

Service Use and Gaps in Services for Lesbian and Bisexual Women During Donor Insemination, Pregnancy, and the Postpartum Period

Lori E. Ross, PhD,¹ Leah S. Steele, MD, PhD,² Rachel Epstein, MA³

¹Women's Mental Health and Addiction Research Section, Centre for Addiction and Mental Health, Toronto ON

²Department of Family and Community Medicine, St. Michael's Hospital, University of Toronto, Toronto ON

³LGBT Parenting Network, Family Service Association of Toronto, Toronto ON

Abstract

Objective: Increasing numbers of lesbian and bisexual women are choosing to have children. This qualitative study investigated the degree to which a sample of Canadian lesbian and bisexual women were satisfied with the health and social services that they received during the process of trying to conceive, during pregnancy, and during the early postpartum weeks and months.

Methods: Three focus groups were conducted: (1) women who were themselves, or whose partners were, in the process of trying to conceive (n = 6); (2) biological parents of young children (n = 7); and (3) women who were non-biological parents of young children or whose partners were currently pregnant (n = 10). Participants were asked to discuss their positive and negative experiences with health and social services during their efforts to conceive and through the perinatal period.

Results: Participants were very satisfied with the care they received from midwives, doulas, and public health nurses. Services directed specifically to lesbian, gay, and bisexual parents were also perceived to be important sources of information and support. Many participants perceived fertility services to be unsupportive or unable to address their different health care needs.

Conclusion: Participants expressed satisfaction with pregnancy-related services provided by non-physicians and dissatisfaction with services provided by physicians and fertility clinics. There is a strong desire for fertility services specific to lesbian and bisexual women, but even minor changes to existing services could improve the satisfaction of lesbian and bisexual patients.

Résumé

Objectif : De plus en plus de femmes lesbiennes et bisexuelles choisissent d'avoir des enfants. La présente étude qualitative s'est penchée sur le degré de satisfaction d'un échantillon de Canadiennes lesbiennes et bisexuelles envers les services sociaux et de santé dont elles ont bénéficié au cours de leur

tentative de concevoir, au cours de la grossesse, ainsi qu'au cours des premières semaines et des premiers mois à la suite de l'accouchement.

Méthodes : Trois groupes de discussion ont été menés : (1) femmes tentant elles-mêmes de concevoir ou dont la partenaire tentait de le faire (n = 6); (2) parents biologiques de jeunes enfants (n = 7); et (3) femmes étant les parents non biologiques de jeunes enfants ou dont la partenaire était alors enceinte (n = 10). Nous avons demandé aux participantes de discuter de leurs expériences positives et négatives en ce qui a trait aux services sociaux et de santé au cours de leurs efforts visant la conception et tout au long de la période périnatale.

Résultats : Les participantes ont été très satisfaites des soins qu'elles ont obtenu de la part de sages-femmes, de doulas et d'infirmières de santé publique. Les services visant particulièrement les parents lesbiens, gais et bisexuels ont également été perçus comme étant d'importantes sources de renseignements et de soutien. Bon nombre de participantes ont perçu que les services de fertilité ne leur offraient pas de soutien ou n'étaient pas en mesure de répondre à leurs besoins particuliers en soins de santé.

Conclusion : Les participantes ont exprimé avoir été satisfaites des services de grossesse offerts par des professionnels n'étant pas des médecins et insatisfaites des services offerts par les médecins et les cliniques de fertilité. L'offre de services de fertilité s'adressant particulièrement aux femmes lesbiennes et bisexuelles est grandement souhaitable; cependant, l'apport de modifications mineures aux services existants aurait suffi à améliorer la satisfaction des patientes lesbiennes et bisexuelles.

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INTRODUCTION

Many lesbian and bisexual women have or wish to have children.¹ Although some have had children in previous heterosexual relationships, a significant number of women choose to have children either through adoption or donor insemination after identifying themselves as lesbian or bisexual.^{2,3}

Through the process of insemination, pregnancy, and parenting, the service needs of lesbian and bisexual women

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will often be similar to those of heterosexual women. However, there are significant ways in which the family context of lesbian and bisexual women differs from heterosexual women, and these differences may have implications for service delivery. For example, lesbian and bisexual women may wish to be inseminated by a man who is known to them but is not a sexual or intimate partner (e.g., a gay male friend or co-parent).³ For women who are in a same-sex relationship, both partners are often potentially able to carry a child, and they must decide which woman will be the biological mother.⁴ During pregnancy and the postpartum period, services developed primarily for heterosexual fathers may not be accessible to or useful for non-biological lesbian mothers.⁵ Homophobia and heterosexism faced by lesbian and bisexual women in their daily lives may be an important determinant of their need for and ability to use health care services. Anticipated or actual discrimination by health care professionals may also determine the extent to which lesbian and bisexual mothers take up pre-conception and perinatal health services.^{3,6}

