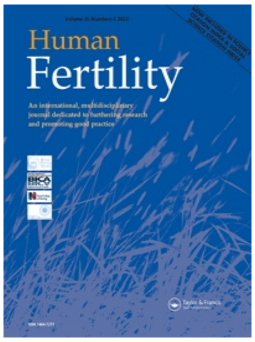

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# Home-insemination: the motivations and experiences of same-sex and gender diverse couples using self-insemination and known donors to conceive in Aotearoa New Zealand

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**ABSTRACT**

Donor conception that occurs outside of clinical fertility settings is understood to be increasingly common, yet research on this practice remains limited. Drawing on interviews with eleven participants, this study explored the motivations and experiences of same-sex and gender diverse couples who used known donors and home insemination methods to conceive. While participants were parents of children conceived after the introduction of the Human Assisted Reproductive Technology [HART] Act (2004) in Aotearoa New Zealand, conception outside regulated settings meant they were not subject to the medical, ethical, or legal procedures implicit within fertility clinics. Four main themes were identified (1) Finding the 'ideal donor'- participants sought donors who were 'good' people; known donors were chosen to enable relational processes and facilitate ongoing connections, (2) Home insemination - perceived as affordable, personal, and offering greater agency; though revealing potential relational awkwardness, (3) Relationship planning/envisaged relationships: not the 'donor dad' - participants constructed donors as 'helping uncles' or extended family members with ongoing, contracted roles, (4) Lack of and need for knowledge, understanding and relevant support for self-insemination using known donors. This study highlights the need for accessible, evidence-based resources and psychosocial support to benefit and protect all donor conception stakeholders.

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Donor conception; sperm donation; self-insemination; home insemination; known donors; LBTQ+

## Introduction

The landscape of donor conception (DC) is continually evolving, influenced by advances in reproductive technology, shifting sociocultural perceptions, growth in communication and information-sharing technologies, and the ongoing adaptation of regulatory frameworks and legislation (Darroch & Smith, 2021; Golombok, 2020; Indekeu et al., 2021; Nastasel et al., 2023; Taylor et al., 2022). A growing number of people, including same-sex couples, who need sperm to conceive but who do not necessarily require clinical interventions to do so (Rodino et al., 2014; Trail & Goedeke, 2022; Wynn, 2022) are using self-insemination (where artificial insemination is performed by the recipient or someone acting on their behalf e.g., their partner, outside a clinical setting) to build their families. Self-insemination does not require specialist personnel or equipment and has proven efficacy for conception in the absence of fertility issues (Mamo, 2007; McNair & Dempsey, 2002; Taylor et al., 2022; Wikler & Wikler, 1991). This method of conception involves direct, private arrangements between donor and recipient outside of the clinical framework and may involve donors already known to the recipient/s, such as family members or friends, or previously unknown donors often recruited online (Bree, 2003; Dempsey et al., 2022). Currently, there are no Aotearoa New Zealand (hereafter Aotearoa) data on the frequency of such

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privately-arranged donations, or records of same-sex couples achieving live births via self-insemination. However, a preliminary environmental scan identified over 60 English-language online donor sperm platforms, with an estimated 350,000 potential recipients worldwide, highlighting the growing prevalence of DC outside regulated settings (Taylor et al., 2022).

This research uses the terms 'same-sex couple' and 'gender diverse' to represent the diversity of sexuality and gender identities of participants, while recognising that multiple and fluid sexual orientations and gender identities are possible within the 'same-sex' reproductive dyad. The terms 'self-insemination' and 'home insemination' (HI) are used interchangeably in this research.

Pursuing DC through a fertility clinic in Aotearoa involves mandatory procedures, encompassing pre-donation health screening for donor and recipient, sperm quarantine, and counselling to explore choices and implications of family building through DC, including with respect to information sharing, number/frequency of donations, roles and relationships, and contact arrangements between donor and recipient families. Further, pursuing DC through the formal clinical setting implies that the DC is subject to the requirements of the Human Assisted Reproductive Technology (HART) Act of (2004), which outlines the rights and responsibilities of parents and donors, mandates the recording of identifying information for donors and DCP, and facilitates donor-linking through the HART register (2004). The overarching intent of the Act is to promote the safe, ethical, and culturally appropriate use of assisted reproductive technology while upholding the rights and wellbeing of donor recipients, donors, and DCP. This includes ensuring that DCP can access information about, and potentially link with, their donors. Private arrangements, however, are not captured by the HART Act, implying that donor information is not formally recorded or registered, and donor linking is not facilitated (Department of Internal Affairs – Te Tari Taiwhenua, 2023; Fertility Associates, 2024). Out-of-clinic arrangements thus circumnavigate clinic procedures, legal requirements (Gilman & Nordqvist, 2023), and the associated clinical treatment costs. All considerations (e.g. health screening, information sharing, number of donations, roles, and contact arrangements) are negotiated between the donor and recipient/s. These situations may involve increasingly complex relationship compositions, potentially leaving donors, recipients, and the DCP born from such arrangements with minimal guidance regarding their relationship to each other (Volks & Kelly, 2023), and the rights and responsibilities of each stakeholder (Surtees & Bremner, 2020).

