

November 2016

Home insemination and HIV prevention among same-sex attracted communities in Victoria, Australia

A qualitative scoping study Jen Johnson

ENQUIRIES

Jen Johnson
BBV Program Coordinator
La Trobe University
Victoria 3086

T 9479 8715

**E j.johnson@latrobe.edu.au
latrobe.edu.au**

ACKNOWLEDGEMENTS

This study would not have been possible without enthusiasm and guidance of the Critical Reference Group: Brent Allan, Dr Deb Dempsey, William Leonard, Suzy Malhotra, Felicity Marlowe, Dr Ruth McNair, Heath Paynter, and Dr Chris Sherman.

Particular thanks to those key informants who gave up their time to participate in interviews and focus groups for this study.

Thanks also to Emerich Daroya for assisting with the review of the literature.

Finally, thanks to Dr Jennifer Power for her interest in this project and her support in finishing this project after my return from parental leave.

© Australian Research Centre in Sex, Health and Society, LaTrobe University

Australian Research Centre in Sex, Health and Society (ARCSHS)

La Trobe University

215 Franklin Street, Melbourne Victoria 3000, Australia

T (03) 9479 8700

F (03) 9479 8711

E arcshs@latrobe.edu.au

latrobe.edu.au/arcshs

Copies of this report can be found at: latrobe.edu.au/arcshs

Suggested citation:

Johnson, J. (2016). Home insemination and HIV Prevention among Same-Sex Attracted Communities in Victoria, ARCSHS Monograph Series No. 108, Melbourne: Australian Research Centre in Sex, Health and Society, LaTrobe University.

Disclaimer

The information contained in this publication is indicative only. While every effort is made to provide full and accurate information at the time of publication, the University does not give any warranties in relation to the accuracy and completeness of the contents. The University reserves the right to make changes without notice at any time in its absolute discretion, including but not limited to varying admission and assessment requirements, and discontinuing or varying courses. To the extent permitted by law, the University does not accept responsibility of liability for any injury, loss, claim or damage arising out of or in any way connected with the use of the information contained in this publication or any error, omission or defect in the information contained in this publication.

La Trobe University is a registered provider under the Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS). CRICOS Provider 00115M

Table of contents

MAIN POINTS	2
EXECUTIVE SUMMARY	3
TERMINOLOGY	7
OVERVIEW	8
DISCUSSION OF FINDINGS	
Part 1- HIV prevention and home insemination among LGB communities	10
Part 2 - HIV positive gay men as donors	17
RECOMMENDATION AND CONCLUSION	20
REFERENCES	22

MAIN POINTS

This qualitative scoping study aimed to better understand the nature of and evidence for HIV risk in the context of home insemination in order to identify ways of supporting lesbian/ gay/ bisexual (LGB) prospective parents and donors to minimise the risks associated with this practice.

This Victorian study explored two questions. Firstly, how is the risk of HIV transmission managed by LGB prospective parents and donors when using home insemination to conceive a child? Secondly, what do we know about HIV positive gay men as sperm donors in the context of home insemination?

How is the risk of HIV transmission managed by LGB prospective parents and donors when using home insemination to conceive a child?

Home insemination can be very safe and low risk as long as prospective parents and donors are equipped with the appropriate information and skills, and allow themselves sufficient time to work through complex discussions.

We found that there was a lack of information for prospective parents and donors, and for the doctors and service providers working with them, about HIV/STI prevention in the context of home insemination.

Information resources for LGB prospective parents and donors need to be easily found online or obtained through community and health organisations. They should include information about sexual health considerations prior to commencing home insemination, the meaning and implications of the window period, and the importance of ongoing testing if the donor is sexually active. There is a need for detailed information, which includes practical tips and discussion points, to assist with starting and continuing conversations. Where possible LGB prospective parents and donors should be supported and encouraged to access an LGBT friendly GP.

Clinicians and GPs working with LGB communities would benefit from a checklist or a set of guidelines for use during discussions with prospective parents and donors. This could include suggested questions and discussion points about STI risk reduction, and ways of initiating and sustaining challenging conversations about sexual practices. Information about the actual logistics of home insemination and tips for maximising chances of successful conception, as well as relevant jurisdictional medical and legal information, would also be useful.

What do we know about HIV positive gay men as sperm donors?

Data collection for this study took place in 2013, before the increased availability of Pre Exposure Prophylaxis (PrEP) and the conclusive findings about HIV Treatment as Prevention (TasP). Nonetheless these biomedical advances were clearly on the horizon.

While participants had no clear evidence that HIV positive gay men were entering into donating or parenting arrangements with consenting women or couples, there was a strong indication overall that discussions on this subject were taking place between prospective parents and donors.

In Victoria, HIV positive men are not legally permitted to donate sperm in a clinical setting. There was a lack of clarity among participants in this study as to whether HIV positive men could donate sperm privately. None of the service providers participating in this study reported working with LGB prospective parents and donors where the donor was HIV positive.

Importantly, there is no law that specifically prohibits HIV positive men from donating sperm in the context of home insemination. Private sperm donation arrangements between HIV positive men and HIV negative women, provided that HIV status has been disclosed and informed consent can be demonstrated, are lawful in Victoria.

Clear and accessible legal and health information relating to HIV positive sperm donation needs to be made available to service providers, clinicians and HIV affected communities in all jurisdictions.

EXECUTIVE SUMMARY

Changes in legislation and social attitudes have resulted in more Australian lesbian, gay, bisexual (LGB) people having children. People wishing to conceive using donated sperm have two main options in Victoria. They can access clinical fertility services, such as IVF, using the sperm of either a known donor or a clinic-recruited unknown donor. Alternatively, prospective parents and donors can enter into a private home insemination arrangement. Home insemination is a non-clinical procedure that involves inserting fresh donor sperm into the vagina, usually with a needleless syringe. It is sometimes called self-insemination or artificial insemination.

Australian lesbian mothers have a long history of reliance on gay men to help them have children. This report specifically focuses on same-sex attracted women who enter into private arrangements with gay men to conceive children.

Very little is known about the way that HIV and STI risk is managed and discussed between LGB prospective parents and donors. Similarly, there is no evidence about HIV-positive gay men and their experiences and intentions in relation to private sperm donation arrangements.

A qualitative scoping study took place in Victoria at the end of 2013 to explore the way that HIV risk is managed in the context of home insemination LGB community. A critical reference group was established at the start of the project to determine the main questions, issues and stakeholders for the project. Reference group discussions were recorded and transcribed. A literature review was undertaken, and interview and focus group data were collected from 28 key informants.

Thematic analysis of the data was undertaken to determine the knowledge, perceptions and experiences of key informants, as well as to develop some recommendations.

Six themes were identified from the data analysis. Themes 1 to 5 outline the general findings related to LGB prospective parents and donors, and theme 6 considers some of the issues arising for gay prospective donors who are also HIV positive.

1. why home insemination?

Many doctors and community-based stakeholders believed that conception via home insemination was on the rise.

All of the community-based stakeholders, and many of the clinicians interviewed, described the way that, in contrast to accessing fertility services, home insemination enabled privacy, intimacy and partner involvement.

Another important factor influencing the choice of method of conception was cost. Several participants described the cost of fertility services as prohibitive, and a major deterrent.

Home insemination practices were identified both in the literature and during the consultation as being, for some, motivated by a resistance to the medicalisation of conception, reproduction and women's bodies in general.

It was not uncommon for LGB prospective parents and donors to inseminate at home as well as use fertility services, perhaps moving from home to clinic if attempts were unsuccessful, or from clinic to home due to the reasons mentioned above.

2. finding a donor

Donors were generally described by participants as difficult to find. Because of this, most participants felt that women and couples were willing to accept some level of risk in order to reach an agreement with a prospective donor. These risks were in relation to the shared beliefs, dynamics and boundaries of donor-conceived families, as well as in relation to sexual health.

