Home-insemination: the motivations and experiences of same-sex couples who use known sperm donors and self-insemination methods to conceive in Aotearoa New Zealand

Angela Jayne Fyfe

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School of Clinical Sciences

Psychology and Neuroscience Department

Supervisor: Associate Professor Sonja Goedeke

ABSTRACT

This qualitative study explored the motivations and experiences of same-sex couples who used a known donor and self-insemination to conceive outside of the regulated fertility framework in Aotearoa New Zealand (hereafter Aotearoa). This research aimed to gain an understanding of what the psychosocial and cultural considerations and experiences are for this diverse form of family building. Specifically, what influences decision-making, how donors were chosen and approached, how relationships were constructed, the challenges faced, and the resources and support sought and available. Participants (n =11) were parents of children conceived since the Human Assisted Reproductive Technology [HART] Act (2004) was introduced, meaning, they were not subject to mandatory medical, ethical, or legal procedures implicit within the current clinical assisted fertility setting. Data was collected via in-depth semi-structured interviews conducted with parents. Interviews were recorded, transcribed, and a thematic analysis was applied. The main findings include that financial considerations and the desire for agency and non-medicalised methods of family building were key motivations for pursuing home insemination. The preference for a relational process, along with the desire for ongoing personal connections and the building of extended family networks, motivated the use of known donors. The process of donor recruitment was often challenging, and the practicalities of home insemination could be difficult, information was often unavailable or uninformed, and support was commonly lacking or inaccessible. Limitations of this study include potential selection bias and small sample size that may not be representative of the diversity within the target population. Research findings may contribute towards identifying the support required to meet the needs of all stakeholders involved in home insemination with known donors i.e., parents, donors, children, and their families. This may include contributing knowledge towards helping equip counsellors and others to effectively support families built in diverse ways.

Keywords. Self-insemination, home insemination, same-sex, known sperm donor, conception, LGBTQ+

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 2 December 2024

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Thank you to the Auckland University of Technology Ethics Committee [AUTEC] for granting approval for this research on 25 March 2024 AUTEC reference number 24/31.

Data Availability

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

CHAPTER ONE: 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; Taylor et al., 2022), Understanding the experiences and implications of donor conception for donor-conceived people (DCP), their parents, donors, families, and the broader community is important for promoting wellbeing and for conceptualising and addressing the rights of all stakeholders. In Aotearoa assisted reproductive technologies (ART) are regulated by the HART Act (2004), which sets out the rights and responsibilities of parents and donors. The practice of DC, however, is performed both within the regulated clinical framework and through unregulated private arrangements. Donor conception that occurs outside of the clinical framework is not captured by the Act (2004) but is a relatively emerging and rapidly expanding area of family building in Aotearoa, with a growing number of women (e.g. same-sex couples and single mothers by choice) who need sperm to conceive but do not necessarily require clinical interventions to do so.

Same-sex couples who utilise self-insemination and known donor (i.e., family member, friend, social contact) conception methods are a sub-group of this unregulated cohort. However, there is minimal research regarding the experiences and motivations of people who choose to conceive and build their families through these processes versus seeking conception via a fertility clinic, either in an Aotearoa context or further afield. Most existing studies approach non-heterosexual family building within a clinical context, often with only a secondary focus on alternative methods of donor conception. Additionally, the variability in legislation and sociocultural contexts across jurisdictions means comparisons of the literature have somewhat limited generalisability and applicability for an Aotearoa population. For example, currently, 39 European countries have established specific ART legislation. In 11 of these countries, access is restricted to heterosexual couples, 30 countries offer treatments to single women, 18 to female couples, and 5 include all groups (Matteo, 2023). Until recently, some states and territories in Australia prevented same-sex couples from accessing fertility services (Hayman et al., 2015) and while sperm is commercially available and can be purchased as required in some jurisdictions (i.e., the United States of America [US]) (Almeling, 2022), the commercial sale of donor gametes is prohibited in Australia and Aotearoa (Goedeke et al., 2020).

This research explores the motivations and experiences of same-sex couples who have utilised self-insemination and known donor methods to conceive in Aotearoa. Semi-structured interviews were conducted with eleven participants to explore how decisions are made, what resources are sought, what challenges are faced, and what the psychosocial and cultural considerations and intrapersonal and interpersonal experiences are for this diverse form of family building.

Therefore, this research aims to describe participants' decisions around conception in their specific, local context, and provide insight into these experiences.

Chapter two provides a comprehensive overview of the theoretical background and context of self-insemination from international and Aotearoa perspectives. Existing literature is examined regarding the motivations and experiences of choosing self-insemination and known donor reproduction methods, thereby providing a foundation for the current research. Considerations include financial factors, barriers related to culture, social infertility, opposition to the medicalisation of natural processes, discrimination and heteronormativity in clinical settings, and the desire for agency and relationality in family building. Chapter three describes the research design, epistemological stance, and methodological approach employed in this study. It outlines researcher reflexivity, participant recruitment, data collection techniques, and thematic analysis methods. Academic rigour and ethical considerations, including informed consent, participant well-being, confidentiality, privacy, and adherence to Te Tiriti O Waitangi are outlined. Chapter four presents the seven themes identified through thematic analysis and illustrated by participants' quotes: 1) Financial factors as motivation: Clinic costs as ‘inaccessible’ versus ‘getting pregnant for free’, 2) Rejecting the medicalisation of family-building, 3) Choosing the ‘ideal donor’, 4) The process, 5) Relationships, 6) Lack of knowledge and understanding: ‘the home experiment’, and 7) Need for resources, support and counselling. Chapter five discusses the findings and implications of this research in relation to existing literature and articulates study limitations and future directions.

Articulation of Identity

The researcher recognises the diversity of sexuality and gender identities, that identities can be fluid, and that people may choose to identify differently over time and depending on context; that LGBTQ+ families are not a homogenous group, and that the composition and experiences of these families can be highly diverse. Not all people within same-sex relationships will identify as women or as lesbians. It is acknowledged that any number of sexual orientations and gender identities may be represented and that multiple gender identities are possible within the "same-sex" reproductive dyad. The researcher chose to use the term 'same-sex couple' while recognising there is a broad scope of sex and gender identities, and the term 'parent' to refer to either member of a couple.

Terminology

The acronym LGBTQ+ typically represents lesbian, gay, bisexual, transgender, and queer-identifying people and is used in this study to refer broadly to gender and sexuality minority groups. Takatāpui is a Māori term that means “intimate companion of the same sex” that has been claimed by Māori to represent diverse sexuality identities, both as an umbrella term and an identity (Kerekere, 2017). In te reo Māori, a pronoun for everyone ‘ai’ can be used as a cultural expression of gender identity. The terms self-insemination and home insemination (HI) are used interchangeably in this research.

