ARK Policy Brief

LGBTQ+ Community's Journey to Parenthood:
considering the health inequalities and the legal implications that exist in the pursuit of parenthood for the LGBTQ+ community in Northern Ireland

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Introduction

This briefing paper sets out emerging evidence regarding the pursuit of parenthood for the LGBTQ+ community in Northern Ireland (NI). It identifies both the health inequalities and the legal implications faced by this community in the pursuit of parenthood and examines the implications for policy. The evidence is drawn from published studies; data from the Northern Ireland Life and Times (NILT) surveys (2012; 2018) and key findings of an in-depth research study that explored the human development and well-being of the LGBTQ+ community in Northern Ireland (NI) (Mackle, 2019). This in-depth study comprised 35 semi-structured interviews with individuals identifying as LGBTQ+ and 5 interviews with stakeholder organisations.

Note: this paper uses the term trans inclusively to cover transgender, non-binary, gender diverse, gender fluid and other non-cisgender identities.

Fertility Policy - The Global and UK Context

The Human Rights (UK) Act (1998) stipulates that having children is a human right (WHO, 2008) however, in many countries, same sex couples (and individuals) are faced with barriers when it comes to pursuing parenthood. The academic literature has highlighted that limited research exists that considers LGBTQ+ fertility (Hodson et al., 2017; Schwartz and Baral, 2015; Thomas et al., 2017). Schwartz and Baral (2015) noted that there is an assumption that LGBTQ+ individuals and couples do not aspire to parenthood. Indeed the literature has noted that 'coming out' i.e. disclosing ones sexual orientation to the self and others often implied a reproductive loss and a life without children due to the inability to conceive in the same vein as heterosexual couples (Smietana et al., 2014; Stacey, 2018; Weeks, 2018).

Other literature has noted however, that approximately 50% of lesbian women (within child-bearing age) desire to be parents (Amato and Jacob, 2004; Chambot and Ames, 2004) and according to the Department for Education (England), 1 in 7 adoptions in England in 2018-19 were by LGBTQ+ adopters (DfE, 2020). A more recent study by Family Equality (2019) has determined that 63% of LGBTQ+ Millennials (aged 18-35) are considering expanding their families, either becoming parents for the first time, or by having more children.

Despite the desire among LGBTQ+ individuals and couples to become parents, international research from the US, Canada and Sweden indicates that access to fertility treatment is often deeply problematic, subject to restrictive legal frameworks, regulatory limitations, patchy service provision and ability to pay (Corbett et al.,2013; Kazyak, and Woodell, 2016; Kissil and Davey, 2012; Rozental and Malmquist, 2015). Similar findings have been evident in UK research. The first Human Fertilisation and Embryology Act (1990) hindered same sex couples from accessing fertility treatment stating that providers had to consider a child's 'right to a father', banning lesbian couples and single women from treatment (Donovan, 2000). Commentators argued that the rationale behind this ban was influenced by public debates that linked delinquency and criminality in young people to the absence of a father figure. However, such claims have been challenged

(Donovan, 2000; Wilson, 2007; Wykes, 2012). The legislation was later ruled to be discriminatory and amended in 2008 to allow lesbian couples and single women access to fertility services (Woodward and Norton, 2006; Wilson, 2007).

Lesbian women (and bisexual women in a same sex couple)

Despite the changes in legislation, there is evidence that lesbian/bisexual women seeking fertility treatment are discriminated against on the National Health Service (NHS) (Evans, 2000; Barbara et al., 2001; Harrison, 2006) leading women to make informal self-fertilisation arrangements. This is influenced by guidelines from the National Institute for Health and Care Excellence (NICE), a non-departmental body providing advice and guidance to improve health and social care in the UK. In 2013 NICE set out guidelines on what NHS funding should be available to lesbian couples seeking fertility treatment, prior to this, there were no official guidelines (Wykes, 2012). The NICE guidelines were updated in November 2020 and deem that access criteria to IVF on the NHS is as follows:

- In women aged under 40 years (with a Body Mass Index of 19-30) who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination), offer 3 full cycles of IVF, with or without ICSI. If the woman reaches the age of 40 during treatment, complete the current full cycle but do not offer further full cycles.
- In women aged 40–42 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination (where 6 or more are by intrauterine insemination), offer 1 full cycle of IVF, with or without ICSI, provided the following 3 criteria are fulfilled: they have never previously had IVF treatment, there is no evidence of low ovarian reserve and there has been a discussion of the additional implications of IVF and pregnancy at this age.
- Where investigations show there is no chance of pregnancy with expectant management and where IVF is the only effective treatment, refer the woman directly to a specialist team for IVF treatment.
- In women aged under 40 years, any previous full IVF cycle, whether self- or NHS-funded, should count towards the total of 3 full cycles that should be offered by the NHS. Take into account the outcome of previous IVF treatment when assessing the likely effectiveness and safety of any further IVF treatment (NICE, 2020).

The guidelines state that lesbian couples who have not conceived after 6 cycles of donor insemination should be offered a further 6 cycles of unstimulated intrauterine insemination (IUI) before IVF is considered (NICE, 2020). The guidance does not stipulate if couples need to have attempted these first 6 IUI attempts via a private clinic or if using private arrangements with donor sperm at home will deem couples eligible for NHS treatment (however, these private donor arrangements will have legal implications in terms of parental responsibility). Stonewall (2017) previously identified that lack of clarity on this issue has led to treatment being offered in England at the discretion of individual NHS health trusts. It has been noted that some trusts in England require lesbian couples to use private fertility clinics to attempt conception before considering NHS funding for IVF (Nordqvist, 2011a).

The most up to date guidelines for Northern Ireland have stated that "women trying to conceive using artificial insemination, who have not conceived after four cycles of donor insemination, should be offered four cycles of unstimulated intrauterine insemination (IUI) before referral for IVF is considered" (Belfast Trust, 2019:1). If after 8 rounds of donor insemination with a minimum of 4 IUI cycles, women will then be offered one round of IVF. Heterosexual couples do not face this additional financial requirement of paying for donor sperm and IUI treatment. As a guide, the most up to date private costs in NI include the initial consultation with scans and blood tests:

£450; donor sperm including delivery: £950; IUI treatment: £1275 resulting in the first round of unmedicated IUI costing women £2675 and subsequent IUI cycles approximately £2,225 (Belfast Fertility, 2021).

Currently, the NI Health and Social Care Board offer one cycle of IVF fertility treatment and one frozen embryo transfer (if applicable) to those who meet the strict criteria in terms of age, BMI etc. from their publicly funded NHS cycle. The inequality becomes apparent when treatment provision is compared to Scotland and Wales where three cycles are offered; the number of cycles offered in England is dependent on the local authority area (Fairness in Fertility, 2021). Self-arranged conception is often practiced by those unable to access treatment on the NHS as a result of age, BMI, inability to prove donor insemination rounds or ability to pay private providers for donor insemination via IUI (Nordqvist, 2011a, 2011b; Priddle, 2015; Wykes, 2012). While the NHS sets a strict BMI limit of 30, private clinics will allow patients with a BMI of up to 40 to pay privately for treatment if their general health is good. Recent research has found that that women who identify as lesbian or bisexual are at increased risk of being overweight or obese (Semelyn et al., 2019). This strict BMI limit may force lesbian women to consider unregulated means of conception if private fertility costs are unaffordable.

There are notable risks associated with unregulated conception both in terms of health and the legalities around parenthood (Nordqvist, 2011a). The NHS and private fertility clinics are regulated by the Human Fertilisation and Embryology Authority; this means that donors are anonymous to couples (however, children can request information about the donor when they are eighteen) and as such, the donor is not considered the legal parent of the child (Nordqvist, 2011a; Wykes, 2012). In self-arranged scenarios, UK law recognises the sperm donor as the father and by law, he can claim parental responsibility. In NHS and private clinics, donors are rigorously screened undergoing physical, mental and sexual health checks (HFEA, 2017). In self-arranged scenarios unregulated sperm may pose a health risk to women and any resulting child, particularly in terms of sexually transmitted diseases such as HIV (Amato and Jacob, 2004; Wykes 2012).