A universal theme of interviews and group discussions was the potentially challenging nature of conversations between prospective parents and donors. It was suggested that sometimes women avoided or limited some conversations in order to preserve their relationship with the donor, and commence the process as soon as possible.

Trust was seen as central to the practice of home insemination, in particular to the level of honesty in the relationship between prospective parents and donors. However women and donors weren't necessarily well acquainted, nor did they share the same views on how much detail was needed in these discussions.

3. talking about sexual health

HIV and STI screening of the donor was understood by most prospective parents and donors to be essential. Participants indicated that HIV testing prior to commencement of home insemination was very common, but also suggested that a negative HIV test generally heralded the end of the discussion about HIV risk. Of course for HIV/ STI prevention to be effective, conversations about testing need to be ongoing and need to realistically reflect the donor's sexual activities throughout the insemination period.

The development of a trusting relationship between prospective parents and donors, and the details of future family dynamics and boundaries, were seen as complex. Having detailed discussions about sexual practice was described by one participant as adding fragility to these already complex discussions.

Participants suggested that these conversations were difficult because some women lacked the knowledge or skills to comfortably talk about safe practices.

Several GPs noted that occasional unprotected sex between men was becoming more common, and many were reluctant to admit to their GP that they may have engaged in it. They felt that it would also be difficult for a donor to tell the recipient that unprotected sex had occurred, especially if there was an agreement that he would abstain from this practice.

Abstinence was raised by several participants. The only way to eliminate risk during home insemination is complete donor abstinence for the duration of insemination and also for six weeks prior, which is the window period for HIV testing. Clinicians suspected that occurred in only a small minority of cases of home insemination. Nonetheless many participants observed that it was not uncommon for women to assume that because the donor was donating sperm that he was therefore abstaining from sex. Another assumption, particularly for women who were using donor sperm from a close friend, was that they would somehow *know* if their friend had sexual risk factors.

The donor's sexual practices were seen as being largely mediated by their own beliefs and perceptions about what low risk actually means. These beliefs were seen as impacting on the donors' sexual practice and on the way that discussions play out.

Several doctors participating in a focus group discussion sensed that their lesbian patients had inadequate sexual health knowledge in general, and in particular that they had a limited understanding of the meaning and implications of the window period.

A number of possible scenarios relating to the donor's partner were identified during the consultation, highlighting the way that arrangements and family structures can change over time. As with any STI testing process, sexual partners are an important consideration. If the donor has a partner, it is essential to consider the sexual practices of both the donor and his partner, especially if they are having unprotected sex within or outside of the relationship.

4. the passage of time

Real or perceived time constraints were seen as having a detrimental impact on conversations about sexual health between prospective parents and donors.

Most participants described how it was common for women in their late 30s to become anxious about loss of fertility and hastily enter into arrangements with donors. The fear of loss of fertility, and of running out of time to conceive, was described as powerful and significantly increased the level of risk people were prepared to accept.

GPs noted that it was not uncommon for people to fail to return for follow up testing at the end of the window period. This was especially the case for people who were in a hurry to get started.

Victorian fertility clinics, in accordance with legislation, impose a six-month quarantine on known donor sperm as a means of eliminating any HIV/STI risk. Many noted that the six-month quarantine was far longer than was necessary, given the 6-12 week window period that applies in other clinical settings. It was widely believed that people who were proceeding along the clinical pathway would also be trying home insemination during the six-month quarantine period.

Pregnancy does not always happen right away. While the majority of women will fall pregnant within 6 cycles, a significant proportion can take considerably longer. The risk of donor fatigue increased with time, potentially impacting on the donor's willingness to continue to donate each monthly cycle. Donor fatigue was also seen as a factor that could erode the donor's adherence to any agreement or intention around safe sexual practices or abstinence.

5. accessing services

There are several high LGBT caseload GP clinics in inner Melbourne that provide medical services, information and referral to prospective parents and donors, and there are many LGBT friendly doctors around Victoria. However it cannot be assumed that all prospective parents and donors in Victoria have access to, or choose to access, these services.

Past experiences of heterosexism and homophobia meant that, for some LGB prospective parents and donors, there was a fear of seeking out health practitioners and speaking openly about same sex conception. Several participants identified that some fertility clinics were not LGB inclusive, and in some instances were described as homophobic.

Doctors tended to see either the donor or the women and, despite a preference for a group consultation, it was unusual for all parties to present at the same time. Conversations with donors focused on testing and the window period; the difference between high risk, low risk and no risk sexual practice. Conversations with women focused on ensuring that their donor completes his HIV and STI tests, understanding the window period, and the importance of talking openly with their donor about his current sexual practices.

It was not uncommon for patients to present to doctors after trying home insemination for many months.

6. HIV positive gay men as donors

While there are many published studies exploring the parenting and/or donating experiences and intentions of gay men, no evidence was found that shed any light on the parenting and/or donating intentions and experiences of gay men living with HIV. Similarly, no evidence was available to quantify the risk of HIV transmission from home insemination practices using sperm from an HIV positive donor. The risk was understood to be similar to the risk for receptive vaginal sex with an HIV positive partner.

There are no Victorian services that cater for HIV positive gay men wishing to become sperm donors or biologically father a child. It was suggested by several participants that the Human Tissue Act 1982 prohibited HIV positive men from donating sperm, however the Act and its amendments are silent on this issue. Public Health and Wellbeing Act 2008 effectively prohibit HIV positive men from donating sperm in the clinical context. In Victoria, there is no law that specifically prohibits HIV positive men from donating sperm. Private sperm donation arrangements between HIV positive men and HIV negative women, provided that HIV status has been disclosed and informed consent can be demonstrated, are lawful in Victoria.

While participants in the study had no clear evidence that HIV positive men were entering into donating/parenting arrangements with consenting women or couples, there was a strong indication overall that discussions on this subject were taking place between prospective parents and donors.

Several doctors articulated that there had been a shift during the preceding five years whereby gay men with HIV, especially younger gay men, were expressing their desires to have children and/or be donors in the future. This was seen as a real change from 10 to 15 years ago, when having HIV and having the choice to biologically father a child were seen as mutually exclusive.

In Victoria there is a designated clinic for HIV serodiscordant couples wishing to conceive. This service only provides reproductive services to opposite sex couples where one or both partners have HIV. Gay men living with HIV who wish to donate sperm to conceive a child are ineligible to access this service, which would virtually eliminate the risk of transmission.

Clinicians reported that patients had presented with enquiries about HIV positive gay men and sperm donation. The lack of clarity about the legal position of HIV positive men donating sperm for home insemination, and the absence of any clear pathway or readily available information, constrained any detailed or ongoing discussion about risk reduction.

Serodiscordant prospective parents and donors, according to both clinical and community stakeholders, appeared to be very carefully gathering information and weighing the evidence about the risk of HIV transmission via home insemination with a HIV positive donor, and about how this risk could be reduced.

Clear and accessible legal and health information relating to HIV+ sperm donation needs to be made available in all jurisdictions.

CONCLUSION

This qualitative scoping study aimed to better understand the nature of and evidence for HIV risk in the context of home insemination in order to identify ways of supporting LGB prospective parents and donors and service providers to accurately assess and minimise the risks associated with home insemination.

A key finding from this study is that prospective parents and donors, and the doctors and other service providers working with them, need information about best practice in home insemination that includes detailed information about HIV/STI prevention.

There are no Victorian services that cater for HIV positive gay men wishing to become sperm donors or biologically father a child. While legislation effectively prohibits HIV positive men from donating sperm in the clinical context, there is no Victorian law that specifically prohibits HIV positive men from donating sperm. Private sperm donation arrangements between HIV positive men and HIV negative women, provided that HIV status has been disclosed and informed consent can be demonstrated, are lawful in Victoria.

Home insemination can be very safe and low risk as long as prospective parents and donors are equipped with the appropriate information and skills, and allow themselves sufficient time to work through the complex discussions. The reproductive rights and needs of HIV positive gay men, particularly in the new era of PrEP and TasP, need to be addressed.

