



British Columbia
Centre of Excellence
for Women's Health

Vancouver, BC
CANADA

Making Choices/Taking Chances

Lesbian/Bi/Queer Women Assisted
Conception, and Reproductive Health

By Jacquelyne Luce

Report available
in alternate formats

assisted conception
sexuality
reproduction
technology
lesbian/bi/queer women
pregnancy

Making Choices/Taking Chances

Lesbian/Bi/Queer Women Assisted
Conception, and Reproductive Health

By Jacquelyne Luce



assisted conception
sexuality
reproduction
technology
lesbian/bi/queer women
pregnancy



**British Columbia
Centre of Excellence
for Women's Health**

**Centre d'excellence de la
Columbia-Britannique
pour la santé des femmes**

Main Office

E311 - 4500 Oak Street
Vancouver, British Columbia
V6H 3N1 Canada

Tel 604.875.2633

Fax 604.875.3716

Email bcewh@cw.bc.ca

Web www.bcewh.bc.ca

Women's Health Reports

Copyright © 2002 by British
Columbia Centre of Excellence
for Women's Health

All rights reserved. No part of
this report may be reproduced
by any means without the written
permission of the publisher,
except by a reviewer, who may
use brief excerpts in a review.

ISSN 1481-7268
ISBN 1-894356-22-5

Executive Editor Lorraine Greaves

Senior Editor Leslie Timmins

Copy Editor Robyn Fadden

**Graphic Design
& Illustration** Michelle Sotto

**Canadian Cataloguing
in Publication Data**

Luce, Jacquelyne, 1971-
Making choices/taking chances

Includes bibliographical references.

1. Lesbians—Health and hygiene—
British Columbia. 2. Human reproductive
technology—Government policy—British
Columbia. I. BC Centre of Excellence for
Women's Health. II. Title. III. Series: Women's
health reports (Vancouver, B.C.)

RA564.87.L82 2002
362.1'086'64309711
C2002-910263-4

Contents

Acknowledgements	1
I. Introduction	2
II. Background	4
III. Research Methods: Doing Queer Health Research	6
IV. Findings: Multiple Meanings of Fertility, Infertility and Assisted Conception	13
V. Conclusion	20
Glossary	22
Endnotes	23
References	25
Suggested Resources	27

Acknowledgments

This paper is based on research completed as part of my larger dissertation project that focuses on queer women's experiences of trying to get pregnant and/or become parents within the context of new developments in assisted reproductive technologies and lesbian, gay, bisexual and transgender rights legislation. I am grateful to the many women who participated in interviews and shared their time, experiences and knowledge with me. I am also thankful to everyone who engaged in informal conversations with me about assisted conception, reproductive health, adoption and sexuality. I would like to acknowledge the significant acts of people who passed information about my project on to potential participants and/or introduced me to their friends, colleagues and acquaintances, thereby broadening the scope of my research and enabling me to interview women living in various locations.

I also thank a number of institutions that supported this project at key stages. My doctoral studies in the Department of Anthropology at York University and the fieldwork completed for this project were supported in part by a Social Sciences and Humanities Research Council Doctoral Fellowship, a B.C. Centre of Excellence for Women's Health Seed Grant, a research affiliation with the B.C. Centre of Excellence for Women's Health (1998-1999), the York University Fieldwork Costs Fund, the York University Research Costs Fund, and the Gay and Lesbian Medical Association Lesbian Health Fund. I completed the analyses and writing for this report while supported by grant number R03 HS11266 from the Agency for Healthcare Research and Quality (US) and a York University President's Dissertation Scholarship.



Introduction

Lesbian/Bi/Queer Women, Assisted Conception and Reproductive Health traces a number of the research “threads” that I followed during my investigation of queer women’s experiences of assisted conception. Based on ethnographic fieldwork conducted between March 1999 and October 2000, this paper is a narrative of my own experiences as a queer woman doing research on other queer women and reproductive health, as well as an account and analysis of the stories of lesbian/bi/queer women¹ who had tried or were planning to try to get pregnant.

Most research on lesbians, bi, and queer women, and women using assisted reproductive technologies, focuses on women living in large urban settings – often the location of large lesbian, gay, transgender, bisexual, queer and questioning (LGTBQQ) communities, and fertility clinics. In contrast, I interviewed women living in a variety of geographical and cultural contexts throughout British Columbia. I interviewed 80 women in 59 interviews over the course of my fieldwork, spending time in communities in the southern interior, the West Kootenays, the northern interior, Vancouver Island, Vancouver and the Lower Mainland. The interviews were open-ended and unstructured, allowing women to focus on the experiences that were significant to them. Most interviews averaged 1.5 to 2 hours; some stretched to 3 to 5 hours, while still others – as the women I stayed with during my travels joked – went on for days. The stories that I have chosen to represent in this paper do not reflect all of the experiences of all of the women I interviewed, although they all inform my analysis. Rather, I selected the experiences that are seldom heard or talked about, stories of lesbians contracting sexually transmitted diseases through donor insemination, of the negative side-effects of fertility drugs, of grieving the missed opportunity to get pregnant.

The story of my own experience as a researcher primarily reflects the fieldwork that I conducted in communities with populations between 2,000 and 100,000. As I did this work it became important to me to examine the expectations that people (straight and queer) had about when it was acceptable to be visible and/or “out” as a dyke, and to relate this to the impact of public homophobia on queer women’s experiences

of reproductive health and well-being. I found that the homophobia and heterosexism that I often viewed as peripheral to the “real” subject of study had a significant impact on the type of research I did, the people I talked to, and my own well-being. Represented here in the form of fieldnotes or journal entries, these experiences are the ones that stand out in my mind because they highlight some of the methodological as well as the daily challenges faced by queer health researchers.

This paper moves forward and backward in time, allowing the women’s stories and my own to be connected by multiple threads of observation and analysis. My goal is to show the complex ideas, expectations, and experiences that inform lesbian/bi/queer women’s reproductive health and well-being. By weaving my own narrative with the narratives of the women I interviewed, I hope to present a montage of images that contest and reconfigure our understanding of the relationships between assisted conception, reproductive health and lesbian/bi/queer women.



