4. Precarious bodily performances in queer and transgender reproduction with ART (Doris Leibetseder)

Introduction

This chapter presents the first outcomes of my still-work-in-progress Marie Skłodowska-Curie Individual Fellowship Program (EU Horizon 2020, Grant Agreement 749218)[1] on queer and trans inclusive assisted reproduction involving studies of 6 European countries: Austria, Estonia, Poland, Spain, Sweden and the UK. In this research I examine the experiences, practices and possible improvements of preserving fertility and achieving reproduction of queer and transgender people in those 6 EU-states. This enables the comparison between more liberal countries towards LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex and Queer) rights and other countries that restrict reproductive possibilities for queer and transgender people. A key aspect of my research is to document the experiences of queer and transgender people using assisted reproductive technologies (ART). This is important because there are very different kinds of guidelines and regulations regarding ART in the diverse European countries.

My focus in this chapter is on the use of ARTs by queer and transgender people, how they have to perform particular bodily and intimate selves in the processes of seeking ART (Mamo, 2007, 2013; Armuand, et al., 2017), and how this precarises them. The bioprecarity of queer and transgender people is produced by the *enactment* of certain kinds of categorical framing (Foucault, 1977, 1990; Somerville, 1995) in the laws regulating ARTs. Prohibitive laws in some states are often circumvented by going abroad. Thus, I argue that queer and trans people's bioprecarity results from the intimate labour they have to undertake to overcome prohibitive laws and hetero- and cisnormative medical institutions as shown e.g. in studies about trans people's experiences with ART (James-Abra, et al., 2015; Armuand, et al., 2017). I understand bioprecarity (see also chapter 2 in this volume) as making some people (their bodies or bodily materials) more vulnerable and precarious than others through either labelling them as a certain category or by them falling outside of pre-existing categories. I refer to intimate labour, when bodily 'work' is required in intimate situations (e.g. using intimate body parts or disclosing one's queer sexuality in a heteronormative environment). I use the term 'emotional labour' only for emotional work, where feelings need to be manipulated or hidden in more general settings that are not specific to intimacy.

Research methods

My research focuses on self-identified queer and trans people who have used or intend to use ART. To date 23 qualitative interviews (average length approx. 1 hour long) have been conducted in the EU-countries involved as well as one focus group (50 min long). An online survey (taking approx. 30 mins to fill in) was posted on the main LGBTQ-websites and Facebook groups in each participating country. Respondents were asked about their experiences with ART, if they had or intended to have their treatments in local clinics or in another country; what kind of treatments they had chosen or intended to have and why; why they could not use ARTs, or if they had chosen other options during the treatment; what their experiences were (positive: interactions with medical staff, support of and familiarity with queer and transgender patients and health concerns; or negative: problems with clinical documentation, impact of providers' cisnormative and heterosexual assumptions, refusal of services; what could be improved to get a better access and treatment of ARTs).

In this chapter I draw on the empirical material I have gathered so far from the online survey, interviews and focus group. At the start of writing this chapter (Dec. 2018) the English-language online survey had in total 739 replies, 165 fully complete, 574 incomplete. Of the total number of replies, 84 came from Austria, 19 from Estonia, 15 from Poland, 16 from Spain, 85 from Sweden, and 31 from the UK. Additionally, because of language issues, two translated surveys have been used: a Spanish one with a total of 146 replies, 84 of them complete, 62 incomplete, and a Polish one, with 16 replies, 10 complete and 6 incomplete.

In demographic terms, the majority of the English-language survey participants lived in the country where they were born (229), in a big city (143), were aged between 26-35 (123), and felt that they were members of a group that is discriminated against (138), 129 on the grounds of their sexuality and 80 of their gender. 27 had had experience of being a trans person. 137 of the participants self-defined as women, and 29 as men. Comparing these basic data with the Spanish and Polish surveys, the outcomes look similar except that in the Spanish survey the majority of the participants (62) did not feel discriminated against (versus 56 who did not). Here 63 self-defined as men, 42 as women. In the Polish survey 13 out of 16 felt discriminated against, 10 of the participants self-defined as women and 2 as men.

Of the 23 interviews to date, 6 are from Austria, 1 from Estonia, 1 from Poland, 10 from Spain, 4 from Sweden, and 1 from the UK. A Spanish focus group with 3 participants has also been held.