DEFINITIONS

Clinic-recruited donor – A sperm donor who is unknown to the recipient. Only deidentified information is made available to the recipient, but identifying information is made available to offspring when they reach 18 years of age.

Fertility services/ fertility clinicians – services and clinicians providing assisted reproductive services such as IVF, IUI and ICSI.

Gay men – used to denote gay, bisexual, queer and other same-sex attracted men

Home insemination - the practice of inserting fresh sperm into the vagina from a known donor in a private (non clinical) setting for the purpose of conceiving a child. This practice is also called artificial insemination or self-insemination. Sexual intercourse is not involved. This report exclusively focuses on known sperm donors who are gay men.

IUI - Intra Uterine Insemination

IVF – In Vitro Fertilisation

ICSI - Intracytoplasmic sperm injection

HIV – Human Immunodeficiency Virus

Known donor – refers to a donor who is known to the recipient. Often there is a pre-existing relationship or connection between known donors and recipients.

Lesbian - used to denote lesbian, bisexual, queer and other same-sex attracted women

LGB - this study focussed on Lesbian, Gay and Bisexual people. Transgender people were initially included in scope of this project however there were no published studies, nor were there any stakeholder insights or experiences into the home insemination practices of gender diverse communities.

LGB prospective parents and donors – this term is used to incorporate the diversity of LGB family arrangements. It is important to acknowledge that men's roles are not limited to being donors, they may also be prospective parents or co parents. The terms 'donor' and 'recipient' are used throughout this paper when there is a need to be more specific.

LGBT – Lesbian, Gay, Bisexual and Transgender

PrEP – Pre Exposure Prophylaxis

Serodiscordant couple – a sexual partnership where one partner is HIV positive and one partner is HIV negative.

STI – Sexually Transmissible Infection, which includes HIV

TasP - Treatment as Prevention

Overview

BACKGROUND

Changes in legislation and social attitudes in Australia have resulted in more lesbian, gay, bisexual (LGB) people having children. Home insemination is a non-clinical procedure that involves inserting fresh donor sperm into the vagina, usually with a needleless syringe. It is sometimes called self insemination or artificial insemination.

Australian lesbian mothers have a long history of reliance on gay men to have children (Dempsey 2012). Some lesbians enter into private arrangements with gay men to conceive children by inseminating fresh donor sperm at home. This report specifically focuses on same sex attracted women and sperm donors who are gay men. In Australia, gay men are the community most affected by HIV, and lesbians have a very low HIV prevalence. Therefore, home insemination in the Australian LGB context may be a means of communicability between high and low HIV prevalence communities.

This Victorian project aimed to gain a better understanding of the nature of and evidence for HIV risk in the context of home insemination. It also aimed to identify ways of supporting LGB prospective parents and donors and service providers to accurately assess and minimise the risks associated with home insemination. Another aim of the project was to explore the issues and barriers facing gay men living with HIV who wish to become sperm donors.

Anonymous donor sperm is not commercially available in Australia for the purposes of home insemination. Victorians wishing to conceive using donor sperm have two main options. They can access clinical fertility services, such as intra uterine insemination (IUI) and in vitro fertilisation (IVF), using the sperm of either a known donor or a clinic recruited unknown donor. Alternatively, prospective parents and donors can enter into a private home insemination arrangement. It is important to note that home insemination practices are not legal in all Australian jurisdictions.

In the Australian context, research shows that home insemination with donor sperm is chosen by many lesbians hoping to achieve pregnancy. McNair (2002) found that 44% of 43 prospective lesbian parents chose home insemination as their preferred method of conception. Similarly, a study of 455 same-sex couples and same-sex attracted single parents in Australia and New Zealand found that 32% had conceived a child via home insemination (Power et al. 2010). Importantly, the vast majority (90%) of lesbians with a known donor used self-insemination as first option for conception, with the remainder choosing to conceive at a clinic. While no comparative data exists to determine whether home insemination practices are becoming more common, anecdotal reports suggest that they are.

Australian and international literature identifies a range of reasons that prospective lesbian parents choose home insemination. One major reason, particularly in the Australian literature, is the cost of clinical fertility services (McNair 2002, Power et al. 2010, Sifris 2004). Medicare subsidies for services such as IVF or IUI are only available for people who are assessed as medically infertile, which means that lesbians with no known or demonstrable fertility issues are ineligible. Sifris (2004) calculated that the cost of IVF in Australia in 2004 was \$5000 per cycle without subsidies from the Federal Government. Conversely, while there is no data available on the costs of home insemination, it is considered a low cost or cost-free option. In Australia, donating sperm is an altruistic act and payments are illegal.

Other reasons lesbian couples choose home insemination include: the desire to create a more personalised space and involve the partner in insemination (Chabot and Ames 2004, Markus et al. 2010, McNair 2002); the desire for the child to know the identity of all biological parents (McNair 2002, Almack 2006), the belief that women have the right to control their fertility without medical intervention (McNair 2002); concerns that disclosure of sexuality will impact on quality of care (Markus 2010), and the desire to have more control of the recruitment of the donor (Nordqvist 2011, Chabot and Ames 2004).

LGB prospective parents and donors are generally aware of the potential for HIV/STI transmission associated with home insemination practices, and for some this risk is a disadvantage or even a deterrent (Almack 2006, Markus et al. 2010, Nordqvist 2011, Luce 2010). However, the literature provides very little detail about the nature of this risk, nor how it is managed and navigated by prospective parents and donors. While Dempsey (2008) contends that “many Australian lesbians and gay men entering known donor negotiations [have] extensive discussions about sexual health and testing for HIV/AIDS and other STDs,” there is very little detail about how and

when these negotiations occur, what they involve, and the process and frequency of testing. Riggs' (2009) work on gay men as donors talks about the emotional impact of STI testing during the insemination process. Riggs concluded that the responsibility of protecting the sexual health of the recipient may be emotionally challenging for sexually active donors, which may in turn hinder open discussion about the donors' needs.

A recent study of 82 Canadian lesbian women trying to conceive over a 20-year period provides some insight into the ways that HIV testing is incorporated into negotiations with donors prior to home insemination (Luce 2010). This study suggests that by the mid-1990s, known donors were almost always tested for HIV and STIs prior to commencing donation. There was, however, no evidence of discussion about the donor's sexual practices and the possibility of him acquiring an infection after the initial negative test result. Thus the HIV testing of prospective donors is seen in this study as a way of excluding a past health risk, rather than one which may be ongoing during the process of home insemination.

While there are many published studies exploring the experiences, intentions and desires of gay men as parents and donors, none of the evidence shed any light on the parenting and/or donating intentions and experiences of gay men living with HIV. For further discussion, refer to Part 2, HIV positive gay men as donors.

METHOD

A qualitative scoping study took place in Victoria, Australia between September and December 2013. A critical reference group formed at the start of the project to determine the main questions, issues and stakeholders for the project. Reference group discussions were recorded and transcribed. A literature review was guided by themes identified during the first reference group meeting. Interview and focus group data was collected from a range of key stakeholders. In total 28 clinical and community based key informants who work with LGB prospective parents and donors participated in the project. These included 15 high LGB caseload general practitioners, 4 health and HIV prevention workers, 3 researchers in the area of LGB families, 2 fertility clinicians, 1 community based worker in the area of LGB families and 1 LGBT policy worker.

Thematic analysis of the interviews, focus group and reference group discussions identified the knowledge, perceptions and experiences of key informants, as well as recommendations and priority action areas.

A summary of the findings from the stakeholder consultation, focus and reference group discussions are presented in this report in two parts:

- Part 1 (pages 10 to 16) will discuss the key themes that emerged from the project.
- Part 2 (pages 17 to 19) will explore in detail the issue of HIV positive gay men as donors.