As demonstrated in the following section, cases such as these raise a number of issues for policy makers.

- Many women cannot afford private clinic costs for donor insemination cycles
- Women may use donors known to them – this brings with it a need to consider legal matters surrounding parenthood.
- Women may meet donors unknown to them, risking sexual violence.
- Women may use unregulated sperm and risk the health of themselves and any resulting child.

Northern Ireland: research findings from the NILT survey and an in-depth qualitative study of the LGBTQ+ community

There is a lack of recent data on public views on the pursuit of parenthood for the LGBTQ+ community in Northern Ireland. The NILT survey (2012) however, did pose attitudinal questions pertaining to the LGBTQ+ community in relation to adoption and access to IVF for lesbian women. At the time of the survey, adoption by LGBTQ+ couples was not legal in NI; however, the adoption legislation was changed in 2013 to allow same sex couples to apply to adopt. The NILT data highlighted that in terms of adoption for female same sex couples, only 39% of respondents approved. The approval for gay men adopting was even less with 34.5%. When asked if lesbian women should be able to access IVF on equal terms as heterosexual women, only 45% of respondents noted their approval.

These views were evident in Mackle's study of the health and well-being of the LGBT community in NI (Mackle, 2019). It was evident that society's common assumption that the family is heterosexual in its composition had led to stigma and that the stigma had manifested in accessing fertility services.

Women who identified as lesbian/bisexual

Women who identified as lesbian/bisexual could not access fertility treatment on the NHS unlike their heterosexual counterparts and same-sex couples in the rest of the UK. Access to fertility treatment for lesbian women in NI only changed in 2019, to allow lesbian women who have attempted four rounds of donor insemination, to undergo a further four rounds of unstimulated IUI before they will be considered for an IVF referral (Belfast Trust, 2019).

This led to risk-taking behaviours amongst lesbian/bisexual women seeking parenthood, such as self-arranged conception, as access to private treatment was prohibitive for most, with one round of IVF treatment with a 33% success rate costing £6,000 (Mackle, 2019; GCRM, 2020).

> Like who has 5 to 10 (£5,000 - £10,000) grand kicking about in their bank accounts? I work for minimum wage, there's no way I could have taken out a loan and I don't own my own house to be able to re-mortgage, it's mad what people have to do to get pregnant (Female, 30).

Despite this, another LGBT participant highlighted that the fact that private fertility treatment is available to lesbian women now is a positive thing, she stated:

> If this had of been available twenty years ago, my life would have been so different, the only way to get pregnant then was with a man (Female, 53).

This risk-taking behaviour included finding "sperm donors" online, meeting them and either self-inseminating or having sexual intercourse, without knowing anything about the man's sexual or medical history:

> Women are putting lives at risk by meeting donors online, they meet at hotel, they don't know the person, they don't know if they will be safe meeting the man, they don't know anything about him or his sexual history, no health checks. Some women are so desperate to become mothers that they will go to any lengths. Some women will have a one-night stand in order to get pregnant (Female, 42).

> The way lesbians are getting pregnant these days is so scary and I am including two of my mates in this, just meeting men off the internet, not thinking about any genetic issues, not thinking about if they will be safe in terms of STDS, never mind the legislative ramifications of this, like, if insemination is not done by a clinic, then the donor has parental rights. Women don't know these men, they are putting their lives at risk (Female, 36).

> I put the add up looking for a donor, within minutes I was receiving really seedy responses from men, it took me ages to wade through the emails to find a guy who didn't want to sleep with me but who was happy to donate his sperm, so I could self-inseminate. We exchanged numbers and he came over to meet me, he seemed like a genuine guy. He used my bathroom to make a deposit, he left agreeing to come back again the next morning and the evening. I self-inseminated on each occasion and madly enough, I got pregnant and my little boy *** is 3 now (Female, 30).