The existing research on motivations for and experiences of same-sex couples using HI to build their families is limited, but it suggests that a range of interrelated factors influence the decision to use self-insemination methods. These include: financial barriers to accessing fertility treatment (Goldberg & Scheib, 2015; Hayman et al., 2015; McNair & Dempsey, 2002; Shaw & Fehoko, 2023); extended wait times due to the limited supply of clinic-provided donor sperm, the restricted range of clinic-provided donors and the lack of information about clinic donors (Bos & Gartrell, 2020; Goedeke et al., 2020; McNair et al., 2002); the perceived unwelcoming nature of fertility clinic environments (Shaw & Fehoko, 2023); and the broader presence of heterosexism and discrimination in medical settings (Gregg, 2018; Hayman et al., 2013; Ross et al., 2014; Sabin et al., 2015). Obstacles to accessing reproductive pathways in the form of policy, law and practice, financial insecurity, gender identity, and sexuality can render individuals socially infertile (Shaw & Fehoko, 2023). Involuntary barriers exist for non-heterosexual couples seeking conception with a lack of sperm being just one factor (Covington, 2022). In Aotearoa, eligibility for public funding of fertility treatment is based on medical infertility criteria and therefore does not automatically include socially infertile people (Shaw & Fehoko, 2023). Notably, in Aotearoa, clinic-based donors can place restrictions on the use of their sperm and can stipulate that their gametes are only to be donated to heterosexual couples (Fertility Associates, 2024). Additionally, there are no authorised private sperm banks within the jurisdiction; donor sperm obtained via a fertility clinic is handled within the clinic's confines and cannot be taken away for private use (Fertility Associates, 2024).

Further, those pursuing HI may value having the agency to choose a donor, and one with whom relationships with ongoing continuity can be established, allowing the DCP access to historic, genetic, and medical information, the ability to form an ongoing social bond with their donor (Hayman et al., 2015; Nordqvist, 2012), and connections with other people genetically related to them i.e., half-siblings (Chabot & Ames, 2004; Folgerø, 2008; Nordqvist, 2012). The involvement of multiple individuals with varying genetic and social relationships to the DCP may necessitate careful role negotiation, and sperm donors to same-sex couples have been found in international research to perform diverse roles ranging from providing gametes with no further involvement, to functioning as a third parent with defined responsibilities (Côté et al., 2020; Côté & Lavoie, 2019; Haimes & Weiner, 2000; Nordqvist, 2012). Notably, in Aotearoa, *de facto* partnerships are considered equal to marriage, meaning that for a same-sex or gender diverse couple, where one partner carries the child and the other consents to the insemination, both partners are recognised as legal parents from birth (Surtees & Bremner, 2020).

This research aims to explore the reasons why people in same-sex and gender diverse relationships pursue known donor arrangements and self-insemination, and to examine their experiences throughout this process. There is limited insight into what the psychosocial and cultural considerations and the intrapersonal and interpersonal experiences are for this diverse form of family building within the Aotearoa context. Specifically, what influences decision-making, how donors are chosen and approached, how relationships are constructed, and the challenges encountered are not adequately documented in the existing literature. Additionally, there is limited understanding of what resources are sought, or the availability of, and engagement with, support networks. This gap in the literature leaves critical questions unanswered regarding the experiences, needs, and considerations of all parties involved. Ultimately, donor conception is complex, and family-building among same-sex and gender diverse people remains marginalised. Understanding the experiences and implications of conception via known donor and HI is important for promoting wellbeing and for conceptualising and addressing the rights of all stakeholders.

## Methods and materials

Data were collected via semi-structured interviews with 11 participants, all recruited through advertisements posted on the consumer group Fertility NZ website and the private Rainbow Families Facebook group between May and July 2024, with the potential for snowball sampling. Eligibility criteria included that participants had to be individuals in same-sex or gender-diverse couple relationships who had achieved pregnancy between the years of 2004 and 2024 using known donor sperm and self-insemination methods to conceive, and that they, and their donor, had to be living in Aotearoa at the time of conception. The 2004–2024 timeframe implies conception after the implementation of the HART Act (2004), giving the sample legislative homogeneity. However, participants had conceived outside the clinical framework, meaning they are not captured by this legislation.

Eight semi-structured interviews with eleven participants aged 28 to 53 years ($M = 37$) were conducted by the first author (AF) between July and August 2024, each lasting between 50 and 80 minutes. This timeframe allowed for the discussion of sensitive topics. Informed consent to participate in this research was gained from all participants; seven interviews were conducted online, and one was face-to-face. Interviews followed a question guide designed to be non-judgmental, unbiased, and predominantly open-ended. Closed questions were used to clarify the meaning or content of the participants' answers and for demographic data collection. Participants were prompted to share their experiences of conceiving within a same-sex/gender diverse couple relationship utilising a known donor and self-insemination methods. They were encouraged to discuss their motivations for choosing this process, including with reference to their decisions, preparation, and experiences relating to choosing and approaching donors, support sought or desired, cultural or spiritual considerations, roles (intended and actual) of each stakeholder, experiences of HI, and any challenges encountered throughout the process.