Discussion of Findings

Part 1: key themes

Six themes impacting on HIV prevention in the context of home insemination were identified:

1. Why home insemination?
2. The search for a donor
3. Talking sexual health
4. The passage of time
5. Accessing services
6. Younger prospective parents and donors

1. WHY HOME INSEMINATION?

There are several options available to lesbian, gay and bisexual people wishing to conceive a child. Legislative amendments that were enacted 2010 enabled lesbians to access Victorian fertility services for the first time. Nonetheless home insemination is still widely practiced. Most stakeholders who participated in the consultation reflected on the reasons why people prefer home insemination to clinically assisted methods of conception.

Intimacy

All of the community based stakeholders, and many of the clinicians interviewed, linked the choice to inseminate at home with the importance that many people place on privacy, intimacy and partner involvement when trying to conceive a child. One participant, who had extensively researched LGB families, articulated that home insemination should first and foremost be understood as a family practice, rather than framed as a practice that carries sexual health risk. People who were inseminating at home were doing so because they felt that clinical methods of achieving pregnancy undermined what should be a very private and even spiritual experience.

Cost

Another important factor which influenced the choice of method of conception was cost. Several participants described cost of fertility services as prohibitive, and it was seen as a deterrent to access fertility services. Cost was also described as an incentive to inseminate at home, a method which has relatively minimal costs. It was also suggested that, following the 2010 legislative changes which enabled lesbians and single women to access Victorian fertility services for the first time, the cost of fertility services in Victoria increased to capitalise on the interest of this new client groups. It was noted that while lesbians were able to access fertility services, they were not eligible for Medicare rebates unless they had a diagnosis of medical infertility. A fertility doctor noted that patients who reported unsuccessful home insemination for a period of 12 months would be considered medically infertile.

Control and resistance of medicalisation

The practice of home insemination, which has roots in women's health movement (Dempsey, 2008), was identified both in the literature and during the consultation as being motivated by a resistance of the medicalisation of conception, reproduction and of women's bodies in general. Several participants talked about the unknown number of prospective LGB parents and donors who chose not to have contact with the medical system, who didn't see the necessity or benefit of accessing clinical services for pregnancy support, or who rejected the medicalisation of women's bodies.

It was also noted that the relatively small pool of clinic-recruited donors was a cause for concern among some prospective LGB parents. There was seen to be a risk that children conceived from these donors could be connected through social networks and be unaware that they had a first degree genetic connection.

Use of multiple methods

While for many the choice was either inseminating at home or using the services of the fertility clinic, it was not uncommon for LGB prospective parents and donors to try both methods. Some people started trying to conceive using home insemination methods, moving to clinical services after not achieving pregnancy within the desired time frame. Conversely, participants suggested that some families started out accessing clinical services then moved to home insemination for a variety of reasons, some of which are described above.

Two specialists from different fertility clinics were interviewed. Both doctors saw patients from the LGB community, predominately lesbian women, and both estimated that around 20% of these patients had been trying home insemination with a known donor prior to accessing the clinic.

2. THE SEARCH FOR A DONOR

It is recognised that men who donate sperm have varying levels of involvement and connection with their donor conceived child/ren. This may range from minimal contact, through to regular contact and even shared parenting responsibilities.

Finding donors

All stakeholders talked about challenges that prospective lesbian parents faced finding donors. Several GPs noted that, while some women found donors through their friendship networks, donors were generally difficult to find. Most participants believed that women and couples were willing to accept some level of risk in order to reach an agreement with a donor, commence home insemination and ultimately achieve a pregnancy. These risks were in relation to sexual health, as well as in relation to future family dynamics and boundaries.

Fertility clinicians and several others spoke about the decreasing supply of sperm from clinic-recruited donors. It was noted that donor numbers have been declining since the legislative frameworks governing sperm donation in Australia moved away from protecting donor anonymity in favour of enshrining donor conceived children's right to access identifying information about their donor.

There are a number of Australian and international websites that match sperm donors with prospective parents. These services were mentioned by several participants, and were described as risky, and as being used by men looking for sexual encounters. Nonetheless many genuine prospective parents and donors were understood to have made their connection through these websites.

Many clinicians interviewed believed that difficulties finding donors directly led to increased risk. One fertility clinician noted that some of his lesbian patients reported having had sex with their donor. Other stakeholders referred to a popular belief that sexual intercourse (also known as natural conception), particularly in the context of declining fertility, was the most effective way to conceive. It was also suggested that some donors would only donate on the condition that sexual intercourse with the recipient occurred, and that some women accepted these terms in order to conceive a child.

In a focus group discussion, GPs identified that limited donor options lead to compromise. It was suggested that sometimes women avoided or limited some conversations in order to preserve their relationship with the donor, and commence the process as soon as possible.

Talking about family matters

A universal theme of all interviews and group discussions was the potentially challenging nature of conversations between prospective parents and donors. Two researchers in the field of LGB families talked extensively about this issue. Communication about family relationships and boundaries was described as being difficult and awkward, but essential to reduce the risk of disagreement. However, very important parts of these discussions were frequently glossed over, particularly in relation to the details of the arrangement after the birth of the baby.

Trust was another issue that was frequently mentioned in interviews and group discussions. Trust was seen as a critical factor in the level of honesty in the relationship between prospective parents and donors. This was associated with how well prospective parents and donors knew each other. Women and donors weren't always necessarily well acquainted, and often had different views on how much detail was needed in the discussions, or whether it was reasonable to put limits on their donor's lifestyle during the insemination process. Trust was seen as central to the practice of home insemination, and most interviews and discussions explored the ways that barriers to trust and openness could develop over time.

Several participants mentioned The Rainbow Families and the Law kit. This resource was commissioned by the Victorian Department of Justice in 2010 to assist LGB families to navigate the legal and relational complexities of donor conceived family structures. It provides detailed guidance to women as prospective parents, and men as prospective parents and/or donors, about the many things that should be covered in discussions, and recommends that formal written agreements be developed to articulate intentions and clarify roles and responsibilities. This resource also provides some information about STI testing for people considering home insemination.

3. TALKING SEXUAL HEALTH

The development of a trusting relationship between prospective parents and donors, and the details of future family dynamics and boundaries, were seen as complex. Having detailed discussions about sexual practice was described by one participant as adding fragility to these already complex discussions.

It is clear from the interviews and discussions that took place during this project, as well as from the published literature, that most prospective parents and donors understood HIV and STI screening of the donor to be essential. Participants indicated that HIV testing prior to commencement of home insemination was very common, but also suggested that a negative HIV test generally heralded the end of the discussion about HIV risk. For HIV/STI prevention to be effective, however, conversations about testing need to be ongoing and need to realistically reflect the donor's sexual activities throughout the insemination period.

Talking about sex

Many participants reflected on the similar challenges arising from conversations about family dynamics, and conversations about sexual health and donor testing. It was felt that prospective parents and donors were much more likely to be aware of risks impacting on future family dynamics than of the risks related to HIV transmission.

One GP believed that many women were not having detailed conversations with their donor about sexual practices because they lacked the knowledge or skills to talk about safe practices. Other participants pointed out that some lesbians may be surprised to learn about the sexual activities of gay men, or may be reluctant to ask too many questions. Another GP indicated that she had several patients who had not even considered that STI transmission may occur during home insemination.

Several GPs noted that occasional unprotected sex between men was becoming more common, even though many men felt embarrassed or ashamed to admit to their GP that they may have engaged in it. It is worth noting that the GP focus groups took place before PrEP was proven to be a highly effective means of HIV prevention. GPs felt that it would be difficult for a donor to tell the recipient that unprotected sex had occurred, especially if there was an agreement that he would abstain from this practice. Communicating about the unplanned nature of unprotected sex can be difficult, both in the moment and after the fact.

According to one community based participant who worked with same sex families, families often desired to have more than one child, and for many families having the same donor was critically important. Some families would do whatever they could to have their subsequent child/ren with the same donor, and work around any issues or changes in circumstance. This desire could impact on conversations and practices relating to HIV prevention.