These background details of the online-survey participants alone speak to the issue of bioprecarity and intimate labour, and how a certain group is categorized and feels

more vulnerable. In the English-language survey the majority felt discriminated against because of their sexuality and a smaller number because of their gender. This indicates that sexual orientation is still a cause of feeling vulnerable in many European states. In Spain, where a small majority did not feel discriminated against, differently from the Polish and English-language surveys, the largest group of participants in Spain were gay cis-men. This could mean that Spanish gay men do not feel vulnerable and discriminated against anymore, and that lesbian cis-women, especially in Poland, but also in other European countries, are still more vulnerable and discriminated against than male same-sex couples in Spain. However, since Spanish gay men rely on surrogacy for reproduction, it could also indicate that Spanish male same-sex couples and families push for normalization and do not see themselves as different from straight families and couples (Smietana, 2015). Before I jump to early conclusions, I will explore the categorical framing of queer and trans people done through ART legislation and the content of the interviews (the audio-recorded data of queer and trans experiences with ART).

Laws regulating ART: Causing reproductive bioprecarity for queer and trans people

In the six EU countries investigated here specific laws regulate the access to ART for all people and heterosexuality is, as Paul B. Preciado (2013) describes it, a 'politically assisted reproductive technology' (n.p.), which is organized and maintained by some states so as not to allow access to ART for same-sex partners, for certain heterosexual persons (outside of a couple, poor people), transgender, asexual or disabled people. These people constitute a reproductive minority, according to Preciado, referring to the phrase 'sexual minority', as for them it is forbidden or made difficult to pass on their genetic material. These groups of people are in a sense politically sterilized. Here the political and economic fight to access ART is connected to the de-pathologization of their lives and to having control over their own reproductive and genetic material (*Ibid.*).[2] Thus, where they are debarred from ART access queer and trans people experience reproductive bioprecarity. Their categorization as queer or trans prevents them from using their bodily materials (genetic or reproductive organs) in certain medical and technical procedures for reproduction in their home country.

The most common issues for queer and trans people in European countries trying to access ART are, first, to have legal access to ART (sometimes only possible when one is in a legal partnership) in their home country. If this is impossible, 'fertility travel' is

required. However, this results in the challenge of how to get the legal documentation (birth certificate, citizenship, parenthood recognition) for the home country. This is also a class issue which leads to stratified reproduction, since only queer and trans people with enough money and flexible time can afford to try to escape their reproductive bioprecarity in their home country. Secondly, even if ART is available to them in their home country, the issue of obtaining legal parenthood as such for same-sex couples and trans people (often combined with legal partnership recognition, or otherwise through adoption or co-parent recognition) is more complicated than for straight cis-gendered couples. A certain kind of administrative violence (Spade, 2015) can be found in these bureaucratic procedures, as I will explain later in an example featuring gay fathers. This includes the issue of having the appropriate terminology on birth certificates (e.g. are two mothers/fathers possible? For trans people: is a birth father possible? For single queer and trans people: is just one parent possible?) is not always straightforward or readily available (Leibetseder and Griffin, 2018: 1 f.). Thus, the reproductive bioprecarity of queer and trans people does not simply have a happy ending with the birth of a child, but continues to sorting out the legal documentation afterwards (possibly for many years, as my Spanish case will show).

The survey responses of the Spanish gay men who rely on surrogacy for reproduction and claim that they are not discriminated against and therefore not vulnerable or bioprecarious because of their classification as gay, prompts a closer look at the LGBTQ-rights and ART-laws in Spain. In 2005, same-sex marriage (the third country in the world to institute this) was introduced. In 2006, the current ART law came into force (Pichardo Galán, 2009: 144; 2011: 17 f.; Pichardo Galán, et al., 2015: 189). Spain was also the first state to allow adoption by same-sex married couples (Imaz, 2017: 6). Gay couples can access adoption (but there are almost no national and international adoptees) and surrogacy abroad, as it is banned in Spain. However, many highlight the gender bias in the Spanish ART law (Ley 14/2006) allowing ART access to all cis-women regardless of their civil status or sexual orientation (Smietana, et al., 2014: 199). This law leads to the reproductive bioprecarity of gay cis men.