The sample of eleven participants (five individuals and three couples) represents the experiences of eight families with a total of nine children conceived via self-insemination and a known donor. Six participants were the gestational parents and five were the non-gestational (social) parents of children conceived by these methods; children's ages ranged from 2nd trimester in utero to 19 years (Table 1). Participants self-identified their ethnicities as Māori ($n = 3$), Pākehā/New Zealand European ($n = 6$), and other European ($n = 2$), and pronouns as she/her ($n = 9$), she/her/ia (a non-gendered singular pronoun in Māori) ($n = 1$), and they/them ($n = 1$) (Table 1). All donors had children of their own, six within heterosexual couples and two within same-sex couples. Two had previously been donors (resulting in DC children), each for a singular family (Table 1). These other DC offspring were not referred to as half-siblings of the participants' DC children. Of the 8 donors, 4 had pre-existing friendships with the recipients, 2 had social or work connections with the recipients, and 2 were recruited online by the recipients

**Table 1.** Participant, donor, and donor-conceived persons' demographic information.

| *Participant | Age range | Gender identity | Relationship status | GP or non-GP | DC child via KD & HI (*name, age) | Year conceived | Participants' other children | Donor connection | Donor family structure | Donors' other DC children (disclosed) |
|---|---|---|---|---|---|---|---|---|---|---|
| Anne | 36–45 | She/her | Married | GP | Kahu, 7 | 2016 | Nil | Online | het. couple & child/ren | Nil |
| Arden | 25–35 | She/her | Married | GP | 3rd trimester | 2023 | Nil | Online | gay male couple & child | 1 (same-sex couple) |
| Julien | 25–35 | She/her |  | non-GP |  |  |  |  |  |  |
| Lily | 25–35 | She/her | Married | GP | 2nd trimester | 2024 | Nil | Colleague | gay male couple & child | Nil |
| Remy | 25–35 | They/them |  | non-GP |  |  |  |  |  |  |
| Virginia | 36–45 | She/her | Dissolved | non-GP | Alex, 11 | 2012 | 2 | Friend | het. couple & child/ren | Nil |
| Kat | >45 | She/her/ia | Dissolved | non-GP | Wiramu, 19 | 2005 | 2 | Social | het. couple & child/ren | Nil |
| Jamie | 25–35 | She/her | Married | GP | Mina, 1.5 | 2022 | 2 | Friend | het. couple & child/ren | Nil |
| Rina | 36–45 | She/her | Married | GP | Drew, 6 & Kit, 3 | 2016, 2020 | 1 | Friend | het. couple & child/ren | Nil |
| Simone | 36–45 | She/her | Married | GP | Jesse, 3 | 2020 | Nil | Friend | het. couple & child/ren | 2 (singular het. couple) |
| Frances | 36–45 | She/her |  | non-GP |  |  |  |  |  |  |

*All names are pseudonyms, gestational parent (GP), non-gestational parent (non-GP), known donor (KD), home-insemination (HI), heterosexual (het.).

(Table 1). Recipients who recruited donors online spent time developing connections before attempting HI. In Aotearoa, 'known' donors refer to donors who have a pre-existing relationship with the recipients, whether this has been developed following meeting online or through existing social connections.

All recruitment, interviewing, and transcription were conducted by AF. Interviews were transcribed verbatim, de-identified, and pseudonyms were assigned for all participants and their children. The data were analysed using Braun and Clarke (2006) six-step thematic analysis process to identify themes. Themes and subthemes were coded and checked by AF and SG. The authors are familiar with out-of-clinic DC and family building amongst same-sex and gender diverse couples, through both personal and/or professional experience. This study was designed to foster collaboration, protection, and respect for all participants in adherence with the principles of Te Tiriti O Waitangi. Ethical approval was granted 25 March 2024 by the Auckland University of Technology ethics committee – AUTEC reference number 24/31

## Results

Four main themes were identified, and are presented below along with illustrative quotes.

### *Finding the 'ideal donor' – someone connected with us, aligned with us, and a good person*

For participants, being able to have agency in choosing someone they felt would be an 'ideal' donor was important. For most, the ideal donor was someone with whom they already had a personal connection, often leading them to approach family and friends as first options, as was the case for Jamie and Rina who were both able to recruit friends as donors.