Abbreviations

AI	Artificial insemination
ART	Assisted reproductive technologies
DC	Donor conception
DCP	Donor conceived person/s
HI	Home insemination
ICI	Intracervical insemination
IUI	Intrauterine insemination
IVF	In vitro fertilisation

CHAPTER TWO: LITERATURE REVIEW

This chapter provides an overview of donor conception (DC) and self-insemination in both an international context and in Aotearoa. The current legislative framework in Aotearoa is outlined in relation to regulated and unregulated DC. Existing literature on home insemination and known donors that inform this study is evaluated, and the rationale for this study is provided.

Context

DC, whereby a third party supplies gametes for the reproductive procedures of others, is a common and steadily increasing practice in the field of assisted reproduction globally (Wyns et al., 2020). The World Health Organisation [WHO] defines infertility as a disease of the reproductive system characterised by the failure to conceive after 12 months of regular unprotected sexual intercourse; WHO additionally acknowledges that same-sex couples and people not in sexual relationships may also require fertility services, including gamete donation (WHO, n.d.).

Artificial insemination

Human artificial insemination (AI) describes reproduction techniques that involve the introduction of sperm into the female genital tract by means other than that of sexual intercourse, whereby fertilisation occurs internally within the body (Newman et al., 2020). The first formally documented AI conducted within a medical setting, utilising donor sperm, resulting in a live birth, was in the US in 1884 (Hard, 1909, as cited in Raperport et al., 2022). Current AI procedures include 'vaginal insemination', of intracervical insemination (ICI) when sperm is placed at the cervix in a location similar to that resulting from sexual intercourse and intrauterine insemination (IUI) when sperm is first processed and then delivered into the uterus via a fine catheter (Matteo, 2023).

AI utilising frozen donor sperm is widely performed in clinical settings, with approximately 49,000 cycles registered in Europe in 2015 (Wyns et al., 2021) and 3262 clinical cycles reported in Australia and Aotearoa in 2018 (Newman et al., 2020). Kop et al. (2015; 2022) studied the clinical ICI conception rates in 890 women across two studies finding that over 30% resulted in a live birth within six cycles of treatment demonstrating the efficacy of ICI as a stand-alone procedure for reproduction. AI can be utilised to address medical barriers to fertility or to assist people who have no access to sperm within a relationship (e.g., same-sex couples, single women) to achieve pregnancy; however, the process does not necessarily require a clinical setting.

Self-insemination

Self-insemination describes when AI (predominantly ICI) is performed by the recipient themselves or someone acting on their behalf (e.g., their partner) outside of a clinical environment (McNair & Dempsey, 2002). Self-insemination (or ‘home’ insemination) is a non-medical procedure that can be performed without specialist personnel or equipment that has proven efficacy for conception when no adverse medical issues or fertility complications are present (Taylor et al., 2022). The earliest recorded HI was reported to have been performed by a couple in the late 1700s who,

following the advice of their doctor, successfully conceived after transferring the man's sperm into the woman's vagina via a syringe (Clarke, 2006). In current times, information regarding how to perform the procedure can be accessed via word of mouth, from the internet, and other media resources (Mamo, 2007). Donor sperm for self-insemination may be sourced from a known or unknown donor either privately or, depending on laws and legislation of specific jurisdictions, from a fertility clinic or sperm bank. In some jurisdictions (i.e., the US), frozen sperm can be ordered from a catalogue and shipped to recipients (i.e., Fairfax Cryobank). In Aotearoa, there are no authorised private sperm banks; donor sperm obtained via a fertility clinic is handled within the clinic's confines and cannot be taken away for private use (Fertility Associates, 2024a).

Donor conception

In early models of clinical DC, services were predominantly available to heterosexual couples facing medical infertility (Williams, 2011), donor anonymity was maintained, often without record keeping, and the non-disclosure of donor conception and donor details was recommended to parents (Daniels, 2005). Anonymity was favoured as it helped to safeguard the recipients' feelings of legitimacy as parents, maintain the appearance of conforming to the biogenetic nuclear family norm, and avoid perceived social stigma related to infertility and the use of ART procedures (de Melo-Martín et al., 2018). Additionally, anonymity was sought for privacy, to protect the recipient family from interference from the donor, and because it shielded the donor from potential future legal responsibilities towards the donor-conceived child (New Zealand Law Commission, 2004).

In contrast, advances in ART, changing social attitudes, and less restrictive legislation have meant that assisted reproduction has increasingly become an option for more diverse forms of family building (i.e., same-sex couples, single parents by choice) (Golombok, 2020). Over time, reproductive technologies have shifted from an infertility-based treatment model to an assisted approach to reproduction. In this way, reproduction has become increasingly separated from being exclusively the domain of heterosexual sexual relationships with new pathways to parenthood becoming evident and available (Mamo, 2007). Donor conception sees variations in family forms outside of a traditional family structure continuing to emerge (Mamo, 2007). These 'new families' can involve multiple social and biological stakeholders who perform varying non-conventional roles (Golombok, 2020). Stakeholders can include the gestational parent, non-gestational parent or 'social parent', sperm donor, donors' partner, new partners of parents or donor, half-siblings and step-siblings from previous, current or future relationships, invested 'chosen' family, and extended family/whānau members. In an Aotearoa context, this can include hapu and iwi affiliations that may be perceived as indivisible from the individual (Davies & Winslade, 1993).

In a growing number of countries, including Australia and Aotearoa, donor anonymity is no longer permitted having been superseded by donor-linking protocols with disclosure to donor-conceived children encouraged (Dempsey et al., 2022). This change reflects a shift towards prioritising the rights and overall wellbeing of donor-conceived people (DCP) and recognising the

importance of addressing their immediate and long-term needs. The trend towards openness stemmed from an acknowledgement that DCP without access to identifying donor information may be disadvantaged by a lack of knowledge related to kinship, including the inability to connect with their donor or donor siblings, access genetic information, or have knowledge of their genealogy (Rodino et al., 2014; Webb & Shaw, 2022).