Despite prohibitive ART laws Spanish surrogacy debates are changing because of a sharp increase in surrogacy arrangements by Spanish citizens abroad (mostly in the US, Canada, India, Georgia and Russia). Many commercial surrogacy agencies have opened in Spain, and several associations are advocating gay men's right to parenthood. Even a political party, Cuidadanos (Blanco et al., 2017), supports legalizing surrogacy (Imaz, 2017: 9; Marre

et al., 2018: 166), despite feminist critiques such as the manifesto *No somos vasijas (We Are Not Vessels)* (No somos vasijas, n.d.) from 2015, and 2017's *#MiVientreNoSeAlquila (My Tummy Is Not for Rent)*. Babies born through surrogacy or adopted abroad pose legal challenges for parenting rights and the citizenship of the baby (Smietana, 2015: 50). A lengthy legal process is required to transfer parental rights, involving in some cases even Supreme Court appeals (Smietana et al., 2014: 199 f.) and therefore prolonging the reproductive bioprecarity of gay cis men. Thus, in 2010 a directive to facilitate the recognition of transnational surrogacy was issued by the Spanish Ministry of Justice, but was vetoed by the Spanish Supreme Tribunal in 2015 (Leibetseder, 2018: 15 f; Smietana, 2015: 51).

Some of the organisations in favour of surrogacy, for example *Son Nuestros Hijos (They Are Our Sons/Daughters)*, argue that to avoid abuses it would be best to legalize surrogacy (Blanco, 2017) and regulate surrogacy to reduce the risk of the exploitation of women. Public opinion seems to be reconciled to surrogacy; according to a Catalan opinion poll in 2017, 73% of citizens are in favour of legalizing surrogacy (*El Periódico*, 2017a). Since 2017 the Catalan government (Generalitat de Catalunya) has allowed paid paternal leave for public-sector employees (incl. for gay parents) who use surrogacy (*El Periódico*, 2017b). Thus, there are regional differences concerning ART access in Spain, with autonomous provinces such as Catalonia having their own regulations (Generalitat de Catalunya, 2016; Leibetseder, 2018: 16) and alleviating the reproductive bioprecarity of gay cis men.

Queer and trans experiences of reproduction with ART

Queer and trans experiences of reproduction with ART are, of course, at least partly determined by the legislative contexts in which queers and trans people operate. The example of the Spanish gay men who opted for surrogacy arrangements abroad, and who claimed not to be discriminated against anymore, can be mapped onto the above mentioned legal provisions which have normalized same-sex couples since 2005, as well as allowing access to a variety of ART procedures. Although fiscal austerity measures were taken to restrict publicly sponsored access to ART for lesbians, these are now lifted again in some parts of the country, e.g. in Catalonia (Leibetseder, 2018: 15 f). However, surrogacy is still not legalized, although surrogacy abroad seems to be more or less accepted and made possible through certain legal and bureaucratic processes.

The parodox of reproductive bioprecarity for gay cis men

As Ulrika Dahl points out in this volume, there is a paradox in the understanding of bioprecarity when it comes to LGBTQ reproduction, family and kin making. This paradox consists of the interdependence of the family or kin members in their giving and taking of intimate labour instead of (sometimes as well as their) biological labour. Dahl highlights another paradox of reproductive bioprecarity in the example of privileged white gay men, who have structural racial privileges and a strong purchasing power. Thus, they can afford transnational surrogacy as a means of reproduction, whereas for most other queer or trans people it is either not accessible or not within their financial means. However, gay men's reproduction is still bioprecarious, as they are also exposed to violence because of their sexual orientation and they have to overcome the challenge to form a family without a female partner. In my interviews the bioprecarity of gay cis men's reproduction and the intimate labour involved in achieving having a baby, the legal documents proving their parenthood and the citizenship of the baby, came up in many different examples. I shall therefore now discuss one gay Spanish cis man's reproductive journey with his partner from around the same time as same-sex marriage was introduced in Spain, in 2005.

