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Building Our Families: Navigating Barriers in 2SLGBTQ+ Family Building Through Doula Supports

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Abstract

Queer and transgender individuals often encounter barriers when attempting to build their families. Beginning by identifying barriers that 2SLGBTQ+ people face in their fertility and reproductive journeys—including limited access to information, inadequate diversity in donor gametes, and minority stress—this article looks to the role of doulas in mitigating challenges by providing critical and tailored support, educational resources, and support and advocacy in navigating medical systems. Using a reproductive justice and intersectional framework, the article highlights the need for inclusive care practices that address the historical and ongoing exclusion of marginalized 2SLGBTQ+ communities. It underscores the importance of improved training for healthcare providers and systemic changes to ensure equitable family-building experiences for 2SLGBTQ+ individuals. By integrating community supports and peer advocacy, the article proposes strategies to enhance both the physical and mental health outcomes of 2SLGBTQ+ intended parents and their families. It calls for a comprehensive approach that combines professional training, systemic reform, and community-based initiatives to create a more inclusive and supportive environment for family-building among 2SLGBTQ+ individuals.

Queer and transgender people trying to build their families by and large report negative experiences with the medical industrial complex (Abra et al. 2015; Tam 2021; Kirubarajan et al. 2021b; Permezel et al. 2022). For those who identify as Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (2SLGBTQ+) a lack of access to information and transparency, additional layers of stress due to their oppression and intersecting inequities, and inadequate diversity in available donor gametes, are among some of the biggest barriers to satisfaction and inclusivity for those who identify as 2SLGBTQ+ intended parents. With limited in-person and virtual education available for 2SLGBTQ+ parents, many do not know where to begin their journeys or who to reach out to with questions (Gregory et al. 2022; Andalibi et al. 2022). Even when basic technical procedures and logistical questions can be answered by peers in online forums or available literature, there is a lack of available information on the politics and barriers specific to 2SLGBTQ+ family building, especially for those who encounter multiple forms of oppression due to race or settler colonialism (Dwyer 2018). While these obstacles currently shape early experiences of pregnancy and parenting for 2SLGBTQ+ community members, there are diverse strategies to support improved care for queer and transgender families, founded in community supports, advocacy, and education from both care providers and peer groups (Andalibi et al. 2022; Yam and Fixmer-Oraiz 2023; Tam 2021).

Importantly, in considering both the barriers and strategies for improved 2SLGBTQ+ family building in Canada, this article utilizes reproductive justice and an intersectional approach as a framework for analysis, understanding that access to care and expectations of oppression cannot be explored without an explicit consideration of the histories of exclusion, sterilization, and labour evacuations that shape both the physical and mental health of Indigenous and marginalized peoples in Canada (Choudhury 2016; Ross 2018; Mietana, Thompson, and Twine 2018). Making support and advocacy for individuals, families, and communities meaningful, means reproductive justice must also integrate decolonial, racial, disability, and class justice among other areas of intersectional awareness.

There is a lack of data on the intersectional experiences of 2SLGBTQ+ fertility and family building experiences, particularly in relation to race, immigration, and indigeneity (Tam 2021; Kirubarajan et al. 2021a; Twine and Smietana 2022.). However, data on broader populations of racialized and ethnic minorities demonstrate the ways in which these identity markers and experiences shape fertility and reproductive health (Gill et al. 2019). We cannot understand how the medical industrial complex operates for 2SLBGTQ+ people without an intersectional approach to care and wellbeing and a consideration of the distinct ways the politics of identity, place, and space shape experience and access of family building and reproductive healthcare.

In this article, I begin by briefly defining the role of the doula in the perinatal journey to provide a framework for understanding their interventions in 2SLGBTQ+ care. I then move to identify key barriers for 2SLGBTQ+ people trying to conceive in Canada. Based on my work as a Fertility Support Practitioner and Full-spectrum Doula, I end by considering the cultural impact of doula care on 2SLGBTQ+ fertility and reproductive experiences. Here, I outline recommendations and strategies for improved care, focusing on how services provided during the early stages of family building can offer support, information, and advocacy that impacts both physical and mental health of intended parents and their families.

Doula Care and The Impact of 2SLGBTQ+ Community Resources

The term doula is derived from the ancient Greek word for woman slave or servant, but popular usage of the word has developed to describe a support worker focusing on providing support, resources, education, and advocacy across multiple milestones and life transitionary periods. Doula services range across a broad-spectrum including abortion, grief, menopause, and death in addition to other times when individuals may need emotional and physical relief. These are all becoming more popular services, though labour and postpartum remain the most common roles. The importance of doula care during labour and postpartum periods have been well documented (Kozhimannil et al. 2016; Ramey-Collier et al. 2023; Falconi 2022; Yam et al. 2023). Research shows that doula support during pregnancy helps to reduce health disparities and inequities, particularly for Black parents and parents who are

from socioeconomically vulnerable and marginalized minority populations, creating important links between doula care and reproductive justice (Chinkam et al. 2023). Doulas also decrease unwanted caesarean delivery, decrease preterm birth, and decrease low birth weight (Ramey-Collier et al. 2023; Falconi 2022; Kozhimannil et al. 2016; Fortier and Goodwin 2015). Evidence supporting the doula's role in advocacy and equity access make the profession and integration of doula care essential to conversations around education, advocacy, and access.

Importantly, the doula profession is unregulated, with some associations and training centres providing certification and formal requirements and other individuals working independently with little formal training (Fortier and Goodwin 2015). Doula associations and training may offer some benefits (liability insurance, formal education, community of colleagues), but may also be cost prohibitive and privilege those with greater financial means. Critiques of white privilege and appropriation have also been lodged against major doula training centres both in the USA and Canada (see for example the open letter written by Doula Support Foundation, 2021). While services provided have a marked benefit to outcomes for intended parents, it is important that the profession is not romanticized, and that training and professional associations are held accountable to continue professional development and ongoing equity initiatives.

