz, 2009). For instance, pregnant women are valued when they have chosen to reproduce in normative and socially acceptable ways; they intentionally plan to have a biogenetic child with their heterosexual spouse (Abrams, 2015; Marvel, 2015). Surrogates are therefore resisting heteronormative discourses that have defined how, when and in what capacity women assume pregnancy and childbirth (Tangri & Kahn, 1993; Shanley, 1995). Surrogates are electing to reproduce in ways that separate genetic, gestational and social motherhood (Blyth, 1994; Markens, 2007; Teman, 2003, 2009), and are negating assumptions of the natural maternal-fetal bond (Ragoné, 1994; van Zyl & Niekerk, 2000). Negative social attitudes that accrue against surrogates may derive from hegemonic feminine ideals that uphold surrogate’s reproductive decisions as immoral and unnatural.

1.5 Research Methodology

The overall purpose of this dissertation is to explore the practice of gestational surrogacy for cisgender gay men in Canada. A qualitative study was conducted to gain knowledge and insight about surrogacy from those who have direct lived experiences. Thus, interviews were conducted with both gestational surrogates and gay fathers across Canada. Granting opportunities for participants to define, describe and interpret their experiences is especially important for populations that have been stigmatized, marginalized and often silenced in social contexts. The perspectives of both gestational surrogates and gay fathers were vital to enhance the interpretation of the findings, and to understand the practice of surrogacy. In the sub-
sections below, I will describe the study’s research questions and my rationale for the selected methodological design.

1.5.1 Research Questions

The overarching research question is: How do gay intended fathers and gestational surrogates in Canada experience the practice of gestational surrogacy? Sub-research questions include: (1) What are the motivations of gestational surrogates and gay intended fathers to pursue surrogacy? (2) How are the relationships between gestational surrogates and gay intended fathers perceived before, during and after a surrogacy pregnancy? (3) In what ways has Canada’s sociopolitical context influenced the experiences of gestational surrogates and gay intended fathers in accessing information, healthcare resources and community supports?

These research questions developed from a scholarly review that demonstrated how motivations, relationships and sociopolitical contexts importantly influence the experiences of surrogacy (as well as long term consequences) for both surrogates and intended parents. As a result, these objectives provide an overall depiction of the factors impacting surrogacy, adding to limited empirical research on gay parenthood and surrogacy in Canada. In particular, as there has been a gap in scholarship specifically in Canada, the political context with respect to same-sex parenting rights and surrogacy are important in framing participants’ experiences.

1.5.2 Methodological Design: Interpretive Hermeneutic Phenomenology

I employed interpretive phenomenological analysis (IPA) to explore the lived experiences of gay fathers and gestational surrogates. Deriving specifically from the philosophy of hermeneutic phenomenology (Smith, 2004), IPA was intentionally selected as an applicable design in which to conduct this research. The aim of hermeneutic phenomenology is to define
and interpret the meaning of individuals’ lived experience through textual analysis (Brocki & Wearden, 2006). Oftentimes, phenomena of empirical interest have remained hidden from public discourse, and have not been largely discussed or understood in social and/or research contexts (Dowling, 2007; Lopez & Willis, 2004). IPA is concerned with investigating significant life transforming events to engage with the subjectivity of personal experience; and to elucidate the importance of the event for an individual (Harper & Thompson, 2011; Leonard, 1989; McConnell-Henry, Chapman, & Francis, 2009). Known as idiography in phenomenology, the focus on a specific event for a particular individual considers how the sociohistorical context shapes understanding and interpretation of phenomena (Smith, 2011).

Consequently, the goal in interpretive hermeneutic phenomenology is to uncover the hidden meaning of the phenomenon, rather than merely conducting a descriptive analysis (as in more traditional Husserlian transcendental phenomenology) (Pringle, Drummond, McLafferty & Hendry, 2011; Smith, 2004). In my dissertation, the meaning of surrogacy and procreation (and, in turn, experiences of reproduction and parenthood) for gay men and gestational surrogates is explored and interpreted. The limited scholarship, as well as negative social, political and ethical attitudes toward surrogacy and gay fatherhood were important considerations in the selection of this phenomenological research design.

Aligned with Heidegger’s interpretive hermeneutics, the concepts of Dasein and Mitsein assist in framing my interpretation and analysis of the practice of surrogacy for gay men in Canada.

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27 According to Butler, the meaning of lived experience is rooted in language, gestures and performative acts. Butler (1988) identifies that, “the body is understood to be an active process of embodying certain cultural and historical possibilities” (p. 521). In this dissertation, the performance of surrogacy is interpreted/embodied within a specific sociopolitical context. Thus, phenomenology is not only a methodological tool, but aligns with the epistemological position of this paper.
1.5.2.1 The Concept of Dasein

IPA situates a phenomenon within a person’s cultural, social and political background, coined by Heidegger as *Dasein* (being-in-the-world). People are embedded in the world they live in and, according to Heidegger, their contexts (including social, cultural, economic, political) shape how they experience phenomena (Lopez & Willis, 2004; McConnell-Henry et al., 2009; Pascal, 2010). This is perhaps reflective of two phenomenological constructs: *temporality* and *historicity*. *Temporality* is a concept that suggests individuals react to current and future events based on prior experiences (McConnell-Henry et al., 2009); they have “interpreted and situated [themselves] within their personal world” (Miles, Chapman, Francis, & Taylor, 2013, p. 274). *Historicity* is to position oneself in relation to one’s historical background, as previous experiences influence how individuals interpret and understand their present (and future) context (Laverty, 2003).

*Dasein* ties closely to the values of the social work profession by deciphering meaning within and from the *person-in-environment* (Leonard, 1989; Pascal, 2010). In social work practice, clients’ experiences cannot be understood without consideration of their unique environment and social context.

1.5.1.2 The Concept of Mitsein

Connected to experiences of *Dasein* (being-in-the-world), *Mitsen* (being-with-the-world) is a relational concept in which individuals’ experiences and the meaning afforded to phenomena is constructed through their social relationships (Freeman, 2011). The concept of *Mitsen* discerns how knowledge is formed through interpersonal relationships and intersubjectivity: “shared insights with others….help to constitute what we know and help constitute an essential part of
who we are, who we were and who we can become” (Freeman, 2011, p. 370). In turn, one’s identity (or selfhood) is relationally shaped through engagement with others, interpersonal connections, and communities and networks. Worlds are thus co-constructed through a shared history and collaborative experiences.

The utilization of the concept of Mitsen is closely aligned with the application of feminist relational theory of autonomy, as explicated in the previous section (1.4.2); an individual “exists in comporting or relating oneself (sich verhalten) to other beings in the world” (Freeman, 2011, p. 369). Mitsen may also be linked to the values and ethics of professional social work practice. Issues that arise in therapy often derive from how clients perceive their social relationships outside of the therapeutic context. The working alliance (rapport) between social worker and client importantly influences the meaning afforded to therapeutic practice.

1.5.3 Critical Hermeneutics

A limitation in only applying interpretive hermeneutics is that interpretations are often grounded in normative discourse (Lopez & Willis, 2004). The aim of critical hermeneutics is to gain understanding of lived experiences of marginalized populations (Byrne, 2001; Jacobs, 2014; Lopez & Willis, 2004). This phenomenological design is utilized to critique “dominant ideologies” and understand “how these ideologies shape and organize the daily lives of study participants” (Lopez & Willis, 2004, p. 731). Textual analysis and the interpretation of the data is conducted to foster structural change and encourage “resistance capable of challenging and transforming existing social practices” (Kögler, 2008, p. 153).
In turn, although concepts from interpretive hermeneutics (e.g., Dasein and Mitsein) are importantly relevant to this dissertation, critical hermeneutics supports an analysis of power that was critical to my study (Kögler, 2008). Understanding issues related to gender hegemony, sexual stigma and patriarchal contexts was essential to incorporate into the interpretation and analysis of my findings. Thus, this justified the use of feminist ethics and queer theory to support my analysis. Critical interpretive hermeneutic phenomenology was purposefully selected to inform understanding of how Canada’s sociopolitical and historical context has facilitated and/or hindered the procreative processes of surrogacy for gay men.

1.6 Data Analysis Strategies

IPA is grounded in textual analysis that I carried out through a simultaneous process of recruitment, interviewing and interpretation to formulate relevant patterns and themes (Wojnar & Sawnson, 2007). Following an IPA approach, I transcribed (and redacted) the audio-recorded interviews, and read these transcripts multiple times. I conducted line-by-line coding to attain an initial understanding of the data (Creswell, 2012) for each individual participant. I selected important and meaningful statements (meaning units) that provided an in-depth and significant understanding of the experience (Smith & Osborn, 2003; Smythe et al., 2008). I then organized these meaning units into “clusters of meaning” (Starks & Trinidad, 2007, p. 1375); a process known as horizontalization (Creswell, 2012; Giorgi, 1985; Moustakas, 1994). In the next phase of analysis, I selected exemplars (certain examples or images) from the clusters of meaning to enrich findings and frame my emerging patterns (Leonard, 1989; Wilcke, 2002). In doing so, I drew comparisons within and across participant narratives, and triangulated data across populations (Crist & Tanner, 2003; Starks & Trinidad, 2007). The aim of IPA is to implement an inductive, critical and rich analysis of the data. Consequently, some methodologists argue
that the use of computer software tools may be insufficient for the rigorous analysis that is necessary for IPA research (Popay, Rogers, & Williams, 1998; St. John & Johnson, 2000). Accordingly, textual coding and interpretation as described above was conducted manually through the meticulous reading of transcripts, underlining and highlighting, as well as the integration of participants’ meaning units and culminating themes into word documents and diagrams.

The selection of IPA as a research design does have its limitations, including that the interpretation (rather than the description) of data comprise a degree of subjectivity and instinct from the researcher (Malim, Birch, & Wadeley, 1992). To mitigate risks associated with potential biases, numerous approaches were employed to enhance the rigor and trustworthiness of the qualitative analysis (Creswell & Miller, 2000). Triangulation, the process of using multiple sources to achieve rich description, was employed (Padgett, 1998; Shenton, 2004). Triangulation efforts included: (1) obtaining data from multiple sources/informants, including: gay intended parents, gestational surrogates, and matched surrogate triads (gay intended parents and their paired gestational surrogate); and (2) employing multiple theories to support my research findings and interpretation of results, including both normative and critical frameworks to help deepen analysis. Peer-debriefing assisted with critical engagement in the data (Padgett, 1998). My thesis supervisor and committee provided important feedback that was integrated into my final dissertation. An audit trail, including memo-writing, was utilized to record my own assumptions and projections through data collection and analysis (Leonard, 1989; Padgett, 1998; Shenton, 2004; Starks & Trinidad, 2007). Member-checking was also performed, as I returned aggregated findings to participants and incorporated any feedback/insights into my analysis.
1.7 Fore-structure: Social Location & Self-Reflexivity

In IPA, the researcher takes on an active role in the analysis to textually analyze and interpret the data. Accordingly, interpretations may be influenced (and perhaps complicated) by the researcher’s own background, perceptions and biases (Brocki & Wearden, 2006). The concept of *fore-structure* in hermeneutic phenomenology entails a process of self-reflexivity to what is known or understood to the researcher prior to interpretation. Previous knowledge, assumptions and experiences influence textual analysis (Tuohy et al., 2013; Mackey, 2005). This research project originally developed from my work at the Lesbian, Gay, Bisexual and Transgender (LGBT) Community Center in New York City during my Master of Social Work at New York University. I was responsible for helping to create a coalition to address intersecting issues between LGBT rights and reproductive justice. I worked to identify reproductive health and access issues for sexual and gender minorities. Based upon findings from a qualitative study, I sought to understand challenges encountered by sexual minorities to access adequate and relevant reproductive health information. Pursuing a PhD in bioethics and social work, my intention was to conduct a qualitative study to understand the practice of gestational surrogacy. With an academic background in bioethics, I reflect on my own ethical deliberations regarding surrogacy before initiating this research\(^2\), my involvement in the LGBT community, and my support of gay men having children and creating families.

Fore-structure also draws attention to the researcher’s previously held biases and prejudices. These are not necessarily negative judgments, but prior assumptions and preconceptions based on one’s social location and context (Geanellos, 2000; Jahnke, 2012; Regan, 2012). As a queer

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\(^2\) The feminist scholar Rosemarie Tong referred to herself as a “chameleon” when elucidating her position on surrogacy; she is easily swayed by different arguments and, even when she has reached a position, she is never entirely satisfied (Tong, 1990). Similarly, my approach to surrogacy often vacillates, an important consideration when situating myself in this research project.
cisgender childless white woman, I recognize my own social location as an outsider conducting
interviews with both gay men and gestational surrogates. As a queer woman, gay fathers’
experiences with sexual stigma, obstacles in the healthcare system, and difficulties in
coalescing gay-father identities had powerful influences on my analysis.

My identity as a woman (and as a researcher who has been accustomed to reading about the
ways in which surrogacy may be used to exploit and mistreat women) and a feminist shaped my
interpretation of the data. I often found myself aligning with surrogate participants’
experiences; this was perhaps based on my personal inclination to signify women’s
disempowerment and subordination, and draw attention to patriarchal and sexist institutional
discourses. This presented obstacles in my analysis of the experiences of gay fathers. I
struggled with how to balance my interpretation of gay men’s encounters of stigma with my
partiality to identify their privileged status as men. Thus, my interpretation of the data was, at
times, more critical of gay men’s procreative processes, unintentionally minimizing their
deleterious experiences. This was perhaps owing to my own focus on interpreting surrogate’s
social standing as women and gendered power differences in reproduction.

However, there were continuous deliberations throughout data collection and analysis. For
instance, as I progressed through data collection and my analysis deepened, I considered how
hegemonic masculinities and feminine norms of reproduction and fertility had powerfully
influenced gay men’s identities. I gained understanding as to how sexist discourses have
particularly subjugated gay men. Patriarchal structures, while detrimental for women, have also
marginalized and stigmatized gay men. This reminder was important to help ground my
interpretation and analysis. As well, I annotated specific quotations and recorded the language
utilized by gay men and surrogates during interviews that challenged my social positioning; I later returned to these perspectives at different stages of analysis and writing. Being forthcoming and cognizant of my own social location helped to situate my thinking, and consider new experiences and understandings that emerged across the data.

In line with hermeneutic phenomenology, my aim was not to bracket my prior assumptions and perspectives, but rather to identify how they may influence the interpretation of my findings (Finlay, 2009; Gearing, 2004; Laverty, 2003; McConnell-Henry et al., 2009; Wilcke, 2002). There were numerous ways in which I tried to maintain self-reflexivity through data collection and analysis. I engaged in memo-writing to reflect upon (and recall) experiences; I documented relevant and pertinent quotations from participants that triggered personal reactions. I also noted questions raised by my participants. For instance, some participants queried why I was conducting this research, leading to questions regarding my social location as a researcher; others, as they explained transitions to parenthood or experiences during their pregnancies, asked whether I had my own children in which to relate to their experiences.

My thesis committee was able to provide me with diverse viewpoints and interpretations that helped inform my thinking and remain cognizant of my own social location. Their different perspectives and critical feedback added a valuable level of analysis that helped reframe some of my initial interpretations. This, according to hermeneutic phenomenology, is the process of the hermeneutic circle (Jacobs, 2014; Mackey, 2005). It is a “reciprocal process that involves

29 In connecting concepts of hermeneutic phenomenology to social work practice, the construct of the hermeneutic circle may also resemble the transference and countertransference that arise in the working relationship. The worker and the client both arrive at the session with their distinct fore-structure and, thus, engage in a process of dialogue to reach a new interpretation and meaning to expand ideas and be open to each other’s perspectives: “as social workers and clients bring their personal and practice experiences to each encounter, so too are they changed by each other - a hermeneutic circle” (Newberry, 2012, p. 15).
back and forth questioning, which leads to an expanding circle of ideas” (Tuohy et al., 2013, p. 20). Through dialogue, the researcher discovers new meaning that is created through continuous levels of re-examination. The *hermeneutic circle* allows researchers to question their prior knowledge, assumptions and expectations by being open to new perspectives and interpretations (Jacobs, 2014; Newbery, 2012). This was achieved through peer-debriefing (engaging in discussions with my committee and integrating their feedback into my analysis), as well as triangulation through the use of multiple critical theories and discourses to guide my inquiries. My thesis committee played an important role in challenging my fore-structure and affording opportunities for me to question my previous knowledge and attain new interpretations of the data.

1.8 Subsequent Chapters

Findings will be presented over the subsequent chapters, culminating in a discussion section that frames a conceptual understanding of this topic. In accordance with the three-paper dissertation, the subsequent three chapters should be considered as independent manuscripts, each containing: literature review, methods, results, discussion and implications. As each paper utilizes the same set of interviews, and is framed by comparable scholarship, it should be signposted that there may be some repetitive material. However, each of the three papers comprises distinct research aims that subsequently yield unique discussions and conclusions.

*Chapter two* is entitled, “The intersections of gender, sexuality and parenthood: A qualitative investigation of the motivations to pursue surrogacy for gay fathers in Canada.” This chapter reports on findings associated with the motivations of gestational surrogates and gay fathers to
pursue surrogacy. Accordingly, queer theory and feminist ethics shape this analysis to illustrate how Canada’s social and political contexts have influenced participants’ motivations.

**Chapter three** is entitled, “Two men & a surrogate: A qualitative exploration of the surrogacy relationship between gay fathers and gestational surrogates in Canada.” Supported by equity theory, this chapter presents a retrospective exploration of the relationships between gay fathers and gestational surrogates: (1) pre-pregnancy, (2) during pregnancy, and (3) post-birth.

**Chapter four** is entitled, “Practicing Surrogacy in Canada: A qualitative study among gay fathers and gestational surrogates.” This chapter specifically considers: (1) the accessibility of information, (2) healthcare environments, including fertility clinics and hospitals, (3) societal attitudes, and (4) legal regulations, all with regard to surrogacy and gay fatherhood. The call for practice and policy reforms was supported by queer theory and equity theory.

**Chapter five** presents a novel conceptual understanding of surrogacy. This chapter will conclude with the implications of this study for social work practice, research and policy. This dissertation is fulfilled in conjunction with the Joint Centre for Bioethics, as part of the collaborative specialization in bioethics doctoral program. Consequently, the interdisciplinary nature of this research, as it relates to bioethics and clinical healthcare practice will be discussed.
Chapter 2
The intersections of gender, sexuality and parenthood:
A qualitative investigation of the motivations to pursue surrogacy for gay fathers in Canada

2 Introduction
The purpose of this chapter is to present findings on the motivations to pursue surrogacy from the perspectives of both gay men and gestational surrogates in Canada.

2.1 Literature Review
The following literature review will provide an overview of scholarship on gay fatherhood and gestational surrogacy, explicating: (1) the legal regulations in Canada regarding gay parenting rights and the practice of surrogacy, and (2) previous empirical research on the motivations of gay men and surrogates to pursue surrogacy. The purpose of this literature review is not to present a comprehensive overview of scholarly work on either surrogacy practices globally or all routes to parenthood for gay fathers. Rather, I introduce a critical analysis to understand how heteronormativity, heterosexism and gender hegemony have shaped previous research on sexual minority parenting and surrogacy, and have impacted reproductive decision-making.

2.1.1 Framing Gay Fatherhood in the Canadian Context
In Canada, greater social and political inclusivity of sexual minorities has led to increasing opportunities for single and partnered gay men to pursue fatherhood outside the context of a heterosexual relationship. The 2011 Canadian Census showed a dramatic increase from 2006 in the number of children under the age of 24 living in same-sex male parent households; results indicate that approximately 2.9% of men in same-sex relationships had children in 2006, compared to 3.4% of men in 2011 (Statistics Canada, 2006); currently, results indicate that an
estimated 1,900 children are living with same-sex male parents (Statistics Canada, 2013). The increase of same-sex male parent households reflected in census data may be a result of the: (1) federal enactment of marriage equality in 2005; (2) legalization of same-sex parenting and second-parent adoption; and, more recently, (3) recognition of three-parent families on birth certificates. Moreover, advancements in assisted reproduction have afforded gay men with alternative routes to parent. Surrogacy, a practice in which a woman agrees to bear a child for another individual or couple, has become an increasingly desired option for gay men (Cribb & Jarratt, 2016; May & Tenzek, 2016; White, 2016). Yet, there is limited scholarship on gay men’s reproductive options and their motivations to pursue surrogacy both in Canada and worldwide.

2.1.2 Framing Surrogacy in the Canadian Context

ART scholarship generally differentiates between two types of surrogacy practices (Appleton, 2001). A genetic surrogate holds both a genetic and gestational connection to the offspring; she provides her own ovum for fertilization and is subsequently implanted with an embryo (using donor sperm) through artificial insemination (Brinsden, 2003; Greenfeld, 2008; Imrie & Jadva, 2014). In contrast, a gestational surrogate holds no genetic ties to the offspring; she is implanted with a fertilized embryo from donated gametes (sperm and ovum) through in-vitro fertilization (Brinsden, 2003; Kashmeri, 2008). Gestational surrogacy, as opposed to genetic surrogacy, is a much more common (and preferred) practice among both heterosexual and same-sex partners seeking to have children through third-party reproduction (Grover et al., 2013; Sanabria, 2013). This is perhaps owing to underlying concern that a surrogate’s genetic connection may foster maternal-fetal attachment, and lead to difficulty relinquishing the child post-birth (Sanabria,
Post-birth, the genetic or gestational surrogate relinquishes the baby to the intended parent(s), an individual or couple who plans to legally and socially rear the child post-birth (Greenfeld, 2008).

In Canada, surrogacy is regulated by the Assisted Human Reproduction Act (AHRA). Commercial surrogacy, the act of financially compensating or advertising payment for surrogates’ services, is federally criminalized (Nelson, 2016). Punitive risks associated with legal violations may include fines or possible incarceration (Reilly, 2007). Altruistic surrogacy, in which a surrogate is only financially reimbursed for out-of-pocket expenditures incurred as a result of surrogacy, is permissible under AHRA regardless of sexual orientation and/or marital status (Busby & Vun, 2010; Nelson, 2016). The current legislation, however, is ambiguous; stipulations with respect to what constitutes legally permissible reimbursements have yet to be determined. This has made it increasingly difficult for service providers and service users to discern and adhere to Canadian law (Nelson, 2016).

2.1.3 Previous Scholarship on Motivations of Gay Fathers

Earlier scholarship investigating gay men’s motivations to parent has primarily been conducted as a comparison to heterosexual men. Research has generally demonstrated that gay men express similar aspirations to parent when compared to their heterosexual counterparts: a desire to nurture, a sense of immortality and fulfillment, and an innate feeling associated with parenthood (Baiocco & Laghi, 2013; Bigner, 1999; Goldberg, Smith, & Perry-Jenkins, 2012; 30

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30 The prevalence of gestational surrogacy may indicate that: (1) the intended parents do not want a surrogate to assume a ‘social mother’ role post-birth and, thus, a gestational (as opposed to genetic) connection may facilitate the relinquishment of the offspring; and (2) there are concerns that a genetic connection may foster a maternal-fetal relationship and enhance a surrogate’s attachment to her pregnancy and the surrogate offspring.
Greenfeld & Seli, 2011). Notwithstanding the importance of these findings, emphasizing such similarities indirectly endorses a belief that heterosexual men’s motivations, behaviors and actions are socially acceptable and normative practice.

Accordingly, scholarship on gay fatherhood may be driven, in part, by heteronormative and heterosexist discourses that question (and perhaps suspect) gay men’s parenting desires. Heteronormativity is a belief that assumes ‘traditional’ family structures, heterosexuality and conventional masculine and feminine gender norms are morally correct (Oswald, Blume, & Marks, 2005). Heteronormativity fuels heterosexism, defined as “an ideological system that denies, denigrates and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community. It operates principally by rendering homosexuality invisible and, when this fails, by trivializing, repressing or stigmatizing it” (Herek, 1990, p. 316). Heteronormativity and heterosexism have not only influenced scholarship on gay parenting, but have also had a tremendous impact on how gay men contemplate parenthood and decide to have children (Kazyak & Woodell, 2016; Oakley, Farr, & Scherer, 2017; Weissman, 2017).

Gay men’s motivations to parent are structured in a context that privileges heterosexual parenting (Berkowitz, 2007; Goldberg, Downing, & Moyer, 2012; Ryan & Berkowitz, 2009). Consequently, gay fathers may seek out routes to parenthood that will legitimize their non-heterosexual families. For instance, findings from an Australian study (n=12) reported that gay fathers elected surrogacy in order to have a biogenetic (biological and genetic) connection and a physical resemblance to their child. These motivations are indicative of the “social and symbolic importance” (Dempsey, 2013, p. 40) of Euro-American heteronormative kinships practices; a web of conceptual (biogenetic), legal (marital) and interpersonal (relational
similarities) relatedness between parents and children (Strathern, 1995). In turn, surrogacy, in this regard, may be perceived for same-sex families as a way in which to mitigate encounters of sexual stigma. In a U.S. based-study, for example, gay fathers \((n=5; 36\%)\) described that surrogacy offered their families more security and legal protection when compared to other routes to parenthood, such as to adoption and foster care (Park, Kazyak, & Slauson-Blevins, 2015).

Sexual stigma, defined as the socially shared knowledge and approval of the devaluation, inferiority and marginalization of non-heterosexual behaviors, relationships or identities (Herek, 2009), may influence gay men’s decisions to pursue parenthood. Stigmatizing attitudes against gay fathers, in particular, may engender: (1) structural stigma through the denial of certain economic, legal and/or social rights (Hatzenbuehler, 2014; Herek, 2007), (2) enacted stigma through overt physical, psychological and emotional harms (anti-gay epithets, ostracism, bullying) (Chi et al., 2014), and (3) anticipated stigma, the expectation that one will encounter stigma (Steward et al., 2012). Gay men, therefore, “cannot rely on a legacy of cultural givens” (Mitchell & Green, 2007, p. 82). Their motivations to pursue surrogacy may be influenced by reproductive practices and policies that have hindered and/or supported their paths to parenthood (Daley & MacDonnell, 2011; Marvel et al., 2016; Mezey, 2013; Ross et al., 2014).

Legal barriers and a lack of information and support (structural stigma), as well as individual discourses that suggest gay fathers are morally unfit to parent (enacted stigma) have affected gay men’s motivations to parent (Bauermeister, 2014; Berkowitz, 2007, 2013; Goldberg, Downing, & Moyer, 2012; Mezey, 2013; Riskind, Patterson, & Nosek, 2013). For instance, participants \((n=7\) gay partners) in an Australian-based qualitative study described the surrogacy
process as “arduous” (Tuason-McCheyne, 2010, p. 315), having to contend with the “discriminatory, conservative, heterosexist and sometimes homophobic attitudes towards gay men and gay fathers” (Tuason-McCheyne, 2010, p. 319). Consequently, some gay men reportedly experience doubt over their ability to be good fathers, question the suitability of their home environment, and demonstrate concern over their child’s well-being and anticipated victimization (Berkowitz & Marsiglio, 2007; Brown, Smalling, Groza, & Ryan, 2009; Mezey, 2013). These experiences may act as hurdles in promoting fatherhood among gay men. Yet, it also is important to elucidate practices that have enabled gay men’s motivations to parent. For instance, a recent Australian-based study (n=30) showed that the visibility of same-sex parenthood, positive public messaging, inclusive practices and supportive regulations importantly facilitated gay men’s motivations to pursue surrogacy (Murphy, 2013).

Motivations to practice surrogacy are influenced by sociohistorical contexts that have either permitted or delegitimized same-sex parenting (Kazyak & Woodell, 2016). As gay men transgress heterosexual conventionality, heteronormativity, heterosexism and sexual stigma may influence their reproductive decision-making and their paths to parenthood. Empirical research is therefore necessary to understand the motivations of gay men to pursue surrogacy in Canada, one of the leading nations of lesbian and gay rights.

2.1.4 Previous Scholarship on Motivations of Surrogates

Surrogacy research has primarily been conducted in the United States (U.S.) and the United Kingdom (U.K.) among women who have acted as surrogates for heterosexual couples experiencing infertility (Blyth, 1994; Bromfield, 2016; Cicarelli & Beckman, 2005; Covington & Patrizio, 2013; Edelmann, 2004; van den Akker, 2003, 2007). Surrogates have reported being
motivated by financial compensation, altruism, a love of pregnancy (Blyth, 1994; Edelmann, 2004; Jacobson, 2016; Kanefield, 1999; Ragoné, 1996) and a sense of value and achievement (Covington & Patrizio, 2013; van den Akker, 2003). Surrogates’ empathy and compassion are responses to intended mothers’ experiences of infertility and longstanding desires to parent. Some surrogates have also expressed guilt and recompense for past reproductive decisions, such as undergoing a previous abortion or putting a child up for adoption (Kanefield, 1999; Parker, 1983; Ragoné, 1994; van den Akker, 2003), as well as experiences of infertility or rape (Jacobson, 2016).

Surrogates’ motivations to gestate a child for heterosexual couples experiencing infertility may, in part, be a manifestation of gender hegemony. Hegemonic gender norms identify women as having natural predispositions to acts of compassion, empathy and love; pregnancy and motherhood are perceived as ideals of feminine behavior (Dyer et al., 2002; Johnston & Swanson, 2006; McQuillan, Greil, White, & Jacob, 2003; Morell, 2000; Shalev, 2012). Consequently, surrogates’ motivations have been interpreted as an iteration of hegemonic gender norms that have associated women with self-sacrificial care, altruism and nurturance (Narayan, 1995; Raymond, 1990; Ruparelia, 2007). As gender hegemony presumes that women should be selfless, caring and self-sacrificing, the motivations of surrogates may reflect conformity to gender role expectations (Ruparelia, 2007). Moreover, surrogates’ empathy and compassion to intended mothers’ narratives of infertility may transpire, in part, because of gender norms that attribute a woman’s feminine identity and social standing with her capacity to reproduce (Purdy, 1996; Shalev, 2012).
Gender hegemony stems from an essentialist understanding of gender roles and behaviors that assume women’s subordination in their relationships to men (Budgeon, 2014). Accordingly, gendered rhetoric that associates womanhood with parenting and caregiving has been utilized as a way in which to disempower women; feminine behaviors and traits are identified as fragile, vulnerable and weak (Sanchez, Westefeld, Liu, & Vlain, 2010; Schrock & Schwalbe, 2009; Superson, 2012). The depreciation of femininity is based upon androcentric models of masculinity that view strength, aggression and virility as symbols of power and dominance (Donaldson, 1993). These opposing gender norms foster power imbalances between men and women, and uphold marginalization through legal, political and social regulations (Meyers, 2010; Schippers, 2007; Tong, 2008). Thus, ethical deliberations have interpreted that surrogacy may, in part, exploit women’s reproductive decision-making and reflect paternalistic decisions in the context of patriarchal hierarchy (Bartky, 1990; Gimenez, 1983; McCormack, 1988).

In Canada, surrogates are increasingly electing to bear children for same-sex male couples (Cribb & Jarratt, 2016; May & Tenzek, 2016; Schoenberg, 2016). However, there is limited empirical research on surrogates’ particular motivations to pursue surrogacy for gay men. Understanding the motivations of gestational surrogates to altruistically bear a child for gay men may be particularly unique when compared to their heterosexual counterparts. Gender hegemony (in the form of hegemonic masculinity) identifies gay men’s behaviors as effeminate, weak and subversive; in turn, gay men have been ostracized and alienated from dominant social and patriarchal hierarchies (Connell, 1992; Fingerhut & Peplau, 2006; Herek, 2007; Hicks, 2006). Their decision to pursue parenthood challenges heteronormative family structures and, as a result, gay fathers may be subjected to even further vulnerabilities due to their childrearing practices and caretaking responsibilities in the home (Giesler, 2012; Hicks,
2006; Meyer, 2011; Schacher, Auerbach, & Silverstein, 2005). Thus, owing to the absence of an intended mother and gay men’s discernable marginalization, the motivations of gestational surrogates to bear a child for gay men are important to elucidate.

Gay fathers and surrogates have constructed their decision to pursue surrogacy within a social context pervaded by gender hegemony, sexual stigma and heterosexist privileges. How surrogates and gay fathers challenge, accept or oscillate between these positions in deciding to pursue altruistic surrogacy is important to consider. Canada’s unique sociopolitical context may form novel insights in which to understand and interpret the motivations of gay men and gestational surrogates.

2.2 Methods

This chapter reports on findings from a larger phenomenological study that sought to understand the lived experiences of gestational surrogates and gay intended fathers pursuing altruistic surrogacy in Canada. The motivations to pursue surrogacy from the perspectives of both gestational surrogates and gay men will be elucidated.

2.2.1 Sampling and Recruitment

From January 2015 to January 2016, gay fathers and gestational surrogates were recruited through advertisements distributed across LGBT (lesbian, gay, bisexual and transgender) community organizations, online business-registered surrogacy consulting services\(^{31}\) and social media networks in Canada. Non-probability sampling, a non-random sampling design, was

\(^{31}\) Online surrogacy businesses are not considered illegal in Canada, so long as they do not facilitate payment between matched surrogates and intended parents. These organizations are typically registered as businesses that provide information, referrals and support to those pursuing third-party reproduction.
employed due to the exploratory nature of this study (Daniel, 2012). The principal investigator (PI) purposefully selected interested participants who satisfied the inclusion/exclusion criteria for participation in this study and would be able to provide in-depth responses to the research question and objectives. In accordance with IPA, participants recruited were those with lived experiences of surrogacy (Daniel, 2012). Using purposive sampling and snowball recruitment strategies, three populations were targeted: (1) single and partnered gay men who completed gestational surrogacy to have a biological child; (2) gestational surrogates who bore a child (or children) for gay men; and (3) single or partnered gay men and their paired surrogate (referred to as a ‘matched surrogate dyad’ or ‘matched surrogate triad’). No timeline was required for when surrogacy was practiced. There were no specifications on whether participants had to have attained Canadian citizenship or permanent residency status; however, participants had to be permanently living in Canada (regardless of their immigration status). All participants had to have pursued surrogacy in Canada, and be living in Canada at the time of the interview.

Participants met the following inclusion criteria: (1) gestational surrogates who had been implanted with one or more embryos from a donated egg and gay fathers’ sperm (either from a single gay father, one of the gay partner’s sperm, or two separate embryos each implanted with one partner’s sperm)\(^{32}\); and/or (2) gay men who completed gestational surrogacy to have a biological child (either for one or both partners). A completed arrangement was determined by the surrogate relinquishing the child at birth and the father(s) socially rearing the child. Thus, individuals who were interested in pursuing surrogacy, in the midst of an arrangement, or experienced a recent failed attempt (e.g., miscarriage, terminated pregnancy, financial

\(^{32}\) Although sperm cannot be ‘mixed,’ some women who act as surrogates for gay men are implanted with two embryos, with each embryo containing the sperm of one of the fathers.
obstacles) were excluded. Transgender participants were excluded from this study due to likely unique experiences of stigma and discrimination against transgender parenthood. The experiences of transgender intended parents deserve to be explored independently from cisgender parenthood. Gay fathers who engaged in transnational surrogacy were also excluded, owing to the particular ethical\textsuperscript{33} and legal complexities of surrogacy conducted abroad.

Interested participants responded to publicly posted advertisements by email. They were provided with a copy of the informed consent outlining the purpose and procedures of the study. Gay fathers and surrogates were initially recruited independently from one another. All informed consent documents inquired about third party contact. A section in the informed consent stipulated whether the participant would be willing to contact the third party (either the intended parent or surrogate) to see if they would be interested in participating in this study. If permission was granted, the PI asked whether the participant(s) wanted to contact the third party, or whether a direct request to participate could come from the PI. Respondents who declined contact with the third-party were still able to provide consent and participate in the study. Offering a choice in how the third party may be contacted was purposeful to mitigate ethical issues related to confidentiality and disclosure. Participants were provided with a $30.00 honorarium for expenses incurred in participation. The study was reviewed by the Research Ethics Board at the University of Toronto.\textsuperscript{34}

\textsuperscript{33} There are numerous ethical complexities that may arise when conducting surrogacy abroad. Although the objective of this paper is not to comprehensively discuss the ethical implications of transnational surrogacy, ethical theorists have suggested that surrogacy conducted abroad typically raises fears of the exploitation of economically disadvantaged and racially marginalized women. Transnational surrogacy is most often conducted in resource-poor settings, such as India, Thailand and Nepal. Thus, ethical considerations surrounding financial compensation and concerns regarding baby-selling and the mistreatment of women are often central to discussions on the use of transnational surrogacy.

\textsuperscript{34} At the time of submission, the PI was a member of the REB. She did not attend the full board meeting when this protocol was discussed and did not consult with any committee members. K.A. (a thesis committee member) became an REB member subsequent to the protocol submission and review, has never discussed the protocol with any committee members, and is no longer a member of the approving REB.
2.2.2 Data Collection

In-depth semi-structured interviews, ranging from 1-2 hours, were conducted by the PI with gay fathers and gestational surrogates. Surrogates and gay fathers were interviewed separately, and joint interviews were conducted with partnered gay men to explore nuanced convergences and divergences of partners’ narratives. Partners were informed about joint interviews, and both partners were required to provide written consent (if both agreed to participate). However, a participant’s partner could refuse participation and, thus, an individual (rather than a joint) interview could be conducted. Individuals who were separated did not require consent from their partner, and their partner was not obligated to participate in the study. At the time of the interview, the PI reviewed informed consent verbally with participants. The purpose of the study, all possible risks and benefits, as well as data storage measures and confidentiality were discussed. The informed consent included questions on contacting the third party, the opportunity to review redacted interview transcripts, the distribution of aggregated findings prior to dissemination and a copy of the final research report. Interviews were conducted either in-person, at a mutually agreed upon location between the PI and the participant, or over the phone. All participants provided written consent prior to the interview.

The semi-structured interview guide comprised questions and detailed probes to address the motivations to pursue surrogacy. Questions included: In thinking about parenthood, how did each of you come to the decision to have a child; how did you decide on surrogacy? Surrogates were also asked to reflect on how they came to the decision to become a surrogate. Detailed probes inquired about factors that supported or hindered this decision. Participants were asked to discuss their identity narratives and values about biogenetic parenthood in relation to their
motivations to pursue surrogacy. No questions were asked directly about monetary payment or financial compensation, to mitigate any legal concerns.

All interviews were digitally recorded and transcribed verbatim by the PI. To protect participant confidentiality and anonymity, identifying names, cities, surrogacy consulting services, community organizations and fertility clinics were redacted from the transcripts. All data were stored on an encrypted password-protected secure server. Informed consents were kept separate from participant data.