Guillermo[3] (around 46-55 years old, living in a big city, professional occupation, coped on present income, married) started his interview by highlighting that in his view it is necessary for gay male reproduction and families to be normalized, because just to be proud at Pride is not enough. He said that the most important issue to highlight to everyone now was that gay male families exist. Why this was so crucial for him became evident in his narrative about his husband's and his own thoughts about reproduction. His partner knew early on that he was gay and therefore thought he was never going to be a father, as for his husband being gay and reproducing did not go together. Guillermo himself found that he was gay much later on in his life and he had always wanted children. Here the first way in which reproductive bioprecarity through categorization is produced becomes evident in his partner's assumption that as a gay person he would not reproduce. A cis male gay family did not appear to exist in his imagination. The restrictive (self-)disciplinary biopower of his context encouraged him to focus his thoughts about reproduction in particular ways: by disavowing that possibility. The second way in which reproductive bioprecarity is induced is through bureaucratic classifications or 'administrative violence' as Dean Spade (2015) calls it. When gay marriage was introduced in Spain in 2005, Guillermo and his partner considered whether to get married or not. His partner was against it because he thought that if they were officially

married and their same-sex status was evident in their documentation, they would never be allowed to adopt a child and Guillermo would never be a father. This is still a valid argument in some EU countries, such as Czechia or Hungary, because adoption is not legal for registered same-sex partners in both countries. In Hungary, additionally, the access to ART is prohibited. The result is a much lower rate of registered same-sex partnerships, especially of lesbian couples who can then access ART in Hungary and adopt each other's' children in both countries (Hašková, et al., 2018: 53-6; Takács, 2018: 75).

However, Guillermo argued that it was equally hard for a single man to adopt a child, and he really wanted to get married since he was not willing to trade in something uncertain (adoption) for something secure (marriage) that he could have at that moment. So they married and started the process of national adoption. At that time Guillermo was working at the same governmental institution where the department for adoptions was based. One day he overheard a conversation in the institution's cafeteria among civil servants in charge of deciding on adoption applicants' aptitude to be parents. The officers boasted that they had just refused a parental aptitude certificate for a same-sex couple; to allow such a certificate for a same-sex couple would only occur over their dead bodies. The only case of a gay couple's successful adoption that Guillermo had heard of was one where the couple was closely related to one of the politicians in charge and their child had brain damage because she was born to a drug-addicted mother. Here administrative violence is quite obvious in how the civil servants categorize potential parents according to their sexual orientation. Guillermo and his partner turned to international adoption, but most agencies told them that there was a scarcity of children. During a business trip to Russia in 2007, Guillermo went to the international adoption office in St. Petersburg and asked about the possibilities for same-sex couples of adopting a child. The English-speaking Russian officer immediately called two security guys who were about to start beating him up, and only when he told the officer that he had to give a presentation at a scientific conference the next day and the officer opened his passport and saw his scientific visa, was he allowed to leave without being beaten by the security staff. In this instance, administrative violence and being more vulnerable than others due to one's classification nearly came down to a literal level, only being relieved by a privileged (class and educational) position. Finally, Guillermo and his husband became parents of twins through transnational surrogacy in California, although they faced very expensive legal battles up to the European Court in Strasbourg so that they would both be registered as legal parents, and to obtain Spanish citizenship for their children. Even more than 10 years after their twin's

birth a Spanish court order would have required them to remove one of their names as a parent from the register, but the Spanish authority could not decide which one, so they never forced this. By the time this chapter is published this order will be barred and their registration as parents cannot be revoked anymore.

Guillermo emphasized their continuing very good relationship (after 10 years) with their surrogate (which came up in most of my interviews with Spanish gay men). This relationship with the gestational woman was also desired by their children who wanted to meet the surrogate's own children. He saw this as a bond of 'siblings of one uterus'. According to him, their surrogate earned more money than his husband, and claimed to be a feminist who would have never agreed to this procedure if she had felt pressured or exploited. However, the question remains if surrogacy does not replace one kind of bioprecarity with another (see Elina Nilsson's chapter in this volume), meaning that the reproductive bioprecarity of the two gay cis men is transferred onto the surrogate, leaving her exposed to her own kind of bioprecarity in relation to the intimate labour she provides. It is not obvious how regulations around surrogacy can be done so that no bioprecarity exists for the gestating woman. This might be the next step towards solving the paradox of gay men's reproductive bioprecarity.