Background

“Well...what I wanted to know first of all is, how do I know when I can get pregnant? Like, when is my body ready for that? And I wanted to know about costs. And I wanted to know about time. And the legal aspect of it all. Because to me that was a big concern. I didn’t want to be jerked around. So, do I need to talk to a lawyer? The one thing that was talked about [by my doctor] was that you go through a psychologist in Vancouver. And you know, what type of support would I get with family and health care, child support, family allowance or something? And the other thing that I wondered about is more for the child’s future. I wanted to meet other people or read on other people that had experienced family life as lesbian couples or gay couples. And also talking to children of gay parents. How did they handle it going through elementary school or junior high school when other kids knew that their parents were gay? That was a big concern for me because I wouldn’t want my child to suffer because of myself being gay.” (Lana)²

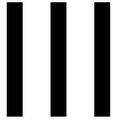
Research in the field of women’s health and reproduction brings to the forefront the significance of reproductive experiences in women’s lives. Much of this research focuses on pregnancy, abortion and childbirth. The process of achieving conception – trying to get pregnant – has become a subject of study more recently as news and images of developments in reproductive science and technology circulate in medical, media and legal venues. Public perspectives on women using reproductive technologies to try to have children have undergone numerous shifts over the past two decades, becoming more commonplace in everyday conversations about pregnancy and parenthood. Many more people seem to know someone who has had trouble conceiving and has turned to fertility specialists and “high-tech” solutions. “Assisted conception” has become a catch phrase for pregnancies that happen with a little help – whether that “help” comes from fertility drugs, donor insemination, in vitro fertilization (IVF) or gamete intra-fallopian transfer (GIFT).

Lesbian/bi/queer women who are trying to become pregnant or are considering parenthood often have experiences with a variety of meth-

I am struck time and again by the way in which lesbians, gay men, bisexual and transgender people are either absent from discussions of assisted reproduction or, in contrast, are posited as the most likely consumers of new technologies.

ods of procreation that fall within the frame of assisted conception. “Assisted conception” is used in this report as a catch phrase for conceptions that occur with assistance from donors, health care providers, fertility drugs and reproductive technologies. However, most medical and health care literature and most research on infertility and assisted reproduction are targeted at and focus on heterosexual women or heterosexual couples. This is due in part to the location of the studies and the population from which participants are drawn. Most research has been conducted in jurisdictions with legislation prohibiting lesbians and gay men from accessing fertility services or in clinics with policies excluding lesbians and gay men.³ On the other hand, emerging public representations of high-tech reproductive technologies often cite the creation of parenting opportunities for lesbians and gay men. For example, the author of a 1999 article in *Scientific American* asserts that: “A very large category of users of human cloning might be lesbian couples” (Green 1999, p. 82). I am struck time and again by the way in which lesbians, gay men, bisexual and transgender people are either absent from discussions of assisted reproduction or, in contrast, are posited as the most likely consumers of new technologies.

Lana, quoted above, has been preparing to “enter motherhood” for the past ten years. The questions she articulates identify many of the issues that confront lesbians, bisexual and queer women who consider becoming parents. Her words highlight the intersecting social, legal and medical domains that inform lesbian/bi/queer women’s experiences of assisted conception and reproductive health. As a queer medical anthropologist interested in reproduction, science and technology, I became aware of the expanding literature on lesbian parenting in the mid-1990s when first conceptualizing this project. I wondered, though, about the process of becoming a parent. Where do queer women’s experiences of assisted conception fit within the reproductive health and social science literature that emphasizes the increasing normalization and naturalization of assisted reproductive technologies?



Research Methods: Doing Queer Health Research

September 1999. Pride Day, Prince George, B.C.

I'm holding Samantha's one-year-old daughter. I see a number of people I recognize from my previous fieldtrip. That's what stands out in my mind: I can see everyone. Samantha looks around at the thin crowd. "I really hope more people come," she says. "This can be really scary." As we walk through the downtown streets, the emptiness of the sidewalks startles me. Occasionally a few people stop to watch. A few people clap.

My research is an ethnographic study of queer women's experiences of assisted reproduction. Ethnographic research focuses on the cultural practices of everyday life and the meanings we give to particular experiences and actions (Rosaldo & Lamphere, 1974; Behar & Gordon, 1995). Over the course of my research, I attended and participated in activities and events that pertain to LGBTQQ health issues, same-sex rights, reproductive technologies, reproductive health and midwifery. My fieldwork also involved everyday practices of research – tracking the most recent information about the pending legislation on reproductive technologies, reading and viewing accounts of lesbian conceptions in public culture (magazines, films, novels, art), and engaging in conversations with people about reproductive health care, reproductive technologies and lesbian health (Luce, 2000a; Luce, 2000b). Queer women's health and queer parenting are far more frequently discussed at forums and workshops facilitated by LGBTQQ community organizations than in health care institutions. Doing this research at the community level, rather than situating myself in clinical settings, also enabled me to speak with lesbians who accessed services but did not come out to providers, lesbians who became pregnant by self-insemination, and lesbians who had tried to get pregnant but had been unable to conceive.

July 2000. Streetfest, Nelson, B.C.

The outside light came on as I pulled the car into the driveway. I was later than I'd expected to be. Probably only 9:30, but it had been a

Women I met around the province over the course of my fieldwork, showed me how the concept of “lesbian kinship” that I use in presentations about my research, refers not only to the intimate ties between lovers, ex-lovers, close friends and family, but also to relations between strangers.

scorcher of a day and I was exhausted. I had watched a few performances and chatted about my research to a number of people. I'd been invited to a party the following night and offered a place to crash close to town. A woman working at one of the festival booths had asked me what I was doing in Nelson. "I'm interviewing dykes about having children," I answered. When I told Donna, one of the women I was staying with that night, about this, she sounded surprised and asked, "Did you know she was a lesbian?" I grinned, "Well, not for certain." But, I thought to myself, she is. And she's thought about having kids.

The first interview for this project took place at the Isle Pierre Pie Company in Prince George, a small city (population 85,000) in a region residents refer to as “not so northern, northern British Columbia.” It was March. In Vancouver tulips were showing and it was most likely raining, but Prince George was just emerging from the blanket of winter. Trying to start my rental car after leaving it out in the cold for hours, and finding myself stuck on icy driveways with little traction, brought back memories of Winnipeg winters when I had learned to drive.