A growing body of evidence has shown lesbians have lower rates of access to general health care services despite having higher rates of health behaviours that put them at risk for illness (including smoking, alcohol use, and obesity).^{7,8} Although little research has investigated the reasons for lack of general health care access, lesbian, gay, and bisexual populations are believed to face personal and cultural barriers to access that lead to delays in seeking care and preventive services. Barriers include the fear of disclosing sexual orientation to providers, a lack of cultural competency among health care providers, and a lack of appropriate services.⁹ Even less research has been done to explore health and social service use by lesbian and bisexual women during donor insemination and the perinatal period. One early survey of 35 lesbian mothers found that participants were generally satisfied with their obstetric care, although women who used midwives for care reported higher levels of support and satisfaction than did women who used physicians.¹⁰ A more recent study combined qualitative and quantitative methods to describe the maternity care experiences of a volunteer sample of 50 lesbian mothers in the UK. In this study, although the majority reported overall satisfaction with their maternity care, problems were noted, particularly in relation to disclosure of sexual orientation to providers and to heterosexism in antenatal classes.¹¹

To our knowledge, no published studies have examined the satisfaction of Canadian lesbian and bisexual women with the health and social services related to pre-conception and the perinatal period. Providers of fertility, obstetrical, and postpartum care have a responsibility to assess how useful and accessible these services will be for the increasing

number of lesbian and bisexual women who choose to use them. With this goal in mind, we report on findings from three focus groups with lesbian and bisexual parents and prospective parents about their experiences using health and social services for pre-conception and perinatal care.

METHODS

Three focus groups were conducted at a downtown Toronto community health centre between November 2003 and January 2004. Toronto has a large and diverse lesbian, gay, bisexual, and transgender and transsexual (LGBTT) community, including a significant number of LGBTT parents. There are also several small suburban and rural communities close to Toronto, which enabled us to include participants receiving services both in downtown Toronto and in smaller communities.

Participants were recruited primarily via email flyers distributed through key contact people and listservs for the LGBTT and parenting communities in Toronto and the surrounding area. Paper copies of flyers were also distributed to local community health centres and women's centres. Interested participants self-referred for the study by telephone or email. They were then screened by telephone to determine their eligibility. In order to be eligible, participants were required (1) to identify themselves as lesbian, gay, bisexual, transgender, transsexual, or two-spirited (see Table for definitions), and (2) to be the biological or non-biological mother of a child less than three years of age, to be an expectant biological or non-biological mother (i.e., one partner being currently pregnant), or to be a prospective biological or non-biological mother (i.e., one partner trying to conceive). Adoptive parents, bisexual women parenting with male partners, and parents of children older than three years were excluded from the focus groups, since they were anticipated to have service needs different from the target participants.

Focus groups were each 1.5 hours in length and were facilitated by the first author (LER). The groups were semi-structured and in each group participants were asked to discuss three primary subject areas. This paper focuses on the results for one of these subject areas: the experiences of participants using health or social services during pre-conception, pregnancy, or parenting. Although the same discussion guide was followed for all three focus groups, its application was flexible and allowed participants to define and discuss other topics they felt were relevant to their experiences.

Written informed consent was obtained from each participant before the focus groups. The protocol was approved by the local Institutional Ethics Review Board.