> *We were kind of on the lookout for a known donor. We wanted someone that we knew. It felt really odd to us to have an unknown donor and we have kind of decent-ish friends.* (Jamie)
>
> *We knew his personality in lots of ways, like we knew him as a single guy, as a partner, and a father.* (Rina)

Simone, who similarly was able to recruit a friend as donor, expressed 'knowing that he was a decent person' was critical. The desire to choose friends and family as donors was closely linked to the belief that these individuals were good people who would have shared values. This sentiment was also mentioned by participants who considered finding donors online and spending time building relationships before deciding on donation. Having a donor whose values were perceived to align with their own was a priority for participants. Kat, for example, who had considered online recruitment but ended up recruiting and getting to know a donor through her social connections, stated that the donor needed to be someone:

> *… that I respected and trusted their integrity and … that I felt like their values kind of were intertwined enough (with mine) that, you know, I could consider approaching them.* (Kat)

The requirement for a personal connection and aligned values contributed to the rejection of seeking a clinic donor. Julien and Virginia expressed the lack of knowing as a deterrent:

> *The more we spoke about it, it's like when you go through the clinic you don't know anything about the donor other than that the medical records are fine and they've probably got a decent sperm count. But you don't know anything about their personality or what they like or anything. And well, actually… we <u>do</u> want to know what the person's like that we're choosing to be half of our child.* (Julien)
>
> *Yeah, you just can't really understand a personality on a piece of paper… you don't actually know what you get with the [clinic] donor. I don't trust it.* (Virginia)

Virginia and her partner were able to recruit a friend; Julien and partner Arden were able to meet, and get to know, an individual they had met online.

For two of the three Māori participants, 'alignment' also meant that finding a Māori donor was either highly desirable or essential. For these participants, the strong preference for a Māori donor was based on Māori valuing the importance of genetic connection in bestowing social connectedness and identity. Kat stated, '*Yes, I absolutely had criteria, Māori… all five, [potential donors] had Māori whakapapa* (genetic heritage/genealogy)' . Lily reflected, '*I'm Māori and we really wanted to find a Māori* *donor and continue that*'. Both Kat and Lily were able to recruit donors through their social connections and develop a relationship prior to donation. Although, Lily's preference for a Māori donor was unfulfilled.

For most participants, the primary consideration was the wellbeing of their DCP, and they explained that their motivation for seeking a known donor was informed by wanting to find someone they believed was a good and 'decent' person, who would be good for their child in the longer term with the assumption made that the DCP would have contact with the donor and there would be a relationship between donor and recipients. All parents equated being 'good' for their child with the donors' willingness to be accessible to the DCP throughout their lives. Julien and her partner, who had established a relationship with a donor they met online, stated, '*It's actually quite important for them to have the option of … the donor being in their lives*'. This was partly for medical reasons – for example, Rina and her partner, whose donor was a work colleague, expressed that knowing the donor would be accessible provided a sense of reassurance, '*… and if it was to go terribly wrong like she needs a kidney, I know where to go.*' However, for most parents, donor accessibility was closely tied to the hope that knowledge of their origins would help give DCP a sense of identity:

> *It's important for our children to know where they whakapapa back to*. (Rina)

> *We wanted our 'future child' to have that kind of sense of identity that you get from knowing where you come from*. (Simone)

In reality however, finding and approaching the ideal donor was tough. Remy explained, '*There's no kind of handbook on how to ask people to be a donor*'. As time stretched out the lack of options became overwhelming for some participants, and choosing a donor who fit their initial criteria gave way to the practicalities of finding an available person who fit their now more basic requirements. As Remy and her partner Lily explained, '*We had had a lot of criteria in mind*'. (Remy) '*… yeah, which had basically gone out the window*'. (Lily). Ultimately, Remy and Lily were approached by a work colleague who offered to be their donor, and they were comfortable with the relationship that developed, even though they described the lack of choice they encountered as restrictive and distressing:

> *It was hard because the more we looked and the more we couldn't find someone, the more desperate we got.* (Lily)

Jamie, who was able to recruit a friend, similarly commented that, '*It wasn't like we were kind of browsing through a catalogue of potential known donors; he was the only option*'. When faced with limited or no choices, participants reached out to their extended networks, as was the case for Kat, who ended up finding a donor who was a social connection, '*And so I said okay, I'm just going to spread the net wider*'. Prior to being approached by their eventual donor, Remy and Lily reflected that they '*were basically going through friends of friends of friends*' (Remy), and that it felt like '*it was kind of a stab in the dark, just reaching out to people who potentially might want to*' (Lily). For some, this included eventually expanding the search to previously unexplored internet-based sperm donor groups. While Lily and Remy did not end up using an online recruited donor, Lily commented that online groups were, '*just really dark places to be*'. Most couples had less agency and less control over who their donor was than they had initially hoped or imagined.

At all stages leading up to the conception process, potential donors were prone to reconsidering their decision to donate. This was the case with Arden and Julien's donor, '*After we lost that baby, that donor then pulled out*' (Arden). Both Kat and Simone explain that their respective chosen donors decided not to donate:

> *We were about to start inseminating … we got a letter saying, "We can't do it; we are pulling out."* (Kat)

> *I think his wife really wanted to be on board with the idea, but, she actually just didn't feel comfortable.* (Simone)

In some instances, the donor's health and fertility status played a role. Both Anne and Kat had initially planned for close friends to be their donors; however, these plans could not be carried out. As Anne put it, '*His swimmers were blank*'. Kat shared:

> *A good friend of mine was going be the father… [he] had some health challenges, he wasn't quite sure if he wanted to pass that on.* (Kat)

Recruiting a donor was often difficult, meaning ideal criteria were commonly compromised. However, some criteria were still held onto, even for online recruited donors. As Anne states, '*We wanted like an uncle-like figure… we weren't prepared to compromise on it*'. For Anne and her partner, this meant getting to know the online-recruited donor first before electing to proceed.