In Prince George I was an outsider in the sense that I wasn't a local. I was similar and different on multiple

points of identification. But I was also a dyke. The women I met here, and many more women I met around the province over the course of my fieldwork, showed me how the concept of “lesbian kinship” that I use in presentations about my research, refers not only to the intimate ties between lovers, ex-lovers, close friends and family, but also to relations between strangers. Two women offered me the extra room in their home and two other women brought over an extra bed to transform the space into a bedroom during my stay. At night I could choose from a collection of lesbian pulp fiction on their bookshelves. Having felt new and somewhat out-of-place in Vancouver – yet another transplant from the East – I felt comfortable in this cold and welcoming environment.

Women living in Prince George introduced me to women living in Vancouver and Kamloops. Women living in Nelson and Nanaimo introduced me to women living in the Okanagan. Women living in Vancouver introduced me to women living on Vancouver Island, and vice versa. As a dyke from out-of-town, I was made to feel welcome, invited to potlucks and community events, given comfortable and safe places to sleep after long days of interviews, and included in conversations about sex, sexuality, butch-femme rela-

tions, alternative health and relationship struggles. As I came to know individuals living in different regions of the province, I became more familiar with the movement of lesbians throughout B.C. in search of employment, community and opportunities for themselves, partners and children.

In the poster that I made to advertise my project, I attempted to convey both the broad and the specific questions I was exploring through my research. I was interested in hearing women's stories about trying to conceive at home, as well as in clinical settings. I was also interested in the stories of women who had trouble conceiving, experienced pregnancy loss, and/or never did get pregnant. The poster read as follows:

LESBIAN/BI/QUEER WOMEN AND ASSISTED CONCEPTION

Are you trying to get pregnant?
Have you thought about or are you thinking about having a child or children? Have you tried to conceive or have you conceived by using reproductive technologies, doing inseminations on your own, or having sex with a man?

Over 18 months I interviewed 80 women in 59 interviews who identify as lesbian, queer, femme, bisexual, dyke, trans and butch, as well as women who don't like labels, don't

identify by their sexuality and/or refer to themselves as women who date women. Thirty-two of the women lived in small cities or rural areas of northern and interior B.C.; sixteen women lived in cities or rural areas on Vancouver Island or small Gulf islands; thirty-two women lived in or around the city of Vancouver.⁴

I interviewed single women and women in relationships. I interviewed women about choosing sperm donors, trying to conceive, miscarriages, abortions, stillbirths and parenting. I interviewed non-inseminating partners and parents, "biological" or "body-moms," adoptive moms, and women co-parents. I interviewed women who moved in and out of these categories of experience over time as they grieved the loss of parenting options or celebrated the arrival of newborns and the finalization of adoptions.

Information about my project was disseminated by word of mouth, email lists, and posters placed in public locations – laundromats, physician and dentist offices, public health units, grocery and retail stores, restaurants, libraries and cafés.

September 2000. Duncan, B.C.

I notice a woman standing in front of a hair salon watching me tack a poster onto the community bulletin

Doing this research means mentioning the project to almost everybody I meet. Some days this works better than others.

board. I cross the street to talk to her. "Hi. I'm doing research around here over the next while. I'm just letting everyone know about the project, in case you know someone who might be interested in sharing their story." "Yeah," the woman nods, reading the poster. "I know a few people who might know someone." "Great. Could you please pass on a flyer?" The woman shakes her head, "No. In my line of work I just can't do that." I know that I am supposed to nod in understanding. But I don't.

I carry on down the street. I notice a jeep with a rainbow sticker on the back window. I place a few flyers on the windshield. A woman working at the gems store around the corner also takes a few. She's pretty certain that she heard two women who come in now and then talking about having a baby. Doing this research means mentioning the project to almost everybody I meet. Some days this works better than others.

In her ethnography examining the social impact of amniocentesis, Rayna Rapp writes about the ways in which "methodology bleeds into everyday life" (1999). Rapp found herself entwined in the lives of research participants as friend, consultant and confidante. Kath Weston, author of *Families We Choose*, notes that the beginning of her fieldwork was defined by the act

of taking notes on her everyday social experiences and those of people in the communities around her (1991). My own ethnographic fieldwork included many incidents that blurred the boundary between "research" and "home," invoking questions regarding the formation and separation of these professional/personal and analytic/everyday categories. When I moved to Vancouver in August 1998, I was immersed in the process of preparing to write the comprehensive exams that would serve as my entry into the fieldwork phase of my doctoral program. The beginning of my fieldwork marked the start of my everyday life in B.C., initiating the process of making British Columbia my home. Conducting interviews and the acts of doing ethnography facilitated my involvement in community events and the development of relationships and ties to women and communities around the province.

November 2000. Vancouver, B.C.

Tracy and I spent the evening talking about babies, cervical fluid and donors. We even talked about the possibility of stopping at a sperm bank in San Francisco on our way home from a camping trip in California we plan to take next spring. When I give presentations on my research I often tell the story of a woman I call "Kacie" who expects to ask her gay friend to

be the donor. Ideally he and his partner would have sex in the next room and then hand a jar of semen to Kacie's partner, who would then inseminate her. I use the story to illustrate the juxtaposition of "natural" versus "clinical" images of "artificial insemination" in lesbian conception stories. Sometimes, especially during conversations like the one I had with Tracy tonight, I am surprised at how often I forget that Tracy is actually the "Kacie" of my academic papers and presentations. Another thing I realize is that as time passes women's ideal scenarios about donors and methods of conception often change.

The question of what constitutes research, and the boundaries drawn around the issues, experiences and interviews that count as data, has been part of a critical feminist rethinking of methodologies. By including personal experiences and personal voice in academic and professional writing, feminists have foregrounded the construction of knowledge, challenging scholarship that purported to reveal objective reality. Similarly, anthropologists schooled in a tradition of thinking through and constructing fieldsites have, in the past decade, written against the imaginings of a "place" of research, shifting the sites and sights of ethnography to new venues, public culture, media,

policy documents and the everyday lives of both participants and researchers (Frohlick, Luce & MacDonald, personal communication). Margaret MacDonald writes that, "Being in the field is more a matter of looking and listening in particular anthropological ways, rather than being in particular kinds of places" (1999, p. 20). Anthropology is a perspective, a lens through which to view the world. Your "fieldsite" can then become everywhere, everything.