Definitions of relevant terms

Lesbian/gay	“Lesbian/gay”: Terms to describe individuals whose primary sexual and affectional relationships are with members of the same sex. The term gay is sometimes used to refer to either men or women, although it is becoming more common to refer to men as gay and women as lesbian.
Bisexual	“Bisexual”: An individual who is attracted to people of either sex or gender.
Transsexual	“Transsexual”: A term for people who feel internally that they are of the opposite sex and gender to that in which they were socialized from birth. Transsexuals may undergo surgery and/or hormone therapy in order to make their bodies fit what they feel is their true sex and gender.
Transgender	“Transgender”: A term for people who cross gender norms but may choose not to modify their bodies medically. People who identify as transgender may identify as and express a gender that does not match their biological sex, or may not embrace binary gender systems at all.
Two-spirited	“Two-spirited”: Some Aboriginal traditions recognize three or four different genders. Two-spirited people are Aboriginal individuals who identify as being of both male and female genders. Two-spirited identity is not exclusively about sexuality but is about physical, mental, emotional, and spiritual expression and experience. Two-spirited people may identify this way based on gender identity or sexual orientation.
Biological mother/non-biological mother	The term “biological mother” refers to a woman who bears a child, and “non-biological mother” refers to the intimate partner of a woman who bears a child, who is involved in parenting that child. Other terms synonymous with non-biological mother that have been used in the literature on lesbian families include “co-mother” and “social mother.”
Homophobia	“Homophobia”: prejudice against (fear or dislike of) LGBTT individuals and behaviour based on this prejudice.
Heterosexism	“Heterosexism”: systemic policies and practices that favour heterosexual individuals and couples over LGBTT individuals and couples; a frame of mind or world view that holds heterosexuality at its core

LGBTT: lesbian, gay, bisexual, transsexual, transgender

Focus groups were tape-recorded and transcribed verbatim. After the accuracy of the transcripts had been verified by the facilitator, they were entered into the qualitative text management software package QSR N6 (QSR International Pty Ltd, 2002, Melbourne, Australia) and analyzed using thematic content analysis. Data from the three focus groups were coded into a number of themes; these themes primarily emerged from the data but were also informed by existing literature. Following the coding procedure, the text under each node was summarized into an analytic theme memo.

RESULTS

A total of 23 women participated in this study: six women participated in the focus group for prospective LGBTT parents, seven women participated in the focus group for biological mothers, and 10 women participated in the focus group for non-biological mothers or expectant non-biological mothers. All of the participants had intimate partners at the time of the focus groups. Participants had a mean age of 33.6 years (range 22–43 years). Participants who were trying to conceive had been doing so for a range of one month to more than two years. The mean age of the

youngest child was 6.2 months for parents in the biological parents group and 11.9 months for parents in the non-biological parents group. Two women in the non-biological parents’ focus group had partners who were pregnant at the time of the interview. Eighteen (78%) of the participants identified as lesbian, with the remaining participants identifying as gay, bisexual, two-spirited, or queer. Eighteen (78%) of the participants were Caucasian, two (9%) were Aboriginal, two (9%) Black Canadian, and one (4%) South Asian. Seventeen of the participants were parenting or planned to parent solely with a partner, two were parenting with a partner and an involved known donor, two were parenting or planned to parent with a partner and other close family and community members, one intended to parent with a co-parent not her partner, and another planned to be the sole parent of her child.

Three main categories of text related to services were extracted from the data: (1) experiences with pre-conception care; (2) experiences with care during pregnancy; and (3) experiences with postpartum services and support.

Pre-Conception Care

Some participants, especially those already parenting, reported being very satisfied with their experiences of medically assisted donor insemination. Some participants used donor insemination services through sperm banks and were pleased with the care they received there. However, most of the focus group discussion about donor insemination and fertility services highlighted negative experiences the women had in the process of trying to conceive. In particular, both non-biological parents and prospective parents were largely dissatisfied with the care they had received from these services, as described below.

High Cost of Semen and Semen Processing

The cost of services associated with donor semen for insemination was described as a significant barrier and stressor for many participants in all groups. At present, the cost of obtaining cryopreserved donor semen in Toronto ranges from about \$700 to about \$950 per cycle. Perceived inconsistency in costs, both between and within sperm banks, created additional stress for participants as they struggled to understand the fees. Some women in the pre-conception group discussed their belief that sperm banks charge much more than is necessary to recover their costs. Women perceived a lack of transparency and consistency in billing that contributed to their sense of being exploited financially:

They would charge \$100 extra per unit [of sperm] and they would say [to her friend] it was for syringes. And then [to a different friend] they said it was GST and PST. . . . It was really shady, and that was probably the biggest stress for me.

Another area where financial barriers were noted was in access to testing of semen from known donors for cryopreservation. The cost of testing, processing, and storing semen from known donors is at least as high as the cost of purchasing semen from anonymous donors and can often be higher:

We thought about using a sperm bank, but because we wanted to use a known donor, it was just financially impossible. Because if you're using a known donor, and using the sperm just for yourself, you have to pay all the costs associated with him donating the sperm and it ends up being . . . some crazy number.