### *Home insemination: affordable, personal, and offering more agency - while often awkward and marked by limited guidance*

Participants were influenced by the high costs of fertility clinic procedures which were considered inaccessible or unacceptable. All participants, except one, expressed that a key motivation for choosing HI was financial. They were aware of the expenses associated with clinic-assisted reproduction and regarded the costs as a barrier, preferring HI as a first, and in some cases only, option. Jamie stated, '*Financially it made no sense to try another way*'. Similarly, Arden framed it by saying, '*If you get pregnant for free then it's a win win, right?*' and Lily that:

> *Clinics are extremely expensive and there's no financial help for those… the cost of IVF is inaccessible.* (Lily)

Some participants, however, conceptualised fertility clinics and the associated costs as a backup option if HI failed while expressing a preference for HI, which Jamie framed as *'a normal, at-home, non-medical intervention*'. Participants' comfort levels engaging with a fertility clinic ranged from finding it undesirable but manageable if necessary, to attempting to avoid it if at all possible, including discomfort with the medical model overall from a te Ao Māori perspective. As Kat explained, '*I'm not comfortable in the medical system at all*'. Lily and Remy expressed experiencing fertility clinics as uninformed with services that failed to meet their needs:

> *I felt like every clinic we went to… I was explaining what home insemination looks like, every step of the way.* (Lily)

> *None of the clinics offer ovulation induction to same-sex couples – if you're not doing IUI* (intrauterine insemination). (Remy)

Participants were reluctant to involve medical professionals in the intimate personal process of conception and wanted to conduct the act of family building in familiar, comfortable environments as opposed to formal medical settings. Lily and Simone, for example, said that:

> *We wanted to do it outside of the clinic so that it felt like it was us and not a series of doctors and several other people being involved, which is not how many people have to go through making a family.* (Lily)

> *It felt really nice to be able to kind of do it at home. That's a little bit casual and it's quite relaxed… it's quite light-hearted.* (Simone)

Information regarding how to perform the HI was accessed via word of mouth, from the internet, and through other media resources. However, couples often expressed that detailed information on when and how to perform the specific steps of sperm collection and insemination could be difficult to find and was often ambiguous or conflicting:

> *One of the disadvantages was trying to figure out how you dealt with sperm and there was a lot of conflicting information about how you handle it.* (Anne)

This lack of clear guidance had the potential to add stress and complexity to the process. Frances explains the process was more complex than initially thought:

> *It turns out that actually, I probably didn't know the ins and outs of you know, testing ovulation first and tracking cycles to see patterns and basal body temperatures and all of that stuff.* (Frances)

For some, uncertainty regarding the most effective procedures meant decisions were made in the moment, based on best guesses thus informing the experience and leaving room for self-doubt.

> *Do you put it in this? … it can't be outside for too long. Do we drive home? Do we not drive home?* (Anne)

While some participants, such as Virginia, found the actual process straightforward:

> *He just came over and did his thing, knocked on the door, left and we just took it, and you know, and it worked straight away.* (Virginia)

For others, the lack of information and actual 'doing' of HI brought about awkward practical interactions that had the potential to be uncomfortable for both the donor and the couple. This awkwardness sometimes only became apparent in the moment, when the donor or recipient had to confront how they would perform the required steps:

> *It just felt really weird doing it in their house, they were totally fine, they were just like 'No, use the spare bedroom', and we were like … this just feels a little weird?* (Anne)

> *I feel like the intimacy around home insemination can be a bit challenging*. (Frances)

The discomfort was often managed with humour but for some the effects could cause distress and compromised the anticipated comfort of the home environment, as in the case of Kat's donor, '*He found it [the act of donating sperm] really, really difficult, but eventually, we got the call, we didn't see him, he left'*. (Kat)

## Relationship planning/envisaged relationships: not the donor dad, but the helping uncle or extended family member by formal agreement

All the couples clearly stated it was never the intention for the donor to play a 'dad' role in the DCP life. Anne (Kahu, 7 yrs) explains, '*We don't refer to our donor as 'Dad', that's probably a biggie for us*'. Similarly, Jamie (Mina, 1.5 yrs) stated, '*He's not 'Dad' – that was very clear'*. Instead, most couples contextualised the donor's role as that of a helper. Virginia (Alex, 11 yrs) said, '*He helped us have you, but he's not your dad'*. Simone (Jesse, 3 yrs) described the donor's conceptualisation of his role, '*I can help you make a family'*.