There is a need for much greater understanding of the health and legal risks involved in unregulated reproduction and a review of the policies and guidelines that hinder lesbian and bisexual couples from seeking fertility treatment on the NHS. Of the women interviewed for Mackle's study, two-thirds aspired to parenthood. Cases of private treatment both in NI and abroad and use of unregulated sperm were uncovered in the study.

Research findings: a study of gay men in NI

It is not just lesbian women who face inequalities in their pursuit of parenthood. Amodeo et al's study (2018) of gay men in NI found that 72% of gay men surveyed stated their desire to become parents. This mirrors the second theme that emerged throughout the course of the interviews in Mackle (2019) which was the hope and desire for gay men to become parents and the difficulties that surround this.

> I know for my parents its hard that they won't be grandparents to children I could have had, I did want to be a parent (Male, 36).

> My partner has three children who are in my life, which has fulfilled a part of me wanting to be a father (Male, 40).

> I am glad to be in a relationship now with a partner who has children. I have always regretted that I was never a dad (Male, 42).

> The opportunity to have a family is more limited to us (LGBT community), if I was a straight man, I would have been a father by now, but no one has gotten pregnant in my relationships as a gay man. To get there is so much more difficult for us (Male, 37).

As with lesbian women, single gay men and gay men in a civil partnership/same-sex marriage can now apply to adopt in NI. The extent of this is unknown as there is no public data available.

Altruistic surrogacy for heterosexual and non-heterosexual couples/individual is legal in the UK, including NI (French, 2017). The law supports gay fathers conceiving through surrogacy in the UK in the same way as it does heterosexual couples non-heterosexual couples/individual's. It allows for applications to the relevant court, for such parents who wish to be named on their child's birth certificate as the legal parents/guardians of the child (French, 2017). While it is legal in the UK, only "reasonable expenses" can be paid to the surrogate and there is no legislation in place to prevent a birth mother from changing her mind and keeping the baby after it is born. Again the lack of available data means that the extent of altruistic surrogacy in the UK is unknown.

The surrogate is the child's legal mother under UK law, regardless of where in the world the child is born (Gov.uk, 2020). Who is treated as the child's father is complicated, and depends on the circumstances of conception, including biology, the surrogate's relationship status and where conception took place (Ngalaw, 2020). The UK legal solution is for the father to obtain a parental order through the courts, which reassigns parenthood fully and permanently to the father, and extinguishes the legal status and responsibilities of the surrogate. It also leads to the re-issue of the child's birth certificate (Ngalaw, 2020). The parental order takes some months to obtain, therefore it is important that fathers think about the legal rights and responsibilities in the interim period before things are fully resolved.

It is illegal for an individual in the UK to advertise for the services of a surrogate, which sets a further stumbling block for potential parents.

Trans routes to parenthood

There is a dearth of academic research that links to trans fertility. The Gender Identity Research and Education Society (GIRES, 2018) estimates that about 1% of the UK population identify as trans, however, this figure could be an underestimate. The 2018 NILT survey reported that in NI, only 30% of respondents do not know anyone who identifies as trans. Mackle's (2019) study collected data from a small number of trans people (5). The issue of parenthood was highlighted by two of the participants.

> I don't know if I will ever have children, it's a fight to even exist at times as myself and to be honest, I've probably left it too late (Trans person, 33).

> I'd have to stop taking T (testosterone) to be able to have kids and that's not an option for me (Trans person, 24).

The World Professional Association for Transgender Health's Standards of Care state:

> Many trans and gender nonconforming people will want to have children. Because hormone therapy limits fertility, it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs... MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy... Reproductive options for FtM patients might

include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry a pregnancy.