Regulated Donor Conception and Legislation in Aotearoa

DC is an increasingly common practice in Aotearoa, as fertility clinic records indicate that approximately 10% of all ART cycles utilise donor gametes (Fertility Associates, 2024b). Same-sex couples have become progressively common users of ART in Aotearoa, with contemporary fertility environments promoting and providing tailored information and services for diverse family-making practices (Repromed, 2024a). In line with developments internationally, the rise of ART, more permissive legislation, and the increased social acceptance and visibility of LGBTQ+ people in Aotearoa are contributing factors towards the accessibility and consequent uptake of ART by non-heterosexual people seeking to create families (Atkin, 2005; Nastasel et al., 2023). Current statistics indicate that just under 50% of all clinical donor sperm insemination in Aotearoa is accessed by single women and people in same-sex relationships (New Zealand Law Commission, 2024). Theirs is usually not a case of medical infertility involving unviable sperm but rather a case of social infertility caused by the inaccessibility or unavailability of sperm (Shaw & Fehoko, 2023).

In Aotearoa, pursuing DC through a fertility clinic requires compulsory administrative and health processes including pre-donation health screening for donor and recipient, sperm quarantine, counselling where a range of possible choices and implications are explored and legal parameters are explained, and registration on the HART register (Blyth, 2012; Fertility Associates, 2024a). Donor sperm can be sourced via fertility clinics, current clinic donor sperm wait times are 6-12 months for an in vitro fertilisation (IVF) cycle and approximately three years for IUI cycles (Fertility Associates, 2024b). When a recipient reaches the 'top' of the waiting list they are commonly offered 3-4 donor profiles to choose from; profile information includes age, ethnicity, education, occupation, health, and physical characteristics (Fertility Associates, 2024b). Clinic-recruited donor sperm is available to infertile couples, single parents by choice and same-sex couples. Alternatively, recipients can recruit a known donor, such as a family member, friend, or social contact, to bring to the clinic, thus removing the wait time. In such cases, the mandatory preparatory processes typically take 4 months to complete before a cycle can be initiated (Repromed, 2024b).

In Aotearoa, ART is regulated by the HART Act (2004), which mandates the recording of identifying information of all donors and DCP and facilitates donor-linking through the HART register (2004). This applies to all individuals conceived via DC within a fertility clinic. Its formation was influenced by Māori cultural values concerning the fundamental importance of information sharing, emphasizing the ability to understand and maintain cultural identity through access to knowledge of whakapapa [genealogy], belonging, genetic ties and kinship bonds that are central to

Māori identity (Webb & Shaw, 2022): the Act states that "The needs, values and beliefs of Māori should be considered and treated with respect" (section 4f).

Since the register was formed in 2005, over 3000 DCP have been born, and the average yearly number of DC births has tripled (Department of Internal Affairs [DIA], 2023). The overarching intent of the Act (2004) is to promote the safe, ethical, and culturally appropriate use of ART while upholding the rights and wellbeing of donor recipients, donors, and DCP. The Act (2004) was intended to address potential negative physical and psychosocial health impacts that anonymous donations may have on these groups. However, while the HART Act (2004) encourages disclosure and supports the wellbeing of all parties affected by donor conception, including DCP, the Act stops short of mandating disclosure, e.g. through birth certificate annotation, and it remains up to the parents to decide whether or not to disclose (Dempsey et al., 2022). Additionally, the Act (2004), does not capture informal donor conception arrangements occurring outside of the clinical framework, e.g., HI, private donations, and cross-border reproductive care (where prospective parents travel overseas for anonymously donated gametes) (Rodino et al., 2014; Wynn, 2022). In these cases, donor information is not recorded or registered, and donor linking is not facilitated (DIA, 2023).

Unregulated donor conception

Similar to the rise of ART in Aotearoa, 'unregulated' donor conception is practised increasingly commonly by people who cannot readily obtain sperm (e.g. same-sex couples, single parents by choice) (Trail & Goedeke, 2022). Informal sperm donation involves direct private arrangements between donor and recipient outside of the clinical framework and may involve either known donors recruited via personal contacts or unknown donors often recruited online via websites and social media platforms (Bree, 2003; Dempsey et al., 2022). Private arrangements circumnavigate mandated procedures (as outlined above), the clinical environment of the formal fertility route (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.

Currently, there is no Aotearoa data on the frequency of privately arranged donations or records of same-sex couples achieving live births via self-insemination. The proliferation of donor meeting websites (e.g., https://www.co-parentmatch.com/, https://www.spermdonorhub.com/), sizeable membership of recruitment platforms (e.g., Sperm-Donation-New-Zealand 2.1K, Sperm-and-Egg-Donors-New-Zealand 3.2K), how-to community pages (e.g., https://hapuhelpers.co.nz/) and references in mainstream media suggest the practice is increasing with a growing number of births via this method each year. These out-of-clinic arrangements can involve increasingly complex relationships that fall outside the mandatory procedures implicit in the medical, ethical, and legal frameworks provided within the clinic setting. Unregulated donor arrangements are not explicitly addressed by family law, meaning donors, recipients, and DCPs are left with minimal guidance regarding conflict negotiation (Volks & Kelly, 2023), and the rights and responsibilities of donors,

DCPs, and parents are not clearly set out (Surtees & Bremner, 2019). Privately recruited donors do not requisitely undergo health screening or professional consultation (e.g., counselling), the number and frequency of donations are not recorded, donation limits are not regulated or necessarily adhered to, and the donor may not accurately disclose donation behaviours. In Aotearoa, while there are no formal limits, guidelines set the maximum allowed sperm donations at ten families, and fertility clinics use a lower maximum of four to five families (Fertility New Zealand, 2024).

Motivations

Same-sex couples who wish to conceive are required to engage in careful and deliberate planning and decision-making; the unavailability of sperm within the relationship means there are no 'happy accidents' resulting in pregnancy (Glover et al., 2009; Hayman et al., 2015). Socioeconomic challenges (Goldberg & Scheib, 2015), personal preferences, and cultural considerations (Glover et al., 2009) all add weight to the decisions made by these would-be parents regarding their chosen reproductive methods. Furthermore, the experience of social infertility, whereby, couples face barriers to conceive due to ideological, biological, structural, and regulatory constraints should not be perceived as being voluntarily chosen or able to be controlled (Covington, 2022; Shaw & Fehoko, 2023).