Bisexuality: Reproductive bioprecarity when categorisations fail

Not belonging to an identity category, whether straight or same-sex category (both these are recognized for ART purposes in EU countries, even if sometimes for the purposes of exclusion), creates other kinds of challenges. These require a certain intimate and emotional labour to overcome reproductive bioprecarity. Ann (around 36-40 years old, living in a big city in the UK with some health issues and a longstanding illness/disability, in paid work, higher education, who found it difficult to live on her present income) self-identified as bisexual and was single during the ART process. She told me about her struggle to find her way through the reproductive jungle. After several miscarriages she went to different medical institutions (GP, NHS, a specialized genetic institution, and a women's health institute) only to discover that for medical reasons she had just about 6 months left to retrieve eggs and get pregnant (sooner or later, depending on if she wanted to freeze her eggs or embryos). This tight timeframe forced her to act quickly. She decided against going abroad as she would have spent too much time trying to find the right institution and to organize the travel, and the costs

would have been equal to private treatment at home. So she stayed with the choices in the UK. The first assumption she encountered there was that she was straight, and she was pushed to freeze eggs and not embryos. This was in case she found a man later whose sperm, the medical staff assumed, she might like to use. She felt that in the first institution 'choices were made for me rather than being based on my sexuality' and she said that: 'I felt angry and frustrated. I mostly felt blocked in a system constructed around couple and not-couple, straight and non-straight.' In the next institution she tried, she therefore said she was lesbian so as not to be confronted with this assumption again. Thus, in the second institution, she developed a different strategy: 'I used a different sex orientation to access their opinion and to play with the system a bit.' The clinic she finally chose was private. They just asked what she wanted, 'and they worked with that and never asked for my sexual orientation in the four contact points I had. This felt right for me'.

Falling outside of the categories of being straight, lesbian and/or in a couple forced Ann to work out herself (which meant going to different medical institutions, doing online research) what kind of ART procedures would be available to her. In the public institutions, assumptions about her sexual orientation were made, and choices made for her that she did not like. There she felt she was forced to trick the system (i.e. lie that she was a lesbian) to receive the treatment she wanted. Her strategy for coping with being outside of the more common social categories in these institutions was to pretend to belong to a category that was recognized in this system and that allowed for the procedures she wanted to have. Finally, she opted for an institution that never asked about her sexual orientation and just administered the treatment she wanted. In the process she was forced into doing additional emotional labour by using the 'pretending-to-be-a-lesbian-strategy', since she had to misrepresent herself by 'lying' to the medical staff.

She started an IVF process and had two mandatory sessions with a counsellor. Here the focus was on whether or not she was ready to be a parent, and she had conversations around how her family would look different from a heteronormative one. She did not mind this. However, she would have wished for an LGBT-counsellor with more experience of how to protect a baby or child from possible homophobia. Her counsellor just referred to her insecurity about being bisexual, which Ann regarded as a very heterosexualized response, meaning that her counsellor did not know much about it. She felt like she needed to apologize for what she was and wanted. In the counselling situation, she would have preferred proper LGBT-treatment which is different from public ART-procedures, where she felt she had to

pretend to be a lesbian to get the treatment she wanted. A straight counsellor did not fulfill her needs, whereas a queer counsellor might have understood better her anxieties about being bisexual and wanting to have a child. Her counselling experience once again (as with the medical ART procedures) forced her to deal alone with her questions about how to confront homophobia with a child. The process required much emotional labour to overcome these challenges posed by this straight counsellor.

The most pressing issue for her was to find and have a network of other bisexual people going through these reproductive procedures. She said it is easier to find a network of families than of people trying to get pregnant. Neither her straight nor her gay friends understood her challenges fully. However, she found Stonewall's (the biggest UK LGBT-organization) web-based information useful, trusted their advice on legal rights around co-parenting, and finally decided to become a single parent based on their information.

In general it can be said that as a bisexual cis woman Ann would have benefited from LGBT-trained medical staff in public institutions who might have paid closer attention to her bisexuality and her being/wanting to be a single parent. A counsellor with LGBT training might have done a better job, as her questions were related to homophobic incidents.

When it came to other people in her social environment, different issues arose. When people asked her during her pregnancy who the father was, she told them about the ART procedure. This frequently caused a chain of reactions. As she put it: 'a desperate grasping of some form of support; such as "very sweet" followed by bafflement - why anyone would choose that? Followed by a question about my sexual orientation, followed by "oh, this is why"; (…) like a domino effect: (…) "I did not realize that"; "maybe I should not asked you that"; "oh but why"; "wait, are you not straight?"'. These people did not seem to be aware of her bisexuality at all.