For most couples, the intended role of the donor was likened to that of an 'uncle':

> *We always said to anyone that we met that we wanted like an uncle-like figure. We had an expectation that you would be involved in our family.* (Anne, Kahu 7 years)

> *My ideal was to have a known donor who was going to have an active role in their lives not as a parent, but actually as kind of an uncle.* (Kat, Wiramu, 19 yrs)

Couples saw DC as involving a choice to build an extended network, whereby, donors (and their families) became connected. Arden (pregnant) put it in the context of, '*They're friends but they're family as well … a mash-up between family and friends*'. These chosen family relationships were desired and deliberate:

> *We wanted our son to not only have us but to have an extended family … that was the biggest thing for us … we wanted them to be a part of our family.* (Anne, Kahu, 7 years)

> *It's a connection of choice … an extended whānau.* (Lily, pregnant)

In cases where the donor had children within their own family, the relationship between these genetic half-siblings was considered. These extended family forms included claimed but fluid sibling connections:

> *The kids will be raised as cousins, if they get older and want to call each other brother and sister, like, that's totally their choice.* (Julien, partner pregnant)

> *We kind of have that mutual agreement that our children can refer to each other as siblings.* (Lily, pregnant)

All of the couples had some form of written agreement in place with their donors specifying the nature of their relationships before attempting insemination. Half of the couples engaged a lawyer to review their contracts, as was the case for Virginia, '*We spoke to a lawyer*', and Rina (Drew, 6 yrs, Kip, 3 yrs), '*We did get everything drawn up legally*'. Remy and Lily (pregnant) expressed an understanding of the limits of their contract:

> *We have a donor contract that we got lawyers to look over, which doesn't hold up in court, but it's like a starting point.* (Lily)

The other four couples used written agreements primarily motivated by a desire to establish and confirm a sense of mutual understanding between the donor and recipients. For some couples, the agreement was a parsimonious checklist to ensure all parties were thinking along the same lines:

> *We gave it to him and said, 'Are we on the same page?' They read it and said, 'Yes, this sounds good'. And we were like, 'OK, good, carry on!'* (Jamie, Mina, 1.5 years)

For other couples the agreements were more in-depth and considered, Kat (Wiremu, 19 years) explained, '*We've got a written agreement with them, it's quite detailed'*. The agreements covered a range of future possibilities, established boundaries, and indicated considerations had been made for the donor, parents and DCP:

> *We put in the agreement that they didn't have to have any financial input at all.* (Kat, Wiremu, 19 years)

> *(There was) an expectation that he would always… no matter what, he would always be reachable. So, if our communication, for whatever reason, broke down, that he still had to be reachable for our son.* (Anne, Kahu, 7 years)

For some, the process of creating these agreements was guided by professional counselling and legal advice, while for others it was a collaborative effort between the couple and the donor. Regardless of the approach, all couples acted to formalise the relationship arrangements prior to conception. Overall, these agreements were founded on a desire to establish understanding, set expectations, and create a protective framework for the future.

### *Lack of and need for knowledge, understanding and relevant support*

Participants, including those who had used HI more recently, described a general public and medical lack of knowledge regarding HI using known donors, which then often manifested as a lack of support. For example, Lily (pregnant) sums up their experience by saying that it was considered as, '*a home experiment*'. Jamie (Mina, 1.5 years) reflected on how healthcare professionals often appeared unfamiliar with the nuances of HI as it was outside of their understanding of conventional practices:

> *She (child health nurse) wasn't quite sure what to do with me because it was like a donor-conceived baby, but not through a clinic. And there was no box for that.* (Jamie)

While participants were supported by friends, family and chosen networks, for some, the support offered was cautious and therefore at times inadequate to meet their needs. Anne (Kahu, 7 years) reflected:

> *It's not saying that Mum and Dad weren't supportive, but they couldn't give me the support that I needed on the journey, I guess because they didn't have to go through it, it wasn't a lived experience for them.* (Anne)

Further, participants reflected on the lack of locally relevant, inclusive resources. Lily (pregnant) explained how seeking information and support online foregrounded her social infertility and emphasised the insufficient support available:

> *A lot of the conceiving pages or groups and in fact all of them in New Zealand and Australia are 100% heterosexual and just highlight[ed] our social infertility. They made me feel a hundred times worse, so all our information primarily came from the gay TTC (trying to conceive) groups, which are very American and also highlights the complete lack of support we have in New Zealand.* (Lily)

Five of the eight couples considered or sought counselling, reflecting their desire to be more informed, including about donor: recipient relationships. As Frances (Jesse, 3 years) put it, '*Yeah, we did [counselling] because we didn't know what we didn't know*'. In some instances, the support was well matched as Jamie (Mina, 1.5 years) explained, '*He (the therapist) was great. He kind of knew what to facilitate*'.

For some, there were conflicts between accessing an informed therapist while also wanting to ensure privacy and confidentiality in their relatively small, specific community.