A family building or fertility doula's role varies based on the client-needs and experiences. While unregulated and diverse in their training and offerings, doulas provide care in navigating circumstances that are often opaque, confusing, or scary. I discuss the role of the family building doula in subsequent sections of this paper, considering how they respond to the gap in literature and support for 2SLGBTQ+ community members seeking family building care.

Reproducing Inequities: 2SLGBTQ+ Barriers in Family Building

There are several exclusionary processes and procedures in fertility and family building care for 2SLGBTQ+ people, which shape the experiences of both parents and their offspring. A lack of transparency in protocols, pricing, and interpretations and implementations of provincial regulations in Canada are ongoing obstacles to

achieving equitable care in the Canadian context (Ross et al. 2006; James-Abra et al. 2015; Marvel et al. 2016; Tam 2021; Kirubarajan et al. 2021b). Individuals beginning their journey often do not know the questions to ask (or who to ask them to). They may not have readily available access to their rights, options for procedures, or knowledgeable medical professionals to answer their questions (Gregory et al. 2022).

Kirubarajan et al. (2021b) note that in their review of literature, several studies indicate insufficiently tailored information for same-sex couples and nonbinary patients, resulting in poor fertility literacy and a lack of awareness about available routes for family building. In a state of vulnerability, with no clear answers to their questions, queer and transgender patients weigh the positive impacts of advocating for their needs up against the labour and energy needed to do so. For transgender intended parents, advocating for transparency and equity may provide both a sense of empowerment and exhaustion - with James-Abra et al. (2015) noting that their survey responses ranged from 'purposeful avoidance of confrontation' to strong endorsement of self-advocacy (6).

Trying to build your family can be an anxiety provoking and difficult process for any family or individual. The focus on how our physical bodies function and what they can and cannot readily produce can trigger feelings of helplessness, anxiety, and confusion, and necessitate a new vocabulary and education on hormones, ovulation, sperm production and mobility, fertilization, and implantation. For queer and transgender families, these experiences are exacerbated, emphasizing our divergence from heteronormative expectations and differences from mainstream Western cisgender norms. Indeed, individuals without gametes (sperm and eggs) available, who choose to enter a fertility clinic to conceive, may be diagnosed with 'biological infertility' or 'social infertility' before any diagnostic testing is even performed. Equating the lack of gametes to an 'infertility' diagnosis – which according to the World Health Organization is a disease 'defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse' – can contribute to the medicalization of 2SLGBTQ+ identities and a lack of personalized care in treatment protocols which assume interventions are a necessary first step.

In addition to an assumption of infertility, when consulting with clinics, 2SLGBTQ+ patients report frustration with a lack of consistency and transparency in billing and costs (Ross et al. 2006; Marshall 2021). While every province in Canada has a distinct funding structure for fertility treatment (or lack thereof), there is not centralized space for 2SLGBTQ+ people to learn about what funding is available for them or how long they must wait to receive it. The failure to provide transparent and clear information on wait times and costs is in part due to a lack of standardization and legislation. In provinces like Ontario, where provincial healthcare covers one round of IVF (excluding medication, donor gametes, and embryo testing), there is no standardized method for prioritizing patients. As Michelle Tam (2021) notes, this has resulted in 'a two-tiered system' where people with funds can access care more quickly or choose to utilize funding when it is available. Policies pertaining to funding for IVF across provinces become even less clear when a family opts for reciprocal IVF (where one parent's eggs are retrieved and transferred into another parent's uterus). Clinics have diverse interpretations of provincial policies for distributing funds, when the second partner wants to use their funding for a subsequent cycle.

Additionally, while intrauterine inseminations (IUI) are covered by Ontario healthcare, clinics may have added fees that are not listed or shared with patients prior to their consultations, such as a 'processing fee,' which can range anywhere from $400-$750 per cycle – in addition to medication costs. Many individuals pursuing family building are initially unaware of the costs associated with assisted reproduction in Canada. Patients note that unanticipated fees, not covered by provincial healthcare, at times necessitate that they stop their fertility protocols entirely (Gregory et al. 2022). The costs of processing, storage, or washing are all at the clinic's discretion and rarely mentioned in the initial stages of consultations with a clinic. As Tam (2021) notes, 'The majority of fertility clinics in Ontario are privatized with no overarching provincial legislation or standardization to govern the practice or fees associated' (3), making it difficult to assess how funds are distributed within and across Canada, who has access to them, or even how to properly budget for your care. While Gregory et al. (2022) note improved care over the last two decades for 2SLGBTQ+ family building, their participants nonetheless continue to

call for more transparency and clarity in potential costs, processes for obtaining gametes, and explicit guides for how to navigate the process.

Finally, laws around known donor gametes changed in Canada in February 2020, with the introduction of the Safety of Sperm and Ova Regulations Act (Canada Legislative Service 2023). While the laws are now more open and inclusive, clinics often fail to provide information online or in the initial consultations on how they are implementing regulations, or if they can accommodate direct donations at all (i.e. using sperm directly from someone a patient knows). Additionally, while the new regulations provide extended eligibility for known or direct donors, they continue to exhibit homophobic and discriminatory practices against men who have sex with men. The Health Canada directive in the Safety of Sperm and Ova Regulations Act bans men who have sex with men from donating sperm to a sperm bank unless they have abstained from sexual intercourse with a man for at least three months prior to donation or are providing a direct donation to someone they know.