2.2.3 Data Analysis

Analysis followed an interpretive phenomenological approach (IPA) (Creswell, 2012; Starks & Trinidad, 2007). IPA primarily focuses on the meaning of a significant life-transforming event that often remains hidden from public discourse (Smith, 2004). IPA is used to gain knowledge and insight from those who have direct lived experience regarding a phenomenon not largely explored or understood in research (McConnell-Henry, Chapman, & Francis, 2009). A person’s cultural, social and political backgrounds are critical facets in the process of analysis (Lopez & Willis, 2004). In the current study, participants’ experiences were considered within the sociohistorical and political context of Canada.

The PI read interview transcripts multiple times; line-by-line coding was conducted, and important and meaningful statements (“meaning units”) were selected that provided a deeper understanding of motivations to pursue surrogacy. The PI selected exemplars from the transcripts to enrich meaning, and this process led the PI to delineate emerging patterns or themes. This occurred with each individual interview; patterns and themes were then organized
from the data manually through textual analysis, and linked within and across participant interviews to generate research findings. In accordance with IPA, inductive analysis was employed to understand the motivations of gay fathers and surrogates to pursue surrogacy in Canada. This idiographic and iterative approach was supported by multiple critical theoretical and conceptual frameworks, including sexual stigma discourse (Herek, 2007), queer theory and feminist ethics. These emic and etic approaches were employed to explore and understand the decisions to pursue third-party reproduction among surrogates and gay fathers.

Triangulation, member-checking and peer-debriefing supported the validity and trustworthiness of the data (Creswell & Miller, 2000). The PI triangulated data sources/informants by including perspectives of both surrogate and gay father populations, and matched surrogate triads. The PI provided all participants with copies of their transcripts for review. Additionally, member-checking was conducted to gain feedback from participants; aggregated findings were disseminated to participants, and their feedback was incorporated by the PI into analysis. To assist with the interpretation of data, peer-debriefing was sought and implemented from experts in the fields of assisted reproduction and gay men’s health.

2.3 Results

The results section will report on the demographics of the study participants, followed by the themes that emerged from the textual analysis of the interview data.
2.3.1 Sample Characteristics

Twenty-two respondents participated in this study. Sixteen participants were gay fathers (seven dyadic partners & two separated fathers), and six participants were gestational surrogates.

Among participants, surrogacy was practiced from 2010-2014. Participants ranged in age from 22 to 50 years old. The average age of surrogate participants was 34 years ($SD=8.09$), compared to an average age of 39 years ($SD=5.55$) among gay father participants. Gay fathers and surrogates were predominantly white (86%); two gay father participants (12%) were Asian (both of whom had white partners), and one surrogate participant was Aboriginal (17%). Half of all surrogates has individual incomes of less than $40,000 (CAD), with one participant reporting an individual income of $81,000-$120,000 (CAD). Two surrogate participants did not report their income. The median individual income of surrogates was less than $40,000 (CAD).

Gay father participants’ individual incomes ranged from $40,000-$80,000 (CAD) (44%) to over $120,000 (CAD) (37%). The median individual income for gay father participants was from $81,000-$120,000 (CAD). Half of surrogate participants held college degrees, and two surrogate participants held Bachelor’s degrees (33%); one surrogate did not report. Two gay father participants (12.5%) had graduated from high school and two had graduated from college (12.5%). The remaining 12 out of 16 (75%) gay father participants had either a university degree or had attained a post-secondary degree in law, medicine or education. Although all participants were living in Canada at the time of surrogacy, there were four gay father participants (two dyads) who had emigrated from other countries (25%); one couple had attained Canadian citizenship prior to the interview. Surrogacies were all completed in Canada, but primarily conducted across cities and/or provinces.
At the time of the interview, two surrogate participants (33%) had previously acted (once prior) as gestational surrogates, and four surrogate participants (67%) indicated that this was their first surrogacy experience. Surrogates had between one and five biological children. This was the first surrogacy experience resulting in a live birth for all gay intended parents, and their first child at the time of interview. Four out of five matched triads matched through the use of online surrogacy consulting services; one matched surrogate triad met through a mutual friend. A separated father indicated that his gestational surrogate was his partner’s sister-in-law, and all other participants (one surrogate and two gay partner dyads) also met through a surrogacy consulting service. Among intended parents, three dyads had twins (n=6; 38%), each child biologically-related to one partner. Surrogate offspring ranged in age from a month old to five years of age at the time of interview.

Twenty-one participants met inclusion criteria and were included in this analysis (Table 1; Table 2). A separated gay father was excluded when he disclosed during the interview that his surrogate was a genetic, as opposed to a gestational, carrier.\(^{35}\) Among included participants, 15 individuals formed matched surrogate triads, consisting of five partnered gay men (n=10) and their paired gestational surrogate (n=5). The separated father included in analysis was married to his partner at the time of surrogacy, and for some time post-birth. Although eligible for inclusion, no fathers who pursued surrogacy as single gay men participated in this study; and no gay fathers identified as bisexual. All surrogates were in opposite-sex marriages while they pursued surrogacy, and at the time of the interview.

\(^{35}\) A genetic surrogate refers to a woman who utilizes her own egg (and donated sperm) to bear a child; she is genetically related to the surrogate offspring. As per exclusion criteria, genetic surrogates were not included in this study.
Quotations from gay fathers (labeled F) and surrogates (labeled GS) are presented in the results with their participant ID and age at the time of the interview. Textual analyses related to motivations of gay men will be presented first, followed by the motivations of gestational surrogates. The discussion will comprise a critical and synthesized analysis of the findings.

2.3.2 Gay Fathers’ Motivations to Pursue Surrogacy

Six themes emerged discerning the motivations of gay fathers to pursue surrogacy: (1) identity narratives; (2) relationship contexts; (3) dissatisfaction with adoption; (4) biogenetic connection; (5) physical resemblance; and (6) visible representations of gay fatherhood.

2.3.2.1 Identity Narratives: “for me, it’s something I’ve been considering forever”

Participants reported an innate and longstanding desire to have a child: “It was always very clear that this was important to me” (F6, 36 y). Motivations to parent were consistent in participants’ life course narrative; parenthood was articulated as an inherent desire since childhood and “something I’ve been considering forever” (F12, 35 y). Participants described that they “just knew from a young age” (F2, 45 y). Participants’ accounts of their desire to have a child were described as instinctive, expressed as “a biological compulsion to have a genetic child. Maybe it’s not biological. Maybe it’s cultural. But I do know that I felt a compulsion to have a child genetically connected to me” (F8, 44 y). For these participants, their identities as gay men were congruent with parenthood:

I didn’t really ever feel that being a gay man was a ticket to not being able to have kids, like a lot of the gay culture believes. But I never felt that, I’m a gay man equals I’m not able to have kids. (F15, 43 y)
His partner similarly articulated: “I think that having children actually solidified the fact that we are out, there’s no way that we are going to go back in the closet sort of thing” (F14, 36 y).

Some partners, however, demonstrated ambivalence towards parenthood, and struggled with coalescing their gay-parent identities. A participant articulated that, “as a gay man you don’t really picture children in the future…but at the same time knowing this is the natural progression of life and relationships” (F5, 40 y). There was an intrinsic struggle between forming a heteronormative life course trajectory, and the inability to discern how or if this could occur as a gay man: “I think you’re socialized to think that early on that you just don’t have children or you’re socialized that gay parents can’t have children, can’t raise children. That’s what society was like when we were growing up” (F5, 40 y). Participants identified institutional obstacles that fostered their identity conflict. For instance, some participants had moved to Canada because of its same-sex marriage and second-parent adoption laws. For those participants who had emigrated from countries where same-sex marriage, adoption and surrogacy were prohibited, parenthood was not previously conceivable: “when we moved here 3 years ago, that helped to shift the way I look at it just because it suddenly became something tangible that we could actually do” (F13, 34 y). His partner explained that in their home country, it was “just legally not allowed to have surrogacy for gay men or for single men. Just for straight couples” (F12, 35 y).

Overall, participants expressed specific narratives that shaped their gay-father identities. For some participants, a desire for children was assumed from childhood. For other participants, uncertainty about fatherhood was attributed to structural stigma, as they described political regulations that hindered same-sex parenting and led to identity conflict.
2.3.2.2 Relationship Contexts: “To say you’re married makes it more like everybody else”

Participants expressed that motivations to pursue surrogacy were influenced by their dating trajectory and relationships. The wish for children was demonstrated as an important selection factor for a partner: “That was my litmus test question. So basically anytime I was into a guy, I would ask them if they wanted kids” (F8, 44 y). A committed and long-term relationship was a prerequisite to parenthood for all participants: “it’s just always been, sort of, if I found the right person and things worked out that would just be part of my life” (F15, 43 y). All participants were married while pursuing surrogacy; marriage was perceived as a more accepted point at which to consider children: “it was important to be married first in really old fashioned standing…I figured that would be easier for [the baby] even though it’s going to be difficult anyways. To sort of say you’re married, it makes it more like everybody else” (F4, 50 y).

Similarly, his matched surrogate reflected on the importance of marriage among gay men interested in pursuing surrogacy: “Maybe that’s what I was drawn to. These guys were married and wanting to have a family” (GS2, 45 y). Participants explained that, as gay men, a relationship enabled their reproductive decision-making:

I’ve always thought about it. Never thought I would be in the relationship to actually do it, much less how easily it would have been in a gay relationship. I eventually met my husband and we got married. From the beginning we talked about it and we started planning for it. (F10, 37 y)

Alternatively, some participants described being motivated to pursue surrogacy because of their partner. A father who separated from his partner after surrogacy indicated that “this desire to have a child wasn’t born of me. It was my partner. And it was ultimately his choice” (F1, 42 y). Another participant articulated that, “I don’t think that I always knew that I wanted to have
kids, personally. I think [redacted partner’s name] always knew that he wanted to have children” (F14, 36 y). Even if the decision was eventually mutually agreed upon, some participants were more motivated than their partners. A participant recalled that it took him “a little longer [than his partner] just because I was not ready” (F3, 36 y), and the motivating partner initiated research on family planning: “he’s the one who researched more about everything. So he was more knowledgeable about the whole, about everything” (F3, 36 y).

For all participants, along with the participants who had separated after surrogacy, children were planned in the context of a stable pre-existing relationship. Participants reported dating with the intention of having children; a family was a ‘natural’, and perhaps a more socially accepted, progression of their relationship. Marriage was described as a stable position that mitigated the anticipated stigma that would ensue against their children for having same-sex parents. Partners who were more ambivalent about parenthood relinquished their uncertainty and initial reluctance when the decision to pursue surrogacy was embraced.

2.3.2.3 Dissatisfaction with Adoption: “It’s going to take years; it’s never going to happen”

Participants considered surrogacy as preferable to adoption. For gay fathers, “adoption was possibly an option but, preferably yes, biological” (F11, 29 y) children were considered ideal. Barriers in the adoption process facilitated the decision to pursue surrogacy. Participants discussed hearing unsuccessful adoption narratives, and personally faced institutional obstacles. For instance, those who considered international adoption encountered “very few countries...allowing gay parents to adopt” (F15, 43 y). Furthermore, due to a couple’s immigration status “there was no real option of adoption. So we were left with surrogacy. So that’s how the decision was made” (F12, 35 y). The bureaucratic challenges of adoption,
including “the lack of control” (F2, 45 y), were common experiences among gay fathers.36

Surrogates also had knowledge about obstacles to adoption: “they tried adoption and stuff, and it didn’t work for them. So it really touched home…they actually wanted kids” (GS1, 37 y).

Surrogacy was consequently perceived as more definitive than adoption: “surrogacy, there was at least something about it that we could be able to control” (F6, 36 y).

Participants also described the challenges associated with raising adopted children:

   It is very easy to adopt a child who is a little bit older in this province. Older and has a lot of medical and emotional issues… from my understanding, you have to be ready to take on some pretty heavy stuff with the kids that you are going to have available to you. (F6, 36 y)

There were concerns over missed experiences of not raising a newborn: “We wanted something more personal and I didn’t want to miss any opportunity. If I had gotten a three-year old for adoption, I probably would have regretted not having the infant experience” (F10, 37 y).37

On the contrary, one gay father who separated from his spouse following the birth of their child recalled being inclined to adopt rather than to have biological children: “for me, there’s a lot of kids who are in social services systems that needed adoption and needed parents…that seemed like the most logical approach. My feelings were to go that way” (F1, 42 y). He ultimately

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36 In Canada, it is estimated that the adoption process can take anywhere between 9 months and 9 years, often dependent on whether one is pursuing a public, private or international adoption (Adoption Council of Canada), as well as if one is hoping to adopt a “healthy” newborn (as opposed to a child with special needs). Retrieved from http://www.adoption.ca/faqs

37 For instance, a public adoption is an adoption through the use of a public agency (e.g., Children’s Aid Societies). According to the Adoption Council of Canada, children are often placed in foster care due to neglect, abuse or abandonment from their biological families. The average age of a child in foster care is about 10 years old, but children can range from infants to teenagers (Adoption Council of Canada). In Canada, there are no legal prohibitions to same-sex public adoption. Retrieved from http://www.adoption.ca/faqs
decided to pursue surrogacy because his partner desired a biological child: “he didn’t want to adopt; he wanted a biological child. So it was kind of quick and straightforward” (F1, 42 y).

Participants initially considered adoption, but opted for surrogacy owing to institutional adoption barriers, challenges in raising an adopted child and the desire for a newborn experience.

2.3.2.4 Biogenetic Connection: “You can’t take them away, because it’s something different”

A biogenetic connection was a critical factor in having a child. As a participant adamantly expressed, “anyone’s dream would be to have your own biological child” (F2, 45 y).

Participants perceived that having a biological connection was “more real” when compared to adoption: “I think the fact that it would be related to me makes it more of a draw; makes it more real…or have more motivation to invest in that” (F7, 35 y). The desire to have a biogenetic connection to the child was indicative of the value participants placed on continuing their lineage. A participant, for instance, explained that “we actually wanted the blood line to be passed on. We wanted something more personal” (F10, 37 y). Legacy strengthened attachment and bonding by “knowing that I am leaving a part of me one day behind; leaving my genetic name” (F11, 29 y).

Participants theorized that a biogenetic connection could also promote security when laws and regulations are not inclusive of same-sex parent families:

having come from the United States where I felt persecuted in many ways for being gay…I had a paranoia that somehow the government, if we adopted, would take our kids away. I felt like I could give them the middle finger and say, no,
these are my biological kids; you can’t take them away because it’s something different. And somehow I rationalized that having a biological connection gave me one level of security more than adoption could. (F8, 44 y)

The importance placed on biogenetic connections was also reflected in fathers’ decisions of paternity, and the selection of whose sperm would be donated. All except for two participants made the decision to have embryos implanted with each partner’s sperm: “We came into the process that we would each donate a sperm….so the process was one of each. One embryo of each would be implanted. Whoever’s took, or both would be lucky” (F2, 45 y). In this way, participants described equity in reproduction by assuming a shared biogenetic contribution. As a participant explained,

One batch of eggs was fertilized with my husband’s sperm and one was with my sperm. Each individual embryo was frozen separately. And then with each embryo transfer attempt we would take one from each batch and transfer two embryos at a time. And it turns out that our twins were born and biologically connected to each other. (F8, 44 y)

Among participants, three dyads (n=6) had twins, each child biologically-related to one partner. Gay partners cannot mix sperm, but as shown in participants’ narratives, they will typically implant two embryos, with each embryo containing a donor egg and the sperm of one of the partners. This provides an equal likelihood of achieving biological parenthood.

Participants, even when they conceived twins, indicated having conversations before implantation regarding turn-taking. Contingency plans were made if the pregnancy did not
result in twins, whereby the non-biogenetic partner would provide his sperm on a future surrogacy process. A participant described this process as follows:

when we decided to put the two embryos in...we decided to put one with my genetics and one with [partner’s name]. There was that talk and that discussion because it wasn’t logical for my embryos to be implanted one time or have three of my embryos for the first surrogacy and we have to follow up with a second surrogacy project for [partner’s name] embryos. What was important was we both wanted our biological children...the decision of whose to implant first wasn’t complicated...we just took one of each and we said if we lost one…then we would do the genetic testing and we would follow up with another surrogacy project. But it just happens that both embryos took and now we have one surrogacy project with two biological fathers. (F14, 36 y)

However, sometimes turn-taking was precipitated by conflict, as described by two gay fathers in this study. One gay father articulated that “we decided my husband was going to be the first donor and we were going to do it again in two years and I was going to be the donor for the second child” (F10, 37 y). In explaining this decision, he recalled:

I didn’t want to be the donor as badly as he did. I was completely happy with us both contributing and the doctor selecting...but he wanted it a lot more. And fine. I don’t really care. It’ll be our child. Because it’s just more important to him to have a legacy carried on, to have his name carried on. (F10, 37 y)

He reflected on this experience by expressing that “it was very selfish of him [his partner] to demand that” (F10, 37 y). The notion of one partner valuing biological parenthood more than the other partner was echoed by a father who separated from his partner after surrogacy:
I come from a big family and...I have siblings with children. So I, there was no need to have my own child. So I just said we can kind of be the social parents...and he said that he wanted one of his own so that he has a child of his own to raise. It was different than raising or being that special uncle to someone else’s child; my partner came to me and asked me to consider having a child...he wanted a biological child. (F1, 29 y)

As indicated by participants, the process of biogenetic parenthood may be quite straightforward, in which both partners purposefully donate their sperm (and implant two embryos for equal likelihood to be biological parents). A contingency plan is then followed if the pregnancy does not result in twins. However, two participants indicated that conflict may arise, often owing to the value and meaning each partner places on biological parenthood. A biogenetic connection was perceived as more personal, described by participants as a symbol of lineage, a safeguard against anticipated stigma and, in some ways, a validation of gay men’s right to parent.

2.3.2.5 Physical Resemblance: “I always wanted a little mini-me”

The desire for physical resemblance between gay fathers and their children was an important motivation to pursue surrogacy: “I always wanted a little mini-me” (F11, 29 y). Participants described the wish to see themselves in their children. A participant recalled that, “we just wanted to sort of see our families’ faces in the baby” (F4, 50 y). For participants, physical resemblance was a primary consideration for using surrogacy: it was “the first thing you think of...you think about those, almost materialistic things, almost vain things, that you want the child to have your same skin tone, have the same dark hair and dark eyes and things like that” (F10, 37 y). Moreover, it was thought that family resemblance could protect against sexual stigma: “it’s that I wanted children who looked more like us so that we wouldn’t have any of
the extra social burdens out in public” (F8, 44 y). This participant explained that there is “a kinship because of that look. We definitely have a feeling of connectedness and it’s reinforced by family and friends who tend to favor those types of things” (F8, 44 y).

Physical resemblance was further emphasized by participants’ egg donor selection. Participants intentionally sought egg donors with similar physical features and characteristics, including consideration of ethnicity or race, particularly among visible minority participants. A participant recalled that physical resemblance “allows them to have that connectivity” and noted that he and his partner

were able to find a half Japanese, half Caucasian egg donor…one batch of eggs was fertilized with my husband’s sperm and one was with my sperm…so one child is one-fourth Japanese and three-fourths Caucasian. And the other one is the other way around. (F8, 44 y)

For one couple, an inability to find an egg donor that matched their ancestry was frustrating: “ideally we wanted to find a Portuguese donor, but there wasn’t” (F10, 37 y). Conversely, a white gay father indicated that when selecting an egg donor, “we decided that minorities were not a good idea since we thought that maybe the kids’ having two gay dads don’t need to be half Asian or half Black or something” (F15, 43 y).

Identifying physical likeness with their children was an important component for pursuing surrogacy. Resemblance and familiarity fostered connectedness and also protection, as it enacted a more socially acceptable form of kinship. Physical resemblance was, for some participants, a way in which to negotiate sexual stigma.
2.3.2.6 Visible Representations of Fatherhood: “it’s something tangible”

Participants identified that visible portrayals of gay men having children influenced fatherhood: “I think as I got older and realized surrogacy was happening…I thought it was a possibility” (F4, 50 y). A participant echoed this experience: “as years went by and I saw different models of fatherhood happening for other gay men, I realized that it can be achieved. It’s something tangible” (F12, 35 y). The prevalence of surrogacy facilitated the reproductive process, as “knowing that, that [surrogacy] existed…that it was legal and that it was possible” (F15, 43 y). Similarly, “we heard more stories about people having kids through surrogacy that kind of helped direct our focus” (F7, 35 y). The visibility of other gay men having children through surrogacy facilitated participants’ thoughts about assisted reproduction: “It wasn’t until I started seeing representation of gay guys having kids. I think that visibility is critical and crucial to the health of our community” (F8, 44 y).

Visible representations of gay fatherhood also included affording rights and privileges to same-sex couples in Canada. The legitimization of gay relationships was an important motivation for parenthood: “now with marriage and gay relations being legitimized, people actually think about commitment as opposed to before where gay relationships didn’t really exist” (F5, 40 y). A participant, whose partner was originally from Japan, reported that he and his partner emigrated to Canada from the United States “because not only were we dealing with the immigration issues around keeping us together as a couple, but we actually wanted a very stable environment for our future children” (F8, 44 y). Participants’ accessed information on social media and, for those who lived in urban settings, courses at LGBT centers provided relevant resources and supports on parenting options for same-sex couples. For instance, a participant reflected on the importance of community involvement: “we discovered that there is actually a
community of Israeli gay couples who do surrogacy. And they all know each other and share experiences and tips” (F13, 34 y).

The presence of role models and visible representations of fatherhood were important components in facilitating reproductive decision-making. Surrogacy and the visibility of same-sex parent families shaped gay men’s parenting options. Fathers were able to gain information about the reproductive process and, in turn, surrogacy became a concrete and tangible opportunity.

2.3.3 Surrogates’ Motivations to Pursue Surrogacy

Four themes emerged discerning surrogates’ motivation to pursue surrogacy: (1) altruism; (2) social justice; (3) visibility; and (4) positive pregnancy.

2.3.3.1 Altruism: “How would I feel if I couldn’t have kids?”

Altruism was a fundamental motivation to pursue surrogacy: “it’s something that I’ve always wanted to do, to help someone expand their family” (GS5, 27 y). A participant who specifically sought to bear a child for a gay couple articulated that she saw surrogacy as “a way that I can help; I was more than happy to do it” (GS4, 36 y). In turn, surrogates connected altruism to feelings of satisfaction and accomplishment. Experiences of self-worth were inherently tied to their altruistic behavior:

I’m getting out of it that this is such a cool thing to do. And that they want a baby more than anything in the world and they can’t have one unless someone helps them out. To be able to say that I had a part in that? To me that’s amazing.

(GS2, 45 y)
Her matched fathers indicated that, “ideally you want somebody [a surrogate] who has a pattern of altruism” (F5, 40 y).

Participants were also motivated by reactions of guilt and sadness for those unable to have children naturally. Surrogates thought about, and placed emphasis on, their own families (as all surrogates had their own biological children) in connection with helping others: “knowing what it’s like to have a kid, and me just imaging not being able to have my daughter. That’s probably the biggest push” (GS6, 22 y). Compassion and empathy played an important role, as surrogates asked themselves, “How would I feel if I couldn’t have kids” (GS4, 36 y)? A participant identified that because her kids were healthy, surrogacy was just “something I could do; maybe pay forward some of my good luck” (GS3, 35 y). Her matched father expressed the importance of his surrogate’s altruistic behavior; he wanted “somebody who…really genuinely wanted to help” (F8, 44 y).

Surrogates consistently remarked on their altruistic motivations to pursue surrogacy, as they felt a sense of fulfillment and pride at being able to assist in the creation of a family.

2.3.3.2 Social Justice: “I’m an LGBT supporter to begin with…”

The promotion of reproductive justice and gay rights was an important consideration of surrogates. Participants described wanting all individuals to have the option to have a family, not just opposite-sex partners: “I think people should have children, families. People should be able to have a family if they really want one” (GS1, 37 y). Another participant described that “there’s a lot of people who would like to have children, and there’s barriers that they face. I
think the injustice of that just bothered me. There’s a lot of people who would make great parents” (GS3, 35 y).

Participants also responded to the discrimination and stigma gay men face as fathers: “I think a lot of it was just because gay couples have no choice…I’m an LGBT supporter to begin with, so this was just kind of an extension of that” (GS4, 36 y). As her matched father recalled, she specifically wanted to do this for same-sex couples, not heterosexual couples…she understands the fact that there are limitations of a same-sex relationship and she does want to help somebody achieve the family that she has and loves so much; she just wants to give to somebody else. (F10, 40 y)

A surrogate echoed this sense of advocacy and inclusivity: “I think there’s a lot of discrimination. There’s a lot of homophobic behavior. And I just can’t stand that. I don’t like it all. That was part of it” (GS2, 45 y).

For one surrogate participant, electing a same-sex couple was not an intentional choice, but had occurred because of the connection that developed with the intended parents: “It wasn’t something that I went into thinking that I would only carry for same-sex couples. I think it’s just who I’ve developed friendships with through the surrogacy community; it tends to be more male couples than male-female couples” (GS5, 27 y).

Surrogates’ views associated with social justice and gay rights importantly influenced their decision to act as surrogates, a perhaps unique contribution among those who intentionally carried for gay men.
2.3.3.3 Visibility: “I knew how much of a struggle my parents had before they adopted me”

Participants expressed that interest in surrogacy derived from family members’ experiences. A participant recalled that her “ex-husband’s sister-in-law carried as a surrogate” (GS4, 36 y), while another participant reported that her mother-in-law had “done three [surrogacy] journeys…so it’s always been kind of there” (GS6, 22 y). Surrogates spoke about their familial connection to fertility and adoption as reasons they pursued surrogacy. A participant articulated that, “my parents had adopted me because they had fertility problems. So it was something I was always interested in just because I knew how much of a struggle my parents had before they adopted me” (GS5, 27 y).

The growth of online surrogacy forums and communities show the increased visibility of surrogacy in Canada: “I think there’s a lot more content out there now than perhaps there was then [in 2010]. It just seems to expand all the time” (GS3, 35 y). Participants’ motivations to pursue surrogacy were fostered by social media, including reading blogs, websites and anecdotes from other surrogates that enabled them to consider this path more concretely. A participant indicated that she “read stories of families who have been helped by surrogate moms and it was just really interesting; it was just something I really wanted to do” (GS2, 45 y). Online surrogacy communities provided sources of information and support: “I joined those online conversations and groups and befriended some other Canadian surrogates who had experience, and who were friendly and welcoming and willing to answer any questions that I had. So that’s why I decided to do it” (GS3, 35 y). For more than half of surrogate participants, these online communities transitioned to important in-person support networks: “we can share our experiences and even in terms of what’s kind of normal and what’s not; it’s really helpful to be able to look to people that have been through the process a few times” (GS5, 27 y).
The existence of online networks played an important role in promoting surrogacy. Online forums offered potential surrogates accurate and relevant information, and facilitated access to resources and consulting services. Having these systems in place, whether from family members or from other surrogates, elicited a sense of support, visibility and connectedness.

2.3.3.4 Positive Pregnancy: “I always assumed I was going to be pregnant one more time”

Surrogates indicated that their motivations to pursue surrogacy stemmed from the wish to re-experience pregnancy, but to not raise a child of their own: “I enjoy being pregnant; I knew we were done having our own children, but I wanted to be pregnant again” (GS1, 37 y). Similarly, her matched fathers recalled that “the reason she’s always told us she did this is because she loves childbirth…she just said that the euphoria is amazing” (F2, 45 y). A surrogate echoed a similar narrative: “my husband and I were done [having children]. I had…a few miles left on my uterus and I was in good health and, with my pregnancies, I didn’t have a problem...so I think I just started thinking about it” (GS3, 35 y). Some participants had anticipated being pregnant again. A surrogate, for instance, indicated that she was expecting to carry for her cousin and, when it did not occur, she considered pursuing surrogacy for a couple she had never met, as she “always assumed I was going to be pregnant one more time” (GS4, 36 y). Her matched father described hearing a similar narrative: “she had five successful pregnancies…but she wanted to, in fact, do this for somebody [else]” (F10, 37 y).

Gestational surrogates proposed that a healthy, positive and enjoyable pregnancy were key determinants in pursuing surrogacy. All surrogates had children previous to the arrangement, and all but one surrogate articulated that they had completed their families.
2.4 Discussion

The current study presents empirical data on the motivations of gay fathers and gestational surrogates to pursue surrogacy in Canada. Findings suggest that reproductive decision-making may be interpreted as both a broadening of conventional parameters that have defined parenthood and kinship, and a mirroring of heteronormativity and hegemonic gender norms (Folgerø, 2008; Hicks, 2006, 2013; Hopkins, Sorensen, & Taylor, 2013; Warner, 2000).

In the current study, most gay fathers described their motivations to parent as instinctive, and recalled a lifelong desire to have children. As they upheld congruent gay-father identities, participants challenged heterosexist ideologies that have perpetuated stereotypes that gay men do not have a natural propensity to nurture or reproduce (Berkowitz, 2007; Giesler, 2012). For some participants, a child actually solidified their gay identity and represented their right to parent. For other participants, heteronormative discourses impeded upon gay men’s perception of their ability to be gay and raise children. To pursue surrogacy, participants adapted their presumed identity narratives (e.g., to be childless) to incorporate fatherhood and coalesce their gay-father identities. As reflected in previous scholarship (Benson, Silverstein, & Auerbach, 2005; Berkowitz & Marsiglio, 2007; Folgerø, 2008; Peterson, Butts, & Deville, 2000), the difficulty in assuming a congruent gay and father identity may manifest as a response to heteronormative constructs of masculinity that participants thoughtfully contested.

Moreover, gay fathers in this study dated with the intention to marry and have children. A stable long-term relationship was a significant determinant in having children, as a partner supported their procreative decision-making. Among participants who expressed ambivalence in fathering, a relationship facilitated this embrace of parenthood. Thus, gay fathers’
motivations to pursue surrogacy refute stereotypes that consider gay men to be promiscuous, involved in transient relationships and uninterested in children (Armesto & Shapiro, 2011; Hopkins et al., 2013). Gay fathers married to form a two-parent same-sex household, intentionally without a woman/mother figure. Importantly, the equal desire for biogenetic paternity among partners was resolved through a shared reproductive process, and the significance both men placed on kinship. In turn, gay fathers’ decision to pursue surrogacy broadens heteronormative definitions of procreation, and resists stereotypical discourses that have assumed gay men’s childless identity narratives (Folgerø, 2008).

The motivations of gestational surrogates may also contest hegemonic gender norms that have equated women with reproduction and child-rearing practices (Gimenez, 1983; Greil, Slauson-Blevins, & McQuillan, 2010; Kissil & Davey, 2012). Surrogates in the current study articulated a desire to re-experience pregnancy without the intent to socially parent the child they gestate, a motivation that has been articulated in previous scholarship. In Jacobson’s (2016) ethnographic research with gestational surrogates in the U.S., all surrogate participants (n=31 surrogates) articulated a love of pregnancy; “surrogates not only enjoy the bodily and social process of gestating and giving birth, but they also appear to deeply identify with their role as mothers” (p. 54). The current study supports Jacobson’s findings, as surrogate participants reported that their altruism was rooted on the emphasis they placed on having biological children and building their own families.

As surrogates disconnect genetic, gestational and social motherhood, they demonstrate their reproductive freedom and procreative liberty (Robertson, 1987; Sistare, 1988). Choosing when and how to become pregnant grants women a sense of control and power over their
reproductive decision-making (Purdy, 1996; Weiss, 1992). Characteristics of altruism and social justice depict women as *autokoenomous*; they value the creation and preservation of relationships, and the emotional needs of others (Narayan, 1995; Tong, 2008). These positive social interactions empower traits of selflessness, care and compassion, transforming them from attributes normatively considered weak and fragile. In turn, the actions of surrogates deeply challenge heteronormative family structures and resist the subordination of hegemonic feminine norms.

However, motivations of gay fathers may also be grounded in a felt obligation to abide by certain cultural norms and socially acceptable conventions; as a manifestation of *compulsory heterosexuality*, people feel as though they have to constrain behaviors in order to attain certain rights and avoid physical, emotional and psychological harms (Herek, 2007; Rich, 1980). Compulsory heterosexuality is a response to a system of rewards and punishments that transpires from sexual stigma (Logie, 2015; Rich, 1980). For instance, surrogates underscored that long-term relationships of intended parents indicated stability and a good home for surrogate offspring. Gay fathers explained that emulating a heteronormative family structure would grant them and their children safety and protection from structural and enacted stigma, and mitigate fears of potential bias and disapproval (e.g., anticipated stigma).

These results are supported by previous scholarship on same-sex biological parenthood. For example, in her research with lesbian families (n=25) across England and Wales who pursued donor conception, Nordqvist (2012a) explains that women’s donor selection and family planning was structured and negotiated within a context that propagated sexual stigma and anti-same-sex parenting. Participants’ approaches were interpreted as a strategy in which to create a
sense of belonging, and represented a pressure to conform to normative family discourses and to mitigate experiences of stigma (Nordqvist, 2012a). Nordqvist’s findings are endorsed in the current study through gay father participants’ concerns regarding their children’s future, such as anticipated encounters of bullying and ostracism, and increased hardships; a biogenetic connection and physical resemblance to their children appeared to make familial attachments seem more real and legitimate, and more favorable to friends and families; the “utilisation of normative family discourses and their attempts to protect their children from homophobia, are suggestive of a social context still characterised by a deeply heterosexualised, geneticised and racialised family discourse” (Nordqvist, 2012a, p. 658).

Moreover, participants shared value of biological parenthood and notions of turn-taking are processes distinct from heteronormative patterns of kinship and family. Heterosexual couples who pursue gestational surrogacy often automatically (if able) donate their gametes to be biologically-related to the offspring; conversely, gay couples have intentional and sometimes onerous conversations regarding sperm donation practices, turn-taking and biological parenthood. The importance of a biogenetic connection is echoed in previous scholarship among gay men who pursued surrogacy in Australia (Dempsey, 2013; Murphy, 2013). Thus, gay fathers in this study may also ascribe to normative patterns of kinship that privilege biogenetic, marital and interpersonal (relational) ties between parents and children (Benson, 2005; Giesler, 2012; Schneider, 1980; Strathern, 1995).

The motivations of gay fathers to marry, and uphold biogenetic connectedness and physical resemblance to their children may be interpreted, in part, as an assimilative practice (Hopkins et al., 2013). Yet, these assimilative practices may signify internal repetitive actions that intend to
subvert and destabilize heterosexual normative behaviors (Allen, 1998; Deutscher, 1997; Jackson, 2004). Gay men who pursue surrogacy are mimicking heteronormative family constructs, but in novel and transformative ways. Gay fathers intentionally want to parent without a mother, and consider reproduction without heterosexuality or sexual intercourse. The purposeful conversation of whose sperm to donate is a novel way of engaging in decisions regarding parenthood and assisted reproduction. In turn, these assimilative practices may be subtle transformations from static concepts of family to a “fluid process subject to interpretation and re-evaluation” (Parry, 2005, p. 288).

Similar to gay fathers, the motivations of gestational surrogates may reflect certain socially ascribed hegemonic gender norms (Anleu, 1990; Jorgensen, 2000, Ragonè, 1994; Rich, 1976; Tong, 2008). In the current study, gestational surrogates exhibited altruistic behaviors in their decision to pursue surrogacy. Gay fathers specifically recalled looking for surrogates who were motivated by a love of childbirth and empathy. Importantly, gay fathers benefited from surrogates’ assumed hegemonic femininity; gay men who sought biogenetic parenthood were reliant upon women adopting traits associated with care, compassion and virtue. Upholding feminine behaviors of altruism and compassion are rewarded and favored across social and political contexts (Ruparelia, 2007; Tong, 2008). This is especially relevant in a Canadian context that permits altruistic surrogacy but criminalizes the financial payment of surrogates (Ruparelia, 2007).

Although surrogates in the current study indicated a sense of value and satisfaction in their decision to pursue altruistic surrogacy, it is important to consider the ways in which gender
socialization and internalized femininity may influence surrogates’ motivations.\textsuperscript{38} Jacobson (2016), for example, elucidates how surrogacy programs often seek “good workers,” wherein ideal gestational surrogates are described as “compliant, kind and giving” (p. 40). The motivations of justice, altruism and compassion are contextualized in a patriarchal system that has disempowered women through their domestic roles, responsibilities and care work; hegemonic feminine ideals are utilized to reinforce gender inequalities and justify women’s powerlessness (Gimenez, 1983).

Consequently, some ethicists have argued that altruistic surrogacy may engender coercion and exploitation (Ruparelia, 2007; Tieu, 2009; Walker & van Zyl, 2016). In particular, when surrogacy is pursued for a female relative, motivations of care, compassion and altruism may be associated with emotional pressure, familial obligations and reactions of guilt (Anleu, 1992; Ruparelia, 2007); “it may also be considered selfish, uncaring, even dishonorable for a woman to deprive a relative of eggs or her gestating abilities” (Raymond, 1990, p. 10). In the current study, surrogate participants had no pre-existing or familial relationships with the intended fathers. Surrogates’ expressions of altruism and a commitment to social justice for an unrelated couple may signal an authentic generosity, indicative of a woman’s ability to make an autonomous decision through self-reflection and social interpersonal relationships.

Moreover, reactions of feminine responsibility and guilt may not influence a woman’s choice to act as a surrogate for gay men. The perceived obligation of a surrogate to bear a child for a

\textsuperscript{38} Although beyond the scope of this dissertation, this may also be reflective of what Hochschild (1983) refers to as \textit{emotion management}: how individuals shape and display their feelings in accordance with institutionalized norms and structures. Emotion management occurs as people work towards appropriating their feelings to match with societal expectations; and \textit{emotional labor}: when emotional management moves into work-related activities to become a relevant part of the job description. These descriptions can be found in: Hochschild, 1983; Jacobson, 2016; Wharton, 2009.
woman experiencing infertility may derive from the assumption that a woman’s social standing is equated to her fertility and reproductive capacity (Purdy, 1996; Shalev, 2012). Previous research has indicated that surrogates are often drawn to heterosexual couples’ narratives of infertility (Berend, 2014; Blyth, 1994; Edelmann, 2004; Greenfeld, 2014; Kanefield, 1999; Ragoné, 1996). Multiple infertility treatments are often sought by the time heterosexual couples decide to pursue surrogacy; for these couples, surrogacy is a last resort (Dar et al., 2015). For gay intended fathers, this history of disappointment, failure, exhaustion and emotional pain (Cwikel, Gidron, & Sheiner 2004; Hadley & Hanley, 2011) may be absent. As gay fathers do not have the same experiences of infertility as their heterosexual male or female counterparts, they may not be supported, treated or comforted in the same manner (Dana, 2011; Webster & Telingator, 2016). This may be owing to sexual stigma and negative biases regarding gay men’s desire to parent. Surrogates who therefore refuse to bear a child for gay men are not necessarily seen as selfish or uncaring, as they perhaps would be for heterosexual couples; there is no normative feminine expectation that a surrogate should bear a child for gay men. In the current study, surrogates’ care and compassion broadens ethically acceptable notions of parenthood. In turn, narratives of altruism, compassion and social justice among surrogates who bear a child for gay men disrupt hegemonic family and gender norms.