Motivations for self-insemination

Research findings indicate that a variety of interrelated factors impact the accessibility and acceptability of fertility clinics and, therefore, play a role in the decision of same-sex couples to use self-insemination methods to conceive. Existing studies recognise financial barriers to accessing fertility clinics as a recurring theme for same-sex couples both in Aotearoa (Shaw & Fehoko, 2023), and further afield (Goldberg & Scheib, 2015; Hayman et al, 2015; McNair & Dempsey, 2002). In Hayman et al.'s (2015) study, 54% of participants identified cost as a factor for choosing home insemination, which was comparable to the 51% found by McNair and Dempsey (2002). Currently in Aotearoa, an initial clinic consultation costs approximately $360, one cycle of IUI with a bring-your-own (known) donor costs $2,345 and with clinic-sourced donor sperm is $4480; without public funding, the average cost of an IVF cycle (treatment and medication) is between $11,500 and $17,000 (Repromed, 2024c). Additional hidden costs include travel, time away from work, ovulation testing, lifestyle changes, and supplements. For many would-be parents, financing these costs is out of reach in contrast to HI which can be conducted essentially for free (Kelly, 2010).

Financial barriers can be compounded by heterosexism which disadvantages non-heterosexual couples by way of funding eligibility. In Aotearoa, to qualify for publicly funded ART cycles women must, at referral, be <39 years old with a Body Mass Index (BMI) <32 and have been trying to conceive for more than 12 months by way of regular sexual intercourse (Fertility Plus, 2024). Access to public funding is based on medical infertility criteria and therefore does not automatically include socially infertile people (Shaw & Fehoko, 2023). Funded fertility treatment eligibility criteria disadvantage same-sex couples, as they find it difficult to meet fertility treatment providers' criterion

of being able to prove that they have been trying to get pregnant (Shaw & Fehoko, 2023). Evidence for funding eligibility would consist of 12 cycles of donor insemination conducted within a clinical setting (Shaw & Fehoko, 2023). This means that social infertility is impacted by the systemic inequities in access to funded treatments adding additional financial barriers to same-sex couples seeking access to assisted reproduction.

The perceived unwelcoming nature and heteronormativity of fertility clinic environments Shaw & Fehoko, 2023), along with heterosexism in medical settings (Gregg, 2018), and homophobic attitudes among healthcare professionals (Sabin et al., 2015; Ross et al., 2014) are understood as factors contributing to couples pursuing alternative pathways to conception. Attempts to avoid sexual minority stress have been shown to impact same-sex couples' access to fertility clinics. Sexual minority stress is defined as psychosocial strain related to societal stigmatisation and marginalisation based on sexual minority status (Holley & Pasch, 2022). Hayman et al.'s (2013) Australian-based study highlighted overt forms of homophobia in clinical settings. Examples included exclusionary practices, such as having only heterosexual options on medical forms, the assumption of heterosexuality meaning couples felt the requirement to repeatedly 'come out' to staff, and inappropriate questioning e.g., asking specific details about methods of conception. Additional covert forms of homophobia were experienced but could not easily be described, however, overall both forms of homophobia resulted in feelings of exclusion and vulnerability. Similarly, Gregg (2018) observed that discriminatory experiences in fertility clinics included clinic staff having difficulty with eye contact, inappropriate questioning, and discriminatory comments when relating to same-sex couples. These situations placed pressure on couples who felt the responsibility to educate healthcare providers in an attempt to normalise same-sex family building (Gregg, 2018; Hayman et al., 2013).

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, 2024a; Melville, 2016). This has the potential to create a dual layer of sexuality-based discrimination for same-sex couples, limiting both their access to sperm and their sense of inclusivity within the clinic environment. Sexuality-related stress brought about by heterosexist assumptions and language (Shaw & Fehoko, 2023), inequity in access to funding, perceived or actual lack of inclusivity, and anticipation of homophobic discrimination (Gregg, 2018; Hayman et al., 2013), may be avoided by opting out of the fertility clinic setting, therefore, motivating same-sex couples towards privately arranged donor conception.

The desire to conceive outside of a regulatory context (Shaw & Fehoko, 2023) and in a non-medicalised way (Hayman et al., 2015) have been identified as motivations to attempt self-insemination. In Nordqvist's (2012) study, same-sex participants claimed to pursue non-clinical conception due to a reluctance to engage with clinics, medical professionals, appointments, medication, and procedures when not experiencing medical infertility. Similarly, Webb and Shaw (2022), found that resistance to compulsory clinical processes e.g. undergoing medical testing

regardless of not being medically infertile contributed to clinic avoidance. This preference reflects a broader opposition to unnecessary medical interventions, including feminist and personal opposition to the medicalisation of natural bodily processes. In McNair et al.'s (2002) queer parenting study (*n*=136), 76% of participants cited beliefs regarding women's fertility rights, and 36% said opposition to medical intervention was the motivation for self-insemination. In Hayman et al.'s (2015) same-sex reproduction research (*n*=30), in all cases IVF was used only after other methods were unsuccessful indicating that, for this sample, the medicalisation of reproduction was seen primarily as a back-up option.

From a cultural perspective, Webb and Shaw's (2022) Aotearoa-based study suggests that for some takatāpui, the fertility clinic environment is perceived as culturally undesirable and unwelcoming. The question of the cultural competence of clinic staff, lack of allowance for cultural practices in clinic settings, and the cultural appropriateness and tikanga of ART overall are factors understood to influence takatāpui (and Māori) engagement with fertility clinics (Glover et al., 2009; 2017; Ruru, 2005). These factors are set against a backdrop of historical mistrust of Westernised medical settings and processes, such as the suppression of Māori healing and health practices, knowledge, and culture (Durie, 2004). Existing research suggests that self-insemination provides a degree of reproductive freedom, meaning the recipient does not need to be accepted as a 'patient' and may sidestep the potentially costly, unavailable, unwelcoming, inequitable, culturally inappropriate, medicalised environment of reproductive services to achieve their desire for parenthood (Chabot & Ames, 2004; Shaw & Fehoko, 2023; Wikler & Wikler, 1991).

In contrast to the potentially unappealing clinic environment the intimacy and comfort of the home setting make it a more desirable location for conception (Chabot & Ames, 2004). Correspondingly, the desire to involve the non-gestational partner in the reproductive process was a motivation for HI in 65% of participants in McNair et al.'s (2002) study. Participants expressed experiencing invalidation of the non-biological mother's role in the family in medical settings. Home-based insemination allows the non-biological parent to participate in the process by assisting or conducting the insemination, therefore, giving the couple more agency and control of their reproductive experience (Chabot & Ames, 2004; Hayman et al., 2015; Kelly, 2010). Additionally, Haimes and Weiner (2000) found that knowledge of others' success with HI was a motivating factor for trying to conceive in this way. McNair et al. (2002) found that often when women did utilise clinical insemination, it was due to unsuccessful attempts to conceive using self-insemination, the increased urgency related to aging, or when they were unable to find a known donor.