What to Expect When You're Expecting Oppression: Minority Stress & Its Impacts

Another significant barrier in the 2SLGBTQ+ family building journey is the impact of inequities, oppression, and minority stress on 2SLGBTQ+ individuals. While not all minoritized individuals experience minority stress (and while care providers should not assume the presence of undue stress and anxiety in patients simply because they are 2SLGBTQ+), I focus here on the impact of minority stress because of the increased risk 2SLGBTQ+ community members experience due to discrimination and heteronormativity in reproductive care environments. Taking an intersectional approach to minority stress theory, Siegal et al. (2022) note that 2SLGBTQ+ parents experience unique stressors including fear of rejection and concealment of family structures. They further explain that minority stress causes psychological impacts—such as emotional dysregulation, social and interpersonal problems and depression, anxiety, and other adverse mental health outcomes – as well as neurobiological impacts which can mirror those found in people who experience PTSD and stress-related disorders. Micro- and macroaggressions such as incorrect names or pronouns, forms that do not provide the options for a family structure, or the absence of images

of similar families in print or digital materials can create a stress response that shapes our expectations and experiences in a medical environment. While not shaping all 2SLGBTQ+ family building experiences, we know that stressors like stigma and discrimination can affect physical health (Minturn et al. 2021).

Studies in Canada demonstrate the impact of discrimination on health disparities: 'as a result of social stigma and discrimination, LGBT2SQ people report higher rates of depression, anxiety and mental health challenges,' including higher rates of suicide, mental and emotional distress, and alcohol and drug use (Rainbow Health Ontario 2020, 7). The impact of such stress emerges from both distal and proximal stressors – meaning the impacts are not only a result of what has occurred or a singular traumatic incident, but also the anticipation or fear of oppression or discrimination (Dorri and Russell 2022). These stressors are experienced by marginalized populations who anticipate experiences of oppression, anxiety, or exclusion based on historical and/or personal histories. While someone might not have experienced stressors firsthand, the knowledge that others in their population have experienced these hardships in and of itself have potential mental and physical impacts on individuals and families.

In their survey of studies on 2SLGBTQ+ perinatal mental health, Abirami Kirubarajan et al. (2022) found that all 26 studies reviewed identified multiple complex mental health challenges during the perinatal period for 2SLGBTQ+ childbearing individuals. They explain that while these challenges were evident, participants in the studies explained that there was frequently pressure to appear to be positive and optimistic. Indeed, two studies noted that stigma and fear of discrimination resulted in a reluctance to pursue mental health diagnosis or support (Kirubarajan et al. 2022).

The impact of perinatal experience on mental health and wellbeing affects not only birthing and gestational parents, but also non-gestational parents who often have fewer resources and supports than birthing parents (Howat, Masterson, and Darwin 2023; Shenkman et al. 2022). For example, lesbian and bi-sexual women report experiences of exclusion and a lack of acknowledgement of non-gestational parents' grief and stress (Peel 2010). There are some supports online for heterosexual fathers who are experiencing stress and mental health struggles related to pregnancy, loss,

and parenting. However, there are currently no supports available online in Canada to support grief and loss of non-gestational parents who do not fit into the category of 'father.' The lack of these particular supports means that these parents are often in groups with fathers whose experiences may not reflect their own. It is not simply intended parents whose experiences are shaped by these stressors in the family building journey, but potentially their offspring as well. Siegal et al. (2022) explain: 'children in LGBTQ+ parent families might be directly impacted by minority stress they experience themselves as well as indirectly through minority stress that their parents experience' (4). The anticipation of stress has been shown to have a marked impact on experiences of navigating family building and parenting for 2SLBGTQ+ people, as well as their offspring (Gates 2015; Dorri and Russell 2022).

Importantly 2SLGBTQ+ minority stress is exacerbated by other social markers and experiences of marginalization. In Gato, Santos, and Fontaine's (2017) review of recent studies on minority stress in relation to queer and transgender parenting they note that racialized and ethnic groups, 'experience significantly more stress, in part due to prejudice-specific stress, than do their white counterparts' (314). Considering not only the impact of experiences of discrimination, but the expectations of oppression in 2SLGBTQ+ family building journeys, provides insight into mechanisms that would remedy current inequities and improve access to information and care.

Discussing minority stress in fertility care is not a means to argue that healthcare providers should assume a universal experience of mental distress, anxiety, or depression in 2SLGBTQ+ community members or their offspring. Only through individualized care and dialogue can we learn about an individual's needs. Rather, discussions of minority stress in these fertility and family building experiences point to how heteronormative environments and expectations shape social determinants of health and the need for small scale and systemic shifts in inclusion and equity practices. In considering barriers to fertility and family building care, mental health and proximal stressors shape 2SLGBTQ+ journeys from pre-conception through to parenthood. It is essential that supports are provided, and that healthcare, mental health, and community resources are in place to remedy inequities and oppression that lead to higher health disparities in minority populations.

Building Our Families: Lack of Diversity in Donor Gametes

While family building presents challenges to all 2SLGBTQ+ individuals, white privilege, access, and inequitable distribution of care produce uneven experiences of inclusion for those with race privilege (Smith 2022). Marvel et al. (2016) note that options for donor gametes (sperm and eggs) are limited for People of the Global Majority (people who are racialized, Black, Indigenous, and people of colour) who are looking to use sperm or eggs from ethnicities similar to their own (413). At the time of writing this article, only one Black donor was available on the Canadian Origin sperm bank and of the 84 Canadian compliant donors on the American donor catalogue Fairfax Cryobank, only three Black donors were available. Abbie E. Goldberg (2022) explains that, 'LBQ women who seek sperm donors of color, and particularly Black sperm donors, encounter a dearth of options from commercial sperm banks, whose donors tend to be disproportionately White' (2). There are several reasons this could be the case and further directed studies are needed to survey justifications for a dearth of diversity in gametes. Taking a reproductive justice lens to understanding the lack of gametes available for anonymous or open ID donors at clinics means exploring the intersections of identity and oppression that shape our expectations and confidence in a healthcare system that inequitably attends to the needs of people of diverse experiences and identities. Indeed, the lack of diversity in donor gametes available in Canada cannot be isolated from other barriers and oppressions in the medical industrial complex.