Abstinence

Assumptions about sexual practices, relationships, and levels of risk were discussed during a focus group of high LGBT caseload GPs. These assumptions were generally made in the absence of specific conversations between prospective parents and donors about risk. It was noted that it was not uncommon for women to assume that simply because the donor was donating sperm that he was therefore abstaining from sex. Another assumption, which was common among women who were using donor sperm from a good friend, was that they would somehow know if their donor friend was at risk of HIV or STIs.

The notion of donor abstinence during the period of insemination, and whether this was assumed, inferred or agreed between the parties, was explored during many interviews and group discussions. The definition or interpretation of abstinence was not seen as absolute. It was suggested that, particularly for the donor, abstinence could mean abstaining only from high risk practices rather than total abstinence from any sexual activity.

Total sexual abstinence was seen by many participants as an unrealistic expectation or commitment given that it could take six or twelve months for pregnancy to occur.

Understanding risk

The only way to eliminate risk during home insemination is complete donor abstinence for the duration of insemination and also for six weeks prior, which is the window period for HIV testing. Complete sexual abstinence was understood by most participants to be practiced in only the minority of cases of home insemination.

The donor's sexual practices were seen as being largely mediated by his own beliefs and perceptions about HIV transmission and prevention. Several participants, including some GPs, talked about the grey areas around low risk activities such as unprotected oral sex, highlighting the importance of a shared understanding between prospective parents and donors about the meaning of low risk. The donor's individual understanding of the meaning of low risk not only impacted on his sexual practice, but also on the way that discussions about risk played out.

GPs talked about their role in advising the recipients of donor sperm about how to conduct a risk assessment with their donor. This included recipients asking questions about the donor's sexual practices, their definition of safe sex, and specifically asking about the donor's practices and perceptions of risk in relation to oral sex. One GP noted that there was a significant subgroup of gay sperm donors who are highly educated and confident about staying safe.

Lesbians are generally underrepresented in research about STIs, which serves to reinforce the misconception that lesbians are not at risk of STIs (Power et al. 2009, McNair 2005, Ripley 2011). This misconception, which is widely perpetuated by clinicians, health promotion practitioners and communities alike, may limit the STI knowledge levels of lesbians, and their skills in discussing and negotiating safer sexual practices.

One fertility clinician noted that most of her lesbian patients recognised that gay men were at increased risk of HIV, and they had taken steps to seek reassurance from their donor. Many had gone through a testing process with their donor. Most of these patients were referred from high LGBT caseload clinics and therefore had received quite good information from their GP. It was nonetheless felt that most hadn't done quite enough.

Several doctors participating in a focus group discussion perceived that their lesbian patients had inadequate sexual health knowledge, and in particular they had a very poor understanding of the meaning and implications of the window period. This was seen as contributing to both inadequate conversations about STI prevention, and incomplete testing processes.

The donor's partner(s)

Sexual partners are an important consideration in sexual health testing, however several GPs felt that discussions about partners did not always occur between prospective parents and donors. If a donor has a partner, it is essential to consider the sexual practices of both the donor and his partner, especially if they are having unprotected sex within or outside the relationship.

A number of possible scenarios relating to partners were identified during the consultation, highlighting the way that arrangements and family structures could change over time. A donor might be single when the negotiations commence then subsequently enter a relationship with a partner of unknown HIV status during the insemination period. It was seen as critically important to discuss future changes to the donor's relationship status even if he was not partnered or sexually active at the start of the negotiations. Likewise, the donor's HIV status, or that of his partner, could change between the conception of the first child and the commencement of discussions about subsequent children with the same donor. Given the importance for many families of children having the same donor, these issues must be carefully considered.

4. THE PASSAGE OF TIME

Real or perceived time constraints were seen as having a detrimental impact on conversations about sexual health between prospective parents and donors.

Fear of loss of fertility

Several participants noted that it was not uncommon for women in their late 30s to be anxious about loss of fertility and to hastily enter into incomplete arrangements with donors. Participants spoke about insufficient time being spent discussing the donor's role in the future child's life, or HIV prevention during the insemination period, in order to quickly commence the process of trying to conceive. The fear of loss of fertility was described as powerful, and the fear of running out of time to conceive was seen to significantly increase the level of risk that people were prepared to accept.

Window period for testing

It can take up to six weeks from the date of infection for evidence of HIV to show up in a blood test. This period of time is known as the window period. Several doctors talked about the way that the window period for HIV testing was perceived by patients. Patients planning on commencing home insemination were said to understand the concept of the window period but many did not acknowledge its significance. It was not uncommon for people to fail to return for follow up testing at the end of the window period, leading GPs to assume that they had commenced home insemination after the initial negative test result. This was especially the case for people who were in a hurry to get started.

Six-month quarantine period

In accordance with the Public Health and Wellbeing Act (Vic) 2008, Victorian fertility clinics impose a six-month quarantine on donor sperm as a means of eliminating any HIV/STI risk during the procedure. Several doctors and a community based participant described the six-month quarantine as a barrier to people accessing the fertility clinic services. It was seen as a major factor for some women and couples, especially older women, deciding to proceed with home insemination. Many noted that the six-month quarantine was far longer than was necessary, given the six-week window period for HIV testing which applied in other clinical settings. It was widely believed that people who had decided to proceed with clinical services would be trying home insemination during the six-month quarantine period.

Waiting for pregnancy

While the majority of women will fall pregnant within six cycles, around one-fifth of women can take considerably longer (Gnoth, 2003). Participants identified that the length of time taken to achieve pregnancy had an impact on conversations and practices relating to HIV prevention. The risk of donor fatigue increased with time, potentially impacting on the donor's willingness to continue to donate each monthly cycle. Donor fatigue was also seen as a factor that could erode the donor's adherence to any agreement or intention around safe practices or abstinence.

One participant, a social researcher, spoke about the impact of infertility. She described infertility as being characterised by monthly expectations and monthly disappointment. Communication about infertility is difficult within relationships, and layers of complexity are added when there is a donor involved. She suggested that conversations about HIV/STI prevention and the donor's sexual practices would certainly be affected by the same dynamic.

5. ACCESSING SERVICES

There are several high LGBT caseload GP clinics in inner Melbourne that provide medical services, information and referral to prospective parents and donors, and there are many LGBT friendly services around Victoria. However it cannot be assumed that all prospective parents and donors have access to, or choose to access, these services.

Safe and inclusive services for LGBT people

Past experiences of heterosexism and fears of homophobia meant that, for some LGBT prospective parents and donors, there was a fear of seeking out health practitioners and speaking openly about same-sex conception.

One fertility clinician indicated that many women, particularly those in outer metropolitan and regional areas, did not have access to an LGBT friendly doctor. These women were perceived to be more likely to enter into sub optimal home insemination arrangements because of previous experiences of homophobia when seeking a referral to a fertility clinic or information about same sex parenting. Some of these women were described as vulnerable.

Another service which was identified as a site for stigma was fertility clinics. During a reference group discussion, as well as during several interviews, participants identified that some fertility clinics viewed home insemination as a practice associated with a high risk of HIV transmission, particularly if the donor was gay. This view was described by one participant as failing to acknowledge that people can negotiate risk and have open and honest conversations. This view also existed in the absence of any evidence that home insemination posed a high risk for HIV. Participants also reported that counselling and administrative services at fertility clinics have been perceived by patients as homophobic.

Clinical experiences

A great deal of practice knowledge and experience was shared by the high LGBT caseload GPs who participated in the consultation. Individual doctors tended to see either the donor or the women and, despite a clear preference for a group consultation, it was unusual for all parties to present at the same time. Interestingly, one GP indicated that when groups did present together, HIV prevention was rarely on their radar. Group consultations were seen as neutral spaces for all parties, where the clinician could provide information and model the language used to talk about sexual practices, thereby making it easier for prospective parents and donors to continue their discussion.