March 1999. Vancouver, B.C.

The taxi driver picked me up outside of my apartment building on Commercial Drive. As we drove up Commercial and then Victoria Street, he commented about the change in the neighbourhood. "It used to be," he said, "that you wouldn't be caught in this area unless you were a screaming faggot." My stomach felt queasy. I wasn't exactly early for my flight and taxis were hard to come by. "You're making me uncomfortable with your comments." I think that's what finally came out of my mouth. "Oh, I don't mean anything by it," he said. "I didn't mean to offend you. I have a lot of homosexual and transsexual clients. Why just last night..." He proceeded to tell me stories about some of his regular clients. When he dropped me off at the airport, he shook my hand and thanked me for the chance to talk.

Advice included leaving the word lesbian out of the funding proposal, making lesbians a “case study” . . . and generalizing the topic of my research to access to care. This advice speaks to an awareness of the homophobia that prevails in society, yet leaves little room for change at the level of access to funding for queer-specific health research.

When you focus an ethnographic lens on everything, everywhere, you realize that there are experiences that you don't want to deal with, don't want to analyze. Jennifer Terry writes about the ways in which lesbians have been compelled to understand ourselves in relation to health care systems and discourses of medicine and science that have historically pathologized our bodies and our desires (1999, p. 324). She reminds us of the energy it takes to make these topics our subjects of study. Terry's remarks emphasize the need to recognize the impact on our own health and well-being as researchers who are encountering homophobia and heterosexism in the stories of the women we work with, in the everyday practices of research and in our own daily lives. In October 1996 I placed two proposals on my doctoral supervisor's desk. One proposal was for a project examining mid-wifery education programs. The other mapped out a project focusing on lesbians and reproductive health. My supervisor asked me which one "claimed my heart," and then she supported my choice, but not without also jotting the name of a right-wing politician across the top of the proposal.

January 2000. Vancouver, B.C.

I'm waiting for a bus, glancing at

today's newspaper. "Lesbians get \$250,000 in handouts from Ottawa." The headline is on the front page of the National Post. The article lists the outrageous sums of tax money being spent to fund research on this small segment of society.

Early on in this project I solicited words of wisdom about how to secure funding for my research. Over the years people's advice included leaving the word lesbian out of the funding proposal, making lesbians a "case study" as opposed to the main focus, and generalizing the topic of my research to access to care. This advice speaks to an awareness of the homophobia that prevails in society, yet leaves little room for change at the level of access to funding for queer-specific health research. As I developed confidence in my work and queer women's stake in talking about reproductive health issues, I chose instead to make it clear in funding proposals that this project is about queer women's experiences only (it is not a comparative study of lesbians and heterosexual women) and that I, the researcher, sleep with women. Since 1996 when I wrote that first proposal, I have benefited from, and greatly appreciated, the financial support from agencies that choose to validate and make visible the need for research on queer women's health.

Few studies have attempted to treat work and home conditions symmetrically, although those that do have found that work conditions may be just as or more important for women's health than for men's.

It is sometimes difficult to be a dyke doing queer research. When you have “straight” days – those days when the entire world seems heterosexual – it’s easy to want to tell new acquaintances that you do something else for a living. If they don’t have a problem with the research focusing on lesbians, they just might have a problem with it being about reproductive technologies. When I talk about the negative responses I have received after answering that well-worn conversation opener, “What do you do?” people often ask, “Why do you have to tell someone you just met about your research?” The question sounds quite similar to, “Why does everyone have to know you are a lesbian?”

November 2000. Vancouver, B.C.

My mom called today. We were talking about my grandparents’ anniversary party and she told me that my 16-year-old cousin had asked her what I’m doing my research on. “She talks to lesbians about trying to get pregnant,” my mom answered. She tells me the room went silent for a moment. I kind of laugh. “Well, that’s what you do, right?” she says. “Maybe a year ago I would have said it differently. I might have just said you were studying pregnancy or reproductive health.”

IV

**“I’m thinking I should
have tried again.
I should have put
more effort into it.
I just sort of let the
clock run out and
now I can’t do it.”**

Findings: The Multiple Meanings of Fertility, Infertility and Assisted Conception

Lesbian/bi/queer women occupy an interesting place in relation to reproduction. One of the most common health care situations in which women’s experiences of having sex with women is likely to arise is in discussions about the type of birth control being used. In this situation a woman might declare that she doesn’t use contraception because she has no need for it. Because she has sex with women. This, of course, does not necessarily mean that this woman won’t ever have sex with men. Nor does it mean she will never have sperm in her body. Nor does it mean she won’t be interested in information about fertility and pregnancy. Nor does it mean that she will never access infertility services, support groups, or experience pregnancy loss, or have an abortion.

“So, there has been that kind of relief. But also kind of a sadness. You know, I just sort of thought, if the opportunity comes again...you know, if I meet a friend, like a male friend and he’s willing to donate sperm, I’ve got nothing to lose. It won’t cost me a penny. I’d also be quite willing to have sex with a guy just for the sake of getting pregnant. That wouldn’t be a problem. So, I knew I would try that if it just came along. As long as I would be somehow connected to a person who I thought I could have a decent relationship with – even if we weren’t lovers – so that we could co-parent. And then, when menopause started about six months ago...I’ve had to start letting go of the possibility of ever getting pregnant. So, again, there’s a bit of a relief now that the decision’s gone. I don’t have to think about it anymore. But there’s also some sadness. Especially since you’ve been here I’ve been thinking about it again. And people are talking about it again. And I’m thinking I should have tried again. I should have put more effort into it. I just sort of let the clock run out and now I can’t do it.”