Donating gametes in Canada are unique from other countries (namely the USA), as donors cannot be compensated for their donation. Donors must undergo a series of physical and mental health assessments over the course of six months to a year and have ongoing periodic follow-ups for as long as their gametes remain available. The process necessitates not only the privilege of 'free' time to attend medical appointments and testing, but also a confidence in the medical industrial complex and healthcare providers that is founded in experiences and expectations of respect, care, and equity. A lack of diverse donor gametes may be related to experiences of poverty, lack of time for appointments, inability to travel to a clinic, or lack of confidence in

care. In Canada, even though there is universal healthcare, patients with low income have lower rates of visiting healthcare specialists (Akuffo-Addo et al. 2023).

Sterilization and other discriminatory reproductive processes are not only common in Canadian history, but also our present practices and norms. Tam notes that, 'Legislated and non-legislated coerced sterilizations were and are currently used as a form of mass birth control for Black, Indigenous, and people of colour, as well as LGBTQ2SIA+ people' (2). Indeed, 'forced sterilization, abusive abortions, or the promotion of birth control for population control ends,' have historically shaped Indigenous people's experiences of reproductive health (Stote 2017, 112). Forced or coercive sterilization and aggressive assimilation policies are present in a not-so-distant past in Canada and continue to shape our healthcare system (Stote 2017). For example, Canada's birth evacuation policy, founded on settler colonial obstetric violence which began in the 1800s and implemented in its current form in the 1960s, requires all Indigenous pregnant people living on rural and remote reserves to evacuate their home communities between 36 to 38 weeks pregnancy and travel to urban centres prior to birth – often with no community members, family, or supports present. As Cidro et al. (2020) note: 'Indigenous women's reproduction was subjected to medicalization throughout the mid-twentieth century, wherein a main assimilationist goal was to transform the culture of childbirth' (175). Investigations into the lack of donor gametes available in Canada-compliant banks from Indigenous populations must seriously consider how ongoing inequities influence the voluntary decision to donate.

With up to 48% of Indigenous women living in remote or rural communities, where access to reproductive care can be limited (Silver et al. 2022), it is imperative that community-led strategies be implemented to ensure safe and culturally specific care is provided to all families. When the state continually attempts to control and oppress Indigenous reproductive experiences and bodies, there is no safe or meaningfully consensual way for Indigenous peoples to donate gametes on their own terms with confidence in the system. People of the Global Majority, transgender people, and people who experience poverty all have just cause to question the medical industrial complex and the surveillance and manipulation of their bodies. Akuffo-Addo et al.

(2023) write that, 'Mistrust of medical advances among racialized populations continues to persist. The mistrust reflects the historical injustices and current systemic deficiencies experienced by racialized and marginalized populations' (940). The cascading impacts of a lack of sperm and eggs from particular communities, ethnicities, and identities influences intended parents and future families who are hoping to build families that 'look like them' and have similar histories, experiences, and identities.

Strategies for Improved Inclusivity and Care

The barriers discussed in this article cannot be solved solely through individual initiatives, training, or programming. We need a systemic shift in medical paradigms that offer accessible community information, better and more equitable care for racialized and Indigenous peoples, and mental health support from practitioners who are members of the 2SLGBTQ+ community. In suggesting protocols and steps to address challenges, I note the need for a multi-pronged approach that works on the individual, institutional, and national scale. As we advocate for meaningful change, we must begin with improved communication, resource sharing, and family building education for the individual, their providers, and their broader community networks.

Learning to Create Change: Professional Education & Improving Healthcare Settings

Improved training for healthcare providers on 2SLGBTQ+ gender affirming, and reproductive care can have a positive impact on increased transparency and knowledge sharing, as well as a reduction of the stressors that result from being excluded in a medical setting. Research in the area of 2SLGBTQ+ fertility demonstrates that one of the biggest barriers to providing equitable care to 2SLGBTQ+ individuals on their family building journeys is a lack of knowledge and education from their providers (Tam 2021; James-Abra 2015; Minturn et al. 2021). In their reproductive journeys, transgender and gender diverse patients report having to educate their providers about their bodies and needs (James-Abra 2015). This lack of LGBTQ health in medical education is problematic across North America as Minturn et al. (2021) note that, 'A 2011 survey of US and Canadian medical schools revealed that the median number of hours in the curriculum dedicated to LGBTQ-related content was 5. Nine of the surveyed schools reported 0 hours of LGBTQ-related

education in the preclinical years, while 44 reported 0 hours of such content during the clinical years' (2). The lack of transparency and direction 2SLGBTQ+ people face is in part because of a lack of knowledge from the practitioners.