There was substantial discussion about the limitations of only seeing one of the parties involved in the home insemination discussion. GPs did all they could to encourage their patient to pass on the HIV and STI prevention information to the other party. Conversations with men focused on testing and the window period; the difference between high risk, low risk and no risk sexual practice; and the importance of honest discussion and shared responsibility for risk reduction. Women were generally advised to ensure that their donor's STI tests and window periods were complete, and to talk openly and realistically with their donor about his sexual history and practices. However, there was no real way for GPs to know whether any of these discussions eventuated. One GP pointed out that this was not that dissimilar to talking with patients about risk reduction with their current sexual partner(s). Other GPs reflected that it was entirely possible that men were presenting for routine HIV and STI tests without specifically disclosing or discussing their intention to donate sperm. This may have been particularly relevant for men who did not have a regular GP, or an LGBT friendly GP.

While many patients presented to their GPs very early on in the process, sometimes even prior to finding a donor, an equal number presented after trying home insemination for many months.

As standard practice, many GPs provided their patients with a referral to a fertility clinic when they first presented to discuss home insemination. This was seen as a back-up plan in the event that pregnancy did not occur within 6 months of inseminating at home, as it could save the prospective parents and donors from waiting out the six-month quarantine period before accessing IUI or IVF.

A regional GP who saw LGB patients identified that poor access to IVF was an issue in regional areas, and suspected that this resulted in more people trying to conceive via home insemination.

Poor fertility knowledge was relatively common, according to one fertility clinician, among people presenting to fertility clinics after trying home insemination. It was estimated that 90% of patients with a history of inseminating at home had a very limited understanding of fertility and were timing ovulation poorly.

6. YOUNGER PROSPECTIVE PARENTS AND DONORS

Very few participants in this study had any experience working with younger prospective parents and donors. Several participants emphasised how little was known about the pregnancy and parenting intentions and practices of LGB young people.

Younger people may not be accessing medical services

Only a handful of participants had any experiences or insights about working with younger LGB prospective parents and donors. The vast majority of women accessing pre pregnancy advice from their GP were in their described as being aged between 37 and 41.

Doctors noted the absence of younger LGB prospective parents and donors in their clinical services, however they did not assume that younger LGB people were not exploring options for achieving pregnancy and having children.

Young people were seen as having more financial constraints than older people, and therefore as being less able or willing to spend money on accessing pre pregnancy medical services or clinical fertility services. Participants also suggested that younger LGB people, when attempting to access pregnancy information from their local GP, may have faced misconceptions or judgements which led them to pursue their goals without accessing further services.

Young people and risk

Several stakeholders discussed some possible risk factors for LGB young people practising home insemination. Young people were described as having a more 'do-it-yourself' approach to health, and as being distrusting of doctors and medical advice. When compared to older people, young people were described as having lower levels of health literacy, being less well informed about the risks of home insemination, and more likely to take risks in general. In addition, young lesbians were seen as having lower levels of knowledge about STI prevention and safer sex due to the general misconception that lesbians are at very low risk of STIs, and the subsequent lack of targeted sexual health information.

Young LGBT people and their thoughts about future parenting

Several participants emphasised how little is known about the pregnancy and parenting intentions and practices of young people. Available evidence suggests that there has been a shift in younger LGBT people's intentions to become parents. The *Writing Themselves In* study revealed a substantial increase in young people indicating that their intentions to have children, from 3% in 1998 to 68% in 2010, however the study did not explore this issue further. (Hillier et al. 2010, Hillier et al. 1998). One stakeholder, based on discussions at support groups for LGBT young people, observed that young people no longer saw themselves as excluded from parenting in the same way that older generations of LGBT people did.

Discussion of Findings

Part 2: HIV positive gay men as donors

BACKGROUND

HIV is a chronic disease that is preventable and treatable. Contemporary HIV antiviral treatments are highly effective at suppressing HIV viral load, which results in control of the HIV infection as well as a significant reduction in the likelihood of onward transmission (Rodger, 2014). In Australia, the majority of people living with HIV are gay and bisexual men and other men who have sex with men.

There are many published studies exploring the parenting and/or donating experiences and intentions of gay men. There is a substantial body of literature that explores the risks, beliefs and practices relating to natural conception (timed unprotected intercourse) among serodiscordant heterosexual couples. However, no evidence was found which shed any light on the parenting and/or donating intentions and experiences of gay men living with HIV.

Several studies have found that serodiscordant couples trying to achieve pregnancy often do so with an understanding and acceptance of the transmission risk involved. For example, 20% of couples in Klein's study disclosed having had timed unprotected sex in the hope of conceiving a child (Klein, 2003). The author went on to suggest that the real proportion of serodiscordant couples attempting natural conception was likely to be higher. The narrative work of McDonald (2011) highlights the complexity faced by serodiscordant couples, and the reality that many serodiscordant couples decide to have unprotected sex to try and conceive naturally. Her work also reminds us that, even before the era of PrEP and TasP, the sex lives of people with HIV did not always consist of 100% condom use.

Epidemiological modelling demonstrates that a significant proportion of HIV transmissions occur as a result of undiagnosed HIV (Wilson et al. 2008). Diagnosed, treated and virologically suppressed HIV infection poses a far lower risk of transmission. A recent systematic review concluded that "unprotected sexual intercourse is a viable conception and sexual option for heterosexual serodiscordant couples in monogamous relationships if the HIV-infected partner has full virologic suppression on cART where both parties understand the limitations of the available data" (Loutfy 2013). Numerous other studies were published between 2010 and 2013 (Cohen, 2011; Baetan, 2012; Thigpen 2012, Das et. al. 2010) which demonstrated that people with a very low and stable undetectable viral load are very unlikely to pass on HIV during condomless sex.

No evidence is available to quantify the risk of HIV transmission from home insemination practices using sperm from an HIV positive donor. The risk is understood as similar to the risk for receptive vaginal sex with an HIV positive partner which is 1/1250 per contact. This compares to a risk per contact of 1/70 for receptive unprotected anal intercourse, the practice that poses the highest HIV transmission risk. Factors that may increase the risk of HIV transmission include high HIV viral load, the presence of other STIs in either partner, and breaches in mucosal integrity (Australasian Society for HIV Medicine, 2013).

In 2013, when this study was conducted, HIV positive men and their female partners were able to access reproductive services at a dedicated Victorian clinic for people with HIV. However, these services were, and still are only available to heterosexual couples. There are no Victorian services that cater for HIV positive gay men wishing to become sperm donors or biologically father a child. The Victorian Public Health and Wellbeing Act 2008 prevents HIV positive men from donating sperm to Victorian fertility clinics, which applies to both clinic-recruited donors and known donor arrangements. Heterosexual serodiscordant couples are not affected by this legislative requirement as partners are treated differently under the law than donors.

It is important to recognise that while HIV positive gay men are excluded from accessing clinical fertility services, there is no Victorian law that specifically prohibits HIV positive men from donating sperm. Private sperm donation arrangements between HIV positive men and HIV negative women are lawful provided that disclosure of HIV status and informed consent can be demonstrated.

DISCUSSION OF FINDINGS

Clinicians, researchers and community based participants in this study were asked a series of questions about gay men living with HIV as sperm donors. Data collection for this study took place in 2013, before the increased availability of PrEP and the consensus about Treatment as Prevention. Nonetheless these biomedical advances were clearly on the horizon.

While participants had no clear evidence that HIV positive gay men were entering into donating or parenting arrangements with consenting women or couples, there was a strong indication overall that discussions on this subject were taking place between prospective parents and donors. Numerous anecdotes of HIV positive men being approached to donate or co parent were shared during interviews and group discussions. It was clear for many participants that prospective parents and donors were conducting their own research, with a particular emphasis on the relationship between undetectable viral load and HIV risk reduction.

HIV positive gay men as prospective parents and donors

Several doctors articulated that there had been a shift during the preceding five years whereby gay men with HIV, especially younger gay men, were expressing their desires to have children and/or be donors in the future. This was seen as a real change from 10 to 15 years ago, when having HIV and having the choice to biologically father a child were seen as mutually exclusive. The future for HIV positive people in 2013 was very different to that of their forebears. Young gay men with HIV were described by participants as being more likely to see themselves as parents or donors in the future. It was noted that while conversations had evolved about LGB parenting, little emphasis had been placed on the reproductive rights and choices of HIV positive men within the LGB community.