Ann also felt that there is still public discomfort around ART, perhaps having to do with sensationalist media programs on ART in the UK at that time, reporting on 'super sperm donors' who are casual unregulated donors on the internet. She wished for more informed media coverage on medicalized and protected routes of becoming a parent with ART that could be useful for both the public and prospective parents.

Trans reproduction: Certain groups are more vulnerable than others

Transmale and transfemale reproduction raise different issues, so I first look at one transmale case. Mario, a queer trans boi (21-25 years old, living in a big city, in an artistic profession, finding it difficult on his present income,) said that he would like to freeze his egg cells, but for that he would need to take female hormones to stimulate his ovaries and he did not want to do that. His potential intimate labour, intervening hormonally in his body that he was already hormonally altering and which would directly contravene his gender trajectory, was already too high a price to pay, as would have been the monetary costs of egg freezing.

The second transfemale case, Karin, (bisexual, who had moved across EU countries and was living in Austria at the time of the interview, was around 36-40 years old, and living comfortably on her present income) was about to start her trans hormone treatment and wanted to secure her reproductive possibilities beforehand. She encountered challenges with finding information because storing her sperm was not allowed in Austria. It is only legal if there is a medical condition for doing so, and as gender dysphoria has been removed from the list of mental diseases, being transgender does not count as a medical reason for conserving gametes. Hence her doctors, complying with the legal frameworks, could not give her any information or advice. She had to find it herself through internet research. Private clinics in Spain and Switzerland offered such services. Since Switzerland was closer, and easier for language reasons, she wanted to go there. However, she still had to ask the clinic for the price of the storage, which has to be paid annually. In her eyes, it was a struggle to achieve the conservation of her sperm, and not everybody is up for such a struggle. When I asked her if she feared encountering transphobia at the clinic she said: 'I am not fulltime "myself" at the beginning, it will currently serve my purpose. If I go there, I will not go being "myself". I will not explain why, I will not need to. If I was "myself", I would be certainly more stressed about it, that is for sure.'

Karin wanted the EU to make storing one's gametes in one's own country more accessible rather than encouraging a form of 'shopping' in other countries: 'I do not see any ethical issue why this should not be allowed. Why is it so behind? It is not about a donor or a surrogate – it is you, you are the donor, you want to keep it and you cannot.' Here, she questions the reason for her reproductive bioprecarity in some countries. She does not understand why she should not be allowed to keep her fertility options, as there are no ethical challenges to solve.

At the end of her interview, she talked about her interview as a positive experience. She felt that with the participation in my project on queer and trans reproduction,

'it is nice to be recognized as a group (…) you are not seen as a defect of nature (laughs). I think I did participate in what one could call a normalization of how we are perceived and that this is happening', and that especially the subject of reproduction was 'subjected to a lot of resistance'. She hoped for a more 'objective vision without attachment to religious condemnation and categorization'. This statement might seem contradictory, as she first mentioned that she liked being recognized as part of a group, but then at the end seemed to be against categorization. Reading this with a bioprecarity lens suggests that she wanted to be recognized as being trans with a wish for reproduction, and that being seen as part of a group with reproductive desires might reduce vulnerability as she was not unique and hence was pressing for the normalization of her desires. However, in a sense she also hoped that normalization would reduce or eliminate categorization.

Conclusions

Early on in this chapter I discussed the responses of cis gay men in Spain, who did not see themselves as discriminated against anymore, but were still experiencing reproductive bioprecarity. The paradox regarding gay men's reproduction is that if they can afford it, they can transfer their own reproductive bioprecarity to women who gestate their babies, leaving these women to deal with the effects of their intimate labour and the bioprecarity they experience in being a surrogate.

If Guillermo is to be believed, their surrogate would have never done it, if she had felt under any kind of pressure. It is therefore possible that there are surrogacy arrangements without any kind of exploitation. Here in this assumed ideal case, the reproductive bioprecarity of the gestating woman would be associated with the intimate and bodily labour of gestating and giving birth with its usual risks, for which expenses she is compensated (in the case of altruistic surrogacy) and an extra amount paid (in commercial surrogacy). Guillermo and his partner were still experiencing administrative violence more than a decade after they had returned with their babies to Spain. Their reproductive bioprecarity continued after birth because of the prohibitive laws in their home country.