In the early 1990s, 19 of 33 assisted insemination programs surveyed by the Royal Commission on New Reproductive Technologies stated “lesbians would be refused treatment at their clinic” (1993, p.454). The final report of the Royal Commission concluded that there is no reason

By framing the reproductive health needs and concerns of lesbians solely within the parameters of clinical donor insemination, lesbians are excluded from discussions regarding a broader range of health concerns related to the use of reproductive technologies.

to exclude lesbians from assisted insemination services, and that lesbians should be given equitable access to fertility services in compliance with the Canadian Charter of Rights and Freedoms. Typically, as in this example, discussions about lesbians and reproductive technologies center on the need to ensure access to fertility services, which is primarily understood to mean access to Therapeutic Donor Insemination. Challenging discriminatory access practices and policies is a key issue. But it is also critical to address lesbian health issues in relation to the material realities of lesbians' bodies and lesbians' lives. By framing the reproductive health needs and concerns of lesbians solely within the parameters of clinical donor insemination, lesbians are excluded from discussions regarding a broader range of health concerns related to the use of reproductive technologies, including the on-going stress of monitoring ovulatory cycles, women's assessment of the risks of using fertility drugs, the emotional and economic costs of intrauterine insemination and in vitro fertilization, and the impact of procedures such as diagnostic testing and selective reduction.

"So, I was sick because of the hyperstim [Hyperovarian Stimulation Syndrome] and they said, 'Actually

that's a good sign.' And I thought, oh yeah, easy for you to say. But they said, 'There's a good chance that you might be pregnant, because...if you weren't pregnant you might not have this reaction.' So, the fact that you're this sick is unfortunate, but it's a good sign. I thought, well, this doesn't seem very good. It's a wonder that the baby survives... It just means that you have to get through this. They called me two or three times, at least twice a day we checked in. I had to measure everything I took in. I had to measure all my output. Because if I got too dehydrated I would have to be hospitalized. And I didn't have to. I survived that. I just lay on my couch and drank Gatorade for about a week. [Speaking to her partner] Remember going in, Stacey? Because they had to keep taking blood tests to check levels in the system and make sure everything was okay? And remember we had to stop at one point and I had to throw up? And, oh God, I was so sick. I could hardly go in there for the blood tests. I could hardly walk. And at two weeks, one of the blood tests they did was a pregnancy test. And I was pregnant. And I thought, okay. I can survive this. I'll live through this. I'm pregnant. At least I'm pregnant. Because I said to Stacey, I remember going that day, I thought, if I'm not pregnant, I don't know, I think I'm done. I'm not sure I could...you know, emotionally and physically...I'm just

The many reasons lesbian/bi/queer women give for choosing known donors, donors from sperm banks, self-insemination, sexual intercourse with men, and/or clinical inseminations are extremely nuanced.

not sure I can do this again. You know, who knows. Hindsight.”

The construction of lesbians in bioethics literature and policy debates as “socially infertile” and, therefore, only in need of sperm due to their “lack of a male partner,” is used to facilitate the argument that assisted reproductive technologies are scarce resources to be reserved for heterosexual couples for whom treatment is “medically necessary” (Millbank 1997; Steinberg 1997). The same designation of lesbians as “socially infertile” is employed to normalize lesbians’ participation in fertility programs. Queer women by default become participants within the culture of infertility rendering it “natural” to undergo diagnostic procedures such as a hysterosalpingogram (HSG) prior to a first clinical insemination and to routinely undergo intrauterine (IUI) rather than intracervical (ICI) inseminations.

The many reasons lesbian/bi/queer women give for choosing known donors, donors from sperm banks, self-insemination, sexual intercourse with men, and/or clinical inseminations are extremely nuanced. For some of the women I interviewed, contacting fertility specialists and fertility clinics was one of the first steps in their attempt to have children. Some of these women ex-

pected to have difficulties conceiving. Some women knew friends who had had positive experiences with the same health care providers. Some felt that a clinical setting would provide them with the “safest” or “cleanest” sperm and would alleviate various legal problems regarding the paternity rights of donors.⁵ The meanings of “safe” and “clean” sperm varied. Women were often referring to sperm from men who were not drug and alcohol users, who were not HIV-positive, and/or who did not have a personal or family history of mental or genetic illness.

Other women I interviewed never considered going to a fertility clinic or including health professionals in the insemination process. Most of the women I interviewed expected that it would likely take four to eight inseminations before they conceived. A number of women became pregnant within this time frame, timing inseminations or sex (with a man) according to their temperature charts, observations of their cervical mucous, and/or commercial ovulation predictor kits. Some women who did not conceive within this time frame pursued fertility treatments. Other women tried to get pregnant for significantly longer periods of time and did not undergo fertility tests or clinical inseminations before choosing to stop trying.

The meanings and understandings of fertility are complex and governed not only by discourses that naturalize reproductive “assistance,” but also by women’s own perceptions of their bodies, well-being, chance and reproductive history. Lesbians who try to get pregnant within medical settings are not necessarily fertile or infertile. Just as lesbians who try to conceive at home (or in campgrounds, hotels or cars) are not necessarily fertile or infertile.

“My straight friends are like, oh jeez, it’s not like you’ve never slept with guys... Because before I realized where I wanted to be I was supposed to be married. I had slept with men and what would it mean for one more time? Well, nowadays, you’ve got to think more than that. It’s not that healthy out there. I’d be worried about what I’d be conceiving. And the fact that you have this male figure that would be coming back 10 months down the road saying, that’s my kid, too, and I want rights. That would be the easiest way to go...definitely the least expensive way to go about it. ...But just, no. There are too many things to consider. You have to go through all this testing. And even then some of the results, or symptoms, don’t show up for five years. I don’t have five years to wait.”⁶

Lesbian, gay, bisexual and transgender families, comprising

queer parents and/or queer children, exist as a result of adoptions and conceptions in heterosexual or same-sex relationships, the blending of families through relationships, co-parenting, and through the queer youth movement. However, within health care settings, images of both reproduction and families are almost always represented as heterosexual. In the Okanagan, the signs on the doors leading to maternity units advise that “only husbands and coaches” may enter. In Vancouver, prenatal instructors persistently divide classes into discussion groups of “mommies” and “daddies.” Books, pamphlets, magazines and newsletters with information for and about queer health and queer families exist, but this material is not typically available on the shelves or coffee tables of physicians’ offices and clinic or hospital waiting rooms. Lesbian/bi/queer women want to know where they can find information about insemination techniques. What are the most current protocols for HIV and STD testing? Are there any tests that women who are planning to inseminate should have done? What information is available on the screening that is conducted by sperm banks on donor sperm? How can women who choose to self-inseminate at home with sperm from a known donor conduct their own “screening?” How do you

assess the “safety” of sperm? The reading materials included at the end of this paper provide information on recommended tests and insemination techniques. Websites for sperm banks as well as on-line lesbian mothers’ groups are wonderful resources. Many public libraries provided free (although limited) access to the Internet.