Motivations for choosing a known donor

Mamo (2007) posits that for many having a known donor is an important part of the family-building exercise. The decision-making process for same-sex couples regarding the use of a known donor typically involves careful and thorough consideration related to genetics, relationships, roles, and the experience of the future DCP. Côté and Lavoie (2019) suggest that choices are informed by

concerns related to heritage, family boundaries, and parental authority and how these elements interact and are negotiated. This means consideration is given to who the child is connected to and what access they will have to their genetic information, what roles are played by each stakeholder, how these roles are defined, and how parental roles are claimed and protected. The importance of identifiable origins and knowledge of genetic connections is understood across the literature to be a central motivation for choosing a known donor versus a clinic donor (Côté & Lavoie, 2019; Hayman et al., 2015; Nordqvist, 2012). These considerations include ensuring the needs of the child are met, particularly in relation to their construction of personal identity, their right to form relationships with their donors early in life, and the rejection of the idea of being unable to fill out the child's story as they grow (Coyle, 2002; Nordqvist, 2012). In an Aotearoa context, for takatāpui, cultural considerations when selecting a donor can involve a deep regard for whakapapa and whānau connections (Shaw & Webb, 2022). From a te Ao Māori perspective, children are viewed as the continuation of their ancestors and the bearers of future generations (Le Grice & Braun, 2016), and continuation of genealogy is a fundamental custom for Māori whereby children are taonga (Ruru, 2005). Glover et al. (2009) found that the need to know about genealogy was a significant issue for takatāpui. The ability for DCP to be linked with their donor from birth facilitated a continuous connection to whānau and whakapapa throughout their lives.

At times, known donors are chosen to facilitate donor matching, where the donor is selected based on physical characteristics that resemble those of the couple (Hayman et al., 2015). In some cases, the emphasis is on selecting donor characteristics that match those of the nonbiological parent. When the donor is a family member of the non-gestational parent (e.g., brother) it provides the opportunity to establish a genetic connection between the DCP and both members of the couple (Nordqvist, 2012). These biological links are valued for their ability to support bonding between the non-gestational partner and the DCP (Chabot & Ames, 2004). In Hayman et al.'s (2015) study, participants who chose a relative of the non-gestational parent as their donor gave reasons including the importance of having a child related to both parents, sharing genetics with the non-gestational parent, establishing a biological link between the DCP and the non-gestational parent, and validating the non-gestational parent's legitimacy as a parent. These motivations align with Gregg's (2018) findings, where non-gestational parents expressed concerns about their emotional connectedness to the child due to the absence of a genetic link.

Known donors are also often sought for the ability for ongoing contact between donor and the DCP and their families. This includes the benefit of being able to access medical information regarding the donor and possibly his family (Hayman et al., 2015). Dempseys' (2010) study exploring alternative family formations (although not necessarily involving self-insemination) found that known donors were sought out to create a reproductive relationship that had ongoing continuity. In these arrangements, attempts were made to frame the donor's relationship with the DCP as one of friendship as opposed to parenthood creating a meaningful bond but one deliberately distanced from the legal,

social, and emotional responsibilities of ongoing caregiving (Dempsey, 2010). Similarly, Côté and Lavoie (2019), found that some same-sex couples choose known donors out of a desire for their child to have a social bond with their genetic father. For some a known donor was sought for the ability to have genetic bonds between future siblings (Folgero, 2008). Some couples, often without a model to use as a guide, expressed a desire to create alternative family forms and establish new family dynamics (Côté & Lavoie, 2019). This includes allowing gay men to have children (descendants) by being the biological parent without taking on a caregiver role (Côté, 2020; Riggs, 2008). Hayman et al. (2015) found that primarily, couples who chose a known donor opted for conception via self-insemination in the first instance. Contrastingly, the study found that the reasons participants chose clinic-sourced unknown donors included the desire for no donor involvement, to avoid the donor attempting to contact or have involvement, feeling uncomfortable about "messy" known arrangements, and to protect the parental position of non-gestational parent.

In some jurisdictions, the choice of a known donor can be influenced by the cost and wait times associated with the short supply of clinic-provided donor sperm (Goedeke et al., 2020) and the lack of range in clinic donors. Being confronted with lengthy waitlists for clinic-sourced donor sperm, lack of information about the donor, and narrow donor options to choose from is thought to influence the decision to seek privately arranged conception. Additionally, lifestyle factors and professional demands have been shown to delay family planning for LGBTQ+ individuals; many may assume they have optimal fertility, expecting that conception and pregnancy will occur if and when they decide to pursue parenthood (Bos & Gartrell, 2020; Glover et al., 2009). McNair and Dempsey, (2002) found that same-sex parents were significantly older than heterosexual parents when having their first child. For many, the decision to start a family was accompanied by a sense of urgency related to maternal age and its impact on biological fertility (McNair et al., 2002), indicating that extended clinic wait times for donor sperm act as a motivation for seeking out-of-clinic options.

Experiences of known donor self-insemination

Research demonstrates that engaging a known donor can be a complex process, often involving extended timeframes that are frequently underestimated. O'Neill et al. (2012) found that the process of identifying and recruiting a known donor often involved lengthy and intricate negotiations, adding unpredictability and delaying the timeline for attempting to conceive. Côté and Lavoie (2019) also show that these negotiations can stretch over several weeks or months, reflecting the time-intensive nature of the process. Bree's (2003) Aotearoa-based study found that for most participants, it took approximately two years of planning and searching for a suitable donor before attempts to conceive could begin. Similarly, Chabot and Ames (2004) found that couples invested significant time in researching and selecting an appropriate donor and negotiating the roles and responsibilities of all parties before initiating insemination.

Existing research shows that men who donate sperm to same-sex couples perform diverse roles that range from providing gametes with no further involvement to functioning as a third parent

with duties and responsibilities (Côté & Lavoie, 2019; Nordqvist, 2012). Bree's (2003) Aotearoa-based study found that participants predominantly sought a known donor who would play an active role in the DCP upbringing. Hayman et al.'s (2015) study included 16 participants who chose a known donor, some sought sperm donation only (*n*=10), while others planned for an ongoing relationship (*n*=6). Donors intended for ongoing relationships were brothers of the non-birth mother (*n*=3) or family friends (*n*=3) and all 'family friend' donors engaged in a parenting role. However, Nordqvist (2012) observed that while a male relative (e.g., a brother) may be preferred to provide a genetic link to both parents, for some the connection is too close. Many couples seek donors from within their close social networks, balancing consideration of genetics with the desire to define clear roles.