Limited Donor Selection

Participants expressed frustration with the limited selection of donors available through sperm banks. This was particularly an issue for women who were not Caucasian or whose partners were not Caucasian and who wanted their child to share their ethnocultural background:

I'm Métis and my partner is First Nations, and we've been trying to do an unknown donor, which is almost

impossible, because sperm banks don't keep First Nations people because of their backgrounds of diseases like heart disease and diabetes . . . so that's been the most trying part because neither one of us wants to raise a child that is not ethnically connected to us.

Some participants were also disappointed with the small number of identity-release donors available (i.e., donors who are willing to have their identity released to the child when the child reaches the age of 18):

When you go to the sperm bank, you can choose someone who is okay with being known in the future or being contacted in the future, and there are so few donors that are willing to do that, that it's limited. And we didn't end up going that route, but that's really what we would have preferred.

Barriers Related to Sexual Orientation

Participants reported barriers to specific fertility services as a consequence of their sexual orientation or that of their donors. This was particularly true for some participants living outside Toronto who were required to undergo a home study and police check before being permitted access to fertility services. Participants who wanted to use a known sperm donor did not have access to insemination services for their proposed donor through their sperm bank or fertility clinic if he had been sexually active with men. In that case, special permission from Health Canada was required, followed by a six-month quarantine period. Most women saw the resulting delay as prohibitive. All participants who were having difficulty conceiving reported that they either would not use or were dissatisfied with fertility clinic counselling services because these services were designed for heterosexuals:

My doctor at one point said, "You might want to access the fertility counsellor," but I haven't because I know that the majority of clients they serve are straight.

Finally, some participants described the environment at their fertility clinics as uncomfortable for lesbian and bisexual women. In some cases, women had the impression that their fertility clinics were serving them not because they wanted to help lesbian and bisexual women form families, but because the clinic staff felt they had no other choice.

The Medicalization of Conception

Those women who used cryopreserved sperm had used insemination services in clinics that primarily dealt with infertility. Many of these women reported that multiple medical interventions (e.g., bloodwork, ultrasound examinations, medication) were often the norm. Some women welcomed these interventions, which they saw as helping them to conceive more quickly, but others were

uncomfortable with the “medicalization” of what they perceived to be a natural process:

I think because at the clinic they are used to dealing with people with fertility problems, it's almost like you got treated as a fertility problem from day one instead of just somebody who wanted to get pregnant. So they had all these tests and stuff that they would do, and I guess we could have said no, but we are also thinking that we want to make sure that it's going to go as smoothly as possible.

LGBTT-Specific Services

Women who were trying to conceive agreed that insemination services developed specifically for LGBTT families would be extremely helpful. Participants reported a desire for a sperm bank with a pool of donors of diverse ethnocultural origins and for access to semen analysis and sexually transmitted infections testing for known donors who are gay.

Many participants reported using information and support services designed specifically for LGBTT parents. In particular, several women had participated in the “Dykes Planning Tykes” course, a program for lesbian and bisexual prospective parents offered through a community centre in downtown Toronto. Some participants living outside Toronto reported either travelling into Toronto to take the course, or making use of the course “textbook.” Participants reported that the course was helpful, not only for the information it provided, but also for the support network it enabled them to create involving other women who shared many of their experiences.

Legal barriers to conception

As noted above, special permission from Health Canada is required for Canadian health care providers to process and distribute donor sperm from a man who has had sex with men. The women in our study often chose gay men to be donors, and these women therefore faced additional barriers to testing and insemination services that were more readily available to other women. Canadian regulations also require that donor inseminations with cryopreserved sperm occur under the supervision of a physician. It may be difficult for women who wish to use cryopreserved sperm to find the appropriate medical services. Finding health professionals who would perform inseminations was a particular challenge for women living outside downtown Toronto:

There are some laws that offer a very oppressive framework for lesbians trying to use fertility clinics to become pregnant. And some clinics have worked hard to work under that framework and still provide good services, but a lot of clinics are not making an effort and use some of the laws as an excuse.

Women faced uncertainty regarding the parental rights of same-sex families should a known donor later petition for custody or access to the child. As a result of this uncertainty, many women felt it was necessary to establish a contract with their donor before insemination. Usually, legal services were needed, which became very expensive since the donor and each partner were required to have separate legal counsel:

We had a very, very long contract drawn up with [the donor] . . . and we were told that although it shows intention, it will really not stand up in court; that it will be interpreted in the best interest of the child, and that may or may not be what we want. So that was pretty stressful. And plus, the lawyers tried to split us up at every path. So every time we drew up a contract, they would send our donor off to get another lawyer, and me off to get another lawyer, and to try at any point to make that contract as a couple rather than two individuals is very hard.