“...And the other thing is that after almost a year of trying [to get pregnant], we found out that Mike is actually a male prostitute. I went and got checked because I was discharging bad and it had a foul order. I had just thought my body was rejecting the sperm. I thought maybe I caught something... I can’t remember what I had, but the doctor gave me something and it was treatable. So I got treated for whatever it was. And I got a whole bunch of other tests to make sure that I didn’t get any permanent diseases. But we didn’t know about that side of his life. He kept it very private. And I also wanted someone that didn’t drink, didn’t do any drugs, no pot, no nothing. They had to be really clean. And Mike and [his partner] Nina appeared to be like that. But then we found out that they lied. So we decided not to have contact with them anymore after that. So, now if I want to [try to] get pregnant again, I’d like to go for a safer way. And it would be preferably with somebody

that I know and that I can trust, of course. I wouldn’t want a complete stranger. But yeah, I’d like to know more about it, in general. Without having to spend thousands of dollars. Because I’m not, because I don’t think I would be comfortable to sleep with a man. It would have to be done with objects that would go from him, be put into my hands or my partner’s hands, and then privately inseminated into me.”

Many of the women I interviewed talked about access to the Internet as a primary source of information. Sperm banks and fertility centres often have websites detailing services offered and fees charged. Some Canadian clinics have hotlinks to financial institutions that provide loans for people undergoing expensive infertility treatments. “Short profiles” of donors can be viewed for free on-line and “long profiles” can be downloaded from the site with a charge to a credit card. Websites such as www.lesbian.org provide links to a number of sites with information of interest to queer moms and women trying to conceive and/or adopt. A number of the women I interviewed participate in lesbian moms’ email discussions – swapping information about fertility awareness, known-donor contracts and the differing legal status of lesbian, gay, bisexual and transgender parents by jurisdiction. For

some, participation in these listservs offers a way to acquire information about lesbian-positive care providers, find out about various forms of donor relationships, and break the isolation associated with feeling that you are the only one trying to do this.

Considering that a common situation in which lesbians tell health practitioners that they have sex with women is in response to questions about birth control, perhaps it should not be surprising that few lesbians regularly discuss aspects of fertility or pregnancy with a health practitioner. It is very rarely assumed that a queer woman might want to get pregnant. Many of the women I interviewed who were out to their family physicians described having to “come out” to their doctor about their plans to have children. A number of the women I interviewed did not have a family physician prior to their decision to pursue parenthood. Thus, the decision to get pregnant initiated a search for a queer-positive reproductive health care provider. Other women never considered including a health practitioner in discussions about conception. Still others believed that a doctor was the most logical person to approach for information about insemination. Supportive physicians helped women to determine fertility patterns and time inseminations. Some assisted

with intracervical or intrauterine inseminations, or made referrals to specialists for women who were experiencing or anticipating difficulties conceiving. Misinformation and homophobic reactions from physicians deterred some lesbians from seeking health care and/or led women to seek a different care provider. It is significant to note that in many small or rural communities, as well as larger cities in B.C., the shortage of family physicians who are accepting new clients can restrict lesbians’ abilities to choose supportive health care providers. This has a critical impact on queer women’s health and well-being.

“We went to this doctor that we had been going to and she made some comment about, if we were going to be using a gay man – and this was a nice woman physician who was, who had been really, we’d been comfortable with her – and she made some comment like... ‘A gay man as a donor? Oh. Are you not worried about it being hereditary?’ Homosexuality being hereditary... ‘And that would be a problem?’ [we asked her.] And she [said] she would love to help us when it came time to have the baby, but had no idea how she could help us get to that point.”

Each story I listened to took me in a new direction or brought me back to a question raised by another woman

Traveling around a vast province, staying with women in different towns and cities, and attending local festivities, allowed me to acquire an awareness of the distance women lived from fertility clinics, a knowledge of problems of access to information and lesbian-positive health services.

I had interviewed. Some days I was surprised by how different women's experiences can be. Other days the similarities leapt out at me. Choosing donors, choosing health care providers, deciding to stop trying or continuing to try to get pregnant for another year – each experience was shaped by so many different factors. By allowing women's stories to lead me both to other women and other communities, I was able to follow a number of different research threads. The rich contexts of women's lives and their perspectives on sexuality, technology and health emerged over lunch or tea and in living rooms, cafés and playgrounds. Ranging in age from twenty-four to fifty-two, the women I spoke with came out in different times and different locations. Their experiences of trying to get pregnant encompass a range of communities, different levels of access to health information and services, and a variety of ideas and beliefs about medical intervention and reproductive technologies.

My understanding and analysis of queer women's relationships to reproduction, and queer women's health more generally, is informed not only by these narratives but also by paying attention to the process of doing research. Constructing and dismantling boundaries that define what counts as research provided

me with distance from everyday homophobic encounters, and allowed me to understand experiences such as driving down the Coquihalla Highway across south-central B.C. as "data." Traveling around a vast province, staying with women in different towns and cities, and attending local festivities, allowed me to acquire an awareness of the distance women lived from fertility clinics, a knowledge of problems of access to information and lesbian-positive health services, and a sense of the visibility of queer women in communities. Events once on the periphery of this project seep into my accounts of fieldwork and show up in my analyses. From the point of conceptualizing a project focusing on queer women to the writing I do now, my work and ideas about sexuality and health have been informed by individual women's experiences, and by my own reactions to the varied responses to this project.

V

Lesbian/bi/queer women's reproductive choices, chances and experiences do not reflect a straightforward continuum of reproductive assistance from low-tech to high-tech procedures, but rather are shaped by multiple social, legal, religious, economic and geographical constraints and opportunities.