Findings suggest that motivations to pursue surrogacy, among both gay fathers and surrogates, are inherently shaped by Canada’s social and political context. The legitimization of same-sex families, and inclusive marriage and parenting laws have created new and concrete opportunities for gay intended parents. Yet, such inclusivity has not necessarily mitigated the residual fear among gay fathers of sexual stigma (Browne & Nash, 2014; Kelly, 2014). For instance, gay fathers expressed difficulty in coalescing their gay-father identities, concerns
regarding the potential ostracism and bullying of their children and fears that their legal right to parent could be revoked, findings that have been supported in previous scholarship (Brinamen & Mitchell, 2008; Oakley et al., 2017). Owing to a history of marginalization in Canada (Marvel et al., 2016; Kelly, 2014; Warner, 2002) and existing political barriers worldwide (Gato, Santos, & Fontaine, 2016), the manifestation of sexual stigma may influence the motivations of gay fathers and surrogates. Hegemonic gender norms that equate femininity with reproduction and motherhood are still prevalent, as are social practices dictated by relationships of domination and subordination between men and women (Shalev, 2012; Tong & Williams, 2009).

Importantly, participants indicated that public acceptance, visibility and social relationships supported motivations to pursue surrogacy. In the current study, legal protections and generational shifts in gay parenting attitudes influenced gay men’s reproductive decision-making. Among gay father participants who immigrated to Canada, the political rights of gay fathers and the legal accessibility of surrogacy facilitated family planning. On account of the prevailing negative attitudes towards gay fatherhood, participation in same-sex parenting groups influenced considerations of parenthood. The visible representations of gay fatherhood helped participants gain information and reflect on the tangibility of surrogacy. This offered gay fathers a sense of community involvement and access to resources and supports to pursue surrogacy. The visibility of gay fathers and the emergence of same-sex parenting resources legitimized gay-parent households and challenged encounters of sexual stigma.

Gestational surrogates articulated that motivations to pursue surrogacy were encouraged by their families and communities. Canada’s surrogacy regulations, as well as negative public
attitudes, may create obstacles for surrogates to access accurate information and seek appropriate services due to legal ramifications (Busby & Vun, 2010; Krishnan, 1994). For instance, it has become increasingly challenging to seek formal support groups or online services for surrogates. Services offered are typically constrained by ambiguous regulations that amount to fear of practice with resulting punitive risks. This may account for the increased number of informal online surrogacy groups. For many surrogates, these groups help add encouragement and support to their reproductive decision-making (Berend 2012, 2014).

The accessibility of online surrogacy networks and the presence of supportive family members facilitated the provision of information, resources and support for gestational surrogates. This promoted community and connectedness among surrogates. The visible representations of both gay fathers and gestational surrogates importantly supported participants’ reproductive decisions. These facilitating processes may be significant in understanding practices and policies of surrogacy in Canada. The findings of this chapter demonstrate that the sociohistorical context of Canada acts as both a facilitator and barrier to gay men’s paths to parent. The continued prevalence of sexual stigma has created obstacles in how gay men think about their procreative opportunities; yet, simultaneously, the increased visibility of gay fatherhood and the evolution of same-sex parenting rights in Canada have established tangible and concrete paths to parenthood for gay men.

The motivations of gay fathers and gestational surrogates are indicative of a cyclical revolution; participants’ actions are contesting heteronormativity and, simultaneously, institutional/organizational changes are facilitating the emergence of these new procreative processes. According to Butler, the motivations to parent may be indicative of subversive resignification,
defined as “ways of corporeally re-enacting norms that undermine the meanings traditionally entrenched within them” (Stone, 2005, p. 14). Corporeal practices, in this sense, comprise surrogates’ decisions to become pregnant in non-socially acceptable ways (without a desire for social motherhood), and gay men’s decisions to form households without a mother to socially rear the offspring. Through repeating (or mimicking) biogenetic family structures and procreative norms, gay fathers and surrogates disrupt heteronormative considerations of parenthood. The collaborative actions of surrogates and gay fathers may therefore be perceived as acts of subversion, only attainable when “inhabiting a context in which others are engaged in similar subversions” (Stone, 2005, p. 15). The motivations to pursue surrogacy among gay men and surrogates demonstrate that reproduction, family and parenting norms are unstable, fluid and subject to renegotiation and modification.

2.5 Limitations

As this was a qualitative study with a small sample size, the aim was not to generalize but to explore motivations to pursue surrogacy. There has been limited research conducted on surrogacy among gay men globally; thus, findings of this study present important and novel insights on Canadian surrogacy for gay men. Owing to the limited research in this area, findings present empirically-based accounts of the motivations that assist gay men and surrogates in pursuing surrogacy, and factors that have supported their procreative decision-making. These results, however, may present a more positive depiction of surrogacy. Matched surrogate triads may represent a more favorable experience, as they were likely to have maintained a

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39 It is important to also identify the challenges that have arisen within Butler’s theory of resignification. There are theorists who have argued that resignification may not be entirely subversive, but may enact a form of “conservative resignification.” Stone (2005) articulates that an example of this may be rooted in marriage equality. As she writes, “These demands are still resignifications, for they modify marriage’s traditional meaning; but, conservatively….the new meaning they propose is already contained within the traditional marital norm. This strengthens the authority of marriage’s traditional meaning” (p. 14).
relationship post-birth. It would be important to address what constitutes unfavorable or less successful surrogacy practices. Due to legal concerns, interview questions did not address financial compensation. As this restriction was elucidated in the informed consent, this could have potentially influenced responses on surrogates’ motivations. It is difficult to surmise the extent to which financial considerations were important in the decision to pursue surrogacy.

Additionally, including perspectives of single gay fathers, transgender men and women, and conducting separate interviews between partners, may help build on the present findings. The majority of gay father and surrogate participants identified as white, had similar socioeconomic statuses and were Canadian born. Therefore, the motivations and experiences are reflective of a very specific homogeneous population. Drawing comparisons as to how sexual stigma and gender hegemony might be reflected in the motivations of those with diverse ethnicities, races, socioeconomic statuses and immigration statuses is a limitation of this study.

Although the sample demographics of this study are consistent with previous research on gay fathers (Benson, Silverstein, & Auerbach, 2005; Armesto & Shaprio, 2011) and surrogates (Ciccarelli & Beckman, 2005), future research should purposefully recruit more diverse populations to examine how intersections of socioeconomic status, race, ethnicity and geographical location influence motivations to pursue surrogacy. This could also result in a more nuanced understanding of experiences with sexual stigma and whether this differs across demographics. These results could perhaps have important implications for future practice and policy decisions. As gay fathers and surrogates called attention to sociopolitical influences, a diverse sample may help broaden understanding of the motivations to pursue surrogacy.
2.6 Conclusion & Implications

This study contributes original empirical research on the motivations of gay men and gestational surrogates to pursue surrogacy. The sociopolitical context of Canada has both supported and hindered the procreative decisions of gay men and surrogates. In Canada, legal protections of same-sex families, accessibility of surrogacy, and shifting social and political attitudes have expanded reproductive opportunities for gay men. However, the enduring prevalence of sexual stigma and hegemonic gender norms have sustained fears of discrimination and impacted motivations to pursue surrogacy. This analysis has important implications for Canadian fertility specialists, reproductive ethicists and allied health professionals.

This study’s research findings can inform dialogues with service users, service providers and policy makers in Canada to: (1) consider relevant and inclusive same-sex parenting and surrogacy resources; (2) develop policies and practices to mitigate negative political and social attitudes against gay men pursuing surrogacy, and enhance visible representations of gay fathers and surrogates; (3) expand research and education to identify non-heterosexual families; (4) introduce empirical scholarly work into ethical discourse to reflect on how discriminatory practices, encounters of sexual stigma and socialized gender norms influence surrogacy; and (5) create opportunities for social media to depict new family paradigms and to incorporate narratives of non-traditional family systems. Shifts in practice, research and education are necessary to reform heterosexist approaches to human reproduction.
### Table 1

**Gay Father Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range (SCAD)</th>
<th>Region</th>
<th>Immigration Status</th>
<th>Number of Surrogate Children</th>
<th>Age of Surrogate Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>42</td>
<td>White</td>
<td>Grade 12</td>
<td>$40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>5 years old</td>
</tr>
<tr>
<td>F2a</td>
<td>45</td>
<td>White</td>
<td>Bachelor’s</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F3a</td>
<td>36</td>
<td>White</td>
<td>College</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F4e</td>
<td>50</td>
<td>White</td>
<td>Law School</td>
<td>$200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (U.S.)</td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F5e</td>
<td>40</td>
<td>Asian</td>
<td>Med School</td>
<td>$200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (Japan)</td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F6e</td>
<td>36</td>
<td>White</td>
<td>University</td>
<td>$40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>(2 twins)</td>
<td>17 months</td>
</tr>
<tr>
<td>F7e</td>
<td>35</td>
<td>White</td>
<td>Post-Grad</td>
<td>$40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>(2 twins)</td>
<td>17 months</td>
</tr>
<tr>
<td>F8f</td>
<td>44</td>
<td>White</td>
<td>University</td>
<td>$161,000-200,000</td>
<td>Urban</td>
<td></td>
<td>(2 twins)</td>
<td>4 years old</td>
</tr>
<tr>
<td>F9f</td>
<td>45</td>
<td>Asian</td>
<td>University</td>
<td>$161,000-200,000</td>
<td>Urban</td>
<td></td>
<td>(2 twins)</td>
<td>4 years old</td>
</tr>
<tr>
<td>F10f</td>
<td>37</td>
<td>White</td>
<td>Some College</td>
<td>$40,000-80,000</td>
<td>Suburban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F11f</td>
<td>29</td>
<td>White</td>
<td>High School</td>
<td>$40,000-80,000</td>
<td>Suburban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F12f</td>
<td>35</td>
<td>White</td>
<td>LLM</td>
<td>$40,000-80,000</td>
<td>Urban</td>
<td>Immigrated to Canada (Israel)</td>
<td>1</td>
<td>1 month old</td>
</tr>
<tr>
<td>F13f</td>
<td>34</td>
<td>White</td>
<td>PhD</td>
<td>$40,000-80,000</td>
<td>Urban</td>
<td>Immigrated to Canada (Israel)</td>
<td>1</td>
<td>1 month old</td>
</tr>
<tr>
<td>F14f</td>
<td>36</td>
<td>White</td>
<td>Bachelor’s</td>
<td>$121,000-160,000</td>
<td>Suburban</td>
<td></td>
<td>(2 twins)</td>
<td>5 years old</td>
</tr>
<tr>
<td>F15f</td>
<td>43</td>
<td>White</td>
<td>Master’s</td>
<td>$121,000-160,000</td>
<td>Suburban</td>
<td></td>
<td>(2 twins)</td>
<td>5 years old</td>
</tr>
</tbody>
</table>

Notes: *Corresponding letters refer to partnered gay men

### Table 2

**Surrogate Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Age at recent Surrogacy</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range (SCAD)</th>
<th>Region</th>
<th>Number of Surrogacies</th>
<th>Number of Surrogate Children</th>
<th>Number of (own) biological children</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS1f</td>
<td>37</td>
<td>36</td>
<td>White</td>
<td>College</td>
<td>&lt;$40,000</td>
<td>Rural</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>GS2f</td>
<td>45</td>
<td>44</td>
<td>White</td>
<td>B.A.</td>
<td>&lt;$40,000</td>
<td>Rural</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>GS3f</td>
<td>35</td>
<td>31</td>
<td>White</td>
<td>College Diploma</td>
<td>&lt;$40,000</td>
<td>Suburban</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>GS4f</td>
<td>36</td>
<td>35</td>
<td>White</td>
<td>Some College</td>
<td>&lt;$40,000</td>
<td>Suburban</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>GS5f</td>
<td>27</td>
<td>27</td>
<td>Aboriginal</td>
<td>BScN</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>GS6f</td>
<td>22</td>
<td>21</td>
<td>Aboriginal</td>
<td>BScN</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Notes: *Letters correspond to Table 1 to reflect the ‘matched surrogate triads’
Chapter 3
Two men & a surrogate:
A qualitative exploration of the surrogacy relationship between gay fathers and gestational surrogates in Canada

3 Introduction

The purpose of this chapter is to present a retrospective exploration of the relationships between gestational surrogates and gay intended parents across three time points: (1) pre-pregnancy, (2) during pregnancy, and (3) post-birth.

3.1 Literature Review

The following literature review will clarify terminology and elucidate surrogacy regulations in Canada. Previous scholarship that has explicitly investigated the surrogacy relationship, both with heterosexual couples experiencing infertility and gay intended parents, will be explicated.

3.1.1 Canada, Surrogacy and Gay Rights

Advances in reproductive technologies and the progress of equal rights for sexual minorities have led to new family planning options for gay men in Canada. The 2011 Canadian Census reported that same-sex couples have risen 42.4%, from 45,300 in 2006 to 64,575 in 2011 (Statistics Canada, 2009, 2013); 3.4% of all male same-sex couples have children at home, and approximately 1,900 children under the age of 24 are living with male same-sex parents (Statistics Canada, 2013).

In particular, a growing number of gay men in Canada are electing to pursue biological paternity through the practice of surrogacy (Kelly, 2014). Surrogacy is a form of third-party
reproduction in which a woman agrees to bear a child for another individual or couple (Appleton, 2001). The woman may either be: (1) a genetic surrogate, supplying her own egg for fertilization (Brinsden, 2000); or (2) a gestational surrogate, in which she is implanted with an embryo from fertilized donor gametes (sperm and ovum) (Imrie & Jadva, 2014). Intended parent(s) refers to the individual or couple who, although may or may not be genetically related to the child, plans to be the child’s social and legal parent(s), and raise the child from birth (Greenfeld, 2008). In Canada, gestational surrogacy, in which the surrogate does not have a genetic connection to the offspring, is more commonly practiced among same-sex intended parents (Dar et al., 2015; Grover et al., 2013). This is perhaps due to fears that a surrogate’s genetic (as opposed to gestational) attachment may foster maternal-fetus bonding, and hinder the surrogate to relinquish the child post-birth (Sanabria, 2013).

In Canada, the Assisted Human Reproduction Act (AHRA) stipulates that it is a criminal offense to pay or offer to pay a woman to act as a surrogate; to pay or offer to pay a person to arrange for the services of a surrogate; to advertise payment for surrogacy or arrangement of surrogacy; or to assist or counsel any person under 21 years of age to become a surrogate. (Reilly, 2007, p. 484)

It is also illegal to pay an egg and/or sperm donor. Thus, only altruistic surrogacy is legally permissible; surrogates are able to seek medical reimbursements associated with surrogacy (rather than financial compensation) from intended parents. However, a lack of legal clarity has

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40 Most provinces across Canada (excluding British Columbia) have what are called “post-birth orders,” known as a declaration of parentage. Legal documents are signed by intended parents and surrogates to obtain a court order declaring the intended parents as the legal parents. The intended parents can then use the court order to obtain a birth certificate for the child. This can only be completed post-birth.
created ambiguity in how to discern legitimate monetary reimbursements between surrogates and intended parents (Busby & Vun, 2010; Nelson, 2016).

### 3.1.2 Surrogacy Relationships

Surrogacy typically involves a formal interpersonal arrangement that entails effective communication, mutual collaboration and matched expectations, goals and interests between intended parents and surrogates (Braverman, 2013). The interactions between surrogates and intended parents may influence perceptions of surrogacy, and may have long-term consequences post-birth (Baslington, 2002; Berend, 2012; Busby & Vun, 2010; Ciccarelli & Beckman, 2005). Relationships between surrogates and intended parents often evolve and shift over the course of surrogacy. However, surrogates tend to enter arrangements with hope and anticipation of developing close, intimate and enduring friendships with their intended parents (Berend, 2012, 2014).

Research shows that the relationship between intended mothers and surrogates is a critical facet of third-party reproduction; a positive relationship is often the underlying sign of a successful and favorable experience for both surrogates and intended mothers (Berend, 2012; Busby & Vun, 2010; Jadva et al., 2012). A qualitative retrospective study conducted in the United Kingdom (UK) among genetic and gestational surrogates who bore a child for heterosexual couples explored surrogacy relationships at three time periods: (1) before pregnancy, (2) during pregnancy, and (3) post-birth/one year follow-up (Jadva et al., 2003). Participants reported their perceptions of the relationship, the frequency of contact and intended parents’ involvement. Surrogates \((n=34; \text{genetic surrogate}=19; \text{gestational surrogate}=15)\) predominantly indicated harmonious surrogacy relationships (97%) with their intended mothers before and during their
pregnancy: 71% expressed being contact at least once a month, 83% reported that the intended mother was very involved in the pregnancy, and 94% of surrogates were happy with her level of involvement (Jadva, Blake, Casey, & Golombok, 2003). Post-birth, the frequency of contact with the intended mother was mixed: 21% of respondents had no contact at all, 32% reported contact at least once a month, and 47% had contact that ranged once a month to once in the last year. A reported five surrogates had no further contact with the family. However, surrogates’ perceptions of the relationship with the intended parents post-birth were not elucidated.

Thus, intended mothers’ behaviors importantly shape perceptions of the surrogacy relationship. Some surrogates, for instance, have reported fears of concealment when working with heterosexual couples, deriving from intended mothers’ embarrassment or shame with infertility and her decision to pursue surrogacy (Bellafante, 2005). For instance, women who experience infertility and pursue surrogacy may struggle with feelings of jealousy, inadequacy and disappointment (Kleinpeter, 2002; MacCallum, et al., 2003; van den Akker, 2007). These reactions may impact heterosexual intended parents’ involvement during pregnancy, and the continued surrogacy relationship post-birth. Surrogates may be unwilling to tolerate intended mothers’ distress, which may result in ineffective communication, discomfort and detachment (Berkowitz, 2013; Stacey, 2006). Surrogates, in general, may struggle to maintain a balanced relationship during surrogacy; they request involvement from the intended mother, and yet inhibit her desire to control or micromanage the pregnancy (Jacobson, 2016).

There is limited empirical scholarship on surrogates’ experiences with gay intended parents and their perspectives of the surrogacy relationship. Research conducted in the U.K. and the United States (U.S.) show that gay men perceive having close relationships with their gestational/
genetic surrogates that deepens during the pregnancy (Greenfeld & Seli, 2011, 2013; Lev, 2006; Mitchell & Green, 2007). As surrogacy is the only option for gay men, anecdotal evidence suggests that gay fathers value a surrogate’s reproductive advice and guidance (Greenfeld & Seli, 2013). In turn, surrogates are integrated into an “elaborate web of procreative, father, and family identities” (Berkowitz & Marsiglio, 2007, p. 378) and play a continued role in the child’s birth story.

However, negotiating the surrogacy relationship may prove difficult for gay fathers, and result in paradoxical attitudes; appreciation and gratitude is felt amid a desire for separation and detachment. During pregnancy, they rely on the surrogate to protect the health and well-being of the fetus and yet expect that she detach from her pregnancy (Berkowitz, 2013; Lev, 2006); post-birth, gay fathers anticipate a surrogate who maintains distance from their family, but also continues to uphold a meaningful role in its creation. Unlike intended mothers, men’s inherent disconnect from reproduction, fertility and pregnancy may enable this paradoxical relationship; they rely on the surrogate for her knowledge and expertise, but simultaneously desire that she inhibit maternal-fetal attachment (Berkowitz, 2013; Lev, 2006). However, with limited research, it is difficult to discern how the relationship between surrogates and intended fathers evolves and shifts over the course of surrogacy, from pre-pregnancy through to post-birth.

There has been a lack of published empirical data investigating surrogacy for gay men from the perspectives of either intended fathers or surrogates. The purpose of this study was to retrospectively explore the relationship between gay fathers and gestational surrogates in Canada at three distinct time points: (1) pre-pregnancy, (2) during pregnancy, and (3) post-birth. It may be signposted that a retrospective approach is limited with respect to recall bias.
and potential socially desirable responses (Jadva et al., 2003); structuring this paper at three time periods may also overlook the surrogacy process as more fluid and that relationships may not evolve in a linear pattern. Notwithstanding these limitations, it is important to reflect on how surrogacy relationships may change and evolve over the trajectory of a pregnancy. The results being structured in this manner derive from: (1) participants’ framing of the surrogacy relationship, and when they described that their relationship and frequency of contact shifted; and (2) the sequential process of a surrogate pregnancy.

Understanding the surrogacy relationship through these three phases may importantly inform the development of practice guidelines for allied health professionals working with both surrogates and intended parents during select phases of the process. Currently, there are no standardized practices or guidelines to oversee the provision of counseling or psychosocial support offered to surrogates or intended parents at any point during surrogacy or post-birth (Marvel et al., 2016). In Canada, intended parents and surrogates may seek support through online surrogacy consulting services that, for a fee, will provide referrals to fertility clinics and reproductive lawyers, and answer questions related to legal regulations surrounding third-party reproduction (Motluk, 2014). Counseling or support is usually provided by the surrogacy consulting service director; across most services, this is typically a former surrogate who, in most cases, does not have any professional skill-set, degree or affiliation with fields of psychology, social work or social service.

Surrogates and intended parents may also seek individual counseling from fertility clinics. Fertility clinics assist with both medical and psychosocial assessments, but remain unable to engage in assisting with contract negotiations or financial payment (as even the facilitation of
financial payment is prohibited under the AHRA). Although the Canadian Fertility and Andrology Society has released guidelines for third-party reproduction, there are a lack of clear and transparent directives for the provision of psychosocial support before, during or after surrogacy. The guidelines are respectively attributed to understanding the range of medical and diagnostic testing, consent processes and only generally recommend that counseling for surrogates and intended parents be sought (Havelock et al., 2016).

In most fertility clinics, it is customary for both intended parents and surrogates to undergo an initial assessment and counseling session prior to an embryo transfer (Havelock et al., 2016). This session assesses the intent of surrogates’ motivations, as well as evaluating their social support, background, attachment styles and coping mechanisms; and attitudes and values with respect to reproductive decision-making (such as abortions, selective termination) and birth plans (Dar et al., 2015). Subsequently, intended parents and surrogates hold a joint session in which to talk about their expectations of the surrogacy process, negotiations of post-birth contact and any potential issues that may arise (Dar et al., 2015). However, the continuation of counseling and support through the pregnancy is often shaped by the individual clinic and fertility counselor.

Although voluntary, most private fertility clinics uphold the standards and guidelines of Accreditation Canada, ensuring that third-party donors, intended parents and surrogates receive counseling, support and appropriate medical testing throughout the process. However, across most fertility clinics, support groups are primarily aimed at intended parents or heterosexual couples experiencing infertility. Consequently, informal supports established through private online communities of surrogates and intended parents (mainly through Facebook) have been
an important mechanism for information, support and validation throughout the process. Overall, surrogacy creates new possibilities for gay men to pursue biological paternity and, as such, research on the evolution of surrogacy relationships between intended parents and surrogates is critical to inform practice guidelines of third-party reproduction in Canada.

3.1 Methods

This analysis stems from a larger phenomenological study looking at the practice of altruistic gestational surrogacy for gay men. Interpretive phenomenological analysis (IPA) was used to gain knowledge on surrogacy relationships from those who have direct lived experience; first-hand narratives can provide unique insight into the experiences of gay men and gestational surrogates living in Canada.

3.1.1 Sampling and Recruitment

From January 2015 to January 2016, gay fathers and gestational surrogates in Canada were recruited through advertisements distributed across same-sex parenting groups, online business-registered surrogacy consulting services and social media. Non-probability sampling, a non-random sampling design, was employed due to the exploratory nature of this study (Daniel, 2012). The primary investigator (PI) purposefully selected participants who satisfied the inclusion/exclusion criteria for participation in this study and would be able to provide in-depth responses to the research question and objectives (Daniel, 2012). Three populations were targeted through the use of purposive and snowball sampling: (1) single or partnered gay men who used gestational surrogacy to have a biologically-related child; (2) gestational surrogates

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41 Online surrogacy businesses are not considered illegal in Canada, as long as they do not facilitate payment between matched surrogates and intended parents. These organizations are typically registered as businesses that provide information, referral and support.
who bore a child for gay men; and (3) single or partnered gay men and their paired surrogate
(referred to as a ‘matched surrogate dyad’ or ‘matched surrogate triad’). ‘Matched surrogate
dyads and/or triads’ were purposefully sought for in-depth comparative analyses. No timeline
was required for when surrogacy was practiced. There were no specifications as to whether
participants had to have attained Canadian citizenship or permanent residency status; however,
participants had to be permanently living in Canada (regardless of their immigration status). All
participants had to have pursued surrogacy in Canada, and be living in Canada at the time of the
interview.

Participants met the following inclusion criteria: (1) gestational surrogates who were implanted
with one or more embryos from a donated egg and either a single gay man’s sperm, or one or
both (through the implantation of two separate embryos) partners’ sperm; and/or (2) gay men
who completed gestational surrogacy to have a biologically-related child with the use of
donated ovum. Although sperm is not typically mixed to fertilize the same embryo, partners
may have chosen to implant two or more embryos, with each embryo consisting of a donor egg
and the sperm of one of the partners. This would allow the partners to have an equal likelihood
of being the biological father of the surrogate offspring. A completed arrangement was
determined by the surrogate relinquishing the child at birth, and the father(s) socially rearing
the child.

Exclusion criteria consisted of gay men and/or gestational surrogates who: (1) were currently
interested in or in the midst of pursuing surrogacy; and/or (2) most recently experienced a failed
arrangement due to either financial obstacles or for other unexpected reasons, such as a
miscarriage or terminated pregnancy. As the relationship post-birth was an important
consideration of this study, surrogacy resulting in the birth of a child was a critical inclusion
criterion. Those who participated in transnational surrogacy were excluded due to the increased
ethical complexity of surrogacy relationships abroad, and the geographical distance between
intended parents and surrogates.

Gay fathers and gestational surrogates were initially recruited independently from one another.
Interested participants responded by email to publicly posted advertisements. They were
provided with a copy of the informed consent outlining the purpose and procedures of the
study. All informed consent documents inquired about third party contact, including a section
asking whether the participant would be willing to contact the third party (e.g., the intended
parents or surrogate) to see if they would be interested in participating in the study. The PI
asked whether the participant(s) wanted to contact the third party, or whether a direct request to
participate could come from the PI. Respondents who declined contact with the third-party were
still able to provide consent and participate in the study. Offering a choice in how the third
party may be contacted was purposeful to mitigate ethical concerns related to confidentiality
and disclosure. Gay fathers were informed about the process of conducting joint interviews, and
both partners were required to provide written consent. Participants were provided with a
$30.00 honorarium for expenses incurred in their participation. The study was reviewed by the
Research Ethics Board at the University of Toronto⁴².

⁴² The PI is a member of this REB. She did not attend the full board meeting when this protocol was discussed and did not
consult with any committee members. K.A. (a thesis committee member) became an REB member subsequent to the protocol
submission and review, has never discussed the protocol with any committee members, and is no longer a member of the
approving REB.
3.1.2 Data Collection

In-depth semi-structured interviews, ranging from 1-2 hours, were conducted with gay fathers and gestational surrogates. Surrogates and gay fathers were interviewed separately, while joint interviews were conducted with partnered gay men. Joint interviews were purposefully completed to obtain richer and more comprehensive data through partners’ diverging and converging narratives. Partners were informed about joint interviews, and both partners were required to provide written consent (if both agreed to participate). However, a participant’s partner could refuse participation. If so, an individual (rather than a joint) interview would be conducted with the consenting partner. Individuals who were separated did not require consent from their partner, and their partner was not obligated to participate in the study. At the time of the interview, the PI reviewed and obtained informed consent verbally with participants. The purpose and procedures of the study were discussed. Interviews were conducted either in-person, at a mutually agreed upon location between the PI and participant, or over the phone. All participants provided written consent prior to the interview.

The semi-structured interview guide comprised of questions and detailed probes to address: (1) perceptions of the surrogacy relationship, (2) frequency of contact, and (3) intended parents’ involvement, at each of the three time points. Questions related to the relationship pre-pregnancy, included: What were some factors in selecting the intended parents/surrogate? How would you describe the contact and relationship you had at the beginning? Questions related to the relationship during pregnancy, included: How would you describe your relationship once she/you became pregnant? How did your relationship develop over the course of the pregnancy? Questions related to the relationship post-birth, included: What was your relationship like after the birth of the child? How did you manage contact post-birth?
All interviews were digitally recorded and transcribed verbatim by the PI. To protect participant confidentiality and anonymity, identifying names and information including geographical regions, surrogacy consulting services, organizations and fertility clinics was redacted from the transcripts. All data were stored on an encrypted password-protected secure server. Informed consents were kept separate from participant data.

3.1.3 Data Analysis

Adhering to IPA methodology, there was a simultaneous process of recruiting, interviewing and interpretation (Crist & Tanner, 2003; Starks & Trinidad, 2007). Textual analysis was conducted through an idiographic and iterative approach by the PI; initial line-by-line coding was first completed and, subsequently, meaningful quotations/statements were extracted from each transcript by the PI. Patterns and themes were subsequently organized from the data manually to generate research findings. Themes were linked across joint interviews, matched surrogate triads and individual interviews of surrogates and gay fathers to clarify divergences and convergences.

Through an iterative inductive approach, multiple critical theoretical frameworks supported textual analysis and the interpretation of results. Equity theory, a social justice theoretical framework, supported an understanding of how elements of power, fairness and justice play a role in establishing trustworthy surrogacy relationships (Opotow, 1990; Skitka & Crosby, 2003). Equity theory was framed with consideration of issues related to relationship expectations, reproductive decision-making, respect and considerations of justice in relation to Canada’s sociopolitical context. Feminist relational theory was also explored, with attention to the ‘silencing of the self’ schema (Jack & Dill, 1992; Szymanski, Ikizler, & Dunn, 2016). This
construct refers to how women inhibit their self-expression, and their own needs and interests, in order to avoid relationship conflict. Triangulation, member-checking and peer-debriefing supported validity and trustworthiness of the data. The PI triangulated data sources by including both surrogate and gay father populations, and matched surrogate triads, as well as including diverse theoretical perspectives. All participants were provided copies of their transcripts for review. Member-checking was conducted through receiving and incorporating feedback from participants on aggregated findings into analysis. Peer-debriefing was sought and implemented from experts in assisted reproduction and gay men’s health scholarship to assist with analyses.

3.2 Results

Participant demographics will be reported, followed by the themes that emerged from textual analysis of the data.

3.2.1 Sample Characteristics

Twenty-two respondents participated in this study. Sixteen participants were gay fathers (seven dyadic partners & two separated fathers), and six participants were gestational surrogates. Surrogacies were carried out from 2010-2014. Participants ranged in age from 22 to 50 years old. The average age of surrogate participants was 34 years ($SD=8.09$), compared to 39 years ($SD=5.55$) among gay father participants. The sample was predominantly white (86%); two gay father participants (12.5%) were Asian (both participants had white partners), and one surrogate participant was Aboriginal. Half of surrogate participants had individual incomes of less than $40,000 (CAD) (50%), with one surrogate participant reporting an individual income of $81,000-$120,000 (CAD); two surrogate participants did not report their income. The median individual income across surrogate participants was less than $40,000 (CAD). For gay father
participants, 9 out of 16 participants (56%) had individual incomes $80,000 (CAD) and above, with 7 participants (43%) having individual incomes from $40,000 to $80,000 (CAD). Gay intended parents’ median individual income ranged from $81,000-$120,000 (CAD). Half of surrogate participants held college degrees, and two participants had college degrees (33%); one surrogate did not report. Two gay father participants (12.5%) had graduated from high school and two (12.5%) had graduated from college. The remaining 12 out of 16 participants (75%) had either a university degree, or had attained a post-secondary degree in law, medicine or education. Although all participants were living in Canada at the time of surrogacy and the interview, two gay father dyads had emigrated from other countries; one dyad attained Canadian citizenship prior to the interview. Surrogacies were all completed in Canada, but primarily conducted across cities and/or provinces.

At the time of the interview, two surrogate participants (33%) had previously (once prior) acted as gestational surrogates, and four surrogate participants (67%) indicated that this was their first surrogacy experience. Surrogates had between one and five biological children. For all gay intended parents in the study, this was their first surrogacy experience resulting in a live birth, and their first child at the time of interview. Four out of five matched triads matched through the use of online surrogacy consulting services; one matched surrogate triad met through a mutual friend. A separated father indicated that his gestational surrogate was his partner’s sister-in-law, and all other participants (one surrogate and two gay partner dyads) met through a surrogacy consulting service. Among intended parents, three dyads had twins ($n=6$; 38%), each child biologically-related to one partner. Surrogate offspring ranged in age from a month old to five years old at the time of interview.
Twenty-one participants met inclusion criteria and were included in this analysis (*Table 1; Table 2*). A separated gay father was excluded when he disclosed that his surrogate was a genetic (as opposed to a gestational) carrier, in which she used her own egg for fertilization. Among included participants, 15 individuals formed matched surrogate triads: five partnered gay men (*n*=10) and their paired gestational surrogate (*n*=5). The separated father in the study was married at the time of surrogacy and identified that his surrogate was his sister-in-law; she declined to participate in this study. Even though eligible for inclusion, no fathers who pursued surrogacy as single gay men participated in this study. Quotations from gay fathers (labeled F) and surrogates (labeled GS) are presented in the results with participant ID and age at the time of interview.

Building upon previous research, results depict the surrogacy relationship at three distinct phases: (1) pre-pregnancy, (2) during pregnancy, and (3) post-birth. Each theme will address: (1) perceptions of the relationship, (2) frequency of contact, and (3) intended fathers’ involvement. The discussion will critically address overall patterns that emerged from the results to understand factors that may comprise a positive surrogacy relationship.

**3.2.1.2 Pre-Pregnancy**

The three sub-themes are: (1) perceptions of the relationship, (2) frequency of contact, and (3) intended fathers’ involvement.

**3.2.1.2.1 Perceptions of Relationship**

Matched surrogate triads reported that their initial pre-pregnancy expectations conveyed a desire for a close, intimate and long-term surrogacy relationship. A gay father elected a
surrogate “who wanted or was willing to maintain some type of relationship going forward” (F8, 44 y). His surrogate echoed this expectation:

I think it would be really odd to go through the whole thing without it [a relationship], or have a close relationship throughout the entire pregnancy and then just sort of sever ties. To never speak to them again. So I guess the objective was to find like-minded intended parents. (GS3, 35 y)

Anticipating a relationship post-birth was an important selection factor among gay fathers and surrogates. A gay father described that, “the expectations were really that we wanted to stay friends. And she wanted to stay friends. So I think that was really the big factor in our connection” (F2, 45 y). His surrogate felt the same way, but seemed more flexible if the relationship could not be sustained: “ideally yes. I wanted a couple that we can keep up and stuff like that too. But you never know. That’s not something you can predict beforehand” (GS1, 37 y). A surrogate explained that “you want to get that stuff out of the way before you build too much of a relationship because then you get attached and possibly compromise your own beliefs and expectations for theirs” (GS4, 36 y).

Some participants expressed uncertainty in maintaining prolonged surrogacy relationships. A surrogate articulated that a relationship was “not something that you can make happen,” and “obviously I can’t hold them to some of the things I wanted from them” (GS5, 27 y). Her matched fathers were ambivalent: “we didn’t have a desire for it [relationship] but it didn’t bother us. It’s not something anyone can guarantee that will happen” (F13, 34 y). His partner agreed: “we thought it was a bit of an exaggerated expectation in advance to promise that we’ll have a friendship after the birth” (F12, 35 y). A gay father reported that his surrogate “had no
expectations from the relationship. She was just very, very flexible” (F5, 40 y). Another father surmised that, “even afterwards there is a possibility we won’t have contact at all” (F5, 40 y).

Gay fathers expressed that a surrogacy relationship was built on trust: “there has to be some level of bonding and obviously underpinned by trust” (F8, 44 y). Their expectations of developing a relationship were based on their surrogate’s reliability: “I don’t know her well enough to know if she’s going to do it properly. Is she going to do it right? Is she completely reliable?” (F4, 50 y); his partner stated, “I want my baby in somebody who’s going to be safe and I can rely on” (F5, 40 y). A father reported that he was looking for “someone that’s obviously going to take care of my, our child, properly because we’re not there constantly 24 hours a day with them. So they have to be responsible enough to carry someone’s child” (F11, 29 y).

3.2.1.2.2 Frequency of Contact

Pre-pregnancy, intended fathers and surrogates were in contact with one another quite frequently. Communication primarily occurred via texting, email or Facebook: “we each got each other on FB [Facebook] which was a big help because of their posting on FB daily or we talk a lot through that way” (GS1, 37 y). An intended father recollected that “we just spoke every day and I think it was more about us getting to know each other. Really what we do is write emails about what our days were like. And we got to know each other purely through email” (F2, 45 y). A surrogate recalled that “I do remember having their cell phone numbers and texting back and forth. It wasn’t exclusively related to surrogacy. I would tell them things that were going on in my life and vice versa” (GS3, 35 y). Another surrogate felt similarly, and described that her and her matched intended parents “started building a relationship even before
the transfer…they were more interested in knowing more about how I was doing” (GS5, 27 y).

The frequency of contact was an important means of learning more about one another before pregnancy. As a gay father explained, “because emotionally you are trying to find a mate…you’re trying to connect with somebody who is going to bear your future children” (F8, 44 y).