Haimes and Weiner (2000) acknowledge that in same-sex family building, the absence of a reference model for alternative family structures, along with the involvement of multiple individuals with varying genetic and social relationships to the DCP, necessitates the negotiation of roles. Negotiation prior to insemination helps ensure the quality of the relationships (Côté et al., 2020), and acts to minimise the risk of conflict (Dempsey, 2012). Additionally, the donor's role is often one that evolves over time (Côté & Lavoie, 2019). A key aspect of this negotiation is deciding what the donor will be called as naming helps to contextualise the donor's position in an ongoing way. Côté and Lavoie (2019) studied same-sex couples who chose a known donor for HI, in cases where the donor acted as a third parent, the term ‘Dad' was used. Others were referred to by their names or as 'donor', reflecting a more distant role. When the donor was the brother of the non-birth parent, they already had a formal family role which they generally maintained. The terms 'uncle' or 'godfather' were used to distinguish the donor's role from that of a parent while still acknowledging the familial connection. Consistent with Nordqvist's (2012) findings, where couples used donors referred to as ‘uncles’, the term ‘Dad’ was rejected to avoid the non-biological parent feeling threatened in their parental role. Ultimately, conceptualising and naming roles is an attempt to define family dynamics and clarify each stakeholder’s position.

Research on known-donor conception relationships identifies a recurring theme of mismatched expectations of the roles to be performed and how these roles play out over time (Côté & Lavoie, 2019). Even when reproductive relationships seem to have been satisfactorily negotiated, research indicates that stakeholders' expectations are vulnerable to change (Riggs, 2008). Riggs (2008) found that known donors who had not considered the psychological impacts of their donation can struggle to understand their role or conform to the expectations of recipient parents after the birth of the DCP. Changes in the donor’s or recipient’s circumstances, as well as, influence from other family members, can have significant outcomes including the donor withdrawing their offer to donate or contrastingly seeking more involvement than originally agreed (Côté & Lavoie, 2019; Glover, 2009). Complex interpersonal dynamics and unforeseen psychosocial changes can affect previously agreed arrangements.

Studies show that conception in a clinical setting is associated with increased health safety due to screening procedures for sexually transmitted diseases (STD), along with the added benefit of access to support and information throughout all stages of the journey (Dempsey, 2010; Hayman et al., 2015). Hayman et al. (2015) note that participants using self-insemination assume some risk of STD transmission. While initial testing may be conducted, risks increase if the donor must practice safe sex month after month; in contrast, a clinic stores quarantined sperm for future use (Glover, 2009). HI involves a high level of trust regarding sexual health regardless of initial STD testing, and even more so if insemination timeframes are extended (Côté & Lavoie, 2019).

Rationale

In Aotearoa, same-sex couples are increasingly creating families outside of the fertility clinic framework by utilising known donors and HI methods. This approach allows donor conception to be achieved without medical intervention or formal record-keeping. However, in this relatively unresearched field, there is limited understanding of how couples navigate the family-building process. Specifically, there is limited insight into the motivations for choosing HI and known donors and the consequent experiences related to these choices. Much is unknown about what considerations are made and how decisions are negotiated along the way. Key aspects, including donor selection and recruitment, donor matching, insemination methods, cultural considerations, and the negotiation of roles that each stakeholder will play are not adequately documented in the existing literature. Additionally, much is unknown regarding what medical or legal resources are sought, or the availability of and engagement with support networks. The gap in the literature leaves critical questions about what the experiences, needs, and considerations, including psychosocial and cultural considerations, are for all involved parents, donors, DCP, and their families.

Hayman et al. (2015, p. 396) suggest that it is important to recognise alternative family forms within society "…as failure to do so has the potential to further marginalise this already vulnerable population". Ultimately, donor conception is complex and same-sex family building remains marginalised. Therefore, this small but meaningful study has the potential to constructively contribute to the existing literature. It is both timely and important for promoting a more comprehensive understanding of diverse donor-conceived family-building practices within the same-sex communities in Aotearoa.

CHAPTER THREE: METHODS

This research aims to understand the motivations and experiences of same-sex couples who choose known donors and self-insemination to conceive in an Aotearoa context. In this section, the ontology, epistemological position, methodological approach, and method are outlined. The process of participant recruitment, data collection, and data analysis is described. The ethical considerations and rigour techniques utilised to ensure research quality are detailed.

Ontological and epistemological assumptions

Grant and Giddings (2002, p. 11) propose that, in qualitative research, the chosen research paradigm offers a framework for "making order out of the chaos of social life" by focusing the researcher's attention in specific ways, allowing for selection, evaluation, and analysis based on defined theoretical and methodological beliefs. The interpretive paradigm was chosen as the best fit for this qualitative research, the ontological assumption of which is that reality is subjective, multiple and socially constructed (Lincoln et al., 2011). Furthermore, this study is informed by the social constructivist theory of knowledge; this epistemological position emphasises that knowledge is constructed through social interaction and is relative and context-dependent (Grant & Giddings, 2002). This study's epistemological positioning of constructivism/interpretivism intends to understand the unique patterns of meaning-making that exist within the specifically defined social context of participants without assuming commonality (Boyland, 2019). The interpretive methodological approach suggests that knowledge is generated in transactional collaboration with participants, and some parts of the truth of a situation can be known by understanding an individual's experiences and the meanings they ascribe to them (Guba & Lincoln, 1994; Putnam & Banghart, 2017). An understanding of specific situations and consequences can be gained by listening to the voices of multiple participants (Boyland, 2019); in turn, reality can be made meaningful through the interpretation of each individual's "self-understandings" and in this way, findings are a result of the collaboration between researcher and participants (Arnett, 2007). Therefore, a social constructivist framework is well suited to this research for its ability to focus on a narrowly defined demographic and social context, i.e., same-sex couples who have used a known donor and self-insemination to conceive in Aotearoa. The question is, 'What is this experience really like for this particular group of people at this specific time?' (Bree, 2003). There is no one reality, but rather multiple realities (Crotty, 1998); there is no answer to the question of conception methods utilised within same-sex couples, the only truth is the individual's experiences. Only ever partially knowable, meaning and interpretation are always situated procedures (Braun & Clarke, 2022).

Study design

Information (data) was collected by way of semi-structured interviews, a format that privileges the participant's voice and offers a framework for the exploration of research questions and participants' subjective meanings, actions, and social contexts (Fossey, 2002). Participants were the

gestational or non-gestational parents from same-sex couples who conceived utilising known sperm donors and self-insemination methods and were asked to share their experiences and views regarding this method of family building. The methodology of using open-ended questions enabled participants to describe their lived experiences freely in their own words, ensuring that their accounts were respected as personal and individual. This interviewing style enables insights and rich data that represent the complexity of subjective experiences and meanings without presuming heterogeneity among the sample (Boyland, 2019). Notably, a qualitative research design is a good fit for emerging research and research exploring acutely personal and sensitive topics (i.e., sex and sexuality, non-normative life courses) (Silverio et al., 2022).