> *I think that's really hard to find counsellors and therapists that are … especially within the community, like, you don't necessarily want to go to a lesbian therapist because the community is really small … But then you actually want to go to somebody … and not have to educate them.* (Kat, Wiremu, 19 years)

## Discussion

Our study suggests that for these couples, the journey to parenthood through privately-arranged DC involved careful, intentional consideration and decision-making that usually involved explicit regard for the DCP's identity and future experience, including the ability to link with their donor and have knowledge of their biogenetic origins on an ongoing basis from birth. Haimes and Weiner (2000) suggest that in same-sex family building, DCP needs are central, but not isolated from other psychosocial considerations. This research found that the motivations for choosing privately arranged conception resulted from an interaction of factors, including personal values, a desire for agency and a more comfortable personal environment, and a commitment to achieving the best outcomes for the donor-conceived child. As previously acknowledged (Goldberg & Scheib, 2015; Hayman et al., 2015; Kelly, 2010; McNair et al., 2002; Shaw & Fehoko, 2023), the high costs of fertility clinic procedures alongside a desire to avoid the medicalisation of a natural process, were also key motivators for pursuing HI, both for those who had used DC some time ago (E.g. Kat, Wiremu 19 years) and those who were currently pregnant through HI. Additionally, a discrepancy in the accessibility of clinical fertility services compared to heterosexual couples was a factor for some participants.

Regarding donor recruitment, the clinical route was seen as incongruent with the requirement for the DCP to have knowledge of their genetic origins, including ongoing connections to whakapapa, from birth. This belief reflects the Aotearoa context of this study, where negotiating customary rights to genealogy for DCP is a cultural principle (Glover et al., 2009; Ruru, 2005; Shaw & Fehoko, 2023). Indeed, participants in this study constructed donation as a relational, not a medical process. The central and enduring motivations for using a known donor were the desire to choose someone who was a good person, whose values aligned with those of the couple, who would be personally connected to the couple, and who would have an ongoing connection with the DCP. Other research in Aotearoa of embryo recipients has likewise highlighted how intending parents seek donors they perceive as similar to or aligned with them – with the belief that such similarity will form the basis of a good relationship between donors and parents, and thus ultimately be in the best interest of DCP who may desire access to and relationship with the donors (Goedeke et al., 2015; Goedeke & Daniel, 2018).

For most participants in this study, this meant that family and friends were the first options, as they had pre-existing relationships, were deemed to have aligned values, and were considered 'decent' people. In contrast, for two couples, the ideal donor from the outset was not necessarily someone they were already connected to, but rather someone with whom they could establish a meaningful connection. Couples wanted to know details about the person they were creating a child with, e.g., personality, physical characteristics, and cultural positioning. The emphasis for all participants in donor recruitment was on choosing someone with whom they could be in an ongoing relationship. Couples' initial motivations and ideal scenarios, however, often required compromise in the face of practical, emotional, and social challenges. Common areas of compromise included the donor's ethnicity and sexuality, as well as the quality and depth of any pre-existing relationship, related to having knowledge of shared values and that the donor was a 'good' person. As reported in existing literature (Côté & Lavoie, 2019; O'Neill et al., 2012), most couples had less agency and control over choosing a donor than they had initially envisaged. These limited choices were experienced as distressing and restrictive and were compounded by a lack of information and support. Nevertheless, couples made persistent efforts to ensure their family-building methods aligned with their values, often in the face of significant challenges. Ultimately, all participants conceived with donors who agreed to remain contactable.

In addition to the difficulty of finding a suitable donor, some participants found the practicalities of HI challenging, with interactions between donor and recipient uncomfortable, both in cases where the donor was a friend, or a relationship had been established through meeting online. Although awkwardness was often managed with humour, tension was a common experience. Additionally, some participants found they were unclear regarding the preparatory and procedural aspects of conception, which added to logistical challenges. Côté and Lavoie (2019) suggest factors that contribute to HI awkwardness, including the requirement to negotiate male sexuality, the logistics of handling the donation, and donor performance anxiety. Furthermore, although all arrangements utilised health screening, the trust required regarding the donor's sexual health between donations had the potential to induce stress. These findings highlight the need for accessible, evidence-based self-insemination information and practical HI support to reduce uncertainty, address conception-related stress and facilitate donor:recipient management of the process.

Interestingly, while all couples except one set out to build a two-parent family, donors were conceptualised as having a role to play in the family going forward. Consistent with previous findings (Dempsey, 2012; Gilman & Nordqvist, 2023; Nordqvist, 2012), the donor's role was most commonly likened to that of an uncle, with the terminology of 'dad' being firmly rejected. Furthermore, most of the couples sought to build what were described as extended family networks with the donor and family; for some, this included donor-sibling connections and in two cases wider whānau and iwi (kinship or tribal group) connections. As in other research in Aotearoa (Goedeke et al., 2023; Hayman et al., 2015; Surtees, 2022), these 'extended family' terms were useful in that they enabled donors to play a role in the life of the DCP, but with circumscribed roles and responsibilities. Further, the 'extended families by choice' construct was favoured for the ability to offer the DCP a wider familial network and to support identity, including cultural identity.

