Reproductive Health Law and Policy Advisory Group

A joint initiative between Queen's University Belfast School of Law and Human Rights Centre and Ulster University School of Criminology, Politics and Social Policy

Briefing Paper

Access to Fertility Treatment for Lesbian / Bisexual women in Northern Ireland

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Introduction

The Reproductive Health Law and Policy Advisory Group is a joint initiative between Queen's University Belfast School of Law, Ulster University School of Criminology, Politics and Social Policy and Manchester Metropolitan University. Its founding members are Dr Fiona Bloomer (UU), Dr Kathryn McNeilly (QUB) and Dr Claire Pierson (MMU), all of whom have extensive research backgrounds in the area of law and policy pertaining to issues of reproductive health. The Advisory Group has been established to provide expertise and knowledge on policy and legal matters related to reproductive health; to facilitate discussions and knowledge transfer between academics, policy and lawmakers, health professionals and stakeholder groups; to provide advice on legal and policy reform.

Research Associate, Danielle Mackle, has joined the advisory group to provide expertise on matters relating to the LGBT community in Northern Ireland. In this briefing paper, Mackle and Bloomer consider the policy context for access to fertility treatment for lesbian and bisexual women and consider emerging findings from Mackle's doctoral study on the well-being of the LGBT community in Northern Ireland, which has been conducted using the theoretical framework of the capability approach. This research has highlighted the negative impact that moral conservativism within politics and policy development has had on the well-being of members of the LGBT community. Further, it identified that that heteronormativity within the education and health systems has a negative impact on mental health and well-being (Mackle, forthcoming).

Lesbian and bisexual women who wish to become parents challenge conservative societal norms of parenting. As demonstrated in this paper, this is emerging evidence that restrictive policies lead to discriminatory behaviour against the women affected.

The briefing paper is presented in three sections:

1. An overview of the global and UK context for fertility policy
2. Research findings a study of lesbian and bisexual women in NI
3. Consideration of research gaps and next steps

1. Fertility Policy - The Global and UK Context

The Human Rights Act (1998) states that having children is a human right (WHO, 208) yet same sex couples come up against many barriers in pursuit of parenthood. Internationally, commentators have noted that there is a dearth of fertility related research for women at the margins, including lesbian/bisexual women, highlighting that limited consideration has been given to lesbian/bisexual women who seek parenthood, with the assumption that there is little desire for lesbian women to be parents (Hodson et al., 2017; Schwartz and Baral, 2015). However, the proportion of lesbian/bisexual women who wish to be parents is approximately 50% (Amato and Jacob, 2004; Chambot and Ames, 2004). Other international research 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 in recent research (Donovan, 2000; Wilson, 2007; Wykes, 2012). The legislation was 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).

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).

> "Women under 40 finding it difficult to get pregnant who have been trying for 2 years or longer or have had 12 cycles of artificial insemination (which is the direct insertion of sperm into a woman's womb or the neck of the womb) are offered 3 full cycles of IVF. A full cycle of IVF involves collecting eggs and sperm, fertilising the eggs outside the woman's body, and placing 1 or 2 fertilised eggs (embryos) into the womb to start a pregnancy. The statement focuses on people who have a possible pathological problem to explain their infertility. It includes women in same-sex relationships and women with or without a partner having artificial insemination" (NICE, 2013:1).

The guidelines state that lesbian couples must have attempted conception 12 times via artificial insemination. The guidance does not stipulate if couples need to have attempted this via a private clinic or if using private arrangements with donor sperm at home will deem couples eligible for NHS treatment. Stonewall (2017) have identified that lack of clarity on this issue has led to treatment being offered at the discretion of individual NHS health trusts. It has been noted that some trusts require lesbian couples to use private fertility clinics to attempt conception before considering NHS funding for IVF (Nordqvist, 2011a). Heterosexual couples do not face this financial barrier. In Wales and Scotland, lesbian and bisexual women are offered the same NHS fertility treatment as heterosexual women (Scottish Government, 2016).