Conclusion

At a time when visual images and minute details about fertilization, ex utero development of blastocysts, implantation, and embryo and fetal development gain even greater public circulation, at-home methods of getting pregnant using donor sperm are shrouded in mystery. Clinical methods often appear to maximize the chances of achieving a pregnancy and absolving the parental rights of the donor, thus minimizing emotional and economic costs. In contrast, self-insemination at home is often characterized as “risky” and “less efficient.” Yet, as the women I interviewed demonstrate, lesbian/bi/queer women try to get pregnant using many different methods. Many of the women I interviewed tried inseminations at home, inseminations with a physician's assistance, and/or used the services of fertility clinics. Over the course of time, many women tried more than one method and had experiences using both fresh and frozen sperm.

Lesbians get pregnant at home and in clinical settings. Lesbians have difficulties conceiving at home and in clinical settings. Lesbians who conceive at home and lesbians who conceive in a clinical setting may experience miscarriages, ectopic pregnancies and late-term pregnancy loss. For some women trying to get pregnant is the easy part. For others it is filled with sadness and grief. Lesbian/bi/queer women's reproductive choices, chances and experiences do not reflect a straightforward continuum of reproductive assistance from low-tech to high-tech procedures, but rather are shaped by multiple social, legal, religious, economic and geographical constraints and opportunities.

December 2000. Vancouver, B.C.

In presentations of my work, I seem to spend just as much time talking about lesbians' abilities to get pregnant without clinical intervention as I spend emphasizing the need to recognize that lesbians are exposed to environmental toxins, occupational hazards and other stress and health-related issues that may result in difficulties conceiving or maintaining a pregnancy. When I began this project, I defined my investigation as focusing on queer women's narratives of conception. Listening to the

Talking and telling

stories are some of the ways in which we learn, share and support one another. They are some of the ways in which we struggle for change.

stories of the women I interviewed, my understanding of the temporal and spatial dimensions of “conception” have expanded in all directions to include the stories of a baby girl who was lost at seven months gestation, of children imagined but never conceived, of a boy who was born in South America and adopted through an agency in the United States, who talked to me non-stop over hot-dogs and salad off a country road in southern B.C..

More than one straight stranger has scrunched up her face and made a comment to the tune of, “Why would anyone want to talk about that?” In my mind I see Meredith taking Carol’s hand as they tell me about their lives raising children in Prince George. I see Tamara laughing, her four-month-old son in the stroller next to us, and her two-year-old daughter playing on the jungle gym. “Oh,” she grins. “Do you want all the details?” I remember J.C. looking at me after an hour-and-a-half and declaring, “Wow, I’ve just spilled my whole life to you and I don’t even know much about you!” I remember asking Patricia if I could give her a hug. I remember standing on the sidewalk and Shane asking if s/he could give me a hug.

Lesbian/bi/queer women’s descriptions of their joys, pain and losses are vivid as they tell their stories, no

matter how recently or how long ago the experiences took place. Talking and telling stories are some of the ways in which we learn, share and support one another. They are some of the ways in which we struggle for change.

Glossary

Assisted Conception: Used here as a catch phrase for conceptions that occur with assistance from donors, health care providers, fertility drugs and reproductive technologies.

Donor Insemination (also Alternative Insemination, Assisted Insemination, Artificial Insemination): Sperm from a donor can be placed by oneself, a friend, partner or health care provider in the vagina, close to the cervix (intracervical insemination). Sperm from a donor can be placed by a health care provider directly into the uterus (intrauterine insemination).

Gamete Intra-fallopian Transfer (GIFT): Eggs are aspirated from the woman trying to become pregnant or from a donor (sometimes a partner), and then the eggs and donor sperm are transferred to the woman's fallopian tube where fertilization can occur.

Hyperovarian Stimulation Syndrome: This is a side-effect of ovulation inducing hormones such as Human Menopausal Gonadotropin (e.g., Perganol and Humegon) used in fertility treatments. The ovaries are over-stimulated, resulting in side effects ranging from fluid retention, enlarged ovaries, and abdominal discomfort to severe fluid imbalance that may require hospitalization.

Hysterosalpingogram (HSG): A diagnostic test in which a dye is injected through the cervix to enable a x-ray image of the uterus and fallopian tubes. The x-ray can then be used to determine whether the fallopian tubes are open, blocked or scarred.

Intracervical Insemination (ICI): Sperm is deposited in the vagina as close to the cervix as possible.

Intrauterine Insemination (IUI): Sperm is deposited directly into the uterus using a small catheter inserted through the cervix.

In Vitro Fertilization (IVF): Eggs are aspirated from the woman trying to become pregnant or from a donor (sometimes a partner), and then fertilized with donor sperm outside of the woman's body. The fertilized eggs (now blastocysts) are then transferred to the woman's uterus.

Endnotes

¹ I use “lesbian/bi/queer women” in order to subvert the assumptions about identity and sexual behaviour that are often made in relation to labels such as lesbian, bisexual or queer, and to acknowledge the politics and power different words have for different women. Words such as lesbian, queer, bisexual, dyke, femme, butch and trans tend to have particular meanings within particular contexts and to particular individuals. Some women identify with a number of terms while others choose to use only one or two. At the time of my research the women I interviewed identified as single lesbian or queer women or as lesbian, bi or queer women in relationships with women. My use of lesbian is not meant to obscure the particularities of bi-dykes’ experiences. Nor is it meant to obscure the reality that some lesbians sleep with men.

² In order to protect the privacy and confidentiality of women who shared intimate details about their life, all names used in this paper are pseudonyms. In this paper I have also chosen not to include details about individual women (i.e., age, occupation) as such details can readily identify lesbians living in small and large cities.

³ Canada does not have federal legislation governing the use of assisted reproductive technologies. I received reports of discriminatory access to services at clinics in Canada during my fieldwork. Currently a number of clinics’ promotional material states that they provide donor insemination services to women without male partners.

⁴ Twenty-three interviews were with thirty-two women living in Vancouver and the Lower Mainland; thirteen interviews were with fifteen women living in northern B.C., primarily in the vicinity of Prince George, although a few women lived between a three-to-six hour drive further west or north; thirteen interviews were with sixteen women living on Vancouver Island, primarily along the east coast between Victoria and Nanaimo, and small Gulf islands; ten interviews were with seventeen women living in the southern B.C. Interior, Okanagan Valley and West Kootenay regions.