Reflexivity

In qualitative research, it is assumed that findings are inherently influenced by the researcher's presence within the field (Dodgson, 2019). Within a social constructivist framework, this influence necessitates a deep awareness of both epistemological and personal reflexivity (Braun & Clarke, 2022). Engaging in epistemological reflexivity involves critically examining how social and cultural elements shape the researcher's worldview and perceptions, and how these factors subsequently affect the research process and the construction of knowledge (Grønmo, 2020). This can be achieved by reflecting on the research question, its definition and limitations, and how the research design and analysis methods facilitate the accurate interpretation of data and findings (Thorpe, 2013). To credibly interpret a participant's story, the researcher must understand and make explicit their position in relation to the phenomenon being studied (Grant & Giddings, 2002). Personal reflexivity further requires the researcher to acknowledge the influence of their own experiences, beliefs, values, goals, and social identity on the research process (Willig, 2001). By addressing their subjectivity, researchers can recognise how their personal experiences influence data collection and interpretation and understand the impact of their presence and biases therefore increasing research reliability and credibility by ensuring that results are not disproportionately shaped by their preconceived notions or unconscious preferences (Boyland, 2019; Jootun et al., 2009).

As a researcher within this qualitative field, I have reflected on my own lived experience of identifying as part of the LGBTQ+ community and conceiving as a gestational parent within a same-sex couple using a known donor (although via a fertility clinic, not self-insemination). Throughout conceiving and parenting my now 13-year-old twins, I have navigated the processes and decisions involved in same-sex family planning, that span psychosocial and cultural considerations. Considerations include negotiating social infertility, societal heterosexism, donor selection and matching, donor disclosure to children, and the beliefs, values, and dynamics within interpersonal relationships, and the expectations of all parties, our broader whānau, and society.

I am a Pākehā mother of known donor-conceived children of Māori descent. Our family structure, at the time of conception and birth, resembled that of a nuclear family, albeit one with two mothers. The donor is an extended family member who has an ongoing 'uncle' relationship with our

children. Disclosure of the donor's role was made from birth and whakapapa connections are deemed significant and are maintained. My values are shaped by a feminist, activist, and environmentalist lens, these influences underscore my current value system, which is grounded in freedom, expression, justice, and community. In conducting this research, I understand the importance of reflecting on my values, cultural background and the implicit biases I may hold. My lived experiences, sociocultural positioning, and social identities shape my perspective as an insider researcher, allowing me to engage deeply with the research context. However, I remain mindful of the potential for preconceptions and assumptions that this insider stance may bring. I recognise the extensive diversity within the reproductive LGBTQ+ communities; no singular experience is representative of this heterogeneous group. Each individual's experience is unique and each person's subjective perspective is deeply nuanced and personally idiosyncratic.

Importantly, my university education pathway in counselling psychology in Aotearoa has influenced my outlook. This person-centred, relational, science-practitioner approach that emphasises cultural competence informed my planning and interaction with participants. A person-centred approach may have assisted in making participants feel comfortable and relaxed. However, my position as an academic researcher has the potential to introduce a power imbalance whereby the researcher is positioned as an 'expert' (Dodgson, 2019). To reduce this power differential, I prioritised rapport building, disclosed my experiences of conceiving within a same-sex relationship using a known donor, used accessible language, and practised active and empathetic listening skills. I maintained a research diary to facilitate reflection and address assumptions and preconceived notions.

Participant recruitment

Purposive sampling was used for this study, participants were recruited through advertisements posted on the consumer group FertilityNZ website and the private Rainbow Families Facebook group in May of 2024. The advertisement was posted to the Queer Wellington Facebook group and reposted to the Rainbow Families Facebook group in July 2024. To allow for snowball sampling, the advertisements were able to be shared, and existing participants were encouraged to recommend the study to others. Interested potential participants were asked to make contact via email with AF, and a participant information sheet outlining the research aims, process and purpose (see Appendix B) was sent to them. Potential participants were given the opportunity to ask any further questions about the research, and those who met the inclusion eligibility criteria were invited to be interviewed.

Inclusion criteria were individuals in same-sex or gender-diverse couples who achieved pregnancy between the years of 2004 and 2024 and who used known donor sperm and self-insemination methods (i.e., not within a fertility clinic) to conceive, who lived in Aotearoa and whose donor lived in Aotearoa at the time of conception. This research acknowledges that donor conception in Aotearoa is likely to be shaped by the jurisdictions' distinct cultural landscape, societal attitudes, and legislative frameworks, therefore, both donor and parent were required to be Aotearoa-based.

Participants may be the gestational or the non-gestational parent of a DCP who conceived within a past or current relationship. For this research Gilman and Nordqvist's (2023) definition of 'known donor' was used and is defined as meaning when the donor and recipient have personal knowledge of one another (e.g., family, member, friend, social contact) prior to conception. Participants were required to be able to converse in English and be aged over 18 years. The 2004-2024 timeframe indicates that all participants conceived since the implementation of the HART Act (2004), meaning the study sample is a homogenous group regarding this legislation (although they fall outside of this legislation). Conception before the HART Act (2004), cross-border donors, single mothers by choice (even when LGBTQ+ identifying), self-insemination not resulting in conception or a current established pregnancy, and conception using unknown donors were excluded.

Eleven potential participants contacted the researcher to enquire about participating in the study, eight directly from an advertisement and three via snowball sampling. Nine enquiries met the research criteria and two did not, of the nine eligible, eight agreed and one declined to participate. Of the two who were not included, one had initially tried unsuccessfully to conceive using a known donor via self-insemination and had switched to a fertility clinic for treatment and the other had successfully conceived using a known donor and self-insemination, but was a single parent by choice, not within a couple. Interviews were arranged for all eligible and interested enquiries at times, dates, and locations suitable for the participant. Overall, eight interviews were conducted, three with couples consisting of a gestational and a non-gestational parent and five interviews were with individuals (three of which were gestational parents and two were the non-gestational parent) (n=11) (Table 1). Of the eight interviews conducted two were with couples during their first pregnancy meaning their lived experiences of parenting in this way were limited. Seven interviews were conducted online, and one was face-to-face.