3.2.1.2.3 Intended Fathers’ Involvement

Surrogates expressed that the involvement of intended fathers pre-pregnancy helped mitigate fears of abandonment: “I was always kind of nervous. Maybe they just want to have kids and they’ll just leave as soon as it’s done. They gave me a feeling of comfort that it wasn’t going to be like that from the beginning” (GS6, 22 y); she recalled that, “the first thing they said, in the end we’re always two men…we’re not going to hide the fact that this is a surrogacy…we want you involved in our lives” (GS6, 22 y). Surrogates also indicated worry of maltreatment: “I also don’t want to be treated like a slave. I also don’t want to be hidden, kind of out of the picture either” (GS1, 37 y). Her matched fathers were able to ease her anxieties; they reported having “no shame in using a surrogate” (F2, 45 y). Another surrogate echoed this fear: “is this suddenly going to be we’ve got our baby and now we just pretend like the surrogate doesn’t exist” (GS4, 36 y). Her matched father described that upon meeting her, he was “sitting there with the person who could possibly give you the greatest gift” (F10, 37 y).

Gay fathers’ involvement seemed to stem, in part, from fear that the surrogate would change her mind: “I think we always kept the mentality that something could go wrong” (F6, 36 y). There was “fear that she would turn around, always…fear that she was going to back out” (F4, 50 y). In turn, one gay father dyad expressed the pressure of their involvement: “we felt we had
to measure up to their [the surrogate and her husband] expectations of us; so it was a very high pressure situation” and suggested that before pregnancy “we were afraid to say no to anything because we were afraid that if we say no to something, it will affect the relationship and her willingness to do this” (F13, 34 y).

For both gay intended parents and surrogates, mutual involvement was important even pre-pregnancy. As an intended father described:

I knew that this was something I don’t want to happen…not knowing this woman, not being able to speak to her, to hear her view about it, why is she doing it or where is she coming from…to thank her. That’s just something that morally I wouldn’t be able to do. So we were looking for a way that we would be able to do all these things and would have that connection. (F12, 35 y)

A surrogate, who had previously bore a child for a gay couple, recalled her previous surrogacy experience where

the dads weren’t too involved in the pregnancy…more geared towards looking at the end product of their child together. So I wanted somebody that wanted to experience the whole process and wanted to be part of the transfers and be part of ultrasounds and prenatal appointments…I wanted somebody who wanted to be involved in everything and who was more interested in being a bigger part of the process. (GS5, 27 y)

Among participants, gay fathers wished to be involved in the surrogacy pre-pregnancy, and surrogates indicated the wish for gay fathers’ involvement.
Overall, matched surrogate triads shared mutual interest in sustaining a relationship post-birth. Surrogates reported that issues of abandonment, exploitation and harm influenced their desire to maintain contact. Gay fathers expressed that a surrogate’s trustworthiness and reliability fostered reassurances that she would remain healthy during her pregnancy and relinquish the baby post-birth. Alternatively, some surrogates and gay fathers showed hesitancy in their expectations, being uncertain how the relationship would proceed during surrogacy.

3.2.1.3 During Pregnancy

The three sub-themes are: (1) perceptions of the relationship, (2) frequency of contact, and (3) intended fathers’ involvement.

3.2.1.3.1 Perceptions of Relationship

Gay fathers and surrogates reported that their relationships with one another shifted after a successful embryo transfer. For some matched surrogate triads, a deeper and more intimate connection evolved during pregnancy. A gay father described that, “it was really during the course of the pregnancy that we solidified our friendship; she became part of our lives in a meaningful way” (F8, 44 y). Gay partners echoed this perspective; during the pregnancy they “felt a closeness and attachment” (F11, 29 y), and she “became like a friend” (F10, 37 y). Their surrogate articulated that “there was definitely a sense of closeness, particularly after the transfer” (GS4, 36 y).

Some intended fathers and surrogates reported feeling more comfortable and relaxed with one another than pre-pregnancy: “It really changed after she became pregnant. We felt much freer to joke…we felt closer. We were less anxious about things we said. Now it’s happening, so they can’t change their mind” (F13, 34 y). He described that “it’s again less about how each one of
us wants the journey to be, and more the thing itself. The relationship itself” (F13, 34 y). A surrogate also described this sense of comfort, and because I’m carrying the baby, it [the bond] got stronger. They are thinking about me, but it’s the babies that are making them contact me more. Like the parental role is taking over with them, which made me more comfortable that I picked the right couple. (GS6, 22 y)

As a gay father articulated, once the surrogate became pregnant, “the relationship changed a lot; it was a lot more focused on the baby” (F2, 45 y).

### 3.2.1.3.2 Frequency of Contact

For most participants, contact increased and became much more frequent during pregnancy. This closeness was reaffirmed by a gay father: “it ended up being that we were in contact almost daily…it evolved to be a real friendship” (F12, 35 y). His partner agreed and that contact was “really frequent, being in touch all the time” (F13, 34 y). A surrogate described that, “once the transfer went through, it was texting three or four times a week, phone calls, emails from time to time. It was more intimate and faster responses between us and the dads…it was a lot more dialogue between us” (GS6, 22 y). A surrogate described “talking constantly; everyday; multiple times a day. Primarily through text” (GS4, 36 y). Her matched intended partner agreed, and suggested they “texted every single day” (F10, 37 y).

Alternatively, for about eight participants (including one matched surrogate triad), pregnancy led to reduced contact. A matched surrogate triad reported difficulties in the pregnancy: “we didn’t actually talk as much as we did beforehand…they didn’t know exactly what was going on and I didn’t tell them. I didn’t think they needed to know. I didn’t think it was necessary”
(GS1, 37 y). The matched father recalled that, “we talked less once she got pregnant; she had a lot more issues going on. So we kind of tried to give her space” (F2, 45 y). For this matched surrogate triad, the surrogate reported experiencing adverse physical and psychological side effects of her fertility \textit{(in-vitro fertilization)} medication, as she described weight gain, mood swings and the emotional distress of having to administer daily injections. She described that the intended fathers “didn’t need to hear me complaining about it.” A separated gay father also reflected on his surrogate’s adverse pregnancy:

in the first part we would call her to see how she was doing…but when the pregnancy became difficult for her, we found it difficult to talk to them [the surrogate and her partner] because we don’t know what she’s going through.

(F1, 42 y)

Although his surrogate did not participate in the study, he described that she faced difficulties during the pregnancy, resulting in physical side effects and culminating in time off work and bed-rest. He described trying to maintain contact, as she stopped working at the end of the first trimester: “so I went over…but I didn’t feel welcome. I didn’t feel wanted there. I felt more in the way. So I never went back…it was very frustrating” (F1, 23 y).

Two gay father dyads described their surrogate’s detachment as indicative of a business relationship rather than an emotional connection: “we were kind of confused why there wasn’t more communication, but at the same time we sort of understood that we didn’t need to talk to her every day” (F15, 43 y). A gay father echoed this experience: “I think we both appreciate that she didn’t need to tell us everything that was going on in her life; we didn’t have any interest in knowing everything” (F7, 35 y). Their surrogates chose not to participate in the
study, yet these gay father participants indicated that the level of contact and involvement was
directed and guided by the surrogate.

3.2.1.3.3 Intended Fathers’ Involvement

The increased closeness between surrogates and gay fathers was facilitated by surrogates’
detachment from their pregnancies, which led to greater involvement from intended fathers:
“they [intended parents] desired to be involved in all aspects of the pregnancy…I wanted
because I didn’t really view it as going to be my pregnancy” (GS3, 35 y). Her matched father
similarly recalled that, “she never considered an ownership or stake beyond the fact that she felt
a duty to raise them as healthy as she can in her body. She always considered herself a
guardian” (F8, 44 y). Another gay father recalled that his surrogate “was very educating along
the way” (F10, 37 y); she explained “constantly let[ting] them know when something was going
on, like when the baby first started kicking” (GS4, 36 y). Similarly, a gay father described that,
“it was very important for us to be there every step of the pregnancy and feel that it’s our
pregnancy too” (F13, 34 y). Surrogates identified the pregnancy as a joint reproductive process;
a surrogate spoke of “getting really excited when I found out we were pregnant. I say we
because we were pregnant, all of us” (GS6, 22 y). Another surrogate also described wanting the
intended fathers “to enjoy the pregnancy with me” (GS5, 27 y).

Intended fathers’ involvement influenced surrogates’ reproductive decision-making and
perceptions of a shared pregnancy: “I have this very important treasure…so some of the
decisions that you make are because you’re obligated to make them. I’m making the decision
for someone else completely. It isn’t me” (GS2, 45 y). Her matched father recalled that, “she
always kept saying this is your baby…she had that separation” (F4, 50 y). A surrogate reported:
“I think I’m almost more nervous about this than if it was our own. If it was our own it would be our own decision” (GS4, 36 y). Some surrogates put aside their own values with respect to reproductive medical choices, suggesting that, “these babies aren’t mine. That’s their choice in the end” (GS6, 22 y). Entrusting gay fathers with reproductive decisions assumed their role as future parents, and “it took away the motherly role that I would have to play” (GS6, 22 y).

In turn, gay fathers’ involvement fostered bonding with their surrogate:

she didn’t want to be a burden on us…[but] we wanted to be part of the journey regardless and we also wanted her to know that we fully supported her. And we would do whatever we could bending over backwards to show her that. (F8, 44 y)

His surrogate recalled that “they were also not interested in micro-managing the pregnancy, and he just put his trust in me” (GS3, 35 y). As a surrogate explained,

you kind of have to make sure you’re on the same page for all these sorts of things just because as much as they’re the parents, the surrogate is still very much calling the shots while the baby is actually in her body; it’s the surrogate who actually makes all the decisions. (GS4, 36 y)

Although fathers wanted to be actively involved in the process, they also supported the surrogate’s needs and wishes during pregnancy: “we tried to take interest in everything that’s happening with her body, and to show that we know her body is changing and we’re not indifferent to it” (F13, 34 y). A surrogate reiterated that, “they were open to my input and how I felt about things. I suppose they acknowledged that it was partly my journey as well” (GS3, 35 y). A father described that even though his surrogate reduced contact during pregnancy, “we
wanted to be as accommodating as possible as what she wanted in terms of the relationship; we
didn’t want to control her…we were willing to do anything she wanted” (F6, 36 y).

In contrast, a surrogate shared ambiguity regarding her intended fathers’ involvement: “I don’t
know if it was real to them because they weren’t seeing me growing daily, they weren’t seeing
the baby…I guess that’s the thing. They didn’t know what exactly was going on” (GS1, 37 y).
A gay intended father also faced difficulties with the surrogacy relationship during pregnancy.
His surrogate distanced herself during pregnancy and this impacted his involvement, as he was
“not allowed to be involved in that [pregnancy] part of it…it was kind of disappointing because
I wanted to be there and be part of it” (F1, 42 y). Another surrogate also expressed anxiety and
worry about her own involvement in her pregnancy: “I was excited and I got nervous…because
I was really, really excited to be pregnant again. Should I be this excited? Am I too excited to
be pregnant?” (GS6, 22 y).

Overall, matched surrogate triads reported that the pregnancy elicited intimacy and closeness in
their relationships. Surrogates generally detached from their pregnancy, and encouraged
involvement and joint reproductive decision-making with intended fathers. For most gay
fathers, the pregnancy resulted in increased contact and engagement in reproduction.
Conversely, about seven gay fathers reported that during pregnancy, there was disconnect in
their surrogacy relationships and reduced contact; for some, this was due to the surrogate’s
physical and psychological discomfort during the surrogacy. Surrogates who encountered
difficulties in their pregnancy seemed to lessen communication with the intended fathers over
the course of the pregnancy.
3.2.1.4 Post-Birth

The three sub-themes are: (1) perceptions of the relationship, (2) frequency of contact, and (3) intended fathers’ involvement. Among participants, surrogacy pregnancies ranged from 2010-2014, and surrogate offspring ranged in age from a month old to five years of age at the time of interview.

3.2.1.4.1 Perceptions of Relationship

Matched surrogate triads expressed a preference for a continued relationship post-birth. For gay fathers, their surrogate reflected their children’s birth story: “if it wasn’t for her we wouldn’t have him. She played a huge part of bringing him in” (F3, 36 y). A relationship was also important for transparency: “we wanted to maintain some kind of relationship. We plan to be very open and tell her [the baby] everything about her birth story and the woman who carried her” (F12, 35 y). A gay father of 17-month old twins reaffirmed this decision: “I think we both agree that our kids will always know who she is and what she did” (F7, 35 y). His partner articulated that, “we don’t want to lie to our kids about how they came to be. We would like them to know that [redacted name] was this amazing lady, and who enabled daddy and papa to have them; we’ll maintain a casual relationship” (F6, 36 y). A father of four-year old twins suggested: “we definitely felt that it’s important...as part of their life story, that they have that anchor in their life as the person who brought them into the world...it’s important for us that our kids have that continuity in their lives” (F8, 44 y).

Gay fathers also expressed gratitude and appreciation towards their surrogate. A gay father felt that “we owed it to maintain the relationship. We felt dedicated to doing that” (F8, 44 y). A gay father described that, “to us, she’s a god; she’s literally an angel...and we are forever indebted
to her” (F2, 45 y). Some gay fathers were also interested in pursuing a second surrogacy: “[I] wanted to maintain a relationship hoping that she would do this again. I still would have kept in touch with her, but it would have been a little bit different…It’s a little bit selfish on my part” (F4, 50 y). A gay father reported maintaining a relationship “because we’ve talked about her being the surrogate for our second child” (F10, 37 y). As this was the first child for all intended gay fathers, three gay partner dyads (n=6) spoke directly about their interest in pursuing a second surrogacy with the same surrogate.

3.2.1.4.2 Frequency of Contact

Contact typically reduced post-birth: “I think we probably took a month to ourselves. I don’t think we talked all that much. It was our new thing” (F2, 45 y). Surrogates explained that interactions lessened as the fathers transitioned to parenthood: “there’s sort of a natural reduction in communication just because of the nature of how their lives changed and how busy they were” (GS3, 35 y). As another surrogate articulated, “things have obviously switched a bit where they are a little bit busier and they can’t always respond” (GS5, 27 y). Some surrogates had to remind themselves to limit communication. For instance, a surrogate of a one-year old (surrogate) offspring reflected that: “I find myself trying to make sure I’m only texting every few days. That I’m not doing it constantly…I don’t want them to feel like I’m checking up on them” (GS4, 36 y). Her matched fathers seemed satisfied with the frequency of contact: “we obviously don’t keep in contact every single day like we used to, but probably once or twice a week…currently that’s all we want” (F10, 37 y). Contact ranged from once a week to approximately once a month; families would visit or spend holidays together once or twice a year, and surrogates would sometimes be invited to birthday parties or family functions. A father of 17-month old twins described: “I think at this point we’re texting once a month. I’ll
send her videos of the kids’ first steps. She’ll send me pictures of her kids, and kind of check in now and then” (F6, 36 y). A father of four-year old twins articulated that “we probably talk about once a month now. We email or text much more. I’d say we text at least once a week or twice a week. Back and forth on a few things” (F8, 44 y). The participants who stayed in contact described how this was a natural progression of their relationship, as there were no formal discussions or arrangements post-birth.

For three out of fifteen gay fathers, the surrogacy relationship was terminated post-birth, although sporadic contact or yearly “Christmas cards” still occurred; however, there was no consistent communication, exchange of photographs or more informal contact between surrogates and gay fathers. A separated father of a five-year old recalled that, “what we ended up doing was picking up the baby and saying goodbye at the hospital” (F1, 42 y). This gay father spoke of his tumultuous experience with the surrogate during the pregnancy, whereby the relationship terminated prior to her giving birth. A gay father of five-year old twins described that post-birth “she [surrogate] left and we never saw her again. I always felt like it was a business contract. And it is. But I thought there should be more emotion to it and, at the same time, very glad there wasn’t” (F15, 43 y). Although there was no discord or conflict in the relationship, this gay father dyad recalled that there was always some disconnect even in the pre-pregnancy stage. His partner echoed this feeling: “once the babies were handed over, she was going to respect our privacy and let us contact her or let the girls contact her if we wanted them to” (F14, 36 y).
3.2.1.4.3 Intended Fathers’ Involvement

For most participants \((n=18)\) gay fathers were still involved in the lives of their surrogates post-birth to varying capacities. Three gay fathers did not have ongoing contact with their surrogates and, consequently, their surrogates did not agree to participate in this study. A relationship post-birth signified a new family construct. A surrogate reflected that “perhaps all of our definitions of family have broadened. And it feels sort of more like family. It’s a bit closer than a regular friendship” (GS3, 35 y). Her matched father concurred that “our families blended together” (F8, 44 y). A gay father described that he and his partner have “an extended little family” (F2, 45 y) and the surrogate and her children “are part of our family now” (F3, 36 y). Family was important among participants who did not have siblings. A surrogate who was an only child described: “I have siblings now. They almost seem like my brothers” (GS4, 36 y). Similarly, a gay father felt that his surrogate “kind of evolved to being that sister I never had” (F8, 44 y).

Establishing a new familial relationship was an important indicator of a successful reproductive process:

my whole journey was, whatever I was trying to get out of it emotionally from the whole thing or from the beginning, from the start, I’ve gotten that emotional bond from the parents that I started with. It was still there. It wasn’t gone after the babies were born…if I couldn’t have that closeness, it would be really hard on me.

(GS6, 22 y)

Alternatively, some gay fathers had fewer expectations of their surrogacy relationship post-birth: “we don’t really have an opinion about it. We’re really happy. We see ourselves as friends…we don’t have any plans to continue. No specific expectations” (F12, 35 y). In contrast, his surrogate perceived that, “we’ve become like family with them” (GS5, 27 y).
Another surrogate recalled telling the fathers post-birth that if they “are not comfortable with this [maintaining contact], don’t feel you need to” (GS2, 45 y). Her matched fathers articulated that geographical distance helped maintain boundaries and reduce anticipated contact: “this [distance] was a huge benefit…she might feel a lot of pressure to have more of a connecting relationship [with us]. I think the fact that this wasn’t a possibility for us worked out very well” (F5, 40 y).

Although contact typically reduced post-birth, matched surrogate triads indicated maintaining some type of relationship, ranging from casual to more familial. Gay fathers explained that they maintained a relationship for purposes of: (1) disclosure and transparency, (2) feelings of appreciation and gratitude, and (3) a second surrogacy. Surrogates attempted to show restraint in the frequency of contact, while gay fathers preferred some distance as they transitioned to parenthood. Three out of 15 gay father participants reported that their surrogacy relationship terminated post-birth; their surrogates chose not to participate in the study.

3.3 Discussion

Findings from the present study draw attention to the emerging complexities of surrogacy relationships. Although most matched surrogate triads consistently reported positive surrogacy trajectories, other participants appeared to experience increased distance which, for some matched surrogate triads, led to termination of the relationship post-birth. Incongruences across participant narratives are important to elucidate. Research has demonstrated that relationships with intended heterosexual parents are indicative of surrogates’ satisfaction (Berend, 2012; Ciccarelli & Beckman, 2005; van den Akker, 2003); a harmonious relationship often predicts a positive surrogacy experience and mitigates feelings of disappointment, regret and distress.
among surrogates (Berkowitz, 2013; Stacey, 2006). Thus, discerning what constitutes a positive surrogacy relationship may enhance understanding of third-party reproduction among gay men in Canada. Although a positive surrogacy relationship may be equally important to achieve regardless of sexual orientation or marital status, empirically-based research can help inform the structure of practices and policies. As suggested in the introduction, there are a lack of standardized guidelines or regulations monitoring or addressing the psychosocial and emotional needs of surrogates or intended parents. Unanticipated complications, reduced contact and terminated relationships can have both short and long-term consequences on all parties. Thus, understanding what constitutes a positive surrogacy relationship for both gay fathers and surrogates in Canada can importantly shape the provision of care among surrogates, intended parents and allied health professionals working in the field of assisted reproduction.

Previous theoretical discourses have explicated surrogacy as an interpersonal social practice that is dependent on the creation of mutual trusting relationships in order to meet the expectations, needs and interests of both surrogates and intended parents (Beier, 2015; Jacobson, 2016). Interpersonal trust is often a necessary addition to establish a positive surrogacy relationship that is maintained post-birth. According to Beier (2015), interpersonal trust consists of: (1) a mutual relationship comprising a trustor and a trustee; (2) a commitment to a certain norm and shared values; (3) freedom to break trust; and (4) a ‘leap of faith’ as an emotional achievement; developing trust requires a ‘leap of faith’ that suspends fears of vulnerability and uncertainty (Beier, 2015). In the current study, surrogates and gay fathers assumed the role of both trustor and trustee. In their initial expectations pre-pregnancy, surrogates trusted that a mutual relationship with gay fathers would ease concerns of exploitation and abandonment post-birth; comparatively, gay fathers relied on surrogates to
assume a healthy pregnancy and relinquish the child post-birth. Interpersonal trust upheld the expectation of developing intimate and long-standing surrogacy relationships. Participants who were hesitant to agree to a continued relationship prematurely expressed a ‘leap of faith.’ Surrogates, in particular, appeared to offer gay fathers the ‘freedom to break trust,’ as their expectations of a post-birth relationship remained flexible and open-ended.

However, other participants expressed unmatched expectations pre-pregnancy. For instance, some surrogates implied that even though they preferred to maintain contact post-birth, they could not demand or expect gay fathers to do the same. Surrogates’ initial ambiguity perhaps acted as a protective mechanism, so as not to be disappointed if contact dissipated. Their doubt and uncertainty appeared to be corroborated by gay fathers who acknowledged that they were less interested in pursuing a relationship post-birth than their surrogate. The decisions among gay fathers seemed to derive from ambiguity in sustaining a future relationship. For some participants, limited conversations regarding expectations post-birth made negotiations, pre-pregnancy, difficult.

In the second stage, pregnancy fostered intimacy and closeness among surrogates and gay fathers. The ability to jointly negotiate expectations and reproductive decisions facilitated interpersonal trust. Surrogates allocated reproductive decisions to the intended fathers and this, in turn, appeared to help surrogates detach from their own pregnancies; this maternal disconnect reinforced a surrogate’s trustworthiness and dependability. Her unwillingness to assume a motherly role and her perception of reproduction as a shared process encouraged gay fathers to assume parenting responsibilities during pregnancy. Gay fathers’ active engagement thereby reassured surrogates that they would be trustworthy and reliable parents post-birth.
In her anthropological fieldwork with Israeli surrogates, Teman (2012) explains that surrogates intentionally detach from their pregnancies, and concede their anticipated maternal identity to the intended mother. Surrogates encourage intended mothers’ involvement by openly communicating about the pregnancy, including attention to physical changes, ultrasounds and medical appointments (Teman, 2012). These distancing techniques benefit both surrogates and intended mothers; they promote a surrogate’s disengagement from the pregnancy and, at the same time, enable an intended mother’s maternal connection. In the current study, surrogates’ maternal separation, frequent communication and shared reproductive decision-making helped gay fathers experience pregnancy. This encouraged bonding, intimacy and closeness; as gay fathers observed that surrogates acknowledged and supported them as parents, they, in turn, demonstrated increased motivation to accommodate surrogates’ needs and interests during pregnancy. Gay fathers and surrogates benefited from such mutual interactions, which importantly fostered a positive surrogacy relationship during pregnancy.

Surrogates’ detachment from pregnancy may be indicative of women’s reproductive freedom. Surrogates’ narratives may refute expectations of maternal-fetal bonding during pregnancy; rather, pregnancy fostered intended fathers’ involvement and collaborative medical decisions. A surrogate’s ability to separate gestational and social motherhood disrupts normative ideologies of pregnancy and procreation (Blyth, 1994; Markens, 2007; Teman, 2003, 2009). The ability for women to try and mitigate fetal attachment fosters procreative liberties. Simultaneously, however, these decisions elicit ethical complexities of autonomous reproductive decision-making in surrogacy. Surrogates appeared to disengage from their embodied identities as pregnant women and, in turn, allowed decisions regarding their bodies be a collaborative, rather than a freely individual autonomous, practice.
Alternatively, some participants reported that there was reduced contact between intended parents and surrogates during pregnancy. In her ethnographic research on surrogacy, Ragoné (1994) describes how intended mothers often seek a “pseudo-pregnancy” during surrogacy; they develop close surrogacy relationships in order to experience pregnancy by proxy. As surrogates and intended mothers collaborate through the pregnancy, this enables a stronger and more positive connection. In the present study, many fathers relied on their surrogate to initiate dialogue and communicate information related to pregnancy and childbirth. This sanctioned gay fathers’ involvement as parents, and confirmed surrogates’ desire to relinquish the baby post-birth. However, when this did not occur, and surrogates reduced contact, gay fathers questioned how to enhance the surrogacy relationship, attach to the pregnancy or envision parenthood.

Consequently, reduced contact from intended fathers may be, as Jacobson (2016) suggests, a way in which intended parents contend with the emotional and psychological stress and potential risks (e.g., miscarriage, stillbirth) of surrogacy, or the possibility that decreased contact may be indicative of a surrogate’s deliberation of whether or not to relinquish the baby. In turn, some gay fathers found it increasingly challenging to build rapport, and thereby distanced themselves from both the surrogacy relationship and the pregnancy. This resulted in a somewhat incongruent experience. Gay fathers limited their involvement in the pregnancy and yet simultaneously anticipated parenthood.

The separation from pregnancy created disconnect between gay fathers’ interest in the reproductive process and the continued development of a mutual trusting relationship. With added concern, gay intended fathers also described reducing contact to placate what they perceived to be the surrogate’s wishes. Gay intended fathers in the current study described
being uncertain how to best support their surrogate during pregnancy, and to respect and value her desire to reduce contact. Thus, reduced contact may also be suggestive of the way intended fathers wrestled with how much to trust the surrogate, not wanting to appear as though they are trying to micro-manage or control the pregnancy. Gay fathers spoke of wanting to meet the surrogate’s wishes and interests while pregnant; reduced contact during pregnancy, however, led to termination of contact post-birth.

Importantly, surrogates may have intentionally lessened contact due to presumptions that intended fathers lack an intimate connection or understanding to experiences of reproduction, pregnancy and childbirth; men cannot relate or empathize with the physical side effects of pregnancy. This reaction may be unique for surrogates bearing a child for gay intended fathers. Among heterosexual couples, surrogates have demonstrated a closer and more intimate attachment to the intended mother than the intended father (Blyth, 1994; Ciccarelli & Beckman, 2005); the intended heterosexual father is often on the periphery of the surrogate relationship due, in part, to a detachment from pregnancy and childbirth (Malik & Coulson, 2008). Women may be more comfortable speaking with other women about issues related to fertility, reproduction, pregnancy and childbirth than men (Blyth, 1995). Consequently, surrogates who bear a child for gay men do not have an intended mother in which to discuss pregnancy-related matters. Thus, without an intended mother, surrogates may not experience the same level of support, ease and familiarity in speaking about their pregnancies with gay intended fathers.

Nevertheless, the actions of surrogates who lessened contact during pregnancy may also be a reflection of hegemonic femininity and relational gendered practices. The ‘silencing of the self’ schema associates femininity with the adoption of self-silencing techniques to establish and
maintain harmonious relationships (Jack & Dill, 1992; Szymanski, Ikizler, & Dunn, 2016). Self-silencing behaviors enable women to suppress their interests, needs and desires for the purposes of avoiding conflict and discord in relationships (Jack & Dill, 1992). Self-sacrificial care encourages women to prioritize others’ needs in order to secure attachments and foster bonding. In the current study, some surrogate participants indicated not wanting to worry or trouble their intended fathers. Some surrogates did not only conceal the physical side effects of pregnancy but, at times, downplayed their expectations of a relationship, their desire for increased contact and their anxieties about pregnancy. This is suggestive of a way in which women attempt to mitigate what they perceive as unnecessary worry or concern (Jack & Dill, 1992). Thus, surrogates’ self-silencing techniques may be an important ethical consideration of surrogacy relationships.

In the third stage of the surrogacy relationship, matched surrogate triads’ relationships post-birth ranged from casual contact to blended familial relationships. Ethical theorists have argued that as intended parents have something to gain from treating the surrogate with respect, they may only do so for their desire to have a healthy child (Shannon, 1988). The concern is that the surrogate is treated as a means to an end; her identity is interwoven with her reproductive capacity. Post-birth, there is fear the surrogate will no longer be valued or protected by the parents. The present study suggests that the surrogate relationship was upheld, to varying degrees, post-birth. Gay fathers articulated the meaningful role of the surrogate in their child’s birth story, and showed a deep sense of gratitude. Accordingly, even after the birth of the child, the surrogate retained a sense of value, respect and appreciation among gay fathers.

43 As suggested in Chapter 2, this may also be reflective of gendered considerations of emotion management and emotional labor (as seen on pages 89 of this dissertation). Surrogates may consequently be regulating their feelings and emotions regarding their adverse pregnancies in their interactions with intended gay fathers.
However, some gay fathers appeared to regulate the frequency of contact and the type of post-birth relationship. In a 2013 Canadian study among 8 gestational surrogates, researchers described that the relationship between surrogates and intended (opposite-and same-sex) parents shifted during and after pregnancy; surrogates were “expected to abide by the good surrogate discourse” (Fisher & Hoskins, 2013, p. 513), and intentionally reduced contact to allow parents to direct how the relationship would proceed. In the current study, although contact decreased post-birth, no participants reported overt conflict or discord. Surrogates seemed to have a ‘leap of faith’ (Beier, 2015) whereby they attributed a lack of contact to the transition to parenthood, rather than the degeneration of their relationship. Surrogates expressed an understanding that lessened communication was ‘natural’ in the transition to parenthood.

Participants who experienced increased distance and reduced contact during pregnancy reported that their relationship terminated post-birth. However, according to participants, termination post-birth seemed to generally develop from mutual expectations. It is important to note that among some participants whose relationships terminated post-birth, their matched surrogate/intended father did not agree to participate in this study. Thus, this has potential implications for how the surrogacy relationship was described. Moreover, contact seemed to range in frequency dependent on when surrogacy occurred. For instance, those with one-year old surrogate offspring or younger appeared to report more frequent communication (e.g., once a week) than those with surrogate children over a year old (e.g., once a month). As well, those with children over a year old reported that visits between intended parents and surrogates occurred only about twice a year on special occasions (e.g., birthdays and holidays). The intended fathers who reported terminated relationships both had children who were five years of age at the time of interview.
Findings from this study may lead to a preliminary understanding of the determinants of a positive surrogacy relationship (Figure 1). Importantly, interpersonal trust encouraged a collaborative relationship among gay fathers and surrogates. For instance, in Jacobson’s (2016) findings, gestational surrogates reported trust as an important component of a positive surrogacy experience; surrogates described that trust could be fostered through effective communication, shared values and mutual expectations.

The findings of the current study support Jacobson’s research, and emphasize the importance of interpersonal trust between gay intended parents and gestational surrogates. Gay fathers benefited from a surrogate’s ability to communicate her own interests and needs, and to encourage their active engagement during the reproductive process. In turn, as surrogates detached from their pregnancies, gay fathers’ presence facilitated their role as future parents. A mutual trusting relationship is a critical facet of positive surrogacy relationships and an important foundation in which to uphold surrogates’ appreciation, value and respect post-birth.

3.4 Limitations

This was a qualitative study with a small sample size among a very specific and hard-to-reach sub-group of the surrogacy population. There has been limited research conducted on surrogacy among gay men; consequently, the aim was not to generalize but to present important and novel insights on surrogacy in Canada. This is one of the first studies to engage with a sample of gay fathers and surrogates, and incorporate the perspectives of matched surrogate triads.

A limitation of the study was that interviews were conducted retrospectively at only one time point. Findings may therefore be influenced by recall bias. A prospective cohort study
Conducted longitudinally may offer in-depth insights that build a coherent trajectory of how surrogacy relationships progress and shift over time. As most matched surrogate triads reported favorable experiences, it would be beneficial to explore negative surrogacy relationships to understand factors that promote distance between gay fathers and surrogates. For instance, in this study, gay father participants who reported that their surrogacy relationships terminated post-birth had pursued surrogacy five years prior to the time of the interview. Thus, it may be important to add to empirical scholarship that has initiated follow-up studies with surrogate families (Blake, Casey, Jadva, & Golombok, 2012; Imrie & Jadva, 2014; Jadva, Imrie & Golombok, 2015). This may importantly help to elucidate how relationships evolve over time between both intended parents and surrogates, as well as between surrogates and surrogate offspring. However, a strength of this study was that both gay fathers and gestational surrogates, and matched surrogate triads, were included in this analysis.

Among some participants whose relationship dissipated or terminated post-birth, their matched surrogate/intended father did not agree to participate. Thus, a complete narrative is absent from this analysis. Additionally, purposefully recruiting more diverse populations may help to examine how intersections of socioeconomic status, race, ethnicity and geographical location influence surrogacy relationships among gay men. Including genetic surrogates may also add a novel perspective. Future research should explore other surrogacy relationships, including the maternal-fetus attachment, as well as the surrogate’s relationship with her own immediate family while pursuing surrogacy, which were both beyond the scope of this analysis.
3.5 Implications & Conclusion

The current findings have important implications for surrogacy practices in Canada (Figure 2). Clinicians and allied health professionals who work in the area of third-party reproduction have an obligation to provide relevant information and effective services for those interested in pursuing altruistic surrogacy; providers need to be mindful of the unique challenges of surrogacy, and remain attentive to these intricate relationships (Sanabria, 2013; Simpson & Hanafin, 2015). Social workers, in particular, are often responsible for conducting psychosocial assessments in fertility clinics, and coordinating expectations of surrogates and intended parents in subsequent joint sessions. Social workers must learn to mediate interests, and seek ways in which to address and manage conflict or unmatched expectations; this involves addressing potential obstacles early on between intended parents, surrogates and their respective families (Simpson & Hanafin, 2015).

Incorporating meaningful and relevant questions into psychosocial assessments and initial interviews can help surrogates and intended parents consider future implications (Sanabria, 2013). For instance, questions may include initial expectations of surrogacy, frequency of contact and involvement during pregnancy, and post-birth considerations (Koert & Daniluk, 2016; Simpson & Hanafin, 2015). Understanding the perspectives of gay fathers and surrogates can foster collaborative decision-making and effective communication pre-surrogacy. As a result, negotiations can help establish mutual goals and intentions, and pre-emptively identify the anticipated expectations of the surrogacy relationship.

Trained allied health professionals may promote mutual respect and shared values to further assist surrogates and intended parents to discern their own expectations, needs and interests
from the beginning; this may help to establish collaborative surrogacy relationships (Simpson & Hanfin, 2015). Furthermore, encouraging a surrogate-focused model of surrogacy may grant surrogates with negotiating power to mitigate risk of exploitation by having surrogates and intended parents jointly negotiate expectations pre-pregnancy to mitigate conflict and discord (London, 2012).

As indicated by many gay fathers and surrogates in the present study, a surrogacy relationship may not merely end post-birth (Koert & Daniluk, 2016). Allied health professionals working in a family therapy context ought to be mindful of non-traditional and non-heterosexual family units (Holley & Pasch, 2015; Marvel et al., 2016; Rozental & Malmquist, 2015; Shilo, Cohen, & Gavriel-Fried, 2016). Importantly, social work practitioners should become knowledgeable about gay men’s reproductive options, and post-birth issues that may arise from surrogacy, including: (1) managing the surrogate’s role in the family context, (2) disclosure to offspring, and (3) transitions to parenthood (Greenfeld & Seli, 2011; Koert & Daniluk, 2016). Therapeutic support may also assist surrogates who encounter difficult emotional and psychological consequences post-birth (Hanafin, 2006; Koert & Daniluk, 2016). As surrogates are members of their own family systems, it is important that social workers care for the surrogate and her immediate family with experiences post-birth.