⁵ Single lesbians and lesbian couples planning children within the context of their relationship expressed different concerns regarding legal

parental status. Lesbian couples seemed more likely to engage in legal processes before and after conception. Single lesbians planning to have children and single lesbian moms seemed less likely to believe that the courts would be supportive of their sole parental status, expressed more concerns regarding legal fees, and often opted for anonymous (or willing to be known) donor sperm from sperm banks as a means of securing their sole parental status.

⁶The current standard protocol at sperm banks is for the donor to undergo blood and urine testing for HIV and sexually transmitted diseases prior to donating and then at regular intervals after that. Semen is held in quarantine for six months after a donation. Sperm banks vary as to the other testing and genetic health screening procedures that they follow.

References

- Behar, R., & Gordon, D., Eds. (1995). Women writing culture. Berkeley: University of California Press.
- Franklin, S. (1997). Embodied progress: A cultural account of assisted conception. London and New York: Routledge.
- Green, R. (1999). I, clone. Scientific American, 10(3), 80-83.
- Luce, J. (2000a). "Feminist/queer: Disciplining identities and practicing ethnography." Paper presented at Canadian Anthropological Association (CASCA). Calgary, AB, May 2000.
- . (2000b). "More than a footnote: 'Straight' comments to a dyke doing reproductive health research." Paper presented at Canadian Lesbian and Gay Studies Association. Edmonton, AB, May 2000.
- MacDonald, M. (1999). "Expectations: The cultural construction of nature in midwifery discourse in Ontario." Unpublished Doctoral Dissertation, Department of Social Anthropology, York University, Toronto, Ontario.
- Millbank, J. (1997). Every sperm is sacred? Denying women access to fertility services on the basis of sexuality or marital status. Alternative Law Journal 22(3), 126-129.
- Rapp, R. (1999). Testing women, testing the fetus: The social impact of amniocentesis in America. New York: Routledge.
- Rosaldo, M., & Lamphere, L., Eds. (1974). Woman, culture and society. Stanford: Stanford University Press.
- Royal Commission on New Reproductive Technologies. (1993). Proceed with care: Final report of the Royal Commission on New Reproductive Technologies. Ottawa: Ministry of Government Services Canada.
- Steinberg, D.L. (1997). Bodies in glass: Genetics, eugenics, embryo ethics. Manchester and New York: Manchester University Press.
- Terry, J. (1999). Agendas for lesbian health: Countering the ills of ho-

mophobia. In A.E. Clarke & V.L. Oleson (Eds.), Revisioning women, health and healing: Feminist, cultural, and technoscience perspectives. New York: Routledge.

Weston, K. (1991). Families we choose: Lesbians, gays, kinship. New York: Columbia University Press.

Suggested Resource

Arnup, K., Ed. (1995). Lesbian parenting: Living with pride and prejudice. Charlottetown: Gynergy Books.

A collection of essays by Canadian lesbians regarding the challenges of becoming parents and parenting.

Moraga, C. (1997). Waiting in the wings: Portrait of a queer motherhood. Ithaca, New York: Firebrand Books.

Moraga's story of her son's premature birth and the difficulties of her struggles, her son's, and her partner's.

Nelson, F. (1996). Lesbian motherhood: An exploration of Canadian lesbian families. Toronto: University of Toronto Press.

Based on interviews with lesbian moms in Alberta, Nelson's ethnography provides perspectives on the different experiences of biological and non-biological mothers.

Pepper, R. (1999). The ultimate guide to pregnancy for lesbians: Tips and techniques from conception through birth. San Francisco: Cleis Press.

This book is informative and includes stories from lesbians, single moms, health providers and activists. Pepper provides a number of resources in her book.

Pies, C. (1985). Considering parenthood: A workbook for lesbians. San Francisco: Spinsters Ink.

A seemingly timeless book. Many of the women I interviewed had this one by their bedside or on the coffee table.

Saffron, L. (1998). Challenging conceptions: Planning a family by self-insemination. (Revised edition). Self-published. ISBN: 0953300900.

You may be familiar with Saffron's regular column in *Diva*. The book offers advice from a UK perspective.

Weschler, T. (1995). Taking charge of your fertility: The definitive guide to

natural birth control and pregnancy achievement. New York: Harper Collins.

Although written for a straight audience, this book has a wealth of information about how to determine the fertile days of your cycle. Recommended by a number of women I interviewed.

Weston, K. (1991). Families we choose: Lesbians, gays, kinship. New York: Columbia University Press.

Weston's ethnography is primarily about the many ways in which we create kinship through choice. She includes a chapter on biological kinship through pregnancy within chosen families.

Magazines and Websites

Proud Parenting (previously Alternative Family magazine) (bimonthly) www.proudparenting.com

Gay Parent (bimonthly) www.gayparent-mag.com

Hip Mama: The Parenting Zine (quarterly) www.hipmama.com

Siren (Toronto-based queer women's magazine with a regular "Dykes n' tykes" column) www.siren.ca

Lesbian.org (links to Love Makes A Family Exhibit, Lesbian Mothers Support Society) www.lesbian.org

Sperm Banks and Fertility Centres

Information regarding current fee schedules and donor profiles is available on the organizations' websites. There are many more sperm banks and fertility centres in Canada and the US. Those listed here have provided services to women identifying as lesbians.

California Cryobank
www.cryobank.com

Genesis Fertility Centre (located in Vancouver, British Columbia)
www.genesis-fertility.com

Pacific Reproductive Services
www.hellobaby.com

Rainbow Flag Health Services and Sperm Bank
www.gayspermbank.com

Repromed Ltd. (Located in Toronto, Ontario) www.repromedltd.com

The Sperm Bank of California
www.thespermbankofca.org

Xytex Corporation
www.xytex.com



Centre d'excellence
de la C-B pour la
santé des femmes

Vancouver, C.-B.
CANADA

Choix et risques

**Les femmes homosexuelles et
bisexuelles, procréation assistée et
santé génésique**

Ce rapport de recherche sur la santé des femmes est offert en français et sous des formes utilisables par les personnes handicapées. Pour plus de détails, veuillez communiquer avec le Centre d'excellence de la C.-B. pour la santé des femmes

ISSN 1481-7268



9 771481 726000 >