A nurse working closely with people living with HIV stated that HIV positive gay men often talked about having children, especially when first coming to terms with their diagnosis. In particular, many newly diagnosed younger men talked about parenting, fathering, and donating sperm in their encounters with support services.

Clinicians reported that patients had presented with enquiries about HIV positive gay men and sperm donation. Several GPs were aware of HIV positive patients who had been approached by lesbian friends to donate sperm. These patients had generally done a lot of research about risk reduction, and generally concluded that home insemination would be safe as long as they strictly adhered to their HIV antiviral regimen and maintained an undetectable viral load. One GP had a patient who referred to the guideline known as 'the Swiss Statement', which was the first major public health declaration of what is now known as Treatment as Prevention. The Swiss Statement specifically says that insemination via sperm washing is no longer indicated on effective ART if it is done only to exclude HIV (Vernazza, 2008). None of the GPs that participated in the consultation said they would advise patients that home insemination in the context of undetectable viral load was safe. Importantly, none of the participants in the consultation had a clear understanding of whether the law permitted HIV positive men to enter into private sperm donation arrangements.

Community and home based HIV service providers indicated that HIV positive gay men had made contact to find out more about sperm donation. One service provider talked about anecdotal reports of HIV positive gay men travelling overseas to access sperm washing for the purposes of home insemination. The lack of clarity about the legal position of HIV positive men donating sperm for home insemination, and the absence of any clear pathway or readily available information, constrained service providers from engaging in any detailed or ongoing discussion about risk reduction.

Victoria's reproductive service for people with HIV

The Chronic Viral Illness (CVI) Clinic was the first multi-disciplinary clinic with ethics approval to treat HIV sero-discordant couples in Australia. A specialist from the CVI Clinic participated in the consultation.

The CVI Clinic only provides reproductive services to heterosexual couples. IVF procedures within a serodiscordant couple are not categorised as sperm donation procedures and therefore are not subject to the section in the Victorian Public Health and Wellbeing Act 2008 about tissue donations and infectious diseases.

Theoretically, a prospective lesbian parent and an HIV positive gay man could present as a couple and access the services at the CVI Clinic. However, the donor would become the legal parent of any child subsequently born, which would have significant family law implications. Other than presenting as a part of a couple, HIV positive prospective donors have no option to access services at the CVI Clinic.

The CVI clinic ensures that all patients understand that there is no way of completely eliminating the risk of HIV transmission, even though that risk is extremely low. At the time of the interviews, the CVI Clinic required HIV positive men to have an undetectable viral load in their blood and their semen for a specified time prior to commencement of IUI/ IVF/ ICSI. The clinical guidelines were then in the process of being updated, with the expected addition of pre exposure prophylaxis (PrEP) for the negative partner, as well as protocols for the limited use of timed unprotected intercourse at ovulation.

Going it alone

While HIV positive men in serodiscordant heterosexual relationships can access clinical reproductive services to conceive a child, Victorian legislation effectively prevents men with HIV from accessing clinical services to become sperm donors. This means that HIV positive gay men wishing to donate sperm to conceive a child are ineligible to access the clinical support services that would minimise the risk of transmission.

Serodiscordant prospective parents and donors, according to both clinical and community stakeholders, appeared to be very carefully gathering information and evidence about the risk of HIV transmission via home insemination with a HIV positive donor. Given the lack of information or services for prospective parents and HIV positive donors, many participants believed that people were seeking guidance from the considerable body of literature and guidelines about the conception options and methods available to HIV serodiscordant couples.

The issue of stigma was raised by several community and home based service providers. HIV stigma was seen as being powerful and pervasive, and it was felt that people considering home insemination with a donor living with HIV would probably be quite secretive about it. One participant described that way that experiences of stigma and discrimination had generally led to people with HIV being quite guarded about talking anything that might be considered to pose a risk of transmission to others. Therefore, the issue of HIV positive donors was seen as something that was not openly spoken about.

Pregnancies, or potential pregnancies, where one parent has HIV, were described in one interview as highly medicalised. The participant had observed the development of a culture of resistance of the medicalisation of pregnancy among many women living with HIV. Given that the resistance of medicalisation was identified in the literature and during the consultation as a reason that LGB people chose home insemination, this may well be a factor for LGB prospective parents and donors where the donor is living with HIV.

Risk reduction

The risk of transmission from a HIV positive sperm donor to a recipient via home insemination is unknown. A clinician specialising in HIV and pregnancy stated that while the risk is believed to be low, there is nothing in the published literature to confirm this. Other clinicians suggested that the lack of mucosal abrasion meant that insemination with a syringe probably posed a lower risk than receptive vaginal intercourse.

Stakeholders from clinical, community and home based services noted the increasing emphasis on undetectable viral load in conversations and community understandings about HIV transmission, reflecting an evolving calculus of risk management among gay men (Gianacas et al. 2013). For many HIV positive people, and for gay men more generally, the possibility of sex without condoms was being openly discussed in detail for the first time since the beginning of the HIV epidemic. One participant perceived that, due to the emerging information about undetectable viral load and unprotected sex, and the fact that at the time the evidence for TasP was much stronger in the context of vaginal sex than anal sex, the line of HIV transmission risk was more blurred than ever before.

At the time of the interviews there were no PrEP trials underway in Australia, and the evidence for its effectiveness was strongest among cohorts of heterosexual serodiscordant couples. Nonetheless several stakeholders pointed out that use of PrEP by gay men was increasing.

Recommendations and conclusion

This qualitative scoping study aimed to better understand the nature of and evidence for HIV risk in the context of home insemination, and to identify ways of supporting LGB prospective parents and donors and service providers to accurately assess and minimise the risks associated with home insemination.

This section summarises the recommendations for action that were identified during the consultation.

RESOURCES AND INFORMATION

The most significant finding from this Victorian study is that prospective parents and donors, and the doctors and other service providers working with them, need information about best practice in home insemination that includes detailed information about HIV/STI prevention. These resources need to be targeted to a diverse audience, and should focus on good practice and health promotion rather than risk in order to minimise the stigma that could arise from their development. These resources should also be inclusive of people who are transgender or gender diverse.

LGB prospective parents and donors need resources and information that can be easily found online or obtained through community and health organisations. Information should include considerations prior to commencing home insemination, the meaning and implications of the window period and the importance of regular testing if the donor is sexually active. There is a need for detailed information which includes practical tips and discussion points for starting and continuing conversations about sexual health. Useful detail would include strategies for discussing the donor's sexual practices and ways of reaching a shared definition of 'safe practices'. Information needs to emphasise the importance of all parties being honest, patient and having realistic expectations of the process, and of the time it can take to achieve pregnancy.

Clinicians and GPs working with LGB communities would benefit from a checklist or a set of guidelines for use during discussions with prospective parents and donors. This could include suggested questions and discussion points about STI risk reduction, and ways of initiating and sustaining challenging conversations about sexual practices. Information about the actual logistics of home insemination and tips for maximising chances of successful conception. Relevant jurisdictional medical and legal information would also be useful.

Resources should be framed by the notion that home insemination can be very safe and low risk as long as prospective parents and donors are equipped with the appropriate information and skills, and allow themselves time to work through the complex discussions. Prospective parents and donors should nonetheless be informed that the only way to completely eliminate the possibility of HIV transmission is to utilise the services of fertility clinics.

Information about pregnancy and home insemination needs to be included in future sexual health resources and programs targeted at lesbians. Likewise, targeted information about donating sperm and home insemination should be included in sexual health or general health resources and programs targeted at gay men. Younger prospective parents and donors in the LGB community may benefit from targeted information about same sex families and the conception options available to them.

Dissemination strategies for resources and information home insemination should consider the early contact points that people might utilise when planning for pregnancy. This includes GPs, naturopaths, social media and online forums, LGBT media and LGBT community agencies.