Establishing effective skills, training and practice modules for allied health professionals can help support intended parents, surrogates and their families after the practice of third-party reproduction. In accordance with the National Association of Social Work (NASW) Code of Ethics, social workers value the importance of human relationships and “seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the
well-being of individuals, families, social groups, organizations and communities” (NASW, 2008). For the benefit of future service users, dialogues with clinicians, allied health professionals and policy makers can encourage more effective guidelines, as well as relevant resources, services and professional systems of support for those who wish to pursue surrogacy.
Table 1

**Gay Father Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range ($CAD)</th>
<th>Region</th>
<th>Immigration Status</th>
<th>Number of Surrogate Children</th>
<th>Age of Surrogate Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>42</td>
<td>White</td>
<td>Grade 12</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>5 years old</td>
</tr>
<tr>
<td>F2*</td>
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<td>White</td>
<td>Bachelor’s</td>
<td>81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F3*</td>
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<td>White</td>
<td>College</td>
<td>81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F4*</td>
<td>50</td>
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<td>200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (U.S.)</td>
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<td>1 year old</td>
</tr>
<tr>
<td>F5*</td>
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<td>Asian</td>
<td>Med School</td>
<td>200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (Japan)</td>
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<td>1 year old</td>
</tr>
<tr>
<td>F6*</td>
<td>36</td>
<td>White</td>
<td>University</td>
<td>40,000-80,000</td>
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<td></td>
<td>2 (twins)</td>
<td>17 months</td>
</tr>
<tr>
<td>F7*</td>
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<td>Post-Grad</td>
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<td></td>
<td>2 (twins)</td>
<td>17 months</td>
</tr>
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<td></td>
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<td>University</td>
<td>161,000-200,000</td>
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<td></td>
<td>2 (twins)</td>
<td>4 years old</td>
</tr>
<tr>
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<td>Master’s</td>
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<td>Suburban</td>
<td></td>
<td>2 (twins)</td>
<td>5 years old</td>
</tr>
</tbody>
</table>

*Notes: *Corresponding letters refer to partnered gay men

Table 2

**Surrogate Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Age at recent Surrogacy</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range ($CAD)</th>
<th>Region</th>
<th>Number of Surrogacies</th>
<th>Number of Surrogate Children</th>
<th>Number of (own) biological children</th>
</tr>
</thead>
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<td>College</td>
<td>&lt; $40,000</td>
<td>Rural</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>GS2*</td>
<td>45</td>
<td>44</td>
<td>White</td>
<td>Bachelor’s</td>
<td>&gt; $40,000</td>
<td>Rural</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>GS3*</td>
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<td>31</td>
<td>White</td>
<td>College Diploma</td>
<td>&lt; $40,000</td>
<td>Suburban</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>GS4*</td>
<td>36</td>
<td>35</td>
<td>White</td>
<td>Some College</td>
<td>&lt; $40,000</td>
<td>Suburban</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>GS5*</td>
<td>27</td>
<td>27</td>
<td>Aboriginal</td>
<td>BScN</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>GS6*</td>
<td>22</td>
<td>21</td>
<td>Aboriginal</td>
<td>BScN</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Notes: *Letters correspond to Table 1 to reflect the ‘matched surrogate triads’
Figure 1

A Conceptual Framework of Interpersonal Trust in the Surrogacy Relationship between Gay Intended Fathers and Gestational Surrogates at Three Time Points

Pre-Pregnancy

- Mutual trusting relationship
- Fears of abandonment and concealment
- Fears of reliability & safety
- Flexibility to break trust
- Negotiations of long-standing and intimate relationships

During Pregnancy

- Mutual trust & joint decision-making
- Surrogates' detachment enables gay fathers' involvement
- Effective communication
- Bonding, intimacy, closeness, & participation

Post-Birth

- Familial to casual relationships
- Gay fathers' continued gratitude, appreciation and value
- Surrogates' 'leap of faith' when contact lessened
### Table 3

**Implications of Gay Men Pursuing Gestational Surrogacy for Allied Health Professionals**

<table>
<thead>
<tr>
<th>Pre-Birth (Pre- &amp; during pregnancy)</th>
<th>Post-Birth</th>
<th>General Training &amp; Skill-Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assessments &amp; joint interviews:</td>
<td>Gay Fathers:</td>
<td>1. Training in effective and</td>
</tr>
<tr>
<td>a. Initial expectations</td>
<td>1. Managing surrogate’s</td>
<td>competent practice with</td>
</tr>
<tr>
<td>b. Frequency of contact</td>
<td>role</td>
<td>non-traditional and non-</td>
</tr>
<tr>
<td>c. Involvement during pregnancy</td>
<td>2. Disclosure to offspring</td>
<td>heterosexual family units</td>
</tr>
<tr>
<td>d. Post-birth considerations</td>
<td>&amp; child’s birth story</td>
<td></td>
</tr>
<tr>
<td>2. Manage expectations &amp; address</td>
<td>3. Transitions to</td>
<td>2. Recognition of own biases</td>
</tr>
<tr>
<td>negotiations</td>
<td>parenthood for gay</td>
<td>&amp; assumptions</td>
</tr>
<tr>
<td>3. Address and mediate conflict</td>
<td>fathers</td>
<td>3. Understanding of the</td>
</tr>
<tr>
<td>4. Surrogate-focused model</td>
<td>Gestational Surrogates:</td>
<td>complexities of surrogacy</td>
</tr>
<tr>
<td>5. Introduce mutual trust &amp;</td>
<td>1. Potential distress</td>
<td>relationships</td>
</tr>
<tr>
<td>collaboration</td>
<td>2. Transition to</td>
<td>4. Surrogacy in the context</td>
</tr>
<tr>
<td></td>
<td>termination</td>
<td>of family therapy</td>
</tr>
<tr>
<td></td>
<td>3. Negotiating future</td>
<td>5. Knowledge of relevant</td>
</tr>
<tr>
<td></td>
<td>contact, relationship</td>
<td>specific resources, services</td>
</tr>
<tr>
<td></td>
<td>and role</td>
<td>and systems of support for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gay men pursuing surrogacy</td>
</tr>
</tbody>
</table>

*All above conducted between:*
- Joint intended parents
- Intended parents & surrogate
- Surrogate & her immediate family
Chapter 4
Practicing Surrogacy in Canada:
A Qualitative Study among Gay Fathers and Gestational Surrogates

4 Introduction
This purpose of this chapter is to delineate the institutional supports and barriers for gay intended parents and surrogates during surrogacy and upon the transition to parenthood.

4.1 Literature Review
The following literature review will situate this research within the sociopolitical context of Canada with regard to gay parenting rights and surrogacy regulations. To critically explore the facilitators and barriers of surrogacy for gay men and gestational surrogates, it is important to understand the legal structures that have affected surrogacy practices and same-sex parenting.

4.1.1 Surrogacy Regulations in Canada
In Canada, surrogacy is regulated by the Assisted Human Reproduction Act (AHRA), under the auspices of Health Canada. Federal legislation in Canada forbids the practice of commercial surrogacy, the act of financially compensating a surrogate; it is a criminal offense to pay or offer to pay surrogates, and to advertise or arrange payment (Busby & Vun, 2010; Reilly, 2007; Snow, Baylis, & Downie, 2015). Accordingly, altruistic surrogacy, wherein surrogates are reimbursed only for out-of-pocket medical expenses incurred as a result of surrogacy, is legally permissible. Altruistic surrogacy, in some respects, has been deemed as a morally justifiable alternative to commercial surrogacy, a way in which to mitigate concerns of exploitation and
coercion that have been associated with the financial compensation of surrogates (Ruparelia, 2007; Walker & van Zyl, 2016).  

Although both genetic and gestational surrogacy are permitted in Canada, gestational surrogacy is more common, and considered a much more acceptable practice across fertility clinics and surrogacy consulting services (Grover et al., 2014; Dar et al., 2015; Sanabria, 2013). 

Gestational surrogacy, as opposed to genetic surrogacy, is when a woman gestates a child for another individual or couple but holds no genetic connection to the surrogate offspring; she undergoes an embryo transfer with the use of donated gametes (ovum and sperm) (Crawshaw, Blyth & van den Akker, 2012; Imrie & Jadva, 2014). Thus, electing gestational surrogacy (as opposed to genetic surrogacy) is often purposeful; the lack of genetic attachment to the surrogate offspring is thought to alleviate the maternal-fetal bond and facilitate the surrogate’s relinquishment of the child post birth (van den Akker, 2003).

Since it was introduced into law in 2004, the AHRA has been subject to both legal and ethical controversies (Marvel, 2015; Snow, 2014; Snow, Baylis, & Downie, 2015). After being enforced in 2007, the Quebec Court of Appeal challenged the ruling and, in 2010, the Supreme Court of Canada declared some sections of the AHRA unconstitutional (Health Canada, 2014). Although the AHRA covers a range of assisted reproduction methods, certain stipulations with regard to surrogacy have been upheld at the federal level (e.g., the criminalization of

44 Although addressing the ethical complexities of altruistic surrogacy is beyond the scope of this paper, emotional coercion and exploitation may exist even without financial compensation, as suggested in the introductory chapter of this dissertation. For instance, women who choose to bear a child for a family member may be influenced by a sense of familial obligation and duty. When altruistic surrogacy is rendered as a form of ‘gift-giving,’ some feminist discourses present the argument that women are socialized to believe that ‘good women’ are nurturers, carers and givers. In this way, women perform hegemonic ideals of femininity by bearing children and recognizing their fertility as a way in which to show compassion and empathy to those who experience infertility; women are only valued so long as they provide for others through self-sacrificial care.
commercial surrogacy) while others remain under provincial jurisdiction (e.g., IVF coverage) (Busby & Vun, 2010; Snow, 2014). In 2013, Assisted Human Reproduction Canada (the agency established to oversee the AHRA) was eliminated due to budgetary concerns and organizational challenges (Health Canada, 2014). This has led to decreased federal oversight, as well as limited guidelines and directives for fertility clinics and surrogacy consulting services (Health Canada, 2014). The legal historical framework of surrogacy in Canada underscores a highly contentious and ambiguous process (Snow, 2014).

The guidelines of the AHRA that regulate financial reimbursements have perhaps caused the most apprehension among service users of third-party reproduction (Cattapan & Cohen, 2013). Receipts of medical expenses incurred as a result of surrogacy are provided directly by the surrogate to the intended parents (the couple who plans to legally and socially rear the child post-birth). However, the language of what constitutes legitimate medical reimbursements under the AHRA remain vague, and currently no federal regulations are in place to govern these practices (Cattapan & Cohen, 2013). This lack of clarity has elicited a sense of vulnerability and high risk for service users; expenditures are submitted without guarantee that they are acceptable under the current legislation, and in spite of possible criminal punishment.45 Some examples of reimbursements typically permitted include maternity clothing and perinatal vitamins (and associated food), travel and accommodation costs pertaining to doctor’s appointments and fertility clinics, expenses for childcare, lost wages and medications related to the pregnancy. Added expenses, depending on the pregnancy, may include costs associated with C-section births, multiple births and required bedrest (Surrogacy in Canada Online, 2017).

45 As aforementioned in the introductory chapter, consequences may include a risk of incarceration or fines.
Moreover, policymakers have yet to develop specific surrogacy-related guidelines on the operating procedures of fertility clinics. Insufficient regulation has, according to fertility lawyers and surrogacy consulting directors, affected the provision of adequate information and formal direction to practice surrogacy; those who pursue surrogacy are “operating under the shadow of the law” (Busby & Vun, 2010, p. 28). The lack of oversight has also influenced the provision of counseling and psychosocial support offered to surrogates and intended parents. There are currently no standardized practices or guidelines in place to monitor or oversee services offered to those pursuing surrogacy. Generally, the Canadian Fertility and Andrology Society has recently released guidelines for assisted reproduction, which acknowledges medical/diagnostic testing for surrogates, and recommends the provision of counseling:

in addition to the consent required by law, gamete donor(s), gamete donor recipients, and surrogates must sign consent forms outlining the process, risks and benefits of treatment(s). They must be informed of and acknowledge their right to withdrawal from treatment at any time prior to gamete donation or embryo transfer for surrogates. (Havelock et al., 2016)

Although not obligatory, most private fertility clinics adhere to Accreditation Canada, whereby standards ensure that those involved in third-party reproduction are able to grant consent to all procedures and procreative decisions.

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46 It is important to note that fertility clinics often seek accreditation through Accreditation Canada. “The Assisted Reproductive Technology (ART) Standards for Laboratory Services are used to assess the quality of procurement, processing, storage and handling, and transport of gametes, embryos and reproductive tissues” (Accreditation Canada, 2017). Standards include “accessibility of ART services, assessment and diagnosis, counseling, consent, treatment, management, follow-up, and disposition. They are based upon the five key elements of Service Excellence: clinical leadership, people, process, information, and performance” (Health Standards Organization, 2017).
Intended parents and surrogates may also seek support through the utilization of online surrogacy consulting services. These organizations, typically managed by former surrogates, help match surrogates and intended parents, provide referrals to fertility clinics and reproductive lawyers, answer questions related to legal regulations surrounding third-party reproduction, and offer support, mediation and advice (Motluk, 2014). However, they are not allowed to help broker any financial payments between surrogates, egg donors and intended parents. In turn, the confusion of Canadian surrogacy law fosters a complicated reproductive process that is nearly impossible to interpret and understand (Busby & Vun, 2010; Reilly, 2007).

Notwithstanding the lack of legal clarity, gestational surrogacy has continued to increase across Canada. Although fertility clinics in Canada are not legally required to report data on assisted reproduction (White, 2016), the Canadian Assisted Reproductive Technologies Register (CARTR), voluntarily created by Canada’s fertility clinic directors, collects, analyzes and reports clinics’ data. In 2013, there were approximately 145 infants born to gestational surrogates in Canada, compared to 67 in 2007 (White, 2016). These numbers do not include surrogates who were unable to become pregnant, miscarried, terminated their pregnancy or had a stillbirth. In 2015, reports show that there were a total of 533 in-vitro fertilization (IVF) assisted reproductive treatment cycles for gestational carriers, compared to 417 cycles in 2014 (CARTR Plus, 2014, 2015).

It is important to stipulate that the above data does not specify the

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47 The year in which AHRA was enforced into law.

48 In-vitro fertilization is a series of procedures associated with assisted reproduction. During IVF, an egg is fertilized by sperm outside of the body. The fertilized egg (a zygote) is cultured in the lab and then implanted into the woman’s uterus, of the woman who is intending to carry the child (e.g., the biological mother, the gestational surrogate).

49 Although genetic and gestational surrogacy are both permitted in Canada, gestational surrogacy is much more commonly practiced among intended parents. In fact, most fertility clinics in Canada encourage the use of gestational surrogates as opposed to genetic surrogates (Marvel, 2015).
number of surrogates, rather, numbers indicate the total number of IVF cycles and live births. Within a year, it is conceivable that one surrogate may go through more than one round of IVF in order to have a successful pregnancy, and/or a surrogate may conceive twins (or triplets). Although the exact number of gestational surrogates in Canada is unknown, the above data provided by fertility clinics do illustrate that surrogacy is a growing practice. Notwithstanding surrogacy’s rapid and dramatic growth, there is a lack of empirical research on surrogacy in Canada.

Understanding how conflicting regulations versus the absence of clear and detailed stipulations regarding medical reimbursements has affected the practice of surrogacy, for both intended parents and surrogates, is critical to inform future practice and policy decisions with regard to surrogacy and the guidelines associated with medical reimbursements. Federal regulations monitoring surrogacy have not been reviewed or amended since 2010. As a result, the lived experiences of those who have pursued surrogacy is often necessary to elucidate in order to guide recommendations on surrogacy and the provision of information. This, in turn, may facilitate the surrogacy process not only for intended parents and surrogates, but also for important stakeholders; lawyers, fertility specialists (e.g., reproductive endocrinologists), as well as nurses, family doctors and allied health professionals working in the area of third-party reproduction and with individuals and couples seeking fertility care would benefit from such knowledge. Research may afford policy makers with empirical data on how to address the increased use of surrogacy in Canada from the perspectives and lived experiences of service users. Scholarship on Canadian surrogacy experiences is therefore necessary to inform practice, policy and research in the area of third-party reproduction.
4.1.2 Gay Fatherhood

Over the past decade, important legislative changes have occurred in Canada with respect to lesbian and gay parenting rights (Rayside, 2009). In 2005, federal legislation enacted same-sex marriage; currently, most provinces legally permit second parent adoptions, the names of both partners on birth certificates and, most recently, have begun to recognize three-parent families. Census data show that in 2011 there were 21,015 same-sex married couples in Canada; 9, 600 children aged 24 and under were living with same-sex parents (Statistics Canada, 2013).

Notwithstanding shifts in public attitudes and federal policies on same-sex parenting in Canada, heterosexual biases often emerge in reproductive care and fertility practices (Beagan, Fredericks & Goldberg, 2012; Bolderston & Ralph, 2016; Corbett, Frecker, Shaprio, & Yudin, 2013; Daley & MacDonnell, 2011; Epstein, 2012; Marvel et al., 2016; Mulé & Smith, 2014; Ross et al., 2014). In an Ontario-based qualitative study, 66 LGBTQ-identified (lesbian, gay, bisexual, transgender and queer) participants articulated their recommendations for assisted reproduction services in their communities (Ross et al., 2014). Findings indicate that providers lacked training and education in LGBTQ identities, terminologies, family structures and non-discriminatory practices. Participants reflected that a lack of inclusive language in forms and documentation, and their perceived invisibility in clinics and sperm banks (such as in websites, pictures, posters and pornography) fostered presumptions of cisgenderism and heterosexuality (Ross et al., 2014). These results are echoed among researchers who advocate for healthcare reforms, shifts in institutional documentation and LGBTQ training to improve the care of

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50 The act of a same-sex partner adopting their partner’s biological or adopted child(ren).

51 Cisgender refers to an individual who identifies with their assigned sex at birth. This may be defined as the opposite of transgender. Cisgenderism is the assumption that all individuals identify with their assigned sex at birth, directly marginalizing, silencing and negating the experiences of transgender individuals.
sexual and gender minority patients, and contest heteronormativity in clinics and hospitals (Bolderston & Ralph, 2016). The use of assisted reproduction in Canada has primarily been conceptualized as a medical treatment for heterosexual couples experiencing infertility. This, in turn, has shaped the practices and policies of fertility care and third-party reproduction.

As the growth of reproductive technologies continues, and the social visibility and legal recognition of same-sex partners and families evolves, empirical research is needed to understand experiences of surrogacy for gay men. However, research has predominantly focused on the fertility experiences of lesbian women (Gartrell et al., 2012; Malmquist & Nelson, 2014; O’Neill et al., 2013; Perrin & Siegel, 2013; Wall, 2011; Rozental & Malmquist, 2015; Yager et al., 2010), or gay men who have pursued fatherhood through adoption (Gibson, 2014; Goldberg, 2013; Jennings et al., 2014; Vinjamuri, 2015). The lack of scholarship exploring surrogacy experiences among gay men may be due to the relative novelty of surrogacy use among gay men in Canada. However, in some respects, limited research may also be a result of: (1) the ambiguity of surrogacy regulation in Canada that has yielded a highly private and secretive process; and (2) heteronormative perceptions of fertility and reproduction that have elicited exclusionary practices for sexual minorities accessing fertility clinics (Busby & Vun, 2010; Mulé & Smith, 2014; Snow et al., 2015). Thus, the specific aims of this study were to consider the facilitators and barriers of surrogacy for gay intended parents and gestational surrogates in Canada.

4.2 Methods

This study employed interpretive phenomenological analysis (IPA) to understand the practice of gestational surrogacy from those who have direct lived experience (Dowling, 2007; Lopez &
Willis, 2004); first-hand narratives may provide unique insight of the experiences of gay men and gestational surrogates in Canada. IPA is most often utilized to gain understanding of phenomena not empirically studied or critically examined in research (Crist & Tanner, 2003; Harper & Thompson, 2011). Through idiography, IPA considers how sociopolitical contexts shapes participants’ understanding and interpretation of the phenomenon (Pascal, 2010). In this study, IPA supports the exploration of gestational surrogacy for gay men in Canada.

4.2.1 Sampling and Recruitment

From January 2015 to January 2016, gay fathers and gestational surrogates in Canada were recruited through advertisements distributed across same-sex parenting groups, online business-registered surrogacy consulting services and social media. Non-probability sampling, a non-random sampling design, was employed due to the exploratory nature of this study (Daniel, 2012). The principal investigator (PI) purposefully selected participants who satisfied the inclusion/exclusion criteria for participation in this study and would be able to provide in-depth responses to the research question and objectives regarding their lived experiences (Daniel, 2012). Through purposive sampling and snowball recruitment strategies, three populations were targeted: (1) single or partnered gay men who used gestational surrogacy to have a biologically-related child; (2) gestational surrogates who bore a child for single or partnered gay men; and, (3) single or partnered gay men and their paired surrogate (referred to as either a ‘matched surrogate dyad’ or a ‘matched surrogate triad’).

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52 Online surrogacy businesses are not considered illegal in Canada, as long as they do not facilitate payment between matched surrogates and intended parents. These organizations help match surrogates and intended parents, provide referrals to fertility clinics and reproductive lawyers, and answer questions related to legal regulations surrounding third-party reproduction. In this paper, some participants utilize the word ‘agencies’ to describe these surrogacy consulting services. Thus, when specific quotes are referenced, the use of agency is interchangeable with these online consulting services.
‘Matched surrogate dyad/triads’ were purposefully sought for in-depth comparative analyses. No timeline was required for when surrogacy was practiced. There were no specifications on whether participants had to have attained Canadian citizenship or permanent residency status; however, participants had to be permanently living in Canada (regardless of their immigration status). All participants had to have pursued surrogacy in Canada, and be living in Canada at the time of the interview.

Participants met the following inclusion criteria: (1) gestational surrogates who had been implanted with one or more embryos from a donated egg and either a single gay man’s sperm, or one or both partners’ sperm; and/or (2) gay men who completed gestational surrogacy to have a biologically-related child. A completed arrangement was one in which a surrogate relinquished the child at birth, and the intended father(s) socially raising the child. Exclusion criteria consisted of gay men and/or gestational surrogates who: (1) were currently interested in or in the midst of pursuing surrogacy; and/or (2) most recently experienced a failed arrangement due to either financial obstacles or for other unexpected reasons, such as a miscarriage or terminated pregnancy. Those who participated in cross-border surrogacy were excluded due to the legal differences in conducting surrogacy abroad. Transgender intended parents are deserving of their own study, so as not to unintentionally value cisgender parenthood over transgender parenthood. Transgender participants were therefore excluded due, in part, to their potentially unique experiences of discrimination when deciding to parent, the

53 Gay men may choose to fertilize and implant one partner’s sperm. This decision represents a form of ‘turn-taking, as the next surrogacy will use the other partners’ sperm. Another option is to have more than one embryo implanted, with each embryo containing one partner’s sperm. This provides the intended fathers with an equal likelihood of biogenetic fatherhood. In some cases, this may lead to the birth of twins, with each offspring having a different biogenetic father.
limited availability of information pertaining to transgender parents, and differences in societal perceptions regarding transgender parenting when compared to cisgender parenting.

Gay fathers and gestational surrogates were initially recruited independently from one another. Interested participants responded by email to publicly posted advertisements. They were provided with a copy of the informed consent outlining the purpose and procedures of the study. All informed consent documents inquired about third party contact. A section in the informed consent asked whether the participant would be willing to contact the third party (either the intended parent or surrogate) to see if they would be interested in participating in the study. The PI asked whether the participant(s) wanted to contact the third party, or whether a direct request to participate could come from the PI. Respondents who declined contact with the third-party were still able to provide consent and participate in the study. Offering a choice in how the third party may be contacted was purposeful to mitigate ethical concerns related to confidentiality and disclosure. Gay father partners were informed about the process of conducting joint interviews, and both partners were required to provide written consent.

Partners were informed about joint interviews, and both partners were required to provide written consent (if both agreed to participate). However, a participant’s partner could refuse participation and, thus, an individual (rather than a joint) interview would be conducted. Individuals who were separated did not require consent from their partner, and their partner was not obligated to participate in the study. Participants were provided with a $30.00 honorarium
for their direct expenses in participating. The study was reviewed by the Research Ethics Board at the University of Toronto.\textsuperscript{54}

4.2.2 Data Collection

In-depth semi-structured interviews (~60-120 min) were conducted with gay fathers and gestational surrogates. Surrogates and gay fathers were interviewed separately, while joint interviews were conducted with consenting partnered gay men. At the time of the interview, the PI reviewed informed consent verbally with participants. The purpose and procedures of the study were discussed. Interviews were conducted either in-person, at a mutually agreed upon location, or over the phone. All participants provided written consent prior to the interview.

The semi-structured interview guide comprised questions and detailed probes to address supports and barriers on: (1) accessible information on surrogacy, (2) healthcare resources in fertility clinics and hospitals, (3) societal attitudes towards surrogacy, and (4) legal regulations in Canada. Questions included: Can you reflect on the resources you used to find information on surrogacy? Probes included: Were there any resources or support services you found particularly helpful or unhelpful in the planning stages? Were there any services you would have liked to have access to but were either non-existent or inaccessible? Participants were also asked: In looking back on your experiences, did you have any encounters with discrimination or stigma? Probes included: What was your treatment like in fertility clinics and with physicians? What was it like in the hospital? The final two interview questions were: Is there anything you

\textsuperscript{54} At the time of submission, the PI was a member of the REB. She did not attend the full board meeting when this protocol was discussed and did not consult with any committee members. There is no further conflict of interest to report. K.A. (a thesis committee member) became an REB member subsequent to the protocol submission and review.
wish you had known about surrogacy arrangements before making this decisions? Is there anything you would want future intended parents/surrogates to know about this process?

The PI digitally recorded and transcribed all interviews verbatim. To protect participant confidentiality and anonymity, identifying names, geographical regions, surrogacy consulting services, organizations and fertility clinics were redacted from the transcripts and all recordings were stored on encrypted password protected storage. Informed consents were kept separate from participant data.

4.2.3 Data Analysis

This analysis describes the accessibility of information, resources, social perceptions and legal regulations of both the practice of surrogacy and same-sex parenting from the perspectives of gestational surrogates and gay fathers in Canada. Adhering to IPA methodology, the PI carried out a simultaneous process of recruiting, interviewing and interpretation (Crist & Tanner, 2003). Textual analysis was conducted by the PI; initial line-by-line coding was first completed, following an idiographic and iterative approach. Subsequently, the PI selected important meaningful quotations or points and organized emerging patterns and themes from the data manually to generate research findings. Themes were linked across joint interviews, matched surrogate triads and individual interviews of surrogates and gay fathers to seek divergences and convergences.

Triangulation, peer-debriefing and member-checking supported validity and trustworthiness of the data (Creswell & Miller, 2000). Data were triangulated by: (1) the inclusion of surrogate and gay father populations, and matched surrogate triads; and (2) the use of multiple critical
theoretical frameworks to support data analysis and the interpretation of results. For example, queer theory was employed to understand discriminatory practices that transpired against gay fathers and surrogates from negative societal attitudes and healthcare contexts. Additionally, feminist ethics was utilized to understand issues related to surrogates’ autonomy, consent and fertility experiences. All participants were provided copies of their transcripts for review, and aggregated findings were disseminated to participants. Participants’ feedback was included in analyses. Peer-debriefing was sought from experts in gay men’s health and assisted reproduction; feedback was implemented to assist with the interpretation of data.

4.3 Results
Participant demographics will be reported, followed by the themes that emerged from textual analysis of the data.

4.3.1 Sample Characteristics
Twenty-two respondents participated in this study. Sixteen participants were gay fathers (seven dyadic partners & two separated fathers), and six participants were gestational surrogates. Surrogacies were carried out from 2010-2014. Participants ranged in age from 22 to 50 years old. The average age of surrogate participants was 34 years (SD=8.09), compared to 39 years (SD=5.55) among gay father participants. The sample was predominantly white (86%); two gay father participants were Asian (both participants had white partners) and one surrogate participant was Aboriginal. Surrogates predominantly had an individual income of less than $40,000 (CAD), with one surrogate participant reporting an individual income of $81,000-$120,000 (CAD); two surrogate participants did not report their income. The median individual income across surrogate participants was less than $40,000 (CAD). For gay father participants,
9 out of 16 participants (56%) had individual incomes $80,000 (CAD) and above, with 7 participants (43%) having individual incomes from $40,000 to $80,000 (CAD) (60%). The median individual income among gay intended parents was from $81,000-$120,000 (CAD). Half of surrogate participants held college degrees, and two participants had Bachelor’s degrees (33.3%); one surrogate did not report. Two gay father participants had graduated from high school and two had graduated from college. The remaining 12 out of 16 participants (75%) had either obtained a university degree, or had attained a post-secondary degree in law, medicine or education. Although all participants were living in Canada at the time of surrogacy and the interview, two gay father dyads (25%) had emigrated from other countries; one dyad attained Canadian citizenship prior to the interview. Surrogacies were all completed in Canada, but primarily conducted across cities and/or provinces.

At the time of the interview, two surrogate participants (33%) acted as gestational surrogates once previously, and four surrogate participants (67%) indicated that this was their first surrogacy experience. Surrogate participants had between one and five biological children. For all gay intended parents in the study, this was their first surrogacy experience resulting in a live birth, and their first child at the time of interview. Four out of five matched triads matched through the use of online surrogacy consulting services; one matched surrogate triad met through a mutual friend. A separated father indicated that his gestational surrogate was his partner’s sister-in-law, and all other participants (one surrogate and 2 gay partner dyads) met through a surrogacy consulting service. Among intended parents, three dyads had twins (n=6; 38%) each child biologically-related to one partner. Surrogate offspring ranged in age from a month old to five years old at the time of interview.
Twenty-one participants met inclusion criteria and were included in this analysis (Table 1; Table 2). A separated gay father was excluded when he disclosed that his surrogate was a genetic (as opposed to a gestational) carrier, in which the surrogate used her own egg for fertilization. Among included participants, 15 individuals formed matched surrogate triads: five partnered gay men (n=10) and their paired gestational surrogate (n=5). The separated father in the study was married at the time of surrogacy and reported that his gestational surrogate was his sister-in-law. Even though eligible for inclusion, no fathers who pursued surrogacy as single gay men participated in this study. Quotations from gay fathers (labeled F) and surrogates (labeled GS) are presented in the results with participant ID and age at the time of interview.

The results demonstrate supports and barriers of pursuing surrogacy, examining the: (1) accessibility of information on surrogacy, (2) healthcare environments, including fertility clinics and hospitals, (3) public attitudes, and (4) legal regulations and resources. Sub-themes will capture encounters of surrogacy in general and subsequently provide experiences related to gay fatherhood. This was conducted purposefully to discern encounters that were reflective of overall surrogacy practices, as opposed to specific facilitators or barriers to gay fatherhood. Moreover, the supports and barriers of pursuing surrogacy are not differentiated in the results. This was purposeful to draw attention to the nuanced and inconsistent experiences of surrogates and gay father participants. Most participants, for instance, described positive experiences and then simultaneously would recall a particularly negative encounter. The discussion section will critically identify overall patterns that emerged from the results to understand surrogacy for gay men in a Canada.
4.3.1 Theme 1: Accessibility of Information

The first theme consists of three sub-themes: (1) general information on surrogacy; (2) surrogacy consulting services; and (3) specific information on gay fatherhood, respectively described in the following three sections.

4.3.1.1 Sub-Theme: General Information on Surrogacy

Surrogates described encountering a lack of suitable and relevant information on surrogacy in Canada: “It would be great if there was more information out there for Canadians and Canadian women that wanted to do this, and know exactly who to go to, or where to seek information or supports that are given; but there’s not” (GS1, 37 y). The difference between surrogacy regulations in the U.S. and Canada affected the perceived usefulness and relevancy of information. A surrogate reported that, “if you just go online and you’re searching, the majority of the information you are going to find is about the States and things are much different there” (GS3, 35 y). Surrogates expressed that there was not a lot of general information on surrogacy: “I ‘googled’ everything and I found that it’s not talked about a lot. Especially in Canada. It’s more slipped under the rug….It’s so quiet and not a lot of people know about it” (GS6, 22 y).

As participants lacked access to formal surrogacy resources, they articulated uncertainty in how to discern the information readily available online. Accessible information was found through

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55 Regulations monitoring surrogacy in the U.S. differ state-by-state but, in actuality, most states do not have detailed laws governing the practice of surrogacy. Although most states are favorable towards surrogacy practices, some states forbid traditional surrogacy (e.g., North Dakota, Tennessee, Utah), some declare commercialized surrogacy void and unenforceable (e.g., Nebraska, New Jersey, Washington), and others permit compensation (e.g., California, Delaware, Maine); women who act as surrogates are permitted to be financially compensated by the intended parents for their services. New York, Michigan and the District of Columbia forbid and criminalize surrogacy. Additionally, it is important to note that even with the 2015 federal enactment of marriage equality in the U.S. some states still have complicated processes to help same-sex couples pursue surrogacy and attain legal parenthood (e.g., Arkansas, Louisiana, Kansas, Texas, Wisconsin).
online blogs and forums written by individuals who had pursued surrogacy in Canada. Thus, participants were reliant on personal narratives for information: “there are forums, blogs and all that kind of stuff. So I was all over the place with it” (F8, 44 y). Another gay father described seeking information through “message boards and meeting people online” (F14, 36 y). A participant never felt “comfortable looking at message boards, and when they are really old posts. It’s just hard to get any real information” (F10, 37 y). Participants described that they had “to do all the research yourself,” (F3, 36 y) and this led to many to feel increasingly overwhelmed by the amount of information presented, and unsure how to properly assess and evaluate personal anecdotes. Some surrogates, for instance, questioned the authenticity of the information they received: “When you try and look up information about surrogacy in Canada, unfortunately you tend to get a lot of, I wouldn’t say horror stories, but you get paranoid” (GS4, 36 y). Another surrogate echoed this perspective; she described that, “when you look online it’s mostly American or surrogates not giving back the baby type thing. So it really makes people wonder…a lot of the articles you read are pretty scary” (GS1, 37 y). A gay father agreed, recalling that “at the beginning, it was very scary because you go online and you find all sorts of stuff” (F6, 36 y).

Many gay fathers advocated for official guidelines rather than utilizing first-hand narratives: “there’s nothing that’s sort of an official guide that outlines the process; here’s where you will have choices along the way, here are the potential costs…sort of an unbiased how-to guide” (F6, 36 y). Another gay father agreed and suggested that “there wasn’t a lot of ‘click here’ for a resource guide or to speak to somebody…it’s just hard to get any real information” (F10, 37 y). Gay father participants expressed that pursuing surrogacy was fraught with confusion and uncertainty, and “you didn’t know exactly what was going on” (F1, 42 y). Another gay father
described that the “surrogacy process very odd. I found the process frustrating and confusing, and I do feel like you jump in with two feet. We had no idea what we were doing” (F2, 45 y).

Overall, surrogates and gay fathers described a significant absence of information on surrogacy (and, in particular, Canadian-specific information). Participants indicated reading personal online narratives, from websites, blogs and Facebook posts, of individuals who had pursued surrogacy. For many participants, a lack of information and the accessibility of official resources and guidelines led to frustration, confusion and secrecy. In turn, there was uncertainty on how to navigate and assess the information sought online.

4.3.1.2 Sub-Theme: Surrogacy Consulting Services

Participants seemed to report diverging experiences with surrogacy consulting services. About half of all participants articulated that the directors of Canadian online surrogacy consulting services were helpful in providing relevant information: “our surrogacy agency was pretty good…whenever we had questions, she was always there to answer 24 hours a day. And she would give us calls to see how we were doing and stuff like that” (F11, 29 y). A surrogate similarly expressed that the agency she worked with was “actually amazing. If I had any questions, they would call me right away. They always messaged me right away. They were fast with replying if I had any issues with anything. They were always there. Every step of the way” (GS6, 22 y). A surrogate reiterated this feeling; she “found the agencies helpful in terms of when you’re starting out and you don’t know a lot. They provide you with a lot of information on kind of the process…and what to expect” (GS5, 27 y). As a gay father recalled, “when we started involving the agency, that’s when I felt a lot more guided. There was a lot less worry in the process because it’s kind of like they were giving us advice and we had great
legal support as well” (F14, 36 y). A gay father similarly expressed the importance of having a “mutual third party that both parties trust, that both parties will be able to talk to…we felt comfortable that someone is making sure that everything is legal, which was something that was important to us” (F12, 35 y). A surrogate explained, “I would rather have somebody with expertise guiding me through this than do it myself and mess it up” (GS4, 36 y). For these participants, accessing online consulting services helped to mitigate anxieties regarding the legal ambiguities of surrogacy.

However, the other half of participants did not find the directors of consulting services supportive or knowledgeable:

the agencies completely scared me off because I didn’t want to get working with somebody and get in trouble. I didn’t know the legalities of it…you know it’s a very grey area anyways so that’s why I avoided agencies completely. It didn’t seem like they offered a lot for the surrogate at the time. (GS1, 37 y)

Another surrogate reported that “after the first initial…matching…you never hear from them again really. They were available, they gave me some information they told me a few things. It was more of an independent thing” (GS2, 45 y). Gay fathers also were unsure how to utilize these consulting services. A gay father described feeling overwhelmed in selecting a consulting service: “Just the legalities and finding a credible company to go with, like an agency….I read up online how some agencies are kind of crooked. So we were a little iffy on, is this real? Is this not? Is this a scam?” (F11, 29 y). As a gay father described, “they [the consulting service] are only good for basically putting the surrogate and the intended parents together, and basically being an accounting system for everything else. There wasn’t necessarily communication throughout the process” (F10, 37 y). Some gay fathers described being “pushed” (F10, 37 y)
into decisions, and felt the services had “very strong opinions or bias” (F6, 36 y) regarding certain services and resources to use, and were using “bully tactics, guilt tactics” (F5, 40 y) on intended parents. As a gay father recalled, “the thing that disturbs me or annoys me the most is how the system, as it is, can really prey upon the vulnerabilities of a couple wanting to have a child….These agencies don’t necessarily care about our feelings” (F5, 40 y).

There were mixed experiences regarding the use of consulting services, as some participants found that they assisted in elucidating the process of surrogacy, while others viewed their role as more hands-off and detached. Some gay fathers were specifically concerned about the legitimacy of consulting services and their treatment by staff.

4.3.1.3 Sub Theme: Specific Information on Gay Fatherhood

Some (n=8) gay father participants attended specific LGBT (lesbian, gay, bisexual and transgender) parenting groups before their decision to pursue surrogacy. Many fathers perceived these groups as helpful resources: “it was surprisingly good in terms of the information…I didn’t think it was going to be that informative and it was” (F13, 34 y). A gay father articulated that there were “local resources…that was very highly accessible; it was very informative, very helpful, and helped me talk with the gay community a little bit” (F15, 43 y).

Eight gay father participants (four dyads) who lived in large metropolitan cities with LGBT community centers recalled attending seminars and specific same-sex parenting groups that helped elucidate the surrogacy process. Through these sessions gay fathers learned how to seek surrogates willing to bear a child for two men. A gay father, for instance, expressed that the group he attended was “excellent;” he described “lots of growing Facebook pages; there are
private groups that you can join in. And you often get into the group based on being part of the more public group about dads, queer and things like that” (F8, 44 y).

Nevertheless, some gay father participants reported a lack of specific information on same-sex parenthood:

I found a lot of information on surrogacy regarding traditional families that could not have children. There was not a lot of publication regarding same-sex families. You always had to read deeper into everything to find out if it might pertain to your situation versus traditional family or heterosexual couple. (F10, 37 y)

A surrogate echoed this perspective; she stated that when I first started surrogacy, I was thinking it was always for a man and a woman that couldn’t have their own children. That’s the first thing that popped into my head. I wasn’t thinking single parents. I wasn’t thinking two men, or two women.

I was always thinking man-woman type of thing. (GS1, 37 y)

A gay father also explained that, “I honestly take that as a fact that this is a, we are a hetero world. It’s just a heteronormative society” (F8, 44 y).

Some gay fathers also expressed a lack of knowledge or awareness of certain groups or resources: “I think it would have been nice if there were groups you could go to, to talk to people in similar situations…had I known that actually existed” (F4, 50 y). Another gay father reiterated this feeling, “I thought that was lacking in Canada. Like an actual place to go to talk to surrogates” (F1, 42 y) for gay men. Finding surrogates who were open to carrying for gay men was an important consideration. For instance, a gay father expressed that “we did
encounter some women who wouldn’t answer messages because we were a gay couple. But, on the other side, we had many surrogates that only wanted to work with gay couples” (F2, 45 y).

For gay men, finding information reflective of the Canadian context was difficult; however, seeking same-sex specific parenting guidelines and resources was an added challenge. This was particularly pertinent among gay fathers who lived in more suburban areas, and who were disconnected from the larger metropolitan cities; larger cities had LGBT community centers and more available and accessible same-sex parenting groups.

4.3.2 Theme 2: Healthcare Environments: Fertility Clinics and Hospitals

The second theme comprises three sub-themes: (1) general fertility clinic practices for gestational surrogates; (2) general hospital practices and policies for surrogacy; and (3) specific practices and policies for gay fathers, respectively detailed in the sections below.