According to the HFEA (2020), whether a trans person can have fertility preservation treatment on the NHS remains unclear and is subject to change. There is limited information available in terms of accessing fertility preservation on the NHS in NI, however, in England, funding decisions about storage and fertility treatment are decided locally by Clinical Commissioning Groups (CCGs). Some CCGs will fund treatment and others will not. At present, the NICE which provides guidelines to CCGs and medical professionals on who should be treated on the NHS, does not provide guidance around fertility preservation for people with gender dysphoria. It is possible to pay private clinics, the Belfast Fertility Clinic website (2020) for instance states that egg collection and freezing for one year will cost £3,127 plus £350 for every subsequent year storage.

There is no clear provision in UK law for trans parents who conceive after having transitioned. If a trans person gives birth, they have the legal rights of a 'mother' (even if you are legally a man), and if a trans person provides sperm, they have the legal rights of a 'father' (even if you are legally a woman).

Key findings

This emerging evidence indicates that in relation to the LGBTQ+ community in NI same sex couples have limited choices when it comes to reproduction.

- Lesbian couples (and bisexual women in a same sex couple) cannot access IVF on the NHS on a par with their heterosexual peers.
- All women accessing fertility services on the NHS in NI will only be offered one round of IVF on the NHS (compared to three rounds in Scotland and Wales and parts of England).
- Women who identify as lesbian or bisexual are at increased risk of being overweight. Women accessing fertility services in the NHS in NI must have a BMI of 30 or below, yet private clinics treat patients with a BMI of 40 or below if general health is good.
- Private fertility treatment can cost upwards of £6,000 per one round of IVF treatment.
- Self-arranged conception brings with it a need to consider legal matters surrounding parenthood.
- Women undertaking self-arranged conception are at risk of placing themselves in situations of sexual violence.
- Unscreened sperm carries the risk of sexually transmitted diseases such as HIV and potential genetic disorders.
- The routes to parenthood are restricted for gay men and the data on the number of successful same-sex adoptions/surrogacies is unknown.
- It is illegal for an individual in the UK to advertise for the services of a surrogate, which sets a further stumbling block for potential parents.
- Little data/research exists into the nuances of surrogacy arrangements for same sex couples in NI.
- It is unclear whether trans people can access fertility preservation treatment on the NHS.
- There is no clear provision in UK law for trans parents who conceive after having transitioned. If a trans person gives birth, they have the legal rights of a 'mother' (even if you are legally a man), and if a trans person provides sperm, they have the legal rights of a 'father' (even if you are legally a woman).

Recommendations

Fertility treatments for same-sex couples in NI should be available on the NHS on a par with heterosexual couples which would mean that all couples accessing IVF in NI should be entitled to three rounds on a par with couples in Scotland, Wales and most parts of England.

Private clinics treat patients with a BMI of 40 if their general health is good; the NHS should consider increasing the strict BMI guidelines.

Further research (and therefore research funding) is needed to assess the extent of risk-taking among lesbian and bisexual women and whether a harm-reduction approach could have a positive impact on health outcomes. This research can then inform policy to highlight the health and legal risks to the women considering alternate "at home" methods, as well as to inform the health professionals responsible for their care. Partnership working should be explored with the RCM and the RCOG. There is a need for a policy and practice review in relation to this area with guidance required for reproductive professionals on the associated risks posed to women using unregulated methods to get pregnant.

The legalities in relation to parental responsibility needs further consideration in order to better inform affected women, potential donors, policy makers and health professionals. LGBTQ+ sector organisations should partner with the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) to consider this issue.

Training should be provided for health professionals to ensure they fully understand the added dimensions and complexities of living with an LGBTQ+ identity and seeking parenthood. This could highlight the misinformation around health, difficulties, risks and legalities associated with becoming a parent without access to NHS funding etc. This awareness training could also help challenge unconscious bias among professionals. There is a need for further information to be made available into the nuances of surrogacy arrangements for same sex couples in NI.

Clarification is needed as to whether trans people, including trans young people (under 18) can access fertility preservation treatment on the NHS and relevant guidelines should be reviewed and amended.

A review of the law is required to allow a person's identity as a child's mother, father or parent to be fully recognised and recorded on legal documents, such as a child's birth certificate.

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