All couples in this study created written agreements with their donor before beginning insemination. Some were guided by professional counselling and legal advice, while for others it was a collaborative effort between the couple and their donor. Overall, these agreements aimed to foster a mutual understanding between donor and recipients. The act of formalising conception arrangements in this way reflects each party's desire to establish a protective framework, and consideration of the DCP future needs. As with collaborative co-parenting arrangements, existing research acknowledges the absence of established precedents or family models to reference (Decappelle et al., 2025). Consequently, donors and couples must actively negotiate the practical and ideological nature of their connection (Surtees, 2023). Such agreements often involve unique and distinct relationship networks that lack clear legal standing. Because donor-recipient contracts are not legally enforceable without a court order (New Zealand Law Commission, 2004), all parties may be left vulnerable to future disputes (Surtees & Bremner, 2020). For example, in *Rangi v. Mable* (2023), the court addressed complexities arising from informal conception agreements, ultimately awarding the 'donor' a guardianship order on cultural grounds (Piebenga, 2024).

Participants commonly navigated their experiences with inadequate or inaccessible information, resources, and support. They encountered a lack of understanding from healthcare professionals, and in some cases, a lack of understanding from family and friends, which translated to a lack of support, or uninformed, uncertain, and cautious support. The implication was that they were vulnerable to being uninformed and unsupported, both during the planning stages and throughout the family-building journey, including in managing ongoing donor: recipient relationships, highlighting the need for more accessible, informed resources and ongoing psychosocial support.

## Limitations

Participants were recruited through online advertisements and snowball sampling, meaning some participants referred others from their social networks. While this method is effective for reaching hard-to-reach populations, it is not random and can introduce selection bias. Further, recruitment through community pages may have primarily reached people with similar perspectives, that is, those who are likely to be more open about their sexuality and 'out' in their personal and professional lives. Together with the small sample size, this means the sample may not represent the diversity of views and experiences that exist within same-sex and gender diverse couples who conceive using HI and a known donor, particularly individuals who are more private and conservative regarding their sexual and gender identity. Moreover, due to the relatively small size of these communities in Aotearoa, there was potential for social desirability response bias, whereby participants may have perceived minimal degrees of separation between the researcher and themselves or their donor, impacting responses. Additionally, while participant responses were similar over time, the inclusion criteria spanning 2004 to 2024 mean that participants' conception experiences occurred across varying periods during which social environments may have changed. While options for diverse forms of family building may not have expanded significantly over this time, social acceptance and consequently support may have. Further, of the eight interviews conducted, two were with couples during their first pregnancy, meaning their experiences of DC were emerging. Finally, due to the variability in legislation across jurisdictions, this research may have some limitations concerning specific legal and sociocultural contexts.

## Future research

Further research is needed to explore the lived experiences of all parties involved in families formed through known donors and HI. Specifically, there is a need to explore how relationships evolve, including how disclosure to the DCP is managed, how contact experiences between the DCP and donor unfold, how the donor is conceptualised by parents and the DCP, how the DCP voice shapes these interactions, how the donor's role compares to initial expectations, and any disputes, challenges or tensions that may have emerged. Knowledge of these factors would help identify potential issues and inform the development of appropriate support services, enabling counsellors and healthcare professionals to better prepare for the diverse needs of the individuals and families with whom they work.

## Conclusion

Understanding the experiences and implications of known donor self-insemination as a method of DC for same-sex and gender diverse couples is important for promoting the wellbeing and for conceptualising and addressing the rights of all stakeholders. Participants' motivations and experiences need to be understood within the context of the limited reproductive options available to sexual minority couples, shaped by financial constraints and social and cultural factors. Study findings contribute to the limited body of knowledge on this topic and indicate that the journey to parenthood for these couples involves careful and intentional decision-making grounded in personal values. Central to this process is the desire for agency, a commitment to the DCP future wellbeing, and the intention to establish ongoing connections with the donor. The couples' initial motivations and ideal scenarios often required compromise in the face of practical, emotional, and social challenges. Nevertheless, the aim of an ongoing connection with their donor, the creation of extended families, and consideration of the needs of DCP remained fundamental.

Home-based self-insemination does not require the involvement of medical staff or clinical procedures, allowing for greater autonomy and avoidance of negative clinic-based experiences. However, participants commonly navigated their experiences with inadequate information, resources, or support. A lack of understanding of diverse donor conception practices translates to insufficient support for all parties involved and has the potential to contribute to inequities in social and health outcomes. Currently, systematic and financial barriers impede access to equitable informed fertility support. There is a need for informed, accessible, culturally responsive, and evidence-based information and resources regarding HI options and processes to increase choices and protect the rights, health, and safety of parents, donors, DCP, and their families.

## Author contribution statement

CRediT: **A. Fyfe**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing; **S. Goedeke**: Conceptualization, Formal analysis, Investigation, Writing – original draft, Writing – review & editing; **E. Du Preez**: Conceptualization, Writing – review & editing.

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## Data availability statement

The data collected for the purposes of this study is not available for access to protect the privacy of the research participants.

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