Research in the UK notes that self-arranged conception is often practiced by those unable to access treatment on the NHS or able to pay private providers (Nordqvist, 2011a, 2011b; Priddle, 2015; Wykes, 2012). 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 terms of health, Wykes (2012) identifies that the use of unregulated sperm may pose a health risk to women and any resulting child, particularly in terms of a sexually transmitted diseases such as HIV (Amato and Jacob, 2004). In NHS and private clinics, donors are rigorously screened undergoing physical, mental and sexual health checks (HFEA, 2017).

There is emerging evidence that NICE guidelines on fertility treatment are not applied appropriately in NI leading to discrimination against lesbian/bi-sexual women. A recent story reported by the BBC (2016) identified that a lesbian couple (both with diagnosed fertility issues) were denied access to NHS funded fertility treatment because they were not a heterosexual couple (Connolly, 2016). As demonstrated in the following section, cases such as these raise a number of issues for policy makers in NI:

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

2. Research findings a study of lesbian and bisexual women in NI

Mackle's PhD study of the health and well-being of the LGBT community in NI has uncovered evidence that risk-taking behaviours exists amongst lesbian/bisexual women seeking parenthood (Mackle, forthcoming). It is the common assumption that the family is heterosexual in its composition. This view is often characterized as 'the norm', and anything that deviates from this norm may be viewed as lesser. LGBT families are thus often subjected to stigmatisation for their parenthood and face many obstacles that arise from the ignorance and prejudices of the public at large (Drucker, 1998). Indeed, in NI, the Northern Ireland Life and Times (NILT, 2012) asked attitudinal questions pertaining to the LGBT community, 58% of those surveyed actively disapproved of adoption by gay couples and to lesbians having access to IVF on the NHS.

In NI women who identify as lesbian/bisexual cannot access fertility treatment on the NHS unlike their heterosexual counterparts and same-sex couples in the rest of the UK. This situation has led women to taking risks, such as self-arranged conception. Mackle's research highlighted how such behaviours were a direct impact of the unequal access to fertility treatment on the NHS.

Fertility treatment in NI is available to lesbian and bisexual women who can afford private clinic costs, the costs are circa £6,000 for one round of IVF treatment with a 33% success rate (GCRM, 2017). However, for those who cannot afford this, the study has highlighted that women are putting themselves and their lives at risk by engaging in risky behaviours such as finding "sperm donors" online, meeting them and either self-inseminating or

having sexual intercourse, without knowing anything about the mans' sexual or medical history.

Here NI (a charity working with lesbian and bisexual women and their families in NI) have recorded that in the last year, over 200 women and couples have sought their advice on starting a family. This indicates a growing need for further 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, travelling abroad for treatment and use of unregulated sperm were uncovered in the study.

This emerging evidence indicates that in relation to the LGBT community in NI:

- Same sex couples have limited choices when it comes to reproduction.
- Women take risks using unregulated sperm via unregulated means.

This raises a number of issues:

- Self-arranged conception brings with it a need to consider legal matters surrounding parenthood.
- Women undertaking self-arranged conception open themselves up to potential sexual violence.
- Unscreened sperm carries the risk of sexually transmitted diseases such as HIV and potential genetic disorders.
- Health professionals, policy makers and other stakeholders need to be aware of these risks.

3. Research gaps and next steps

There is limited fertility related research in relation to lesbian/bisexual women in NI; however, emerging research indicates risk-taking behaviour among lesbian/bisexual women, with the health service unable to meet their needs. This issue potentially impacts significant numbers of women, with UK research suggesting approximately 50% of lesbian/bisexual women aspire to parenthood (Amato and Jacob, 2004). Further;

- It appears that NI's restrictive policies limit access to fertility services.
- There is a need for further research to assess the extent of risk-taking behaviour, and consider if a harm-reduction approach, including a policy and practice review, could positively impact health outcomes.
- Reproductive professionals may need guidance on risk associated with choices made by affected women and the impact this may have on their overall health and well-being.
- The legalities around parental responsibility need to be considered further to better inform affected women, potential donors, policy makers and health professionals.

We recommend a large-scale, comprehensive study on risk-taking and health, and the development of a practitioners' guide to risk reduction and improved health outcomes. The findings will inform policy development, the provision of services/training for

providers, the wider public debate and theory development on motherhood/the family/deviance/ stigma/morality and heteronormativity.

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