As Ulrika Dahl mentions in her chapter in this volume, interdependency is needed to overcome precarious situations. In this example, the gay couple was interdependent with their surrogate with whom they and their children still had a very good relationship, and with the legal system in their country and in the EU. A way to overcome the struggles around

reproductive bioprecarity and intimate labour of all the people involved (intended parents, surrogate (mothers), potential children) would be to pay attention to this interdependence and to clarify and make these forms of interdependence visible, rather than attempt, for example, to adjust or assimilate this reproductive constellation to traditional heteronormative family norms.

In her research on 'troublesome surrogacy' Ingvill Stuvøy comes to the conclusion that it is better to 'find a way to think in the terms of reproductive relations' (2018: 40). She argues for acknowledging those who assisted others in their biological reproduction and that these 'assisters' should not just be erased so that the intended parents can fit the traditional family and parenthood norm. For her the goal is to move away from the current surrogate processes and instead move towards a more relational-being-together (as already occurs in many gay men's surrogacy arrangements, as my data show). This would also 'expand our ideas of family to include more categories of people' (Lewis, 2018: 222; Stuvøy, 2018: 40) and would have the advantage of reflecting the collaborative effort and treating the 'assisters' as 'full human beings' (Rudrappa, 2015: 186; Stuvøy, 2018: 40). Stuvøy recognizes that this will not occur readily, but I think it could be a start to tackle reproductive bioprecarity on both sides. In order to register these collaborative efforts to create new forms of family and reproductive relations, new laws and administrative models have to allow for reproductive constellations involving more people and different family positions than just the hetero- or homonormative couple norm, which should be changeable over time according to the wishes, duties and agreements of the involved persons. Perhaps a pragmatic solution to the messiness of these reproductive relations would be, as Gabriele Griffin and I have suggested elsewhere (forthcoming), to create different kinds of registration: one which is a public document and which is adjusted to more traditional family norms and can be used even in more discriminatory environments (for example if the family moves to a more discriminatory country), and another, restricted document only accessible to the people involved in the specific reproductive constellation or with their consent, and which contains details of the names and positions (categories) of all involved people.

The above case shows how the concept of bioprecarity may be mobilized to analyse the challenges of reproduction for gay cis men. As Judith Butler has argued, precarity (in distinction from vulnerability) serves as a political tool towards self-transformative politics (2009: 3, 25-28). In the above case we can see how particular forms of reproductive bioprecarity could be solved with transformative family regulations. In the other cases such as

having a bisexual identification and being single in institutions used to dealing with hetero- or homosexual couples, reproductive bioprecarity occurs in so far as certain medical procedures are assumed to be the best choice for the client without taking her bisexuality into account and leaving the intending parent alone to find the right information and procedure for themselves, which can also be the case for intended trans parents. More readily available information, and medical and psychological staff training can improve this situation, as would more bisexual networks for intended parents.

Trans people's reproductive bioprecarity is even worse, as being categorized as trans fosters the notion among cis gendered people that trans people have no reproductive wish. Here the first step in order to reduce their reproductive bioprecarity would be just to normalize the idea that trans people too want to have children with their own gametes. Many of them, depending on the couple constellations and on their own bodies, would not even require a donor or surrogate to reproduce; they may simply need to store their own gametes. But we seem some way away from achieving such redress, at least in many European countries.

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[1] The full title of the MSCA-Fellowship is *QTReproART: Towards an Inclusive Common European Framework for Assisted Reproductive Technologies (ART): Queer & Transgender Reproduction in the Age of ART* (H2020-MSCA-IF-2016, Grant Agreement 749218). More information about the project is available under https://www.gender.uu.se/forskning/qtreproart/.

[2] 'Jusqu'à maintenant, nous avons payé notre dissidence sexuelle par le silence genetique de nos chromosomes. Nous n'avons pas seulement été privés de la transmission du patrimoine économique: notre patrimoine genetique aussi nous a éte confisqué. Homosexuels, transsexuels, et corps considérés comme "handicaps", nous avons été politiquement sterilizes ou bien nous avons été forcés de nous reproduire avec des techniques hétérosexuelles' (Ibid).

[3] The name has been changed to preserve anonymity, and the interview paraphrased and translated into English by this author.