In 'Creating Community, Creating Family,' Audrey Dwyer writes of the distinct experiences of 2SLGBTQ+ intended parents in the Global Majority. Dwyer's reflection on their experience at a 2SLGBTQ+ intensive weekend workshop in Toronto, Ontario focused on family building centreing the diversity of needs within the family building journey. More specifically, the need to respond to not only technical or logistical questions of family planning, but also the emotional ones. In response to a lack of resources, they discuss how community-run and grassroots organizing can provide the insights necessary to respond to emotional impacts of the journey:

> Due to colonization and white supremacy, we queers have so much to push against. We try to work through all of these obstacles while building community and nourishing people. We take care of each other's emotional states through active listening, warmth, and in ways that are nonformal and heart-based. (Dwyer 2018, 234).

In order to improve health outcomes, mental health, and family building experiences for 2SLGBTQ+ individuals and families more focus must be given to patients' specific physical needs, family structures, and protocols. This entails not only an overview of how hormones, donor gametes, and laws function throughout the process, but also how to communicate effectively and respectfully with 2SLGBTQ+ families, a skill that is often overlooked or ignored in preparing medical students to work with diverse populations. Indeed, in a survey of Canadian medical students nearly 50% of respondents, 'reported witnessing offensive jokes or discriminatory behavior directed toward LGBTQ people by classmates or other health professionals' (Minturn et al. 2021, 2). Doctors, nurses, technicians, and other care-providing staff should be educated on inclusivity practices that help them to better identify implicit bias, respect of diverse family needs, and proper behaviour and language to use in relation to 2SLGBTQ+ individuals and families, including gender diverse parents, polyamorous relationships, and platonic co-parent structures.

In addition to improving education and communication practices, clinic managers need to revise all protocols and forms to include all identities and family structures. While many clinics have rainbow logos on their websites and explain the basics of 2SLGBTQ+ options online, there is a need to revise all patient forms, signage, and verbal and written communications to ensure equity of experiences of people of diverse genders, abilities, races, and kinship structures. In their discussion of transgender individuals' experiences seeking reproductive and family building care, James-Abra et al. (2015) note that their participants often had to revise intake forms and documentation to properly reflect their identities. Trans clients could not represent or 'accurately describe themselves and their AR needs (e.g., man wishing to conceive; woman wishing to bank sperm)' (5). Even after the forms were corrected by the patient, some clinics and providers still used their dead name (name assigned at birth), or the sex assigned at birth. Such care is not only suboptimal, but detrimental to the individual and family, invalidating their experience and identity and creating undue stress and pressure on the patient to educate and improve the system that oppresses them.

Options for pronouns and documentation to ensure proper names are used by staff (particularly if these differ from legal names and gender) are essential to creating an inclusive environment. One of the foundational issues we need to address is that the change towards inclusive care cannot just be a change for some patients, but a change that shifts how we view and interact with all patients. Doctors should give *everyone* the opportunity to share their pronouns and should make *all forms* inclusive not just those that might apply to 2SLGBTQ+ people. All technicians, staff, nurses, and doctors need to be further trained on best practices for meaningful inclusion. While some clinics in Ontario have already implemented community-based advisory committees to support 2SLGBTQ+ change, there are few resources and limited time available to implement recommendations. Clinics must invest in change through allocated time, education, and financial contributions to carry out such meaningful and important changes.

Training and workshops from 2SLGBTQ+ doulas must address both the lack of education for healthcare practitioners in providing equitable and evidence-based

medical care, as well as addressing communication practices and inclusive behaviours and language for engaging with diverse communities, individuals, and families. Changing forms, signage, and protocols for sharing private information, names, and pronouns, will further improve 2SLGBTQ+ family building experiences.

For community members, who frequently note the lack of accessible information on 2SLGBTQ+ care, we need to create services that teach the options for family building and provide outlets and trained care providers to answer questions along the way. We need knowledge in order to know what we don't know. We need an understanding of processes, laws, anatomy, and options before we can begin to formulate a plan that attends to our individual needs. In our current system there are few spaces to access Canada-specific information and when information is available, it may be biased towards a particular clinic, gamete bank, or doctor. One effective way to address these gaps in knowledge is to deepen and expand the opportunities for community engagement and non-medicalized care.

Family Building Doulas: Providing Patient and Parent-Facing Care

There are multiple strategies and approaches to creating improved experiences of reproductive health and family building journeys in Canada, both through patient-facing resources, supports, and education, as well as improved education, training, and service offerings for healthcare providers. In both cases, doulas and 2SLGBTQ+ family building educators can offer resources and supports that work towards improved access and care, as well as a deeper understanding and implementation of consent in medical practice.

Despite the increasing popularity of diverse doula supports across major life transitions, most literature on doula care – both scholarly and for public consumption – focuses on labour and postpartum supports. Indeed, in researching 2SLGBTQ+ family building and fertility doulas, no prior publications on the use of "fertility doulas" were located through a Google Scholar search – excluding personal accounts and business promotion. While many labour and delivery doulas offer fertility care and pre-conception support there is limited literature on doulas specializing in this area. The dearth of research in this area is indicative of the lack

of knowledge and visibility of professionals working in the field, particularly in relation to marginalized identities and 2SLGBTQ+ family building supports. Yet, family building doula services such as increasing resources, education, and community networks for 2SLGBTQ+ people have all been shown to improve quality of care and experiences in reproductive journeys.

A family building doula and fertility support practitioner's role is to provide individuals with information in navigating their fertility, surrogacy, or other reproductive journeys. It is a process which is client-focused and client-led and differs from person to person. People who have sperm, eggs, and a uterus readily available may enlist the support of a doula to learn how to chart a menstrual cycle, understand ovulation, or offer education if they are experiencing infertility or repeated losses. If gametes and a uterus are not easily available to individuals or families looking to conceive or grow, a doula's role shifts to education, referrals, recommendations, and often to a larger degree advocacy. This is because of the barriers that are too often experienced by people who do not meet hetero- and cissexist expectations in medicalized settings. With limited diversity in gametes available, intended parents need resources and information on the options they have for procuring gametes that meet their needs. Alternative routes like direct donations and strategies for communicating with banks about waitlisted donors are options rarely shared by fertility clinics. Family building doulas and knowledgeable community supports can directly assist 2SLGBTQ+ intended families in navigating their options or next steps.