4.3.2.1 Sub-Theme: General Fertility Clinic Practices for Gestational Surrogates

Some surrogates appeared to have positive experiences in the healthcare system: “I don’t think I had one experience where support staff or medical staff or anybody, or even my own family doctor, weren’t very welcoming, very supportive, very excited” (GS2, 45 y). However, even amid positive experiences, all surrogate participants felt that fertility clinics were not necessarily knowledgeable or clear regarding the physical risks of surrogacy:

So I find that the fertility clinics are looking out for the best interest of their patients…they don’t necessarily always consider the surrogates the primary focus when they’re looking at the risks…I think they were more interested in protecting the intended parents. (GS5, 27 y)
She continued by suggesting that “overall, the medications and everything, in terms of the IVF [in-vitro fertilization] process, it was actually a lot more than I initially expected. Doing daily injections was not something I thought would be part of my journey” (GS5, 27 y).

Surrogates described wanting more transparency and adequate information on surrogacy:

I wish I did know a bit more from the clinic. It would be nice to have more explanations or more this is the process, this is what we’re going to do, this is what’s going to happen. I had no idea what they were going to do. I don’t know whether they just assumed you know everything, or a lot of doctors don’t explain things. They use medical terms and that’s it. (GS1, 37 y)

Another surrogate agreed, as she implied that the nurse at the clinic “wasn’t very explanatory as far when she started doing the test” (GS2, 45 y). Although all surrogate participants reported not having enough information regarding the process, one surrogate specifically spoke of her discomfort in talking to her fertility specialist. In seeking out other surrogates online for information or support, she described how “it’s easier to talk to somebody that’s been through the process compared to the fertility doctor who has never been through the process. Because he’s a man” (GS5, 27 y).

Surrogates encountered medical issues and physical side effects during their pregnancies: “the hardest part was probably the drugs…you’re doing three suppositories a day, a needle every morning and numerous pills. It wreaks havoc on your system and you don’t realize what they do to your mind and your brain” (GS1, 37 y). Another surrogate articulated: “There were things like my blood pressure got very high throughout the pregnancy. In the end, I had a C-section because of preeclampsia…I ended up getting the steroid shot for the lungs in case we had to
deliver early” (GS6, 22 y). Another surrogate echoed these side effects: “Physically it was a little bit harder for my body…and I was diagnosed with depression during the pregnancy…I hadn’t had a sort of mood disorder or anything with the previous pregnancy” (GS5, 27 y). Many surrogates explained that a gestational surrogacy pregnancy was remarkably different from their previous pregnancies with their own biogenetic children:

Surrogates really need to know what they are getting into medically. Getting pregnant by IVF is very, very different than getting pregnant normally. Just as far as having to deal with medications, the number of times I’m trying to give myself a needle…it’s an undertaking dealing with the medication end of it. (GS4, 36 y)

In all cases, surrogates described invasive IVF procedures, medications and reproductive risks; five out of the six surrogates were required to undergo either planned or emergency C-section deliveries which, for many participants, was not their original intended birth plan.

Surrogates predominantly reported that the practices of fertility clinics were welcoming and inclusive but lacked the ability to properly detail the procedures and medical risks for surrogates. Most surrogates reported health and/or mental health complications during their pregnancies.

4.3.2.2 Sub Theme: General Hospital Practices and Policies for Surrogacy

Some organizational policies in hospitals were perceived as unwelcoming of surrogacy pregnancies. For example, some intended fathers reported not being provided with a bed and/or room in the hospital pre-and/or post-birth; they were not considered the parents. A father of a one-month old recalled that the hospital’s
policy is to keep the baby in one room with the mother, with the birth mother. They would only be able to give us one private room if at all. If it’s a shared room then we can’t stay at the hospital because only a woman can stay overnight. So we would actually be considered visitors. (F12, 35 y)

Their surrogate recalled that the hospital where she delivered was “completely in the opposite direction in terms of being surrogacy friendly, and being supportive of the new parents and also my self-recovery” (GS5, 27 y). A gay father of a one-year old reported having encountered a similar experience upon the birth of his child: “they were a little backwards…they should have gotten us a room and put the baby in our room. They wouldn’t do that. They got us some other room and put the baby in the NICU” (F2, 45 y). His matched surrogate echoed this frustration:

I know a lot of hospitals still don’t accept surrogacy. Like the baby had to have my last name on his band for the whole time he was in the hospital. I had to go back in and discharge the boys [babies] a day later…which I thought was wrong. I’m not the parent. (GS1, 37 y)

Overall, practices among hospital staff demonstrated an unfamiliarity with surrogacy: “it was the social worker at the hospital who was a bit of an idiot at the time of the birth; the hospital…was not really used to surrogates” (F5, 40 y). His partner reiterated this experience, as he recalled that the social worker at the hospital “kept referring to it [surrogacy] as an adoption…and then she filled out some forms wrong or incorrectly…and they wouldn’t let us go [from the hospital]” (F4, 50 y). Their surrogate recollected that the post-birth paperwork “was a bit of a nightmare…it wasn’t very organized. Nobody had done this; it was a new experience. Nobody knew what they were supposed to do” (GS2, 45 y). Inconsistent and
arbitrary care seemed to be at the forefront of participants’ experiences. As a surrogate, who had given birth a month ago, recalled

the social workers are kind of helpful but it depends on who you get. Some of them are not particularly great. Some of them are a bit biased. But that just generally comes with being in healthcare….I just found their [social workers] experience was from the intended parents side because both of them had been intended parents and had decided to go into that field of social work and third party reproduction after being intended parents. So I just found some of the biases…around attachment, bonding and their own personal thoughts…they were more interested in protecting the intended parents. (GS5, 27 y)

Another surrogate indicated that the hospital where she gave birth “does need to be more accepting…it’s not in their textbook guidelines. It’s not something they were told so they don’t know how to deal with it; and they aren’t always the kindest in dealing with it” (GS1, 37 y).

Many participants reported non-inclusive hospital practices and policies towards surrogacy. For instance, hospital policies were not described as welcoming of surrogacy pregnancies or in their treatment of intended parents. How hospitals treated and managed surrogacy pregnancies were factors that influenced the experience of surrogacy and, in particular, the birth of surrogate offspring.

4.3.2.3 Sub-Theme: Specific Practices and Policies for Gay Fathers

Some gay fathers expressed that service providers at fertility clinics were supportive and inclusive. A gay father recalled that the fertility clinic was “very gay friendly” and the physician was “very personable and was willing to explain things to us” (F4, 50 y). Gay fathers
also had positive experiences in the hospitals upon the birth of their child. A gay father of five-year old twins recalled that while the baby was in the NICU, “we were surrounded by wonderful, wonderful nurses who loved us and loved the babies, and they were just so good at showing us and modeling everything from feeding to bathing the kids” (F15, 43 y). A gay father of a one-year old also recalled that, “we were treated fine. Everything was equal. We were the parents” (F10, 37 y). In referencing his experiences in the hospital when his five-year old was born, a gay father articulated that there was “no discrimination because we were gay and having a child. Nowhere along, like doctors or anything like that” (F1, 42 y). Although a few gay fathers reported general positive experiences, they concurrently indicated negative encounters with individual healthcare providers. For example, one gay father of a one-month old recalled “one nurse that we felt treated us a bit differently; that since we’re two men, we are probably not qualified enough to take care of a baby” (F13, 34 y). Their surrogate had a similar experience, as she identified that one of her midwives “wasn’t particularly thoughtful…there were several occasions where she would say ‘well, because it’s not your baby.’ And she would say that to the dads. That is quite offensive…so I think maybe some of it was her own bias” (GS5, 27 y).

Gay fathers also indicated encounters of discrimination, and reported a lack of LGBT training in fertility clinics. A gay father of four-year old twins described how the clinic we worked with at the time was so not gay friendly. Not saying they were anti-gay. They just weren’t inclusive. They just didn’t know what gay was and how to be inclusive with language, on documentation or anything related to us as a couple. (F8, 44 y)
Similarly, a gay father of a one-year old reported uncertainty about the clinic’s environment: “we didn’t know how we were going to be received being a same-sex couple. I kind of felt that to cover up, maybe the uncomfortableness about two gay parents, they were here to take care of the mother...we kind of felt like nothing” (F10, 37 y).

Two gay partner dyads (of four-year old twins and five-year old twins) reported difficulties at the sperm bank when providing semen specimens for IVF treatment: “they told us that we weren’t allowed to go into the room together [to provide a semen sample]…we were just the only gay couple” (F15, 43 y). A gay father echoed this experience; being told him and his partner could not enter the room together to provide the semen specimen, he recalled thinking:

> how dare you deny me one of the most symbolically rich moments of my married life? The very act of creating our family or its conception. And you are going to deny us the ability to be intimately connected to each other. And just boil it down to a clinical act. (F8, 44 y)

Although some gay fathers encountered positive interactions with healthcare providers at fertility clinics and hospitals, other participants recalled discriminatory practices ranging from a lack of inclusive language and materials to sperm banks that were not supportive of gay men. Overall, gay fathers seemed to describe positive encounters in the hospital post-birth; notably, discriminatory experiences in fertility clinics prior to birth were more prevalent among respondents.
4.3.3 Theme 3: Public Reactions to Surrogacy

The third theme comprises two sub-themes: (1) general attitudes towards surrogacy; and (2) specific attitudes towards gay fatherhood, described in the following sections.

4.3.3.1 Sub-Theme: General Attitudes towards Surrogacy

All surrogate participants’ encountered negative public attitudes regarding their choice to pursue surrogacy. Surrogates explained that this seemed to result from general unfamiliarity or a misunderstanding of financial compensation: “people in general have a lot of questions…it’s just the whole surrogacy process that people are not familiar with. I think there are a lot of myths” (GS3, 35 y). Another surrogate expressed that, “you know having a baby for someone else, you are going to get judged no matter what…you are going to get looked at that it’s all about money” (GS1, 37 y). Surrogates also described the inability to conceptualize why one would act as a surrogate: “one of the biggest things was what are you getting out of it?” (GS2, 45 y). As a surrogate recalled being asked: “I mean, why would you do it?” (GS3, 35 y).

There was an overall desire to mitigate stigma:

I wish there was less stigma around the idea of surrogacy. People have a tendency to think that if you’re carrying as a surrogate…you are either a saint, which I’m not saint. Or they think that you’re doing it for the money. It’s kind of an extreme on either end. And I think that a lot of that is just that there is stigma. People don’t understand it. And because they don’t understand it, they just make assumptions on what they think they know. (GS4, 36 y)

Gestational surrogate participants sought to inform and clarify for others that financial compensation was not a factor in pursuing surrogacy.
Gay fathers also received some backlash on their decision to pursue surrogacy. A gay father reported that some assume “it’s quantifying women’s bodies…which I think the majority of the Canadian public probably believes” (F4, 50 y). Another gay father encountered a similar experience: “some people…highly educated people, have very strong opinions about it and think that surrogacy at its core is abuse of women and exploiting women’s bodies” (F13, 34 y).

As a surrogate reported, people need to realize and not assume that if someone is being a surrogate, they are doing it for the money. Particularly in Canada. I think what people honestly need to do is stop trying to push their own morals onto other people. (GS4, 36 y)

As a surrogate echoed, “it’s a legal process. There’s an act. We are not baby farming or whatever you think” (GS2, 45 y). Assumptions regarding financial compensation and the morality of surrogacy influenced negative public attitudes of surrogacy that were encountered by both gay fathers and surrogates.

4.3.3.2 Sub-Theme: Specific Attitudes towards Gay Fatherhood

Gay fathers reported that, overall, the communities in which they lived supported their same-sex parent families. For instance, a gay father recalled that “we got no negativity from the community” (F2, 45 y). In contrast, some gay fathers reported encountering negative reactions. For instance, a father recalled that his place of employment “just said I’m going on leave. It wasn’t parental leave; it was just called a leave. If this were a woman, or if this were a woman even going to adopt…it would have been announced as a parental leave” (F15, 43 y).

All gay fathers experienced some discriminatory practices after the birth of their child. Gay fathers reported encountering anti-gay parenting epithets, including: “how dare you bring that child into this kind of world…God will damn you for it” (F1, 42 y). All gay fathers indicated
hearing micro-aggressions that consisted of statements such as, they are “giving the wife a break or it’s daddy’s babysitting type of thing” (F8, 44 y). Another father recalled that, “a lot of people make assumptions that we have given mommies the day off. We hear that all the time” (F6, 36 y). As well, a gay father reported facing negative comments from gay friends:

we don’t have a lot of gay friends but the ones we know that are older and not married and have not taken that traditional route…they think you are conforming too much to society by wanting to get married, wanting to have a baby.

(F12, 35 y)

In comparison, all gestational surrogates experienced discrimination, and articulated confronting stereotypical attitudes from individuals regarding their decision to act as a surrogate for gay men. A surrogate reiterated the challenges she faced of disclosing that the intended parents were gay men:

I was hesitant at first to tell anyone that it was two dads…it’s so unconventional;
I didn’t give everybody the details right away…because I didn’t want to listen to this as I got adjusted to doing it. I was waiting for someone to say something.

(GS2, 45 y)

A surrogate echoed this experience:

when they found out it was a gay couple I was carrying for, there were a couple of times I got the side eye. You know, it’s such a nice thing you’re doing. And then they find out it’s for a gay couple and they don’t think it’s that nice anymore.

(GS4, 36 y)
Some surrogates had anticipated facing discrimination from their communities based on attitudes surrounding gay fatherhood. For example, some surrogates articulated that this derived, in part, due to their geographical location. Surrogate participants predominantly lived in more rural communities, when compared to their gay father counterparts: “I live in a very small farm rural community. They’re very racist, prejudiced. They weren’t accepting that it was for two guys. I was…getting emails and people calling me horrible names. It was very difficult” (GS1, 37 y). Her matched gay father reaffirmed her experiences: “she was receiving a lot of negative comments from strangers…she was getting a lot of negative backlash from her family and community too” (F3, 36 y). Another surrogate echoed these difficulties, as she suggested that “people are so ignorant in the proper sense of the word…to add that it’s not just that I’m having a baby for someone I don’t even know, it’s that they’re gay” (GS2, 45 y).

Additionally, some surrogates indicated that religion played a role in such negative attitudes:

one of my coworkers…was actually quite brutal, who was quite religious; who felt that I was doing a horrible thing by carrying for a same-sex couple just because, in her opinion, same-sex couples have chosen to be gay so they should not be able to reproduce. (GS5, 27 y)

Another surrogate recalled a family member who “was very old school and very religious. So when we finally told her I was a surrogate, we never mentioned it was for two men…and tell [my mom] how I’m going to hell because…I’m carrying for two men” (GS6, 22 y).

Although gay father participants reported encounters with discrimination more frequently post-birth, surrogates also described being confronted with negative social attitudes regarding their choice to bear a child for gay men while pregnant.
4.3.4 Theme 4: Legal Regulations in Canada

Theme four consists of one sub-theme: (1) general surrogacy laws, described below.

4.3.4.4 Sub-Theme: General Surrogacy Laws

All participants advocated for legislative change to Canada’s surrogacy laws:

I definitely wish the Government’s take on stronger families were not so archaic; were much more progressive; were able to be more inclusive and thoughtful and mindful. Essentially what they are doing is creating an underground paranoia situation. And there are many women who would love to be surrogates for families who just won’t because of fear. Because the way that our system is structured…I think we need more support in our society…instead of doing the shame-game.

(F8, 44 y)

A surrogate reiterated, “I really do think it’s something the government needs to revisit and kind of set up in a more sensible manner…as a surrogate, they make you feel like you’re doing something wrong all the time” (GS4, 36 y). The association of shame in pursuing surrogacy was reiterated among gay fathers: “to me that’s maybe one of the issues that has led to there being so much misunderstanding…people feel it should be a private thing. And that’s society. That’s the Government. That’s whatever is making people feel that way” (F6, 36 y). As a surrogate explained, “if there was more of a mainstream, this is what you’re doing, this is how it is, this is the law…it would be so much easier. So then you wouldn’t be hiding” (GS1, 37 y).

Participants advocated for more clarity regarding surrogacy. For instance, a surrogate advocated that surrogacy law needs to be explained “for people to understand…it needs to be more legalized. It needs to be more accepted in Parliament to get everybody on board to accept it…it
needs to not be so grey. Some things are really vague” (GS1, 37 y). The ambiguity of surrogacy regulation in Canada acted as an impediment to finding accurate information and clarity regarding the process: “everything’s overwhelming just because of the ambiguity of the law in Canada” (GS5, 27 y). A gay father agreed that it is overwhelming due to “the legalities and finding a credible company to go with, like an agency” (F11, 29 y). Another surrogate echoed this perspective by suggesting that “the law is very specific that you can’t be paid for your surrogacy, but it’s very vague. They are very adamant that you can’t be paid…but the law itself is very vague as far as addressing what can be reimbursed” (GS4, 36 y).

Accordingly, instituting some political transparency was recommended: “I think the first step is to actually have a process. Like a more streamlined transparent process in place” (F5, 40 y). As his partner reiterated: “I think if the regulations weren’t so airy fairy, and it was more controlled and everything, that might make it easier” (F4, 50 y). A lack of oversight was also reflected in experiences with surrogacy consulting services:

Because of the way the laws are set up in Canada, there’s not really any oversight.

You’re kind of just counting on the agencies themselves to self-regulate because they can’t really be regulated…so there’s not really anyone looking over them to make sure anything is being done right. (GS4, 36 y)

A surrogate reiterated this feeling, as she stated that services were not “particularly helpful with, and which is kind of a grey area in Canada, will be reimbursements that the agencies handle” (GS5, 27 y).

A lack of regulations also created obstacles with respect to accessing benefits for IVF treatment. A surrogate recollected that IVF was covered under her benefits but
I couldn’t get the clinic to bill anything in my name and my insurance company wouldn’t reimburse anything that wasn’t in my name. And they [intended parents] couldn’t run it through their benefits because I was the one actually physically having the IVF treatment…as far as I’m concerned that’s discrimination. As a gay couple, you’re basically being told that because you’re gay, your IVF treatments aren’t covered. (GS4, 36 y)

Another surrogate used her benefit plan to cover the cost of drugs: “I actually used my drug card and got all the medication that we needed” (GS3, 35 y). Although in some provinces these legal stipulations have changed (e.g., Ontario now covers the first round of IVF, regardless of sexual orientation), federal regulations have created a complex process with respect to financial reimbursements and health insurance plans.

While writing this dissertation, the Canadian federal budget announced a 10-year retroactive tax break for single women and LGBT (lesbian, gay, bisexual and transgender) individuals and couples who have sought assisted reproduction to help alleviate financial burdens associated with reproductive care (Thompson, 2017). For years previous to this announcement, federal tax credits were offered only to heterosexual couples who pursued assisted reproduction as a result of a medical diagnosis of infertility. All participants expressed their frustration with the lack of clarity regarding surrogacy regulation and called for transparency and clarity on surrogacy laws in Canada.

4.3.5 Theme 5: Inclusive Resources for Gay Fathers Post-Birth

The fifth theme consists of two sub-themes: (1) governmental post-birth documents for gay fathers; and (2) specific post-birth services for gay fathers, respectively described below.
4.3.5.1 Sub-Theme: Governmental Post-Birth Documents for Gay Fathers

All gay fathers described impediments upon completing post-birth orders and birth certificates for their child due to confusion and uncertainty. For instance, governmental forms (such as birth certificates and health insurance cards), and governmental office personnel, assumed heterosexuality: “when we went to the statistics office to actually go in for her birth certificate, we were discriminated against because we are fathers. We’re not mothers. The statistics office is not well set up for gay men having children” (F1, 42 y). A gay father reiterated this experience: “The biggest struggle I’ve had is the government…filling out forms and having to be referred to as ‘mother’ in every document. It’s just so black and white…it always goes to the mother” (F10, 37 y). He continued by describing the somewhat paradoxical position of the rights of gay fathers in Canada:

you are allowing a child to be born to two gay parents and give them full legal rights, but you still will get slapped along the way. You make such huge strides but then there is something so insignificant that would be a quick simple change.

(F10, 37 y)

The lack of recognition of same-sex parenthood on legal documents resulted in confusion for many gay fathers. Some participants completed forms incorrectly which caused delays in receiving the child’s birth certificate or health insurance coverage:

we just listed me as the father. So we wanted her last name to be a combination of our last names. So that’s how we filled it out. They rejected it. So we had to

---

56 “Post-birth orders,” known as a declaration of parentage, are legal documents signed by intended parents and surrogates to obtain a court order declaring the intended parents as the legal parents. The intended parents can then use the court order to obtain a birth certificate for the child. This can only be completed post-birth. Quebec and Manitoba are the only provinces to have regulated surrogacy, whereby surrogacy contracts have no legal right to be enforced. British Columbia has instituted what are typically referred to as ‘pre-birth orders,’ whereby a court order is not necessary to attain.
have a name change initially, refill out the paperwork, send it back to notarize.

(F5, 40 y)

His partner explained that “nobody seems to know what to do exactly. It’s a lot of me telling them, especially in the healthcare system, at the hospital, or at the passport office, educating them” (F4, 50 y). Another gay father echoed this confusion:

when you register the birth, you have a form that says ‘mother’ and ‘father/other parents.’ So if you are two mothers, you’re good. But if you’re two fathers, you actually need to strike it out. And if you do it online, you can’t strike it out. So you need to provide one of the fathers’ names under the mothers’ names.

(F12, 35 y)

Gay father participants described the ambiguity and frustration of the language employed in governmental forms. Many participants found the terminology confusing and expressed that healthcare providers, social workers and statistics office personnel experienced similar uncertainty, as well as limited expertise and appropriate training.

4.3.5.2 Sub-Theme: Specific Post-Birth Services for Gay Fathers

All gay father participants indicated a lack of available and accessible parenting resources specifically for gay fathers post-birth. Some gay fathers articulated that certain services did not exist due, in part, to geography: “for me being up north, it’s kind of weird showing up in a drop-in play group with mommies. All of those things are accessible to me. It’s just getting over my own weirdness around it” (F6, 36 y). A gay father also reported that “everything’s in Toronto and there’s nothing more suburban” (F10, 37 y). Alternatively, other gay fathers were not aware of certain parenting groups:
we’re not really very involved in the gay community unfortunately…so I think that’s something that we could have done just to be more active, to meet more people who are interested in the same process. I wish we had known that there were many people going through this. Sometimes I feel like we were the first ones to do this. (F14, 36 y)

Many gay fathers spoke of feeling disconnected from the gay community but wanting parenting resources that were specifically for fathers or same-sex families. Alternatively, there was one gay father who did join a “gay dad’s network” (F1, 42 y) after the birth of his child.

In general, gay fathers expressed discomfort to join groups that were mainly for heterosexual parents, and primarily attended by mothers: “the only thing that’s weird…there’s a lot of these groups that are all women and there’s no men. There’s definitely no gay men….I’m going to be the odd person out. I don’t find there’s that kind of support” (F4, 50 y). Accordingly, gay fathers wanted access to same-sex parent support groups: “I wish there would be more of a resource for same-sex fathers’ groups. But there’s not really anything out there” (F10, 37 y).

Other kinds of support groups included pre-natal classes, formula feeding education and first-aid courses; gay fathers felt that these support groups catered to heterosexual parents: “pre-natal courses for intended fathers; for people that are not women” (F13, 34 y). His partner additionally reported that,

it’s very hard to find good enough information about formula feeding. The system encourages, and I can see why it encourages, breastfeeding. But it’s so extreme that you actually don’t get anything from the hospital about formula feeding because they don’t want to encourage it. But we need it; we have no other options. (F12, 35 y)
A gay father recalled that “we didn’t want to take them [baby first aid course] and be with all those opposite-sex parents that were there. I didn’t want to be there” (F4, 50 y).

Gay father participants expressed a lack of post-birth resources and support. Participants articulated that this perhaps resulted from: (1) their geographical location, (2) their awareness of available services, and (3) a general discomfort with attending parenting groups intended for heterosexual parents, and predominantly attended by women.

4.4 Discussion

Findings from this study present a complex and intricate analysis of surrogacy in Canada. Some participants recollected positive experiences in accessing fertility clinics and hospitals. However, surrogates and gay fathers predominantly encountered a lack of accessible information online. Moreover, reports of non-inclusive practices and negative attitudes against both surrogates and gay fathers showed not only a lack of understanding and unfamiliarity regarding surrogacy among healthcare providers, but overt discriminatory practices. Importantly, participants suggested that the behaviors of healthcare providers in fertility clinics and hospitals seemed to derive from limited knowledge and training of surrogacy and same-sex parent families. The current study’s findings address that both individual and structural changes are needed to not only promote guidelines and directives for pursuing surrogacy, but to also enhance inclusivity and resist heteronormative practices that have created obstacles to surrogacy.

In Canada, the absence of official guidelines have appeared to impact the provision of services among reproductive healthcare providers, fertility lawyers and hospital workers (Busby & Vun,
In the current study, participants articulated their frustration in trying to find relevant, adequate and trustworthy information on surrogacy. Participants either utilized information from the U.S., or relied on personal anecdotes from blogs, websites and Facebook groups. As participants in the current study expressed uncertainty on how to navigate these online communities, they advocated for official resources and guidelines to facilitate the process. The lack of oversight of surrogacy consulting services seemed to result in a range of participant experiences, whereby the involvement and information received differed remarkably across participant narratives (Cattapan & Cohen, 2013). This is perhaps reflective of the lack of procedural standards that accompany fertility clinics and surrogacy consulting services in Canada (Busby & Vun, 2010).

Participants’ struggles with trying to find relevant information on surrogacy allude to the ambiguity of surrogacy legislation in Canada; limited governmental oversight is perhaps caused by policymakers who have chosen a hands-off approach to a controversial and contested reproductive practice (Cribb & Jarratt, 2016; Lozanski, 2015; Nelson, 2016; Ruparelia, 2007; Scotti, 2016; Snow et al., 2015). In general, the moral complexity of surrogacy has led to public discomfort and negative social attitudes on the use of third-party reproduction (Krishnan, 1994; Ruparelia, 2007; Weiss, 1992). For instance, participants in the current study expressed having to rationalize their decision to others, while encountering widely held assumptions regarding surrogates’ monetary compensation and reproductive autonomy. In turn, findings suggest that negative societal attitudes against surrogacy have prompted a secretive underground process; stories about court cases, conflict in reproductive decision-making and un-relinquished offspring are continuously portrayed in the media, perhaps justifying and encouraging the
criminalization and stigma against surrogacy (Ruiz-Robledillio, 2016; van den Akker, Fronek, Blyth, & Firth, 2016; van den Akker, Camara, & Hunt, 2016).

Consequently, federal legislation governing surrogacy has resulted in a lack of reliable and accurate information that has perhaps fostered a system wherein service users and providers are ill-equipped to manage, understand and address surrogacy pregnancies (Nelson, 2016; White, 2016). Due to ambiguous legislation and fears of punitive consequences, many experts in the field (including fertility lawyers, surrogacy consulting directors and fertility clinic teams) remain confused and frustrated by the lack of guidelines and detailed regulations; this has created difficulty in being able to assist service users through the legalities of surrogacy (Busby & Vun, 2010; White, 2016). Participants expressed recommendations to amend surrogacy regulations in Canada to enhance clarity, develop the provision of adequate information and promote inclusive hospital policies for surrogacy pregnancies.

Nevertheless, recommendations for fertility clinics and hospitals may be identified even without drastic changes to the law (Table 2). Many participants’ experiences were contingent on the training, competencies and skills of an individual healthcare provider, nurse or allied health professional, reflecting arbitrary and inconsistent care. For instance, surrogate participants expressed a lack of insight on reproductive risks and testing, uncertainty regarding post-birth documentation at hospitals, and discriminatory policies that either excluded intended parents, or relied heavily on surrogate’s parental decision-making post-birth. According to participants, limited competencies and skills among allied health care professionals and fertility specialists in managing surrogacy may yield further hurdles to an already challenging and complicated process. The establishment of collective guidelines and organizational policies can inform
effective and systematic practices. For instance, in a recent 2015 white paper on ARTs, the Canadian Medical Association (CMA) declared: “monitoring research related to ART, training physicians in ART, and guidelines for medical procedures and accreditation of facilities where ART is practiced, would be better addressed by national standards developed by the relevant bodies” (O’Neill & Blackmer, 2015, p. 17).

Participants in this dissertation project also demonstrated a lack of surrogacy and parenting resources to reflect the growth of same-sex families (Statistics Canada, 2013). Some gay fathers indicated attending parenting groups at LGBT community centers and described healthcare providers as welcoming and inclusive. Conversely, other gay father participants reported exclusionary and discriminatory practices and policies that fostered obstacles and delays to parenthood. For example, participants described a lack of information on gay fatherhood, non-inclusive policies at sperm banks, as well as inaccessible gay parenting groups post-birth (e.g., first-aid courses, formula feeding and play groups). Administrative documentation elicited confusion and frustration among new fathers. Even though Canada legally recognizes same-sex parent families, governmental forms have yet to reflect these inclusive rights (Marvel et al., 2016; Mulé & Smith, 2014; Epstein, 2012). These experiences indicate that presumptions of heterosexuality are still promulgated across institutions, laws and structural procedures; “heteronormativity affects daily life, shapes social norms and impacts on public policy by building the tacit assumption of heterosexuality into those practices, norms and policies” (Chambers, 2007, p. 674).

The experiences among gay fathers, in particular, highlights the discriminatory and exclusionary practices and policies that hinder access to gay men’s fertility and reproductive
care (Holley & Pasch, 2015; Kelly, 2014; Ross et al., 2014). Importantly, participant narratives draw attention to prevailing negative social attitudes that gay fathers have to continuously encounter post-birth. Gay fathers reported being confronted with anti-gay epithets while out with their children, and faced delays with health insurance documents and birth certificates after leaving the hospital; with only space to include the names of the ‘mother’ and ‘father,’ these administrative hurdles overtly discriminated against gay fathers. Interestingly, although surrogates experienced negative attitudes regarding their decision to pursue surrogacy, gestating a child for gay men was perceived as an added challenge; negative reactions intensified upon hearing that the intended parents were two men.

The reported experiences among gay fathers and gestational surrogates, therefore, provide empirically-based evidence to inform individual and institutional strategies to confront biases in healthcare practices and social services. In addressing the heteronormativity of fertility practices, structural changes across fields of practice, organizational procedures and guidelines are necessary to interrupt and prevent repeated occurrences of sexual stigma. Thus, notwithstanding the importance of individual level education, training and awareness to promote competent practice (Holley & Pasch, 2015; Shilo, Cohen & Gavriel-Friend, 2016; von Doussa et al., 2016), resistance strategies that refute heteronormative and heterosexist discourses that have become embedded in fertility care are necessary to counteract negative societal policies and attitudes against gay fatherhood. Addressing heteronormativity at both individual and institutional levels are imperative next steps.
4.5 Limitations

This was a qualitative study with a small sample size among a very specific and hard-to-reach sub-group of the surrogacy population. There has been limited research conducted on surrogacy in Canada, and even less empirical research specifically on gay fatherhood; consequently, the aim was not to generalize but to present important and novel insights on surrogacy practices in Canada. This is one of the first studies to engage with a sample of gay fathers and surrogates, and incorporate the perspectives of matched surrogate triads.

A limitation of the study was that the majority of participants live in large metropolitan cities and had high levels of education and high socioeconomic status. Purposefully recruiting more diverse populations may help to examine how intersections of socioeconomic status, race, ethnicity, immigration status and geographical location influence the provision of adequate and inclusive information, resources and services. Additionally, due to legal concerns, interview questions did not address financial compensation. As this restriction was elucidated in the informed consent, this could have potentially influenced responses. As a result, how Canada’s surrogacy laws play a role in the ambiguity regarding financial compensation of surrogates cannot be surmised from these findings. However, given the lack of empirical research on surrogacy in Canada, this study is important in addressing the experiences and perspectives of intended parents and surrogates.

Future research should include perspectives of single gay fathers, as well as transgender men and women to help build on the present findings. This could perhaps result in a more nuanced understanding of experiences with sexual stigma and parenting resources for other marginalized communities. Additionally, interviews with fertility lawyers, healthcare providers, surrogacy
agency and fertility clinic directors may help to enhance these findings and provide diverse perspectives.

4.6 Implications & Conclusion

Assisted reproductive technologies (ARTs) have been conceptualized in research and practice as a medical intervention for the treatment of infertility. Those who utilize ARTs are thus presumed to have functional infertility, a consequence of a diagnosed medical condition (Dana, 2011). This assumption has shaped the way fertility clinics, health providers and allied health professionals treat and manage those who seek assisted reproductive services. Moreover, it impacts the way research has been conducted, particularly empirical studies exploring the prevalence or experience of infertility (Roth, 2016a; Zrenchik & Craft, 2016). However, this single definition overlooks the use of assisted reproduction for structural infertility, a term that applies to single men and women and same-sex couples who require another party to conceive a child (Dana, 2011). Recognizing the incidence of structural infertility confronts the heteronormativity of fertility and reproduction. The findings of this study suggest that healthcare practitioners ought to be trained to address non-heterosexual parenting practices, and promote substantial administrative changes (including governmental forms, birth certificates, and health cards) to mirror federal legislation. These recommendations may help to mitigate the barriers and discriminatory practices that have defined gay men’s access and involvement in reproduction.

The recognition of same-sex surrogacy may facilitate the provision of accurate and relevant information, resources and support that is specifically intended for non-heterosexual families (Brown, Smalling, Groza, & Ryan, 2009; Holley & Pasch, 2015; Zrenchik & Craft, 2016).
Finding healthcare providers, family physicians and allied health professionals who are empathic, knowledgeable and supportive is a critical component of the process (Kissil & Davey, 2012; von Doussa et al., 2016; Zrenchik & Craft, 2016). Healthcare providers ought to be mindful of individual assumptions and biases towards same-sex parenting and/or surrogacy in order to promote competent and ethical practice (Roth, 2016b; Shilo et al., 2016). Fertility clinics, hospitals and parenting groups may establish innovative guidelines, policies and services to develop training on surrogacy, and to provide accessible resources to non-heterosexual families. Moreover, surrogates require adequate information to understand the risks, side effects and challenges associated with surrogate pregnancies. Issues related to a surrogate’s autonomy and consent have been addressed through guidelines introduced by the Ethics Committee of the American Society for Reproductive Medicine (ASRM, 2013), as well as the Canadian Fertility and Andrology Society’s clinical practice guidelines (Havelock et al., 2016). Future practice and policy recommendations can encourage dialogues with service users, service providers and policymakers. Finding ways in which to consider inclusive clinical approaches to surrogacy for gay men is imperative, along with developing legislative action that promotes a transparent, well-defined and informative process for third-party reproduction in Canada.
### Table 1

**Gay Father Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range (CAD)</th>
<th>Region</th>
<th>Immigration Status</th>
<th>Number of Surrogate Children</th>
<th>Age of Surrogate Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>42</td>
<td>White</td>
<td>Grade 12</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>5 years old</td>
</tr>
<tr>
<td>F2*</td>
<td>45</td>
<td>White</td>
<td>Bachelor’s</td>
<td>81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F3*</td>
<td>36</td>
<td>White</td>
<td>College</td>
<td>81,000-120,000</td>
<td>Urban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F4*</td>
<td>50</td>
<td>White</td>
<td>Law School</td>
<td>200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (U.S.)</td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F5*</td>
<td>40</td>
<td>Asian</td>
<td>Med School</td>
<td>200,000+</td>
<td>Urban</td>
<td>Immigrated to Canada (Japan)</td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F6*</td>
<td>36</td>
<td>White</td>
<td>University</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>2 (twins)</td>
<td>17 months</td>
</tr>
<tr>
<td>F7*</td>
<td>35</td>
<td>White</td>
<td>Post-Grad</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td></td>
<td>2 (twins)</td>
<td>17 months</td>
</tr>
<tr>
<td>F8*</td>
<td>44</td>
<td>White</td>
<td>University</td>
<td>161,000-200,000</td>
<td>Urban</td>
<td></td>
<td>2 (twins)</td>
<td>4 years old</td>
</tr>
<tr>
<td>F9*</td>
<td>45</td>
<td>Asian</td>
<td>University</td>
<td>161,000-200,000</td>
<td>Urban</td>
<td></td>
<td>2 (twins)</td>
<td>4 years old</td>
</tr>
<tr>
<td>F10*</td>
<td>37</td>
<td>White</td>
<td>Some College</td>
<td>40,000-80,000</td>
<td>Suburban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F11*</td>
<td>29</td>
<td>White</td>
<td>High School</td>
<td>40,000-80,000</td>
<td>Suburban</td>
<td></td>
<td>1</td>
<td>1 year old</td>
</tr>
<tr>
<td>F12*</td>
<td>35</td>
<td>White</td>
<td>LLM</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td>Immigrated to Canada (Israel)</td>
<td>1</td>
<td>1 month old</td>
</tr>
<tr>
<td>F13*</td>
<td>34</td>
<td>White</td>
<td>PhD</td>
<td>40,000-80,000</td>
<td>Urban</td>
<td>Immigrated to Canada (Israel)</td>
<td>1</td>
<td>1 month old</td>
</tr>
<tr>
<td>F14*</td>
<td>36</td>
<td>White</td>
<td>Bachelor’s</td>
<td>121,000-160,000</td>
<td>Suburban</td>
<td></td>
<td>2 (twins)</td>
<td>5 years old</td>
</tr>
<tr>
<td>F15*</td>
<td>43</td>
<td>White</td>
<td>Master’s</td>
<td>121,000-160,000</td>
<td>Suburban</td>
<td></td>
<td>2 (twins)</td>
<td>5 years old</td>
</tr>
</tbody>
</table>

*Notes: *Corresponding letters refer to partnered gay men

### Table 2

**Surrogate Participant Demographic Information***

<table>
<thead>
<tr>
<th>ID</th>
<th>Age at Interview</th>
<th>Age at recent Surrogacy</th>
<th>Race</th>
<th>Education</th>
<th>Individual Income Range (CAD)</th>
<th>Region</th>
<th>Number of Surrogacies</th>
<th>Number of Surrogate Children</th>
<th>Number of (own) biological children</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS1*</td>
<td>37</td>
<td>36</td>
<td>White</td>
<td>College</td>
<td>&lt; $40,000</td>
<td>Rural</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>GS2*</td>
<td>45</td>
<td>44</td>
<td>White</td>
<td>B.A.</td>
<td></td>
<td>Rural</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>GS3*</td>
<td>35</td>
<td>31</td>
<td>White</td>
<td>College Diploma</td>
<td>&lt; $40,000</td>
<td>Suburban</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>GS4*</td>
<td>36</td>
<td>35</td>
<td>White</td>
<td>Some College</td>
<td>&lt; $40,000</td>
<td>Suburban</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>GS5*</td>
<td>27</td>
<td>27</td>
<td>Aboriginal</td>
<td>BScN</td>
<td>$81,000-120,000</td>
<td>Urban</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>GS6</td>
<td>22</td>
<td>21</td>
<td>Aboriginal</td>
<td>BScN</td>
<td></td>
<td>Suburban</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Notes: *Letters correspond to Table 1 to reflect the ‘matched surrogate triads’
### Table 3:

**Recommendations for Fertility Clinics and Hospitals on Managing Surrogacy for Gay Men**

<table>
<thead>
<tr>
<th><strong>Fertility Clinics</strong></th>
<th><strong>Hospitals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations on care provision for gay men</td>
<td>Recommendations on care provision for gay men</td>
</tr>
<tr>
<td>- Visible LGBT positive environment (e.g., posters, forms, physical space)</td>
<td>- Policies that respect intended parents’ reproductive decision-making</td>
</tr>
<tr>
<td>- Pamphlets, resources and services specifically aimed to assist gay intended parents through surrogacy</td>
<td>- Hospital beds and/or rooms for the intended parents to stay in the hospital with the newborn</td>
</tr>
<tr>
<td>- Parenting resources for gay fathers post-birth</td>
<td>- Staff who are knowledgeable about forms and familiar with post-birth documents that are non-inclusive and confusing</td>
</tr>
<tr>
<td>- Inclusive language and active representation of same-sex parents and families</td>
<td>- Social workers and allied health professionals who can support gay fathers on their transition to parenthood</td>
</tr>
<tr>
<td>- Consideration of inclusivity of sperm donation</td>
<td>- Refer to the intended parents as the parents</td>
</tr>
<tr>
<td>-</td>
<td>- Formula feeding consultations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Recommendations on care provision for surrogates</strong></th>
<th><strong>Recommendations on care provision for surrogates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Clear/easy to understand informed consent:</td>
<td></td>
</tr>
<tr>
<td>a. Procedures</td>
<td>- Hospital staff who are understanding and supportive of surrogacy pregnancies</td>
</tr>
<tr>
<td>b. Medications</td>
<td>- Managing reproductive questions in a respectful way that recognizes surrogate’s detached role post-birth</td>
</tr>
<tr>
<td>c. Perinatal Risks</td>
<td>- Provide intended parents’ last name to newborn, rather than the surrogate’s name</td>
</tr>
<tr>
<td>d. Childbirth contingency plans</td>
<td>- Training on how to care for the surrogate post-birth</td>
</tr>
<tr>
<td>e. Risks to offspring</td>
<td></td>
</tr>
<tr>
<td>- Counseling and therapeutic support during the process</td>
<td></td>
</tr>
<tr>
<td>- Information on expectations and guidelines of: medical process, reproductive testing, potential mental health issues, and potential birth and delivery complications</td>
<td></td>
</tr>
</tbody>
</table>
5 Introduction

Through interpretive phenomenological analysis (IPA), my dissertation explored the practice of surrogacy from the perspectives of gay fathers and gestational surrogates in Canada. The objectives were to elucidate: (1) initial motivations to pursue surrogacy among gay intended fathers and gestational surrogates; (2) relationships between surrogates and gay intended fathers retrospectively before, during and after the surrogacy pregnancy; and (3) institutional/systemic supports and barriers that emerged throughout the surrogacy process for both gay intended fathers and gestational surrogates. As there has been limited scholarship in this area, the empirical findings importantly bring to the forefront the lived experiences of those who have pursued gestational surrogacy in Canada.