The inclusion of enhanced content about HIV/STI prevention and home insemination and negotiating safety in future versions of LGB family resources such as Rainbow Families and the Law (Rainbow Families Council, 2010) would be highly beneficial.

This study also suggests that some LGB people are not receiving appropriate support and information in the primary care setting in regard to the reproductive choices available to them. Where possible LGB prospective parents and donors should be supported and

encouraged to access an LGBT friendly GP to obtain information about home insemination, including negotiating the complex issues related to HIV/STI prevention.

HIV POSITIVE DONORS – POLICY AND PRACTICE

There are no Victorian services that cater for HIV positive gay men wishing to become sperm donors or biologically father a child. While the Victorian Public Health and Wellbeing Act 2008 effectively prohibits HIV positive men from donating sperm in the clinical context, there is no Victorian law that specifically prohibits HIV positive men from donating sperm. Private sperm donation arrangements between HIV positive men and HIV negative women, provided that HIV status has been disclosed and informed consent can be demonstrated, are lawful in Victoria. The legal issues arising from this scenario are similar to those that would arise in the context of a sero-discordant couple having unprotected sexual intercourse, where the person with HIV has disclosed their HIV status to their sexual partner.

There was a lack of clarity among participants in this study about whether HIV positive men could donate sperm privately, and none of the service providers participating in this study reported working with LGB prospective parents and donors where the donor was HIV positive. This study revealed a major gap in policy and practice in relation to the issue of HIV positive donors. It also revealed that the broader question of the reproductive rights of HIV positive gay men has not been addressed.

Clear and accessible legal and health information relating to HIV positive sperm donation needs to be made available in all jurisdictions to service providers, clinicians and HIV affected communities.

CONCLUSION

This qualitative scoping study aimed to better understand the nature of and evidence for HIV risk in the context of home insemination in order to identify ways of supporting LGB prospective parents and donors and service providers to accurately assess and minimise the risks associated with home insemination.

Home insemination can be very safe and low risk as long as prospective parents and donors are equipped with the appropriate information and skills, and allow themselves sufficient time to work through the complex discussions. The reproductive rights and needs of HIV positive gay men, particularly in the new era of PrEP and TasP, need to be addressed.

References

- Almack, K. (2006). Seeking Sperm: Accounts of Lesbian Couples' Reproductive Decision-Making and Understandings of the Needs of the Child. *International Journal of Law, Policy and the Family*, 20(1): 1-22.
- Australasian Society for HIV Medicine (2013). National Guidelines for Post-Exposure Prophylaxis after Non-Occupational and Occupational exposure to HIV. Available at <http://www.ashm.org.au/pep-guidelines/NPEPEPGuidelinesDec2013.pdf>
- Baeten, J.M. et al (2012). Antiretroviral Prophylaxis for HIV Prevention in Heterosexual Men and Women, *The New England Journal of Medicine*. 367(5):399-410
- Chabot, J. and B. Ames (2004). "It wasn't let's get pregnant and go do it!:" Decision Making in Lesbian Couples Planning Motherhood via Donor Insemination. *Family Relations* 53(4): 348-356.
- Cohen, M.S. et al (2011). Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *The New England Journal of Medicine* 365(5):493-505
- Das, M., Chu P.L., Santos G.M., Scheer S., Vittinghoff E., McFarland W., Colfax G.N. (2010). Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. *PLOS One* 5(6):e11068
- Dempsey, D. (2008). ART eligibility for lesbians and single heterosexual women in Victoria: How medicalisation influenced a political, legal and policy debate. *Health Sociology Review* 17(3): 267-279.
- Dempsey, D. (2012). Gay male couples' paternal involvement in lesbian-parented families. *Journal of Family Studies* 18(2-3): 155-164.
- Gianacas, C., Prestage, G., Brown, G., Triffitt, K., Ellard, J., Down, I. (2013). Experiences of HIV: The Seroconversion Study Report 2013. Monograph, The Kirby Institute, The University of New South Wales, Sydney Australia
- Gnoth, C., Godehardt, D., Godehardt, E., Frank-Herrmann, P., and Freundl, G. (2003), Time to pregnancy: results of the German prospective study and impact on the management of infertility. *Human Reproduction* 18 (9): 1959-1966
- Klein, J., Pena, J.E., Thornton, M.H., Sauer, M.V. (2003), Understanding the motivations, concerns, and desires of human immunodeficiency virus 1-serodiscordant couples wishing to have children through assisted reproduction. *Obstetric Gynaecology* 101(5 Pt 1):987-94.
- Loutfy, M.R., Wu, W., Letchumanan, M., Bondy, L., Antoniou, T., et al. (2013) Systematic Review of HIV Transmission between Heterosexual Serodiscordant Couples where the HIV-Positive Partner Is Fully Suppressed on Antiretroviral Therapy. *PLoS ONE* 8(12)
- Luce, J. (2010). *Beyond Expectation: Lesbian/Bi/Queer Women and Assisted Conception*. Toronto, University of Toronto Press.
- Markus, E. B., et al. (2010). Lesbian Couples Seeking Pregnancy With Donor Insemination. *Journal of Midwifery & Women's Health* 55(2): 124-132.
- McDonald, K. (2011). The old-fashioned way': conception and sex in serodiscordant relationships after ART. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, 13:10, 1119-1133
- McNair, R. (2005). Risks and prevention of sexually transmissible infections among women who have sex with women. *Sexual Health* 2: 209-217.

McNair, R., et al. (2002). Lesbian parenting: Issues, strengths and challenges. *Family Matters* (40-49).

Nordqvist, P. (2011). 'Dealing with sperm': comparing lesbians' clinical and non-clinical donor conception processes. *Sociology of Health & Illness* 33(1): 114-129.

Power, J., et al. (2010). Diversity, Tradition and Family: Australian Same-Sex Attracted Parents and their Families. *Gay & Lesbian Issues and Psychology Review* 6(2): 66-81.

Power, J., et al. (2009). Absent sexual scripts: lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information. *Culture, Health & Sexuality* 11(1): 67-81.

Public Health and Wellbeing Act 2008 (Vic), available at http://www.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/

Rainbow Families Council (2010). "Rainbow Families and the Law", available at <http://www.rainbowfamilies.org.au/wp-content/uploads/2011/06/Rainbow-families-and-the-law-Info-Kit-October-2010-web.pdf>

Riggs, D. (2009). The Health and Well-being Implications of Emotion Work Undertaken by Gay Sperm Donors. *Feminism & Psychology* 19(4): 517-533.

Ripley, V. (2011). Promoting sexual health in women who have sex with women. *Nursing Standard*, 25(51), 41-6.

Rodger, A., Bruun, T., Weait, M., Vernazza, P., Collins, S., Estrada, V., et al. (2014). HIV transmission risk through condomless sex if HIV+ partner on suppressive ART: PARTNER study. Presentation delivered at the 2014 Conference on Retroviruses and Opportunistic Infections (CROI 2014), 3–6 March, Boston. Abstract 153LB.

Sifris, A. (2004). Dismantling Discriminatory Barriers: Access to Assisted Reproductive Services for Single Women and Lesbian Couples. *Monash University Law Review* 30(2): 229-268.

Thigpen, M.C. et al (2012). Antiretroviral Preexposure Prophylaxis for Heterosexual HIV Transmission in Botswana, *The New England Journal of Medicine* 367:423-434

Vernazza, P., Graf, J., Sonnenberg-Schwan, U., Geit, M., Meurer, A. (2011). Preexposure Prophylaxis and Timed Intercourse for HIV-discordant Couples Willing to Conceive a Child, *AIDS*. 2011; 25(16):2005-2008.

Vernazza, P., Hirschel, B., Bernasconi, E., Flepp, M. (2008). Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle. *Bull Med Suisse* 2008;89:165-169,

Wilson, D & National Centre in HIV Epidemiology and Clinical Research (Australia) (2008). Mathematical models to investigate recent trends in HIV notifications among men who have sex with men in Australia. National Centre in HIV Epidemiology and Clinical Research, Darlinghurst, NSW.