Ultimately, doula work is about connection: it is about having someone present on your team who can assist you in navigating an unfamiliar process, provide evidence-based information, and help you to create the plan to fit your needs. While a doctor may be able to propose a protocol for treatments, a doula can help you to understand, ask questions, and prioritize your own values and goals beyond the medicalized process. Barriers in care can mean that intended parents must change course, make new decisions, and strategize new protocols, often with little understanding of their rights or options. Community resources and supports offer the opportunity to learn about process and how to advocate for your needs. For queer and transgender individuals, building a family is not just checking boxes on a to-do list, but at times

it can feel this way. Doulas and community networks can help 2SLGBTQ+ parents reconnect with their own needs, recentre their priorities, and personalize what can be a medicalized experience.

In my own private practice as a doula, in early meetings with clients, I adapt a common resource used in labour and birth planning. A practice among both midwives and doulas is to work with an expectant parent to create a "birth plan": a reflection and guide identifying the preferences and ideal processes that a parent is seeking during their labour and delivery. The birth plan is also a means of informed consent and communication, that ensures that the intended parents have a medium to both share their preferences and make changes (Rysdam 2019). This might include questions around pain management, partner(s) involvement, hospital and doctor care, and how they want to address challenges and changes. Rysdam notes:

> Doulas can teach and enable conversations that cultivate an ethos of consent within the medical industrial complex and more broadly. In doing so, they can create a cultural shift in how women navigate healthcare system. (96)

Indeed, a birth plan is one means by which a doula can identify and advocate for client needs. This productive tool can be adapted to the fertility and family building journey, where family building doulas work alongside their clients to identify preferences for family building and strategies to address change when ideal methods and processes cannot be pursued.

The preference sheet I offer through my private practice as a family building doula helps clients think through emotional touchstones and changes in their journey, but also key decisions they must make early on in their process pertaining to 1) the preferred method they want to start building their family with (at home; IUI; IVF; Reciprocal IVF); the gametes (egg and sperm) they want to use, if they aren't readily available (donor bank; open ID; anonymous; direct/known donation); 3) the space they prefer to start in (at home; at a clinic) and the questions they want to ask care providers in order to find someone who meets their needs. Part of this preference sheet and the conversations that ensue as we complete it together is also identifying coping strategies for mental health, community supports, and preferred steps to take

if desired protocols are not possible (second opinion; follow initial medical recommendation; take a break or pause, etc.). Answering these questions is often the first-time families have been able to identify the options available to them, how to access them, and the strategies that work best to maintain their mental health. Having these conversations early in the family building journey ensures that 2SLGBTQ+ families have more control over their care and are following a consent-based model for medical intervention and reproductive care.

Finally, as a doula, I focus not only on individual one-on-one care but also navigating the process of family building by building community. Since February 2020, I have worked with Gab Griffith, to facilitate a monthly meeting group for people in the 2SLGBTQ+ community who are trying to build their families. This group has been integral to community members, who continue to come monthly into their parenting journeys in order to provide resources, peer support, and community to those still on their journeys. The importance of online communities for 2SLGBTQ+ individuals has been well documented and in family building and parenting journeys they help not only to address feelings of exclusion, but also the dearth of information available on rights, resources, and strategies to grow their families. Andalibi et al. (2022) note that 2SLGBTQ+ online groups for pregnancy, loss, and parenting are imperative to provide an affirming and safe space based on shared experiences. Participants in the study noted that they felt, 'known and seen—like they belonged in and were validated by the group' (18). Importantly however, these groups are often overwhelmingly white, further marginalizing intended parents from the Global Majority. 2SLGBTQ+ support groups should be coordinated or facilitated by individuals from marginalized groups to respond to determinants of health and lack of representation, equitable care, and diversity that currently exists.

Growing Caring Communities and Making Meaningful Change

Community-based initiatives that increase visibility and ease of access to information and extend networks of belonging are essential to 2SLGBTQ+ advocacy and family building. This article and recommendations for care emerge from practical engagements with the 2SLGBTQ+ community as a fertility support practitioner and family-building doula. This work aims to provide resources and support that help

individuals and families make the best choices for themselves, particularly when the options available to them are not readily apparent. Much of my own work in this field is conducted through community engagement through Birth Mark in Ontario, Canada. Birth Mark is a charity that offers free doula care and non-medical perinatal support to marginalized populations, free of cost.

In 2019, Birth Mark launched Seed and Sprout, led by program coordinator Gab Griffith, in response to a needs assessment highlighting the gaps of family focused 2SLGBTQIA care, offering a variety of in-person supports, community gatherings, and workshops. Seed and Sprout is the only self-referral program at Birth Mark catering to individuals in 2SLGBTQ+ communities and providing perinatal care to diverse queer and transgender people in the Greater Toronto Area and Hamilton. At Birth Mark and Seed and Sprout, full-spectrum doulas and reproductive and parenting support workers, provide wraparound support to clients navigating any reproductive event, including pregnancy, birth, postpartum, pregnancy loss, and abortion. Our programs fill current service gaps by offering training to organizations to be more affirming, providing virtual resources to the 2SLGBTQIA community, running monthly community family building support and information meetings, and providing full-spectrum doula care through pregnancy and post-partum.