Results show that normative constructs of parenting, kinship and family are continuing to broaden and expand. The empirical data presented in this dissertation support a new conceptual model in which to understand the use of gestational surrogacy among gay men. Drawn from previous empirical and theoretical scholarship, this model is presented to illustrate factors that have shaped procreative identities of gestational surrogates and gay men (Figure 1). Accordingly, practices and policies need to be established to address these procreative processes and to consider ways in which to provide inclusive, informative and competent reproductive care.
5.1 Previous Conceptual Frameworks

There are two conceptual frameworks that importantly influenced the development of my own model of procreative identity. The first framework presented below (5.1.1) describes men’s procreative decision-making. The second framework (5.1.2) identifies three intersecting principles to understand women’s experiences of infertility and their decision-making regarding assisted reproduction.

5.1.1 Men’s Procreative Identities

The concept of procreative identity was initially framed in Marsiglio and colleagues’ (2013) structural model of men’s experiences in the procreative realm. The authors examine how cisgender men, both heterosexual and gay, engage in reproductive decision-making and become involved in fertility practices. The term, procreative identity, is explicated through two inter-relating concepts: (1) procreative consciousness and (2) procreative responsibility. Marsiglio (1991) defines procreative consciousness as “men’s phenomenological experiences related to their fertility” (Marsiglio, 1991, p. 269); this refers to men’s attitudes, feelings and the way in which they think about reproduction and the decision to have children, irrespective of relationship status (Marsiglio, Hutchinson, & Cohan, 1991). Procreative responsibility is the “beliefs, attitudes, preferences, and behaviors related to expectations and involvement in contraception (and fertilization technologies), pregnancy resolution, childbearing, and child-care activities” (Marsiglio, 1991, p. 269). This often refers to involvement in reproductive-related events (e.g., accompanying a partner to an abortion, choosing an ART method), as well as the level of engagement in a partner’s pregnancy.
Through this framework, factors that shape procreative identity include: (1) individual, (2) interpersonal, such as romantic relationships, and (3) ecological/systemic; cultural discourses foster perceptions of masculinity, family and sexuality that influence men’s engagement with procreation (Marsiglio et al., 2013). For instance, thoughts on contraception (e.g., condom use), the use of assisted reproductive technologies (ARTs), and involvement in pregnancy, labor and delivery are important issues to consider. Yet, each of these components is examined through a predominantly heteronormative lens. As aforementioned in the preceding chapters, heteronormativity is a “set of ideas, norms, and practices that sustain heterosexuality and gender differentiation and hierarchy, including romantic love, monogamy, and reproductive sexuality” (Hopkins, Sorensen, & Taylor, 2013, p. 98). Although the authors acknowledge that opportunities to parent have expanded for gay men, gay men’s unique procreative identities are not differentiated from those of their heterosexual counterparts.

5.1.2 Women Experiencing Infertility

Davis (1987) identifies three transecting principles to understand women’s experiences with infertility: (1) individual decision-making regarding the use of medical fertility treatment; (2) interpersonal interactions within a couple, family or third-party; and (3) systemic norms, behaviors and practices that are shaped by one’s cultural context that has impacted individual responses to infertility. The way in which these three factors convey a woman’s procreative identity when experiencing infertility are palpable. Yet, how these intersecting factors relate specifically to gestational surrogates’ experiences with ARTs, as opposed to women experiencing infertility, is an important consideration for fertility health teams.
5.2 New Conceptual Framework

The previous conceptual frameworks have importantly drawn attention to how men and women assume their procreative identities. However, the heteronormative approach within these frameworks, perhaps an indicator of heteronormative parenting and fertility scholarship in general, limits these models’ relevance and application when considering ART use for non-heterosexual families. ARTs are primarily delineated in previous frameworks as medical interventions to assist with infertility. This is problematic, as it restricts infertility to a clinical definition that presupposes an unsuccessful pattern of heterosexual sex with the intention to conceive a child. In turn, this overlooks structural infertility; the experience of single men and women and same-sex couples who require another party to bear a child (Dana, 2011). A broader understanding of procreation (and, in turn, ARTs) is needed to include the perspectives of non-normative parent families in assisted reproduction and fertility care.

Consequently, my dissertation builds on these conceptual frameworks to present a new understanding of how procreative identities are formed for gay intended fathers and gestational surrogates (Figure 1). This framework discerns how individual, interpersonal and systemic factors influence experiences before, during and after the completion of surrogacy. The culminating analysis of my dissertation is supported by empirically-based data to illustrate: (1) procreative consciousness, (2) procreative responsibility, and (3) procreative transitioning for gay intended fathers and gestational surrogates. The term ‘procreative transitioning’ is a new concept that I label for procreative identities post-birth; and one that I will elucidate in the corresponding sub-section below.
5.2 Procreative Consciousness

In the second chapter of my dissertation, I demonstrate the initial motivations of gestational surrogates and gay intended fathers to pursue surrogacy. Findings are indicative of how gay intended fathers and gestational surrogates shift their procreative consciousness in response to sociohistorical contexts that have reshaped ideologies of family, kinship and reproduction.

Some gay intended fathers described their motivations to pursue surrogacy as a way in which to have a biogenetic connection and uphold physical resemblance to their offspring. The use of surrogacy fulfilled their innate and longstanding desire to have children, particularly when faced with obstacles to adoption. Surrogates’ motivations were described as rooted in expressions of altruism, social justice and prior positive pregnancies; they were motivated to help those who were unable to bear children, and articulated that their motivations intersected with a desire to facilitate the creation of same-sex parent families.

Thus, the procreative consciousness of gay intended fathers and surrogates may be construed as both broadening and mirroring heterosexuality (Folgerø, 2008; Hopkins et al., 2013). The use of queer theory demonstrates how gay men and surrogates are oscillating between societal scripts; their procreative consciousness is either conforming to heteronormativity (and normative femininity), or resisting (and queering) normative parenting and reproduction. The motivations to parent are consequently framed as a response and reaction to institutional processes that have both hindered and supported the parenting decisions of gay men and gestational surrogates (Berkowitz & Marsiglio, 2007).
Marsiglio (1991) articulates that “at the macrolevel, social structures, processes, and policies can influence the manner and extent to which males develop and integrate procreative consciousness themes into their life experiences” (p. 270). In building upon Marsiglio’s framework, this dissertation explicates that the procreative consciousness of gay men and gestational surrogates may be grounded in institutional practices that privilege heterosexual ideologies. *Doing gender* is the way in which social contexts promote normative gendered behaviors, attitudes and interactions (West & Zimmerman, 1987). Individuals are obliged to perform repeated acts that are easily identified as feminine or masculine, and are aligned with their ‘sex category.’ Through this, one’s performance of gender is under constant judgment and scrutiny by individual and institutional contexts (West & Zimmerman, 1987). In turn, those who reject or disobey socially acceptable gender norms are subject to ostracism and disempowerment, such as through the denial of certain economic, legal and social rights. Heteronormativity privileges and rewards normative behaviors, relationships and structures (Chambers, 2007). Consequently, the motivations of surrogates and gay fathers to pursue third-party reproduction may be interpreted as a way in which to attain legitimacy and recognition. Gestational surrogacy, according to Jacobson (2016), although may appear to “transgress traditional ideologies of the family, actually reinforces notions of the strength of biological kinship ties” (p. 36).

Butler’s *theory of performativity*, in turn, posits that through these repetitive actions, opportunities are subsequently created to deconstruct and renegotiate normative patterns of behavior (Borgerson, 2005; Jackson, 2004; Jagger, 2008; McKinlay, 2010; Powell & Gilbert, 2007). As gay men consider their procreative consciousness, they are broadening normative patterns of family and kinship; surrogates are congruently shifting definitions of reproduction
and parenthood. Thus, gay intended fathers and surrogates are mimicking (or repeating) heteronormative family structures with the intention that their same-sex parent families transgress conventions of parenthood (Hicks, 2006; Meyer, 2011).

Berkowitz (2007) theorizes that transformations in the definitions of family and what it means to be a gay man are occurring as gay men increasingly traverse pathways to fatherhood. At the same time, it is these very changes that shape how gay men are developing, negotiating, and experiencing their procreative consciousness. (p. 186)

The procreative consciousness of gay men and surrogates may be influenced by a desire to abide by ‘compulsory heterosexuality’;\(^{57}\) yet, it is these exact practices that have directly broadened and expanded heteronormative family structures (Berkowitz, 2007). Informed by queer theory, the ability to reframe and contest heterosexual parenting and reproduction discourses is to “challenge the historicity” of heterosexist ideologies, an important concept related to hermeneutic phenomenology (Jackson, 2004, p. 682). As Strathern (1995) theorizes, the progress of assisted reproduction has facilitated a new autonomy of kinship, and has led to new knowledge regarding conception introducing the capacity to make novel procreative decisions.

As this dissertation was supported by an interpretive hermeneutic phenomenological approach, the concept of fusion of horizons may be an applicable framework in which to conceptualize these two seemingly opposing interpretations of procreative consciousness (Clark, 2008;\(^{57}\)

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\(^{57}\) As aforementioned in chapter 2, compulsory heterosexuality is when “people feel as though they have to constrain behaviors in order to attain certain rights and avoid physical, emotional and psychological harms” This has also been referred to in Butler’s readings as the ‘heterosexual matrix.’
Jacobs, 2014; Newberry, 2012; Regan, 2012). A horizon refers to an individual’s “background of various assumptions, ideas, meanings and experiences” (Lopez & Willis, 2004, p. 730). Fusion of horizons suggests that individuals interpret phenomena differently as a result of their unique perspectives, social contexts and biases. As each individual comes to understand a phenomenon (in this case, procreative consciousness) from a distinct standpoint, individuals’ horizons merge (fuse) through collective interactions and dialogue.

Consequently, these social discourses influence (and challenge) individual thought processes and prior insights. In turn, horizons are adaptable, subject to renegotiation through conversations, and result in broader organizational change (Newberry, 2012). This exchange of ideas yields entirely new interpretations and understandings of the experience. The dichotomous interpretations (mirroring vs broadening) of procreative consciousness coalesce to present a completely novel understanding of family, kinship and parenthood. The interpretations of the procreative consciousness of gay intended fathers and surrogates merge to actively shift and reinterpret heteronormative reproductive processes (Mamo, 2007; Nordqvist, 2012b; Roth, 2016a).

Findings from chapter 2 also suggest that institutional practices and policies, and one’s social location, may influence procreative consciousness. This is reflective of feminist relational autonomy, suggesting that autonomous procreative decisions are enabled by positive social relationships and sociopolitical contexts (Ball, 2005; Keller, 1997; Sherwin, 2002; Stoljar, 2015; Toledano & Zeiler, 2017). Gay intended fathers expressed that the Canadian environment influenced decisions of parenthood, indicating: (1) increased visibility of gay fathers, (2) legality of parenting for sexual minorities, and (3) access to resources. The accessibility of
surrogacy, the rights of same-sex parent families, and relationships with gay fathers promoted gay men’s procreative consciousness. Previous scholarship has shown that considerations of parenthood are often contingent on the legal and inclusive right to adopt, practice surrogacy and/or parent (Baiocco & Fiorenzo, 2014; Berkowitz, 2007; Kazyak & Woodell, 2016).

Scholarly work has also demonstrated that individuals who come from a privileged socioeconomic status typically have stronger support systems, greater access to resources, and increased levels of confidence to parent (Dempsey, 2013; Mezey, 2013); socially welcoming and accepting neighborhoods tend to offer gay couples a supportive environment and a strong community network in which to make procreative decisions (Stacey, 2006). Thus, the motivations of gay intended fathers to pursue surrogacy may be a reflection of their demographics; many lived in large urban cities, with access to community support groups, fertility clinics and services in which to initially consider fatherhood. Moreover, gay father participants were predominantly white, with high education levels and socioeconomic statuses. These demographics are perhaps indicative of their position in which to afford, access and understand surrogacy resources that subsequently fostered their procreative consciousness.

Findings demonstrate, however, that social location does not necessarily protect against experiences of sexual stigma. For instance, some gay father participants described pursuing surrogacy because they had no other parenting option, as they were not allowed to legally adopt and did not see co-parenting as a desired option. Some gay intended fathers also spoke of initial difficulty coalescing their gay-father identities, as they had seemed to always associate their sexual orientation with childlessness. Additionally, other gay intended fathers indicated concerns regarding the ostracism, bullying and exclusion their children may face from having
gay parents; they wanted their families to be favorable to their friends, family, community and government. These considerations stemmed from previous experiences with enacted sexual stigma (overt practices of sexual stigma), gay fathers’ anticipated stigma (the expectation of encountering stigma), as well as contexts that privilege biogenetic and relational kinship practices. Thus, gay fathers’ social location did not shield them from experiences of heteronormativity and sexual stigma.

Surrogates’ procreative consciousness was facilitated by: (1) the visibility of infertility, surrogacy or adoption in their immediate families, (2) access to surrogacy information through online communities, including Facebook groups, blogs or surrogacy consulting services, and (3) altruism and compassion towards narratives of infertility. Surrogates’ motivations developed from personal encounters with fertility that accompanied their own life course trajectory. For instance, many surrogates in this study had family members who struggled with infertility or had previously acted as surrogates; one surrogate was, herself, adopted. All surrogates deeply reflected on what it would be like if they could not have children. Consequently, these social relationships and self-reflexivity provided a more personal and intimate link to facilitate their procreative consciousness; this yielded an intimate network of family members who could offer support, guidance and compassion through the process.

Internet-based community hubs facilitated a system that fostered surrogates’ belonging and inclusion. The importance of online communities may be a reflection of surrogates’ social location. The majority of surrogate participants lived in rural settings and tended to have lower educational levels and socioeconomic statuses than their gay father counterparts. Thus, finding online communities broadened their social support networks and lessened experiences of
isolation due to their geographical location. Online forums elucidated the intricacy of third-party reproduction in a way that was accessible and informative. Creating greater opportunities to access information on surrogacy, through personal narratives of altruism and empathy, enabled surrogates’ procreative consciousness and supported a framework of relational autonomy.

5.3 Procreative Responsibility

According to Marsiglio (1991), procreative responsibility manifests in two ways: (1) through practical aspects ranging from conception to gestation (e.g., choosing to utilize birth control, selecting an ART method); and (2) through males’ perceptions of social fatherhood that evolves at points prior to, during and after pregnancy. The procreative responsibility of both surrogates and heterosexual intended parents is often managed through their interpersonal relationships. Research exploring surrogacy use among heterosexual couples shows that intended mothers often struggle with disappointment, failure, shame and anger resulting from their inability to conceive a child (Berkowitz, 2013; Stacey, 2006). This may yield tense or dissatisfactory relationships, as surrogates have issues coping with the intended mother’s emotional stressors. Surrogates have subsequently reported disconnecting from the relationship, a reaction, in part, to fear that the intended mother will conceal or hide the surrogate’s role in the child’s life (Berend, 2012, 2014; Ragoné, 1994).

Although these results notably demonstrate some of the challenges associated with surrogacy, gay men’s relationships with their gestational surrogates may be different. Gay men may not have the same emotional pain associated with experiences of clinical infertility; they are realistically unable to hide the surrogate’s role in their child’s birth story. Accordingly, gay men
identify surrogacy as a fundamental opportunity to bear children, rather than being sought as a last resort (Berkowitz, 2013; Norton et al., 2013). Experiences of humiliation, shame and anger are exchanged for signs of hope and the anticipation of parenthood. The procreative responsibilities of gay men and surrogates are importantly connected to forming reciprocal, and mutually beneficial, relationships (Toledano & Zeiler, 2017; Walker & van Zyl, 2016). In turn, inequity between parties (as suggested in equity theory) may generate obstacles for gay men to consider their procreative responsibilities. The reliance on the surrogate’s active engagement and effective communication may create unanticipated difficulties that then hinder gay intended fathers’ attachment to the surrogacy pregnancy and their anticipation of social parenthood.

Chapter 3 of this dissertation explored the relationships between surrogates and gay intended fathers: (1) before pregnancy, (2) during pregnancy, and (3) post-birth.

5.4.1 Before Pregnancy

Before pregnancy, surrogates expressed that a desire for ongoing contact was a way in which to mitigate anticipated concerns of exploitation and abandonment post-birth. Similarly, gay intended fathers trusted that surrogates would uphold a healthy pregnancy and effortlessly relinquish the child. The way in which both these expectations were met was through frequent and ongoing contact between surrogates and gay intended fathers. In turn, the relationship pre-pregnancy was fostered by reciprocal interpersonal trust and mutual respect. Gay intended fathers and surrogates assumed roles as both trustor and trustee as they desired to equally benefit from the ensuing relationship. Gay fathers and surrogates articulated that similar values, interests and goals were key aspects that would enable a positive and longstanding relationship.
Thus, the procreative responsibilities pre-pregnancy were determined by expectations of a trustworthy and collaborative relationship to facilitate a positive surrogacy experience.

5.4.2 During Pregnancy

During pregnancy, the procreative responsibilities of surrogates and gay intended fathers shifted. As intimacy and closeness developed and contact became more frequent for some participants, surrogates encouraged gay intended fathers’ active involvement in the pregnancy. Surrogates’ procreative responsibilities were to: (1) detach and disassociate from their pregnancies, and (2) enable gay intended fathers’ social parenting role. During the pregnancy, surrogates allocated reproductive decision-making to gay intended fathers; they promoted effective communication by involving their intended fathers in medical testing, doctor’s appointments, ultrasound visits and the progress of their pregnancies. This, in turn, allowed gay intended fathers to accept their procreative responsibilities, and: (1) adjust to social parenthood through informed reproductive decision-making, and (2) actively engage in the evolving pregnancy.

As surrogates distanced themselves from their pregnancies, this reflected their negation of maternal-fetal bonding or their anticipation of social motherhood. These actions subsequently promoted gay intended fathers to bond with their unborn offspring. These findings have been echoed in previous research that indicates surrogates play a fundamental role in permitting gay men to emotionally connect to their unborn child (Carone, Baiocco, & Lingiardi, 2016). As gay intended fathers showed dedication and interest to be involved in the surrogate pregnancy, this even further promoted surrogates’ detachment; the intended fathers were entrusted as social parents. These reciprocated exchanges increased the closeness and intimacy between gay
intended fathers and surrogates, and led to frequent and relaxed contact. The interdependent procreative responsibilities fostered a shared and collaborative reproductive experience.

Alternatively, when contact dissipated or a surrogate reduced communication, gay intended fathers were uncertain how to enact their procreative responsibility. As these surrogates discouraged gay intended parents’ involvement, this impeded upon gay men’s procreative responsibility. These gay intended fathers struggled with how to simultaneously respect the needs of the surrogate and also anticipate fatherhood. In turn, when a lack of contact occurred and adverse experiences ensued, the reliance on the interpersonal relationship to identify one’s procreative responsibility was absent. This subsequently created difficulties during pregnancy.

5.4.2 Post-Birth

Post-birth, contact primarily dissipated between surrogates and gay fathers. Surrogates intentionally reduced contact as gay fathers transitioned to parenthood. Thus, surrogates’ procreative responsibility was framed as a distancing technique, allowing gay fathers the time and space to adjust and adapt to social parenthood. Surrogates anticipated maintaining a close relationship to the family; their procreative responsibility post-birth ranged from casual to more familial, as they navigated a close but distant relationship with the fathers. Gay fathers were appreciative of the meaningful role the surrogate played in the birth story of their child, but intentionally desired to raise the child without a mother figure. As demonstrated, procreative responsibilities are directly conferred between intended parents and surrogates. The procreative responsibilities post-birth are conversations that are had prior to pregnancy and are then shifted and explored throughout the pregnancy. Thus, the social and relational process of surrogacy is critical to elucidate. Effective communication, shared values and mutual respect importantly
helped structure the procreative responsibilities in non-heteronormative family systems; this resulted in a positive and harmonious surrogacy experience.

5.4.2 Procreative Responsibility as a Whole

Through all three phases of surrogacy (pre-pregnancy, during pregnancy and post-birth), the procreative responsibilities of gay intended fathers and surrogates are formed through reciprocal interpersonal relationships. Gay intended fathers and surrogates were relationally dependent on one another to acclimate to their specific roles and responsibilities pre-pregnancy, during pregnancy and post-birth. This, according to Erving Goffman, is known as the reflexive model; one’s identity (‘selfhood’) is shaped through interpersonal interactions within a specific social context (Brickell, 2005). In turn, Goffman posits that it is through these interactive dialogues one can change and subvert heteronormativity. Joint interactions renegotiate and challenge previous interpretations/definitions of the phenomenon (e.g., procreative responsibility) that have been rooted in sociohistorical contexts and institutional structures (Brickell, 2005).

Therefore, the relationships between surrogates and gay intended parents during surrogacy shape procreative identities. Simultaneously, these reciprocal interactions directly challenge and restructure heteronormative constructs that have defined reproduction and pregnancy experiences. For instance, the surrogate’s detachment from maternal-fetal bonding and her desire to share in the pregnancy and allocate reproductive decisions to the intended fathers resist feminine gender norms and normative pregnancy processes. Similarly, the engagement of gay intended parents in the pregnancy broadens normative behaviors that have excluded men from fertility and reproduction. When heterosexual men assume procreative responsibility, they
often do so with the close proximity to their opposite sex spouse or partner who is pregnant. Thus, these men may have both a physical and emotional closeness to the pregnancy and to the woman who is carrying the child. With the utilization of ARTs, scholarship has shown that: (1) men are often alienated from the decision-making process surrounding ART use; (2) that responsibilities during ART use may also be affected by marital dissatisfaction and the pain and distress from having gone through infertility treatment; and (3) that surrogates develop a closer attachment to the intended mother. This has resulted in a surrogate’s often less consistent involvement or prolonged relationship with the intended father as compared to the intended mother (Jadva et al., 2003).

Surrogacy entails a distinct process as the surrogate disassociates from her pregnancy and, when conducted among gay men, places emphasis on the men’s involvement and engagement with pregnancy and reproduction. The intended gay fathers must then learn to be actively a part of the pregnancy, while still remaining somewhat physically and emotionally distant from impending parenthood. The interactive and relational processes between gay parents and surrogates advances a new interpretation of procreative responsibility. As suggested by queer theory, gay intended parents and surrogates are subverting gender norms; through their procreative responsibility, gay men are subverting hegemonic masculinity to showcase involvement and dedication in pregnancy, reproduction and childbirth.

Additionally, the relationships between gay fathers and surrogates post-birth extends the family unit beyond the normative two-parent family system; families of choice include the close network of individuals and communities that are involved in gay parenting (Berkowitz & Marsiglio, 2007; Berkowitz & Kuvalanka, 2013; Donovan, Heaphy & Weeks, 2004; Greenfeld
& Seli, 2013; Weston, 1997). The act of subversive procreative responsibility alters the idealized model of the nuclear family, and presents new discourses and meanings that challenge heteronormative roles and responsibilities during pregnancy. This may be reflective of what Strathern (1995) refers to as dispersed kinships; the development of assisted reproduction has broadened kinship to include individuals affiliated with acts of conception/procreation (e.g., surrogates), as well as those who assume child-rearing responsibilities. Thus, even with no genetic link, some gestational surrogates assume relational kinship ties to the intended parents and offspring. Acts of subversion restructure individual and institutional practices and policies to identify and support non-normative reproductive processes (Brickell, 2005).

5.5 Procreative Transitioning

The findings of chapter 4 draw attention to institutional supports and barriers that have influenced the experiences of surrogacy for both gay fathers and gestational surrogates in Canada. As this stage of procreative identity has not yet been framed (to my knowledge) in previous conceptual frameworks, I build on Marsiglio’s work and label this: ‘procreative transitioning.’ When heterosexual couples bear a child, the transition to parenthood typically involves maternity leave, access to parenting support services (e.g., breastfeeding consultations), as well as online and in-person mothering groups; resources and information help new mothers adjust to genetic and social parenthood. Thus, systemic practices and policies have approached procreative transitioning in primarily heteronormative ways. However, the process of procreative transitioning may be different for gay men and gestational surrogates.

58 The notion of dispersed kinships may also be understood as rationale for why gay intended fathers sought the same surrogate in their desire to have a second child. Although the gestational surrogate does not have a genetic connection to the offspring, the surrogate’s interpersonal (relational) connection to the intended parents and first offspring is significant. Although beyond the scope of this dissertation, this decision also reflects parents’ desires for similarities across siblings (this is known as ‘kinship of siblinghood’ as discussed in Nordqvist, 2012a).
Importantly, findings may help to inform effective and inclusive services for gay men, and hospital policies that consider how to care and treat surrogacy pregnancies.

The separation of genetic, gestational and social parenthood creates a distinction from heterosexual biological parenting transitions that, in turn, requires shifts in practices and policies. I argue that in surrogacy, procreative transitioning may not simply occur at one time-point, post-birth. As a surrogate’s role is that of a gestational carrier (rather than a biological or social parent) it may be proposed that she has two procreative transitions: (1) subsequent to a successful IVF cycle, in which she becomes pregnant and assumes the role of gestational carrier; and (2) post-birth, in which her role as a gestational carrier is terminated; yet, she does not undertake social parenthood. A surrogate’s procreative transition post-birth is more so indicative of her relationship with the gay intended fathers rather than with the offspring.

In this dissertation, most surrogate participants encountered barriers in their first stage of procreative transitioning. Surrogates reported a lack of relevant and accessible information, ambiguous legal processes, and limited knowledge and information regarding medications, perinatal risks and childbirth contingency plans. Surrogate participants reflected on their unfamiliarity of procedures and risks of ART use. Surrogates advocated for more training and education regarding their medical decisions, as well as a more transparent process to understand the legalities in pursuing third-party reproduction. Moreover, while pregnant, surrogates described encountering negative societal attitudes related to their surrogate pregnancy.

Upon surrogates’ procreative transitioning post-birth, participants described their frustrations with hospital policies. For instance, many surrogates reported that newborns were provided
with the name of the gestational carrier, and medical questions were directed to the surrogate. This instigated complexities in gestational surrogates’ transitions post-birth, and triggered discomfort among surrogates. The completion of surrogacy elicits a procreative transition for the surrogate, from gestational carrier to an external participant in the child’s birth story. Surrogates’ interactions with healthcare practitioners at the hospital seemed to blur these reproductive boundaries and create hurdles in their procreative transitioning after delivery.

Gay men primarily encountered obstacles upon their transition to social (and genetic) parenthood post-birth. Although gay intended fathers may experience a ‘procreative-like’ transition after a successful IVF cycle, many participants in this study indicated that it was difficult to envision parenthood so early on in the pregnancy. Some reasons may be owing to their physical detachment from the pregnancy, as well as enduring concerns of unanticipated adverse pregnancy events, or that the surrogate may choose not to relinquish the child.

Gay intended fathers’ procreative transitioning seemed to predominantly occur post-birth. Participants expressed the need for: (1) information on surrogacy for gay men; (2) inclusive practices and policies in fertility clinics; (3) healthcare providers who were knowledgeable about administrative forms and processes for same-sex parents; (4) post-birth materials, including governmental registration forms, such as birth certificates, post-birth orders and insurance forms that utilize inclusive language for same-sex parents; (5) shifts in governmental legislation in terms of fertility benefits, plans and paternity leave that recognize same-sex parent families; and (6) resources that are intended for non-heterosexual parents, including first-aid courses, support services, formula feeding and play groups.
Consequently, gay fathers described hurdles in their procreative transitioning, being confronted by barriers that delayed the attainment of legal parent status and exclusionary practices that resulted in a lack of accessible resources. Heteronormative practices also fostered individual micro-aggressions. Micro-aggressions are common everyday verbal or behavioral discourses that are subtle, indirect and often unintentional negative actions that discount and further marginalize the experiences of minority populations (Hudak & Giammattei, 2014). Gay fathers described experiencing what seemed like daily ‘coming out’ processes. For instance, gay fathers’ transition to parenthood consisted of deliberating on how to respond to heteronormative biases from strangers; they drew accustomed to hearing that they were babysitting or had given ‘mom’ a day to rest. When they were with their children, gay fathers had to thoughtfully consider how to address these presumptions and, depending on the age of their child, how to discuss these incidents as a family.

Institutional policies fuel individual level biases that, perhaps not malicious or intentional, still disregard the visibility of gay fathers (Greenfeld & Seli, 2011; Holley & Pasch, 2015; Roth, 2016a; Shilo et al., 2016; von Doussa et al., 2016). These practices were further substantiated by surrogates as experiences of discriminatory social attitudes were encountered when it was disclosed that intended parents were gay men. These negative societal attitudes are rooted in heteronormativity that promotes heterosexist ideologies and beliefs propagated through institutional contexts, political regulations and social interactions (Chambers, 2007). Thus, the procreative transitioning practices of gay fathers and gestational surrogates subvert these heteronormative ideals of procreation and kinship. Their actions create new ways in which to make sense of regulations, organizations and relationships that guide reproductive decision-making and paths to parenthood.
According to Butler’s theory of subversion, there is a need to deconstruct, renegotiate and recreate constructs that have been restrained by heteronormative systems of power. The act of subversion occurs through an “internal repetition” (Chambers, 2007, p. 661), in which the actions of gay men and surrogates are able to transform heteronormative procreative and family structures. Thus, Butler’s theory of subversion does not assign responsibility to merely individual actors, but centers on restructuring the heteronormative social context that has justified exclusionary and discriminatory practices and policies. Dissimilar to Goffman (as utilized in the procreative responsibility section of this chapter), Butler’s ideology focuses directly on issues of power and systemic inequalities rather than interpersonal relationality (Chambers, 2007). In turn, fertility clinics, hospitals and community resources are important sites of subversion. The procreative processes of gay fathers and gestational surrogates are forms of resistance, as these seemingly normative actions work to oppose heterosexual paradigms of fertility, reproduction and parenthood.

5.6 Limitations

This dissertation was a qualitative study aimed to investigate the experiences of gestational surrogacy for gay men in Canada. The intention of this study was not to generalize but, rather, to enhance limited scholarship on surrogacy and gay fatherhood. The research sampling frame was unique in that surrogates and gay fathers were recruited to investigate their experiences of surrogacy, but to also discern the perspectives of matched surrogate triads.

Notwithstanding the importance of these findings, there are a number of limitations. As discussed in the introductory section of this dissertation, surrogacy has become a highly private and underground process due to ambiguous federal legislation. This has resulted in difficulties
with recruitment and engagement in research. To mitigate legal issues with respect to disclosure, I did not ask participants questions on financial compensation or medical reimbursements. The legal risks associated with this type of practice were delineated in the informed consent. Cautioning participants about the legality of this process may have influenced responses in terms of participants’ motivations to pursue surrogacy or shifts in the surrogacy relationship. However, this was an important step to help mitigate legal concerns for the researcher, the participants and the institutional research ethics board.

Moreover, as this was a small qualitative sample, participant demographics largely represent a homogeneous population. Gay fathers were predominantly white, lived in urban areas, and had high socioeconomic statuses and educational levels; this may be reflective of those who have the resources to access and use third-party reproduction. Surrogates, on the other hand, were white, tended to live in more rural settings and had lower socioeconomic statuses and levels of education when compared to gay fathers. Notably, the socioeconomic status (individual income) reported across gay father participants was more diverse than what has been shown in previous scholarly work. As commercial surrogacy is illegal in Canada and access to healthcare is covered under provincial insurance plans, this may explain, in part, some of the lower incomes documented among gay father participants.

Nevertheless, purposefully recruiting more diverse populations may help to delineate findings across socioeconomic status, race, ethnicity, immigration status and geographical location. Understanding diverse communities’ experiences of surrogacy and their access to reproductive care would be important to advance scholarship. Similarly, it may also be informative to understand the experiences of those who initially considered surrogacy but decided to pursue
another route to parent, those who had unsuccessful surrogacies (either the result of termination, miscarriage or stillbirth) and those who were unable to afford or access surrogacy. This may help to further elucidate barriers across third-party reproduction.

As signposted in the introduction section of this dissertation, this project looked at the experiences of cisgender gay men using surrogacy. Including the experiences of transgender men and women, as well as single gay men, is an important consideration for future research. Although single gay men were included in the recruitment strategy, all gay father participants were in relationships when they pursued surrogacy. Moreover, the perspectives of healthcare providers, consulting service agency directors, fertility clinic directors and policymakers, could build upon this study’s findings. Dialogues between service users, service providers and policymakers may help inform practices and policies to create a more streamlined surrogacy process. Heterosexual models of ARTs that have excluded gay men from parenting discourses may also be restructured to amalgamate gay activism and reproductive justice advocacy. Finding ways in which these two groups can unite may foster opportunities to collectively engage in resisting heteronormative discourses of procreation.

5.7 Ethical Research Considerations

The research ethics protocol was reviewed by the University of Toronto’s Health Sciences Research Ethics Board (as provided in the appendix). As a member of this board, I did not attend the full board meeting when my protocol was reviewed, I did not discuss my protocol with affiliates, and I did not seek reviewers’ feedback outside of the formal review process. Additionally, a member of my thesis committee (K.A.) joined the board after my protocol had already been reviewed and, at the time of writing this dissertation, is no longer a member. At
the time of recruitment, he also held a paid position at a fertility clinic in the province of Ontario. To mitigate any potential conflicts of interest, I chose not to recruit from this clinic. To further ensure the confidentiality of participants, he did not have any contact with potential participants. My committee was only provided with aggregated findings of the analysis in order to protect the confidentiality and anonymity of participants in this study.

This research study employed a three-arm qualitative research strategy with the intention to sample matched surrogate dyads/trimads. The ethical considerations of this sampling frame led to a specific recruitment strategy to seek informed consent. A section in the informed consent (as provided in the appendix) queried whether participants would be willing for the other party to be involved in the study (whether it be the intended parents or surrogate). If permission was granted, I then asked whether the participant(s) would like to contact the third party personally, or whether I could directly inquire about their interest in participating in the study. Offering a choice in how the third party may be contacted was purposeful to respect participants’ autonomy; it recognized that gay fathers and surrogates could make a joint uniform decision on what aspects of their surrogacy process they wished to disclose in the interview. Allowing participants to directly contact the other party helped to mitigate ethical concerns related to the disclosure of personal and potentially confidential information in the interviews. Having the opportunity to discuss the project together before participating was considered to facilitate an environment of trust, honesty and transparency.

Moreover, issues of disclosure, confidentiality and privacy regarding the surrogacy contract was elucidated in the informed consent. I suggested that surrogates and gay fathers not discuss or elaborate on aspects they perceived as confidential. In turn, issues related to financial
compensation (as discussed in the limitations section) were also explicated in the informed consent. If participants were concerned about potential legal risks or breaches of confidentiality, they were advised to use pseudonyms or remain anonymous; however, this would omit the possibility of withdrawal after the interview was conducted. No participants chose to remain anonymous during data collection and no participants withdrew from this study.

5.8 Implications

The following sub-sections will describe the implications of this dissertation for social work practice, education, research and policy, and implications for bioethics practice and scholarship.