Care During Pregnancy

Prenatal Classes

Some participants reported positive experiences with their prenatal education. For example, in some cases there were other same-sex couples in the classes, and participants had the opportunity to discuss their shared experiences. However, many participants reported heterosexism in their prenatal classes, particularly with regard to the use of exclusive language:

I thought that the language was exclusive to a lot of people. It was, “you and your husband, you and your husband.” Well, there are single people here; there are people who aren't married. She'd keep correcting herself after the fact—“I mean partner, whatever.” . . . No, it's not whatever.

Obstetric Care

Participants reported only positive experiences with care from midwives and doulas. Indeed, one participant described midwifery care as “the best health care we ever got”:

We were planning a home birth but ended up having to go to the hospital, and [the midwife] was a dream at the hospital. I think that she helped shepherd this lesbian couple through things. The nurses were good, but I think that she cleared the way. We had one offensive doctor . . . she dealt with him in a really efficient way.

Participants were pleased with midwives, not only for the health care they provided, but also for their willingness to act as patients' advocates in interactions with other health care providers. For some participants, primary care

providers and gynaecologists also acted as advocates, for example, referring them to hospitals or fertility clinics that they knew to be more accepting of lesbian families. Negative experiences with obstetric services tended to occur when participants encountered hospital staff with whom they did not have a pre-existing relationship, or when hospital policies did not account for same-sex family structures:

There was no connection there to my partner, whereas, I think if we were a straight couple, they would have been more looking at my husband . . . so I don't know if it was the fact of the actual birth plan, or the fact that we were a same-sex couple, or because we said this is what we want to do—we were getting some resistance from the staff.

From the very first day when [her daughter] was born, we're in the hospital, and they give us the wrist bands. . . and the wrist bands say "mother," and the other one says "father," right on the wristband. And I thought, couldn't you just give us two "mother ones, is that going to confuse everybody too much?

Postpartum Services and Support

Participants reported using few services for postpartum support. Most support after the birth seemed to be provided by informal sources such as friends and family members. However, one participant described a very positive experience with a public health nurse who visited the home to provide postpartum support.

After childbirth, most participants used the legal system to complete the process of second-parent adoption. In Ontario, a non-biological mother must adopt her child through second-parent adoption before she can have a legally recognized parental relationship. Because Canadian law currently states that a child cannot have more than two legal parents, lesbian couples who have an involved sperm donor must consider carefully whether that donor will waive his legal rights to the child, enabling the non-biological mother to become a legal parent. A legal clinic was the service participants in the focus group for non-biological parents wanted most. This was suggested as a program that could be offered as part of a family health centre.

Participants who were non-biological parents reported some problems using pediatric and child care services. In particular, participants reported that some pediatric and child care service providers were unwilling to recognize the non-biological mother as a legitimate parent.

DISCUSSION

This is the first study to focus on the experiences of Canadian LGBTT women who are trying to conceive, who

are pregnant, or who are newly parenting, in their use of public services. Participants in our study faced added challenges in the process of trying to conceive that were often directly related to their sexual orientation or the sexual orientation of their chosen donor. Positive experiences were reported in relation to care in pregnancy delivered by midwives and doulas. After childbirth, participants tended to be supported by accepting family and friends rather than the health system. The challenges facing participants who were new parents were most often legal challenges related to parental rights.

Like many qualitative studies, this study is limited by a small, mostly Caucasian, volunteer sample. Results may not generalize to the broader community of lesbian and bisexual women using pre-conception and perinatal health care. Although transgender and transsexual women were eligible to participate in this study, we were unsuccessful in recruiting transgender or transsexual women with children younger than three years of age. Further research that focuses on the transgender and transsexual communities would be valuable.

CONCLUSION

There are several simple steps that providers can take to improve the delivery of existing services to the LGBTT population and to reduce barriers to care. Health care providers who offer fertility services can ensure that LGBTT women do not face hurdles to care, such as requirements for home studies or police checks, that heterosexual women do not face, and can ensure that clinic intake and hospital forms use language that is inclusive of different types of family structures, including same-sex partners. They could seek to include women's partners and, if requested, women's sperm donors or co-parents in discussions related to conception and childbirth. Care providers can become knowledgeable about LGBTT-positive health services that are available in their community and facilitate their patients' referral to these services. Finally, they can advocate for federal and provincial policies that will establish the provision of assisted reproductive services that are accessible, equitable, flexible, and cost-efficient.

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