This article is being written as Seed and Sprout launches its new initiative called '2SLGBTQ+ Family Building Canada' (FBC), created by and for our community members focused on advocacy and community-based research. Funded by Community One's Rainbow Grant, FBC aims to move beyond the basics of reproductive care and access by launching a national online platform for community support and healthcare provider training (familybuildingcanada.com). The site is not simply a by-product of community conversations, but instead a collaborative community creation, reflecting efforts, advocacy, experiences, and resources created by 2SLGBTQ+ individuals with first-hand experience navigating family building in Canada. Through community-led programming, the group aims to gather data focused on intersectional barriers facing 2SLGBTQIA in their journeys, advocate for systemic change, and provide resources and training for healthcare professionals that improve equitable access to reproductive care.

To meaningfully support and advocate for individuals, families, and communities, 2SLGBTQ+ family building care must integrate the lens of reproductive justice, exploring how the historical and current practices of sterilization, violence, and oppression continue to shape reproductive rights and access in Canada. A lack of gametes from racialized donors and increased surveillance of Indigenous and racialized families complicate family building processes for marginalized queer and transgender community members. The impact of current and intergenerational trauma, ongoing effects of settler colonialism, and oppressive treatment of marginalized individuals shapes our expectations and experiences of family building in this country. Ultimately, a doula's role in the 2SLGBTQ+ family building journey can be to respond to these challenges by providing individuals with consent-based communication practices, resources, and education to help them advocate for their needs and learn their rights, and guidance on how to build their families on their own terms.

References

Akuffo-Addo, E., Udounwa, T., Chan, J., & Cauchi, L. (2023). Exploring biologic treatment hesitancy among black and indigenous populations in Canada: a review. *Journal of racial and ethnic health disparities,* 10 (2), 942-951.

Andalibi, N., Lacombe-Duncan, A., Roosevelt, L., Wojciechowski, K., & Giniel, C. (2022). LGBTQ Persons' use of online spaces to navigate conception, pregnancy, and pregnancy loss: an intersectional approach. *ACM Transactions on Computer-Human Interaction* (TOCHI), 29 (1), 1-46.

Canada Legislative Service (2023, July 27). Consolidated federal laws of Canada, safety of sperm and OVA regulations. Safety of Sperm and Ova Regulations. https://laws-lois.justice.gc.ca/eng/regulations/SOR-2019-192/index.html

Chinkam, S., Ibrahim, B. B., Diaz, B., Steer-Massaro, C., Kennedy, H. P., Shorten, A. (2023). Learning from women: Improving experiences of respectful maternity care during unplanned caesarean birth for women with diverse ethnicity and racial backgrounds. *Women and Birth*, 36 (1), 125–133. https://doi.org/10.1016/j.wombi.2022.05.004

Choudhury, Cyra Akila. New Approaches and Challenges to Reproductive Justice. *FIU Law Review*, vol. 12, no. 1, Fall 2016, p. 1-8. HeinOnline.

Cidro, J., Bach, R., & Frohlick, S. (2020). Canada's forced birth travel: towards feminist indigenous reproductive mobilities. *Mobilities*, 15 (2), 173-187.

Dorri, A. A., & Russell, S. T. (2022). Future parenting aspirations and minority stress in US sexual minority adults. *Journal of Family Psychology.* 36 (7), 1173–1182.

Doula Support Foundation, Open Letter https://doulasupport.org/post/open-letter-anti-racist-action

Dwyer, A. (2018). Creating Community and Creating Family: Our QTBIPOC Parenting Group. In J. Haritaworn, G. Moussa, S. M. Ware (Eds.), *Marvellous grounds: Queer of colour histories of Toronto. essay, Between the Lines.* http://ebookcentral.proquest.com/lib/utoronto/detail.action?docID=5917095.

Falconi, A. M., Bromfield, S. G., Tang, T., Malloy, D., Blanco, D., Disciglio, R. S., & Chi, R. W. (2022). Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. *EClinicalMedicine*, 50.

Fixmer-Oraiz, N., & Shui-yin, S. Y. (2023). 'Redefining Our Own Center': An Interview with Stevie Merino. *Rhetoric of health & medicine*, 6 (2), 201.

Gates, G. J. (2015). Marriage and family: LGBT individuals and same-sex couples. *The Future of Children*, 67–87. https://doi.org/10.1353/foc.2015.

Gato, J., Santos, S. & Fontaine, A.M. To Have or Not to Have Children? That Is the Question. Factors Influencing Parental Decisions Among Lesbians and Gay Men. *Sex Res Soc Policy* 14, 310–323 (2017). https://doi.org/10.1007/s13178-016-0268-3

Gill, P., Axelrod, C., Chan, C., & Shapiro, H. (2019). A step towards equitable access: understanding the use of fertility services by immigrant women in Toronto. *Journal of Obstetrics and Gynaecology Canada*, 41 (3), 283-291.

Goldberg, A. E. (2022). LGBTQ-parent families: Diversity, intersectionality, and social context. *Current Opinion in Psychology*, 101517.

Gregory KB, Mielke JG, Neiterman E. (2022) Building Families Through Healthcare: Experiences of Lesbians Using Reproductive Services. *Journal of Patient Experience*. 2022; 9. doi:10.1177/23743735221089459

Howat, A., Masterson, C., & Darwin, Z. (2023). Non-birthing mothers' experiences of perinatal anxiety and depression: understanding the perspectives of the non-birthing mothers in female same-sex parented families. *Midwifery*, 120, 103650.

James-Abra, S., Tarasoff, L. A., Green, D., Epstein, R., Anderson, S., Marvel, S., & Ross, L. E. (2015). Trans people's experiences with assisted reproduction services: a qualitative study. *Human Reproduction*, 30 (6), 1365-1374.