5.8.1 Social Work Practice, Education and Research

Social workers employed in fertility clinics are often responsible for working with intended parents and surrogates to conduct psychological assessments/screenings, counseling and to facilitate joint discussions (Blyth, 1993; Koert & Daniluk, 2016; Shilo et al., 2016). Hospital social workers’ responsibilities post-birth may also include assisting intended parents to complete administrative documents and facilitating post-birth care. Owing to social workers’ active role in fertility care, it is critical that practitioners are knowledgeable regarding gay men’s reproductive options and aspects related to surrogacy (Burnett, 2006; Lev & Sennot, 2013; Shilo et al., 2016). This may include understanding the unique motivations of gay men to pursue surrogacy, prior encounters with discrimination on their route to parenthood, as well as legal stipulations that may create obstacles post-birth. Lev and Sennott (2013) suggest that “becoming parents for most LGBTQ people requires conscious preparation and complex decision making” (p. 231). Thus, it is a social worker’s responsibility to facilitate surrogacy
processes through the provision of ethically competent practice, with familiarity of inclusive and informative resources and support.

Accordingly, social workers’ self-reflexivity must be incorporated into their training and skill development (Shilo et al., 2016). Through the study’s findings, social workers were specifically identified as practitioners who held implicit and explicit biases against gay men. Allied health professionals must find ways in which to recognize, address and mitigate their own heteronormative assumptions. This research may help social workers become attuned to how their attitudes and biases influence their work as practitioners. For instance, in the current study, the use of ‘adoption’ language and unfamiliarity with administrative documents for same-sex couples were important limitations that created obstacles for gay fathers post-birth. Social workers must seek ways in which to provide competent, inclusive care that, furthermore, actively confronts normative procedures and policies in their organizations, clinics and hospitals (Greenfeld & Seli, 2011, 2013; Hicks, 2006; Hudak & Gimmattei, 2014; LaSala, 2013; Shilo et al., 2016). They must call attention to restrictions in guidelines and directives to promote institutional-level strategies for non-normative families. Social workers should position themselves as advocates for social and reproductive justice (Fronek & Crawshaw, 2015). In accordance with the values and ethics of the profession, social workers have a responsibility to identify reproductive opportunities for sexual minorities and support the development of healthcare practices and policies that promote inclusive and equitable fertility access (Palattiyil, Blyth, Sidhva, & Balakrishnan, 2010).

Additionally, social workers are often members of interdisciplinary teams comprising diverse healthcare professionals. Consequently, training opportunities, workshops and critical dialogues
should be encouraged across healthcare disciplines to advance the reproductive care of gay men (Berkowitz, 2013; Holley & Pasch, 2015; Oswald et al., 2009; Quinn et al., 2015). Such opportunities may help to create more equitable access to sexual minorities. Healthcare providers who work in the area of fertility care and assisted reproduction must identify, like social workers, their own *a priori* assumptions and biases regarding surrogacy and same-sex parent families (Roth, 2016a; Shilo et al., 2016). Healthcare environments must proactively restructure normative fertility practices and create physical spaces that are inclusive and welcoming to gay men (Heiden Rootes, 2013). This, according to Mamo, is a step towards “queering the fertility clinic” (Mamo, 2013, p. 227). Social workers, in particular, may play an important role in actively engendering change. The National Association of Social Workers (NASW) Code of Ethics states that “social workers pursue social change…[and] strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.” Thus, it is the individual responsibility, professional obligation and ethical duty for social workers to assist in repairing and renegotiating the exclusionary practices described by participants.

Moreover, Blyth (1993) proposes that training social workers on surrogacy pregnancies may also prove beneficial. Social workers may offer valuable therapeutic support, educational resources and supportive care for surrogates before, during and after the completion of surrogacy (Koert & Daniluk, 2016). This may be particularly salient after the relinquishment of the child and upon termination of their relationship with intended parents. As there are no standardized guidelines, directives or formal support programs for surrogacy counseling either in fertility clinics or hospitals, most service users seek supports informally online. These
findings may therefore help frame processes in fertility clinics and consider appropriate and relevant post-birth care of surrogates and intended parents.

As surrogates do not make these choices in a vacuum, they are often reliant on the involvement of their spouses and children (Jacobson, 2016), social workers ensure that issues have been raised among family members, particularly for the surrogate’s spouse and children. This may involve family therapy to help identify and communicate differing preferences and expectations. In turn, the practice of surrogacy may reshape family therapy (Few-Demo, Humble, Curran, & Lloyd, 2016; Heiden Rootes, 2013; Hudak & Gimmattei, 2014; LaSala, 2013; Shilo et al., 2016). Social workers, even beyond the field of reproduction, may encounter non-normative family structures. To work with diverse clients, couples and families, social workers must identify their own biases and assumptions through a process of self-reflexivity (Shilo et al., 2016). It is a social worker’s responsibility to provide ethically competent practice, and offer meaningful resources and support. For instance, if children are conceived via surrogacy, social workers might need to become attuned to issues of disclosure and concerns related to child-parent attachment, transitions to parenthood and micro-aggressions that may be encountered among same-sex parent families; counseling, both pre-and-post surrogacy, has been an important component in practice guidelines for third-party reproduction (ASRM, 2017; CFAS, 2009).

Hudak and Gimmattei (2014) describe a family therapy approach to challenge language conceptualizing ‘family’ as a heterosexual paradigm and stigmatizing non-heterosexual family structures. The authors propose to establish new concepts of the family to identify and recognize diverse family formations, and resist heteronormative discourses that have influenced
(and directed) family scholarship, education and therapy (Few-Demo et al., 2016; Hudak & Gimmattei, 2014). This new family therapy approach incorporates perspectives of same-sex families into teaching curricula; yet, it also endorses theoretical frameworks and empirical evidence-based practices that actively queer reproduction and support non-heterosexual approaches in scholarship and education. Within the current dissertation, I broaden this proposition to draw attention to family therapy discourses and practices that seek to guide engagement with gay (intended) fathers as well as the pursuit of third-party reproduction.

In turn, social work education courses that teach couples therapy and family practice might consider structured readings and in-class discussions that encourage students to contemplate how family therapy has shifted with the advent of new reproductive technologies and the emergence of same-sex parenthood (Shilo et al., 2016). It is necessary to afford future social work practitioners with tools, competencies and directives in which to approach the diversity of their practice and new family formations. Future practitioners must be equipped with the knowledge in which to challenge heteronormative and heterosexist individual and institutional levels of care. Without this specialized training and skill-set, social workers may become unknowingly complicit in perpetuating stigmatizing practices that negate and denigrate the experiences of same-sex headed families and their unique paths to parenthood.

My dissertation builds on previous theoretical scholarship that advocates for research to assume a new model of infertility and ART use. This study may reshape family scholarship to consider the procreative decisions of gay men and third-parties that have often been overlooked in empirical research. Surrogacy should no longer be interpreted as a last resort but, rather, as an intentional and meaningful choice that symbolizes gay men’s inclusive procreative right.
5.8.2 Implications for Policy

This dissertation explicates how Canada’s federal policies have impacted the practice of surrogacy for service users. Participants articulated their frustrations of the lack of oversight and indicated a need for accurate and relevant resources on surrogacy. In turn, participants advocated for changes to Canada’s federal legislation monitoring assisted reproduction. There was a repeated call to action to create a more transparent and streamlined process to facilitate the experience for future service users. This was specifically in reference to advancing guidelines on medical reimbursements, and developing official and accessible Canadian-specific information.

As the use of surrogacy continues to steadily rise in Canada, fertility clinic and hospital policies must effectively address the treatment and care of surrogacy pregnancies, and deliberate on how to appropriately involve the intended parents. For instance, the provision of educational tools and policy materials to service providers can promote knowledge of third-party reproduction and impart skills to address potential ethical and legal inquiries. Fertility clinics also need to consider ways in which to effectively disseminate information and actively work towards repairing discriminatory healthcare practices. Supports must also be in place to assist surrogates’ emotional and physical well-being post-birth. Institutional level changes in hospitals and fertility clinics are necessary to reflect the emergence of non-normative families; standards and directives of these organizations must be developed to meet surrogates’ needs, interests and experiences during labor, delivery and post-birth.

Although Canada legally recognizes same-sex parent families, these shifts in equal rights have not been reflected in practice. The empirical findings of this dissertation may facilitate
opportunities to encourage dialogue with policymakers, gay activists and reproductive justice allies to acknowledge the need for accessible information, regulated inclusive guidelines and knowledgeable healthcare providers. Institutional policies in hospitals and fertility clinics must reflect the growth of surrogacy in Canada. Standard healthcare procedures and policies can inform practitioners how to proactively create inclusive spaces that recognize gay men’s procreative decisions, and that resist exclusionary practices that have resulted in stigmatizing encounters and deleterious experiences for both surrogates and gay men.

This research may help to transform heteronormative policies that have restricted access to fertility care for both surrogates and gay men, and have afford opportunities to identify and address the increasing visibility of non-heterosexual families in Canada. Social workers, in particular, have a responsibility to resist sociopolitical and cultural contexts that have restricted access to fertility care and parenthood for gay men and have perpetuated stigma against surrogates’ reproductive decision-making. It is important to consider recommendations for procedures in hospitals and fertility clinics to help guide service users and service providers, and advocate for social and reproductive justice.

5.8.3 Implications for Bioethics

The ethical implications of gestational surrogacy have importantly been deliberated upon in theoretical scholarship. However, ethical discourses on surrogacy have largely been explored without reference to empirical research. Substantiated evidence is needed to enhance theory; a lack of scholarly work has limited the capacity in which to have informed ethical discussions. This dissertation, combined with future research, may importantly add an empirical analytical lens to understand and address the ethics of surrogacy for gay men in Canada.
Gestational surrogacy for gay men is an important issue in clinical ethics. Previous scholarship has suggested that gay men have often experienced hurdles in their access to care. They have reported negative clinical experiences and exclusionary physical environments (e.g., pamphlets, posters, demographic forms) (Marvel et al., 2016; Ross, et al., 2014). This has resulted in unwillingness among patients to disclose their sexual orientation, and has led to an expectation of bias and mistreatment from providers (Mollon, 2012). Fears of discrimination may lead individuals to avoid healthcare settings (Bare, Margolies, & Boehmer 2014; Krehely, 2009). Thus, emerging issues in clinical ethics ought to identify how to provide inclusive and relevant information, as well as to maintain active engagement to support sexual minorities interested in parenthood. Inclusivity encourages active welcoming environments that aim to not only promote inclusive language, relevant pamphlets and posters and safe spaces, but to also ensure equitable practices and policies that include sexual minority families.

The issue of surrogacy also raises questions regarding informed consent and reproductive risk. Many surrogates, for instance, felt as though they were not provided with sufficient information on perinatal risks, medications and delivery procedures. The limitations of the informed consent process for surrogates implies that clinicians may also “lack sufficient information to provide the full disclosure needed for truly informed choice” (Shanner & Nisker, 2001, p. 1590). Thus, transformations at both individual and institutional levels must identify practitioner competencies, inform organizational guidelines and standards, as well as develop legislative oversight for surrogacy processes in fertility clinics. For instance, the Canadian Fertility and Andrology Society (CFAS) released a 2016 statement on the guidelines for third party reproduction that “in addition to the elements of consent required by law...surrogates must sign consent forms outlining the process, risks and benefits of treatment(s). They must be informed
of and acknowledge their right to withdraw from treatment” (Havelock et al., 2016, p. 7). These recommendations may importantly help to protect healthcare providers and service users.

In general, debates in clinical ethics have deliberated upon the health of egg donors, perinatal outcomes of surrogates, risks to offspring(s) and resource allocation. Although these topics are beyond the scope of this dissertation, these are important conversations for future research. The practice of surrogacy is evolving and, as such, healthcare providers need to be mindful of ways in which to enhance ethical and proficient fertility care. Scholarship in general must continue to enhance surrogacy research to inform practice and policy. Queering bioethics scholarship means that discourses on the ethics of surrogacy include the perspectives of sexual minorities.

### 5.9 Considerations for Future Research

There are numerous areas in which to conduct further empirical scholarship on gay fatherhood and gestational surrogacy. A few important considerations may include: (1) the experiences, perspectives and needs of healthcare providers and allied health professionals working in fertility clinics or in hospitals that have managed surrogacy pregnancies; (2) the attitudes and perspectives towards gay men pursuing surrogacy (and gay fatherhood, in general) among healthcare providers and allied health care professionals (3) informed consent among gestational surrogates, and their health and mental health; and (4) the influence of online communities and media messaging on gestational surrogates’ decisions to pursue surrogacy.

An important future area of research may include consideration of a prospective cohort study, looking at the experiences of gay intended parents and gestational surrogates longitudinally, understanding shifts in the surrogate-intended parent relationship, the continued involvement of
the surrogate in the child’s birth story and gay men’s disclosure and coming-out processes to their offspring. Importantly, this type of study could follow families long-term to look at the well-being, mental health and relationships of three parties: (1) gestational surrogates, (2) intended parents, and (3) surrogate offspring. This may have important implications for future practice, education, research and policy.

Additionally, as this dissertation did not present on all themes explored across interviews, further research may consider the: (1) relationships between gestational surrogates and their spouses before, during and after pregnancy; (2) process of disclosing surrogacy to gestational surrogates’ children; and (3) surrogate-offspring relationship post-birth. Research projects may consider the perspectives of other marginalized communities, including: (1) transgender individuals and/or partners pursuing surrogacy and their encounters in healthcare systems, (2) single gay men, as well as (3) single or partnered bisexual men.

5.10 Concluding Remarks

The aim of this dissertation was to explore the use of surrogacy from the perspectives of gay men and gestational surrogates. The findings may ultimately help to advance queer bioethics. Defined by Wahlert and Fiester (2014), queer bioethics is “a methodology of scholastic, bioethical, and critical scrutiny that not only addresses the needs of LGBT persons in healthcare settings but also considers the perspectives, histories, and feelings of such parties” (S56). In turn, queer is utilized as a “verb…to employ a non-normative lens to what is taken to be standard and ordinary” (S57).
The implications of this dissertation span across social work, bioethics and medicine to advocate for the right to parent; gay men are entitled to equal and inclusive access to fertility care, assisted reproduction, as well as guidelines and procedures that accurately and essentially reflect the legal reality of same-sex parenthood (Wert et al., 2014). Queering ethical and empirical scholarship on fertility and procreation may help create novel approaches to biotechnologies and identify the emerging, life-transforming possibilities that ensue for women and gay men. As a result, further evidence-based research is necessary to inform understanding of these new approaches to reproduction, family and kinship.
Figure 1

A Conceptual Model of the Formation of Procreative Identities Before, During and After the Completion of Surrogacy for Gay Fathers and Gestational Surrogates

Social Context

Individual Motivations before Surrogacy
  Procreative Consciousness

Interpersonal Relationships during Surrogacy
  Procreative Responsibility

Pre-Pregnancy
  During Pregnancy
  Post-Birth

Institutional Practices after Surrogacy
  Procreative Transitioning

Gestational Parenthood
  Biological Parenthood
  Biological Parenthood

Social location
  Broadening & resisting
  Mirroring & enacting

Perceptions of relationship
  Frequency of contact
  Involvement of gay fathers

Government legislation
  Healthcare practices & policies
  Societal attitudes and resources
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Appendix A

Demographic Form Provided to Each Participant

ID (filled out by researcher):

Age:

Sex:

Sexual Orientation:

Ethnicity:

Race:

Religion:

Education (highest degree held):

Occupation:

Current Relationship Status:

Individual Income:

- Less than $40,000
- $40,000-$80,000
- $81,000–$120,000
- $121,000-$160,000
- $161,000-$200,000
- More than $200,000

Live in:

- Urban
- Rural
- Suburban

Total Number of Children in the Household:

  Number of children who are biological:
  Number of children who are non-biological to you (e.g., adopted):
Appendix B

Informed Consent for Gay Male Parents:

Sophia Fantus (Doctoral Candidate)
Factor-Inwentash Faculty of Social Work, University of Toronto
246 Bloor Street West, Toronto, ON M5S 1V4
sophia.fantus@mail.utoronto.ca

To Whom This May Concern,

My name is Sophia Fantus and I am a doctoral student at the University of Toronto Factor-Inwentash Faculty of Social Work. Under the supervision of Dr. Peter A. Newman, a professor in social work, I am conducting a research project looking at gestational surrogate arrangements among partnered gay men. I am interested in exploring the relationships that develop over the course of using gestational surrogacy between: a) you and your partner; and b) you and your surrogate. I am also interested in exploring the challenges and benefits of this practice. Due to the limited research in this area, my hope is that this study may lead to a more in-depth understanding of the reproductive choices of gay men, enhancing public knowledge and the accuracy of information provided to future service users.

Role as Participant:

Participation in this study is purely voluntary. If you agree to participate, you will: (1) fill out a short anonymous demographic form; and (2) take part in a 60-90 minute interview at a time and place that is confidential and convenient, such as at the Faculty of Social Work, University of Toronto. You may be asked to participate in a second interview if more information is needed or the interview was not able to be completed. All interviews will be audiotaped and transcribed.

Topics will include: (1) how you decided to become a parent and your thoughts about parenthood; (2) your expectations and experiences of using gestational surrogacy; and (3) how the process shaped the relationship between you and your partner, as well as with your surrogate.

You have the right not to answer questions, pause the interview, or stop the interview completely and reschedule. You also have the right to withdraw from the study without consequence. This means that you can stop the interview or contact me afterwards and all your data will be destroyed and omitted from future analysis. As you will be interviewed along with your partner, even if only one of you wishes to withdraw, this request will have to be respected and the complete interview will be omitted from data analysis. However, if data analysis has already begun, I cannot remove your information as it will be impossible to distinguish your responses. All data that is analyzed and published in any reports will remain anonymous and pseudonyms will be utilized. This means that you will not be personally identifiable.
Risks and Benefits:

By participating in this study, you are entitled to know of any risks and benefits that may impact your involvement in this study. Discussion around surrogacy and parenting can be sensitive and personal. You may feel uncomfortable during the interviews and various emotions may arise. All questions are voluntary and do not have to be answered. I will also have a list of referrals and support services that will be provided to you upon completion of the interview. You can contact these resources if you feel the need to speak to someone after the interview.

I am also aware that there are certain legal regulations in Canada with respect to commercialized surrogacy. Please note that I will not ask any questions related to financial reimbursement, monetary payment or legal parentage in your surrogacy arrangement and it is recommended that you not bring this up in the interview. These are completely confidential. If you are concerned with any legal risks, you can be interviewed using a pseudonym or choose to remain completely anonymous. However, in doing so, you will not be able to withdraw after the completion of the interview, as I will not know which data belongs to you. If there is any information that you and your surrogate agreed not to discuss, or you are uncertain they would want you to disclose, please keep this confidential.

There are no direct benefits to you participating in this study. This research can initiate an important conversation regarding the practice of surrogacy and its use among same-sex male partners. This research may enhance information on surrogacy and help inform effective practices, more directive guidelines and relevant resources, services and professional systems of support.

Confidentiality and Privacy:

All interviews will be audiotaped and transcribed verbatim and stored on an encrypted password-protected server. All names and organizations mentioned in the interviews will be omitted in the transcription. After transcription, all audio recordings of the interviews will be permanently deleted. All information will be de-linked, and you will be provided with a numerical code to protect your privacy. All hard copy data will be secured in a locked cabinet in my private office at the Faculty of Social Work and only accessible by the research team. All data analysis will be conducted on an encrypted password-protected computer at the Faculty of Social Work. Hard copy data will be kept for 7 years upon completion of this research project. After this time, all information will be destroyed in accordance with the guidelines of the Faculty of Social Work. Aggregated findings will be shared with the research team.

Results may be disseminated in presentations or publications. However, no identifying data will be presented in any reports. You will have the opportunity to check the transcript of your interview for accuracy and to receive an aggregated report of the research findings.

Withdrawal and Dissemination:

Please remember that this study is purely voluntary. You can withdraw at any time before data analysis. You may skip questions, pause the interview, or you may ask for the interview to be rescheduled. You also may skip or not answer questions on the demographic form. If you choose not to participate, this will in no way impact any services or health care you receive.
Please contact me if you would like to be provided with a research report of the findings and responses. No personal identifiable information will be in this report.

**Contacting Your Surrogate:**

As I am interested in exploring the emerging relationship between you and your surrogate, it would be important to involve your surrogate in this study. I would interview her one-on-one and ask her similar questions as I am asking you. I am, therefore, asking for your permission to contact your surrogate.

You would: (1) identify her; and (2) provide me (or her) with relevant contact information.

If she does agree to participate, the interview process will be similar to yours and all data attained will be treated with the same degree of confidentiality, privacy and anonymity that has been explained in this informed consent. In addition, I will not ask any information related to payment or for any information that she wants to keep confidential. All responses, both yours and hers, will not be shared with either party and will be stored securely in my office at the Factor Inwentash Faculty of Social Work.

If she does not agree to participate, all her information I received will be destroyed and omitted from any analysis or future publications.

Do you give me permission to contact your surrogate? YES ☐ NO ☐

Would you prefer to contact the surrogate directly? YES ☐ NO ☐

**General Contact Information:**

If you have any questions, please feel free to contact myself or the University of Toronto’s Office of Research Ethics. You can contact the Research Ethics Manager, Daniel Gyewu, at 416-946-3273 or ethics.review@utoronto.ca

**Questions:**

1. Would you like a copy of your transcript to review? YES ☐ NO ☐

2. Would you like to receive a copy of preliminary findings to provide feedback? YES ☐ NO ☐

3. Would you like a copy of the final research report? YES ☐ NO ☐
Summary:

I have read and understand all the information that was provided. I have been offered the opportunity to ask any questions regarding the study and have been given appropriate responses.

I am giving my consent to participate in this study and I understand all the potential risks and benefits involved. I understand that my participation is purely voluntary and that I may withdraw, without consequence, before data analysis. At the time of withdrawal, all my information will be destroyed and none of the information I disclosed will be included in analysis. I understand that all my information will be kept confidential within the Faculty of Social Work, in either locked cabinets or on an encrypted and password-protected computer.

If requested, I will be given a copy of the transcribed portion to check for accuracy, the themes that have emerged from the data before dissemination, as well as a copy of the final report.

Please sign and print your name with today’s date. This will confirm that you have agreed to participate in the study. In advance, we appreciate and thank you for your time. If you do have any questions, please ensure they are answered before signing the form.

________________________________________________________
Signature of Participant        Name of Participant (printed)  Date

________________________________________________________
Signature of Participant (if required)        Name of Participant (printed)  Date

________________________________________________________
Signature of Investigator        Name of Investigator (printed)  Date
Appendix C

Semi-Structured Interview Guide (gay men)

1. In thinking about parenthood, how did each of you come to the decision to have a child?
   a. What were factors that led up to this decision? Hindrances?
   b. Life-course trajectory?
   c. Social support networks?
   d. Values/beliefs about biogenetic parenthood?

1b) How did you come to the decision to have a child as partners?

2. In coming to this decision, how did you decide on surrogacy?
   a. What resources did you use to receive more information?
   b. How did you speak about this decision with friends and family and each other?

3. Were there any resources or support services you found particularly helpful or unhelpful in the planning stages?
   (e.g., fertility services, physicians, lawyers, support groups, friends, family)

4. Were there any services you would have liked to have access to but were either nonexistent or inaccessible?

5. What was your experience in finding a surrogate to carry your child?
   a. How did you find a surrogate? How did you select a donor egg?
   b. Through a network of friends? Acquaintances? Family?
   c. Did you utilize a fertility center? Family lawyer?
   d. Advantages? Disadvantages?

6. What were some of the factors that helped you decide on the surrogate? How did you come to select your surrogate? What was this experience like for you and your partner?

7. What were the planning stages like after you found a surrogate?
   a. Setting up a contract?
   b. Meeting the needs/expectations of the surrogate with your own expectations?
   c. Having a lawyer involved?

8. Can you tell me about the experience of planning the surrogate arrangement? What was the experience like as a couple?
9. How would you describe the contact and relationship you had with your surrogate at the beginning (e.g., contracting/donation/IVF/Pregnancy)? What was your experience of finding out your surrogate was pregnant?
   a. Reflect upon the frequency of contact and type of contact
   b. Reflect on the relationship: was there a sense of closeness? Attachment? Discomfort? Unease?
   c. Perceptions of the relationship

10. What do you think were some similarities and differences in how each of you connected with the surrogate?

11. How would you describe your contact and relationship with your surrogate over the course of the pregnancy, and once she became pregnant?
   a. How was it different or similar between the two of you?
   b. How would you describe the relationship?

12. How did your involvement in surrogacy and your relationship with the surrogate mother impact your own relationship?
   a. How were both of you involved in the arrangement?
   b. Can you describe your individual attachment and relationship to the surrogate?

13. Could you describe and reflect upon some of the challenges or benefits to your relationship during the process of surrogacy?

14. What was it like for the two of you after the birth of your child?
   a. How did you divide your parenting roles?
   b. Reflect upon your transition to parenthood
   c. How do you think the surrogate relationship impacted your relationship?

15. What was your relationship like with the surrogate after the birth of your child?
   a. Did you keep in touch with the surrogate?
   b. Is she still part of your lives or the life your child?

16. In looking back at your experiences, did you have any encounters with discrimination or stigma surrounding your choices?
   a. Either from the general population or from professionals
   b. What was your treatment like in fertility centers/lawyers/physicians?
   c. How did your family/network of friends influence the process?

17. Is there anything you wish you had known about surrogacy arrangements before making this decision? And, related to this, anything you would want future intended parents to know about as they work through the process?

18. Do you have anything else to add or any concluding thoughts?
Appendix D

Informed Consent for Surrogate:

Sophia Fantus (Doctoral Candidate)
Factor-Inwentash Faculty of Social Work, University of Toronto
246 Bloor Street West, Toronto, ON M5S 1V4
sophia.fantus@mail.utoronto.ca

To Whom This May Concern,

My name is Sophia Fantus and I am a doctoral student at the University of Toronto Factor-Inwentash Faculty of Social Work. Under the supervision of Dr. Peter A. Newman, a professor in social work, I am conducting a research project looking at gestational surrogate arrangements among partnered gay men. I am interested in exploring the relationships that develop with the intended parents over the course of being a gestational surrogate. I am also interested in exploring both the challenges and benefits of the process. Due to the limited research in this area, my hope is that this study may lead to a more in-depth understanding of surrogacy, reproduction and third-party arrangements to enhance public knowledge and the accuracy of information provided to future surrogate mothers.

Role as Participant:

Participation in this study is purely voluntary. If you agree to participate, you will: (1) fill out a short anonymous demographic form; and (2) take part in a 60-90 minute one-on-one interview at a time and place that is confidential and convenient for you, such as at the Faculty of Social Work, University of Toronto. All interviews will be audiotaped and transcribed. You may be asked to participate in a second interview if more information is needed or the interview was not able to be completed.

Some questions you will be asked about include: (1) how you decided to become a surrogate and reflections surrounding this decision; (2) your expectations and experiences of the surrogate process; and (3) how the arrangement shaped your relationship with the intended parents. If you do have a partner (or had one while being a surrogate) some questions may revolve how becoming a surrogate mother impacted your relationship with your partner.

During the interview, you have the right not to answer questions, pause the interview, or stop the interview completely and reschedule. You also have the right to withdraw from the study without consequence. This means that you can stop the interview, or contact me afterwards, and all your data will be destroyed and omitted from future data analysis. However, if data analysis has already begun, I cannot remove your information as I will not know which data belongs to you. All data that is analyzed and published in any reports will remain anonymous and pseudonyms will be utilized. This means that you will not be personally identifiable.

Risks and Benefits:

By participating in this study, you are entitled to know of any risks and benefits that may impact your involvement in this study. Discussion around surrogacy and parenting can be
sensitive and personal. You may feel uncomfortable during the interviews and various emotions may arise. All questions are voluntary and do not have to be answered. I will also have a list of referrals and support services that will be provided to you upon completion of the interview. You can contact these referrals if you feel the need to speak to someone after the interview.

Additionally, I am aware that there are certain legal regulations in Canada with respect to commercialized surrogacy. Please note that I will not ask any questions related to financial reimbursement or monetary payment in your surrogacy arrangement. These are completely confidential. It is recommended that you do not bring this up in the interview. Also, if there are any agreements between you and the intended parents about things you may have agreed not to discuss, or if you are uncertain whether they would want you to disclose, I advise you to not talk about this in the interview. If you are concerned with any legal risks, you can be interviewed using a pseudonym or choose to remain completely anonymous. However, in doing so, you will not be able to withdraw after the completion of the interview.

There are no direct benefits to you participating in this study. This research can initiate an important conversation regarding the practice of surrogacy. This research may enhance information regarding surrogacy and help inform effective practices, more directive guidelines and relevant resources, services and systems of support.

Confidentiality and Privacy:

All interviews will be audiotaped and transcribed verbatim on an encrypted password-protected server. All names and organizations mentioned in the interviews will be omitted in transcription. After transcription, all audio recordings of the interviews will be permanently deleted. All information will be de-linked, and you will be provided with a numerical code to protect your privacy. All hard copy data will be secured in a locked cabinet in my private office at the Faculty of Social Work and only accessible by the research team. All data analysis will be conducted on an encrypted password-protected computer at the Faculty of Social Work. Hard copy data will be kept for 7 years upon completion of this research project. After this time, all information will be destroyed in accordance with the guidelines of the Faculty of Social Work.

Results may be disseminated in presentations or publications. However, no identifying data will be in any reports. You will have the opportunity to check the transcript of your interview for accuracy and to receive an aggregated report of the research findings. Aggregated findings will be shared with my research team.

Withdrawal and Dissemination:

Please remember that this study is purely voluntary. You can withdraw at any time as you complete the interview and up until data analysis. You may skip questions, pause the interview, or you may ask for the interview to be rescheduled. You may also choose to skip or not answer questions on the demographic form. If you choose not to participate, this will in no way impact any services or health care you receive.

Please contact me if you would like to be provided with a research report of the findings and responses. No personal identifiable information will be in this report.
Contacting the Gay Male Parents:

As I am interested in exploring the emerging relationship between you and the gay fathers, it would be important to involve the gay male partners you were a surrogate to in this study. I would interview them as a couple and ask them similar questions as I am asking you. I am, therefore, asking for your permission to contact the gay male partners. You would: (1) identify them; and (2) provide me (or them) with relevant contact information.

If they do agree to participate, the interview process will be similar to yours and all data attained will be treated with the same degree of confidentiality, privacy and anonymity that has been explained in this informed consent. In addition, I will not ask any information related to payment or any information that they would like to keep confidential. All responses, both yours and theirs, will not be shared with either party and will be stored securely in my office at the Factor Inwentash Faculty of Social Work.

If they do not agree to participate, all their information I received will be destroyed and omitted from any analysis or future publications.

Do you give me permission to contact the third party? YES ☐ NO ☐

Would you prefer to contact the third party directly? YES ☐ NO ☐

Contact Information:

If you have any questions, please feel free to contact myself or the University of Toronto’s Office of Research Ethics. You can contact the Research Ethics Manager, Daniel Gyewu, at 416-946-3273 or ethics.review@utoronto.ca

Questions:

(1) Would you like a copy of your transcript to review? YES ☐ NO ☐

(2) Would you like to receive a copy of preliminary findings to provide feedback? YES ☐ NO ☐

(3) Would you like a copy of the final research report? YES ☐ NO ☐
Summary:

I have read and understand all the information that was provided within this document. I have been offered the opportunity to ask any questions regarding the study and have been provided with the additional information I wished to receive.

I am giving my consent to participate in this study and I understand all the potential risks and benefits involved. I understand that my participation is purely voluntary and that I may withdraw, without consequence, before data analysis. At time of withdrawal, all my information will be destroyed and none of the information I disclosed will be included in analysis. I understand that all my information will be kept confidential within the Faculty of Social Work, in either locked cabinets or on an encrypted and password-protected computer.

If requested, I will be given a copy of the transcribed portion to check for accuracy, the themes that have emerged from the data before dissemination, as well as a copy of the final report.

Please sign and print your name with today’s date. This will confirm that you have agreed to participate in the study. In advance, we appreciate and thank you for your time. If you do have any questions, please ensure they are answered before signing the form.

________________________________________
Signature of Participant            Name of Participant (printed)            Date

________________________________________
Signature of Investigator           Name of Investigator (printed)           Date
Appendix E

Semi-Structured Interview Guide (surrogate)

1. How did you come to the decision to become a surrogate mother?
   a. What were factors that led up to this decision?
   b. Life-course trajectory?
   c. Social support networks?
   d. Values/beliefs about biogenetic parenthood?

2. In coming to this decision, how did you plan to become a surrogate?
   a. What resources did you use to receive more information about the process?
   b. How did you speak about this decision with friends and family.

3. Were there any resources or support services you found particularly helpful or unhelpful in the planning stages?
   (e.g., fertility services, physicians, lawyers, support groups, friends, family)

4. Were there any services you would have liked to have access to but were either non-existent or inaccessible?

5. What was your experience like of meeting the intended parents and how did you choose to become a surrogate specifically for gay men?
   a. How did you find them?
   b. Through a network of friends? Acquaintances? Family?
   c. Did you utilize a fertility center? Family lawyer?

6. What were some of the factors that helped you select the intended parents you worked with?

7. What were the planning stages like after you made this decision?
   a. Setting up a contract?
   b. Meeting the needs/expectations of the surrogate with your own expectations?
   c. Having a lawyer involved?

8. How did you make sure your needs and expectations were heard by the intended parents? And, if you do have a partner, how did he or she play a role in this preliminary process?

9. How would you describe the contact and relationship you had with the intended parents at the beginning (e.g., contracting/donation/IVF/Pregnancy)? What was the experience like when you found out you were pregnant?
   a. Reflect upon the frequency of contact and type of contact
   b. Reflect on the relationship: was there a sense of closeness? Attachment? Discomfort? Unease?
   c. Perception of the relationship
10. Can you tell me about your contact and relationship with the intended parents over the course of your pregnancy?

11. If you are in a partnership, how do you think the relationship you had with the intended parents influenced your intimate relationship at all?  
   a. Were there arguments or disagreements during the process?  
   b. Was there a sense of detachment? Or conflict?

12. What was it like for you after the birth? What was it like for you to give the child to the intended parents? What was it like terminating the contract (not necessarily the relationship)?

13. What was your relationship with the intended parents after the birth?  
   a. How did you choose whether to maintain contact or not? Frequency of contact?  
   b. Perception of relationship/Involvement  
   c. What was that experience like?

14. In looking back at your experiences, did you have any encounters with discrimination or stigma surrounding your choices?  
   a. What was your treatment like in fertility centers/lawyers/physicians?  
   b. How did your family/network of friends influence the process?

15. Is there anything you wish you had known about surrogacy arrangements and the process before you entered into the agreement? And, related to this, anything you would want future surrogate mothers to know about as they work through the process?

16. Do you have anything else to add or any concluding thoughts?
Appendix F: Original Research Ethics Approval Letter

PROTOCOL REFERENCE # 30673

October 2, 2014

Dr. Peter Newman
FACULTY OF SOCIAL WORK

Ms. Sophia Fantus
FACULTY OF SOCIAL WORK

Dear Dr. Newman and Ms. Sophia Fantus,

Re: Your research protocol entitled, "The practice of surrogacy in the Canadian context: Understanding the experiences of same-sex male couples and surrogate mothers in the Province of Ontario"

ETHICS APPROVAL

Original Approval Date: October 2, 2014
Expiry Date: October 1, 2015
Continuing Review Level: 2

We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to the above-named research protocol, for a period of one year. Ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Elizabeth Peter, Ph.D.
REB Chair

Daniel Gyewu
REB Manager

OFFICE OF RESEARCH ETHICS
McMichael Building, 12 Queen’s Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3270 • Fax: +1 416 946-5783 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/research-administrators/ethics/
Appendix G: Research Ethics Amendment Approval Letter

UNIVERSITY OF TORONTO

PROTOCOL REFERENCE # 30673

June 12, 2015

Dr. Peter Newman
FACULTY OF SOCIAL WORK

Ms. Sophia Fantus
FACULTY OF SOCIAL WORK

Dear Dr. Newman and Ms. Sophia Fantus,

Re: Your research protocol entitled, “The practice of surrogacy in the Canadian context: Understanding the experiences of gay fathers and surrogates across Canada”

We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to an amendment (Received May 22, 2015) to the above-referenced research protocol under the REB full board review process. This amendment approval letter only applies to what was outlined in the request form under section 5.a) or otherwise marked in the revised protocol.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.

Best wishes for the successful completion of your research.

Yours sincerely,

Elizabeth Peter, Ph.D.
REB Chair

Daniel Gyewu
REB Manager
Appendix H: Annual Renewal Ethics Approval Letter

PROTOCOL REFERENCE # 30673
October 2, 2015

Dr. Peter Newman
FACULTY OF SOCIAL WORK

Ms. Sophia Fantus
FACULTY OF SOCIAL WORK

Dear Dr. Newman and Ms. Sophia Fantus,

Re: Your research protocol entitled, “The practice of surrogacy in the Canadian context: Understanding the experiences of gay fathers and surrogates across Canada”

We are writing to advise you that you have been granted annual renewal of ethics approval to the above-referenced research protocol through the Research Ethics Board (REB) delegated process. Please note that all protocols involving ongoing data collection or interaction with human participants are subject to re-evaluation after 5 years. Ongoing research under this protocol must be renewed prior to the expiry date.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your protocol. Note that annual renewals for protocols cannot be accepted more than 30 days prior to the date of expiry as per our guidelines.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible. If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Elizabeth Peter, Ph.D.
REB Chair

Daniel Gyewu
REB Manager

OFFICE OF RESEARCH ETHICS
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Tel: +1 416 946-3273 ● Fax: +1 416 946-5763 ● ethics.review@utoronto.ca ● http://www.research.utoronto.ca/for-researchers-administrators/ethics/
Appendix I: Confirmation of Study Completion Report for Research Ethics Board

PROTOCOL REFERENCE # 30673

September 21, 2016

Dr. Peter Newman       Ms. Sophia Fantus
FACULTY OF SOCIAL WORK  FACULTY OF SOCIAL WORK

Dear Dr. Newman and Ms. Sophia Fantus,

Thank you for submitting the study completion for the protocol entitled “The practice of surrogacy in the Canadian context: Understanding the experiences of gay fathers and surrogates across Canada”. Your file is now officially complete as per Tri-Council Policy Statement guidelines and you are therefore not to engage in the research activities contemplated under the protocol. If appropriate, you may spend any remaining research funding on eligible non-protocol related activities.

Congratulations on the completion of your study, and thank you for taking care to observe the process and standards of ethics review.

Office of Research Ethics