Kirubarajan, A., Barker, L. C., Leung, S., Ross, L. E., Zaheer, J., Park, B., Abramovich, A., Yudin, M., & Lam, J. S. H. (2022). LGBTQ2S+ childbearing individuals and perinatal mental health: a systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology,* 129 (10), 1630-1643.

Kirubarajan, A., Patel, P., Leung, S., Prethipan, T., & Sierra, S. (2021). Barriers to fertility care for racial/ethnic minority groups: a qualitative systematic review. *F&S Reviews*, 2 (2), 150-159.

Kirubarajan, A., Patel, P., Leung, S., Park, B., & Sierra, S. (2021). Cultural competence in fertility care for lesbian, gay, bisexual, transgender, and queer people: a systematic review of patient and provider perspectives. *Fertility and Sterility*, 115 (5), 1294-1301.

Kozhimannil, K. B., Hardeman, R. R., Alarid-Escudero, F., Vogelsang, C. A., Blauer-Peterson, C., & Howell, E. A. (2016). Modeling the cost-effectiveness of doula care associated with reductions in preterm birth and cesarean delivery. *Birth*, 43 (1), 20-27.

Marvel, S., Tarasoff, L., Epstein, R., Green, D. C., Steele, L., & Ross, L. (2016). Listening to LGBTQ people on assisted human reproduction: access to reproductive material, services, and facilities. *Regulating Creation: The Law, Ethics, and Policy of Assisted Human Reproduction*, ed. Trudo Lemmens (University of Toronto Press).

Marshall, K. (2021). *Reproductive rainbow: Exploring fertility intentions and family planning experiences within the 2SLGBTQ community* (Doctoral dissertation, University of Saskatchewan).

Minturn, M. S., Martinez, E. I., Le, T., Nokoff, N., Fitch, L., Little, C. E., & Lee, R. S. (2021). Early intervention for LGBTQ health: a 10-hour curriculum for preclinical health professions students. *MedEdPORTAL*, 17, 11072.

Peel, E. (2010). Pregnancy loss in lesbian and bisexual women: An online survey of experiences. *Human Reproduction*, 25 (3), 721-727.

Permezel, J., Arnold, A. S. C., Thomas, J., Maepioh, A. L., Brown, R., Hafford-Letchfield, T., McNair, R. P. (2023). Experiences in the delivery of preconception and pregnancy care for LGBTIQA+ people: A systematic review and thematic synthesis of patient and healthcare provider perspectives. *Midwifery*, 103712.

Rainbow Health Ontario. (2022, April 22). Health Equity Impact Assessment (HEIA): LGBT2SQ populations supplement. *Rainbow Health Ontario.*

https://www.rainbowhealthontario.ca/resource-library/health-equity-impact-assessment-heia-lgbt2sq-populations-supplement/

Ramey-Collier, K., Jackson, M., Malloy, A., McMillan, C., Scraders-Pyatt, A., & Wheeler, S. M. (2023). Doula Care: A Review of Outcomes and Impact on Birth Experience. *Obstetrical & Gynecological Survey*, 78 (2), 124-127.

Ross, L. E., Steele, L. S., & Epstein, R. (2006). Service use and gaps in services for lesbian and bisexual women during donor insemination, pregnancy, and the postpartum period. *Journal of Obstetrics and Gynaecology Canada*, 28(6), 505-511.

Rysdam, S. (2019). Doula advocacy: Strategies for consent in labor and delivery. In *Women's Health Advocacy* (pp. 90-101). Routledge.

Shenkman, G., Levy, S., Winkler, Z. B. D., Bass, D., & Geller, S. (2022). Higher levels of postnatal depressive symptomatology, post-traumatic growth, and life satisfaction among gay fathers through surrogacy in comparison to heterosexual fathers: A study in Israel in times of COVID-19. *International journal of environmental research and public health*, 19 (13), 7946.

Siegel, M., Legler, M., Neziraj, F., Goldberg, A. E., & Zemp, M. (2022). Minority stress and positive identity aspects in members of LGBTQ+ parent families: Literature review and a study protocol for a mixed-methods evidence synthesis. *Children*, 9 (9), 1364.

Silver, H., Sarmiento, I., Pimentel, J. P., Budgell, R., Cockcroft, A., Vang, Z. M., & Andersson, N. (2022). Childbirth evacuation among rural and remote indigenous communities in Canada: a scoping review. *Women and Birth*, 35 (1), 11-22.

Smietana, M., Thompson, C., & Twine, F. W. (2018). Making and breaking families–reading queer reproductions, stratified reproduction and reproductive justice together. *Reproductive Biomedicine & Society Online*, *7*, 112.

Smith, Z. (2022). Lesbian Motherhood and Artificial Reproductive Technologies in North America: Race, Gender, Kinship, and the Reproduction of Dominant Narratives. *Pathways*, 3 (1), 71-81.

Stote, K. (2017). Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice. *Atlantis: Critical Studies in Gender, Culture & Social Justice/Études Critiques sur le Genre, la Culture, et la Justice*, 38 (1).

Tam, M. W. (2021). Queering reproductive access: reproductive justice in assisted reproductive technologies. *Reproductive Health*, 18, 1-6.

Twine, F. W., & Smietana, M. (2022). The racial contours of queer reproduction. In *The Routledge Handbook of Anthropology and Reproduction*. Taylor & Francis

Yam, S. Y. S., & Fixmer-Oraiz, N. (2023). Against Gender Essentialism: Reproductive Justice Doulas and Gender Inclusivity in Pregnancy and Birth Discourse. *Women's studies in communication*, 46 (1), 1-22.