At the time the interviews were conducted all participants resided in Aotearoa, eight within greater Auckland, two in rural North Island and one in rural South Island. Participants' ages ranged from 28 to 53, (M=37) (Table 1). Three participants identified their ethnicity as Māori, six as Pākehā/New Zealand European, and two as other European. Nine participants identified their pronouns as she/her pronouns, one as they/them, and one as she/her/ai. All participants identified as belonging to LGBTQ+ communities, one identified as bisexual, and two identified as takatāpui. The sample of eleven participants (five individuals and three couples) represents the experiences of eight families with nine children conceived via self-insemination and a known donor.

As shown in Table 1, of the eleven individuals interviewed nine were in same-sex (or gender diverse) marriages and two were single parents following the dissolution of the same-sex relationship that their child/ren were conceived within. Of the eight families in this study the number of known donor and self-insemination conceived children include five families with one child conceived in this way, two families with two children conceived in this way, and one family with three children conceived in this way. Of the eleven participants interviewed, three had the singular experience of

being the non-gestational (social) parent of a DCP conceived using a known donor and self-insemination methods, eight had been the gestational parent utilising the same methods, four of whom had experienced both roles. The known donor self-insemination conceived children's ages ranged from 16 weeks in utero to 19 years old.

Table 1.

Participant and Donor-Conceived Persons Demographic Information

*Participant	Age	Gender identity	Ethnicity	Marital Status	DCP (KD/SI) (*name, age)	Gestational (GP) or non-gestational (non-GP) parent	Other children
Anne	42	she/her	NZEuro	married	Kahu, 7yrs	GP	nil
Arden	32	she/her	NZEuro	married	34 wks. pregnant	GP	nil
Julien	30	she/her	Māori			non-GP	
Lily	28	she/her	Māori	married	16 wks. pregnant	GP	nil
Remy	28	them/they	NZEuro			non-GP	
Virginia	37	she/her	NZEuro	relationship dissolved	Alex, 11yrs	GP x2, non-GP x1	2
Kat	53	she/her/ia	Māori	relationship dissolved	Wiramu, 19yrs	non-GP	2
Jamie	35	she/her	NZEuro	married	Mina, 1.5yrs	GP x1, non-GP x1	2
Rina	40	she/her	NZEuro	married	Drew, 6yrs, Kit, 3yrs	GP	1
Simone	39	she/her	OtherEurop	married	Jesse, 3yrs	GP	nil
Frances	39	she/her	OtherEurop			non-GP	

Note. *All names are pseudonyms, KD = known donor, SI = self-insemination

Braun and Clarke (2016) suggest that ten is an adequate sample size for a thematic analysis. The objective of qualitative research is the richness and depth of the data rather than the breath meaning a smaller number of participants can constitute a suitable sample. Larger sample sizes may jeopardise the chance of adequately capturing the complexity and subtleties present in the data (Braun & Clarke, 2006). During the study design and before recruitment a suitable participant number was set at 8-10 for this research. The narrow criteria of this study drew a highly specific group of participants that inhabit a niche in the field of donor conception. The study was purposefully kept small allowing AF to conduct all the recruitment, interviewing and transcription therefore facilitating researcher immersion in the data, supporting insight across the depth of participants' experiences while developing and maintaining researcher reflexivity.

Data collection

Data for this qualitative research were gathered through semi-structured interviews, a method that allowed participants the freedom to naturally share their thoughts, feelings, perspectives, and experiences (Kallio et al., 2016). The semi-structured interview design facilitated flexibility and adaptability, enabling the interviewer to prompt with open-ended questions without unduly influencing the direction of the responses. These open-ended questions were employed to elicit detailed, descriptive responses, aiming to provide rich, nuanced insights into the participants' experiences, perceptions, and motivations. Open-ended questions encourage individuals to explore and articulate their thoughts freely, facilitating a deep understanding of complex topics (Hill, 2020).

All interviews were conducted by the primary researcher in July and August of 2024, each lasting between 50 and 100 minutes. Depending on the participants' preferences, location, and availability, interviews were conducted either online via Teams (n=10) or in person (n=1) at a private residence. Before the interviews, all participants were emailed a copy of the Participant Information Sheet (Appendix B), which outlined the study's aims, process, and protocols. Directly before each interview, participants were given the opportunity to ask any questions related to the research. In accordance with the standard AUTEC consent process, all participants were asked to provide their consent via the AUTEC oral consent protocol, and these consents were stored as mp3 audio files on secure AUT OneDrive, protected with multi-factor authentication and accessible only by AF and SG.

Following rapport-building introductions, with the consent of the participant, the meeting recording was begun. All interviews began with the question, "How did you arrive at the decision to build a family?" Questions then followed the attached Interview Guide (Appendix B). The questions were designed to be non-judgmental, unbiased, and predominantly open-ended. Closed questions were occasionally used to clarify the meaning or content of the participants' answers and to gather demographic data. Participants were prompted to share their experiences of becoming a parent within a same-sex couple utilising a known donor and self-insemination to conceive; they were encouraged to discuss their motivations for this process, as well as the experiences and challenges encountered along the way. At the conclusion of the interview, participants were given the opportunity to provide any additional information or comments.

Upon completion, each interview was transcribed verbatim and manually rechecked by AF using clean transcription. To protect participant privacy and confidentiality, each transcript was de-identified, and demographic questions asked at the conclusion of each interview were recorded in a de-identified spreadsheet. The audio recordings were then deleted. All participants declined the offer to choose their pseudonyms, so AF allocated pseudonyms on their behalf. Participants were given the opportunity to review their deidentified interview transcription to confirm the accuracy and were able to request changes.

Thematic analysis

Braun and Clarke's (2006) reflexive thematic analysis approach was chosen as the best fit for this research. The six-phase process involved phase one, data familiarisation, whereby AF played back and transcribed each audio-recorded interview, repetitive reading of the transcripts and making notes facilitated deep engagement and immersion in the data, leading to familiarisation with the content of the dataset. Step two was the systematic process of developing codes by manually tagging features of data "potentially relevant" to the research question (Braun & Clark, 2022, p. 60). This was done by reading and rereading each transcript to identify recurring patterns and interesting features of the data. Generated code labels were discussed with SG to develop deeper insight and maintain exercise reflexivity. In the third phase, codes were grouped, and initial themes and subthemes were developed to encompass patterns of meaning in the data; some labels were recoded or removed. In

phase four, themes were refined and reviewed in an iterative process, returning to the original data to ensure the themes were consistent and unique from each other. In phase five, themes were given clear names and definitions. Phase six involved writing up the final report into a cohesive narrative, linking themes to the research question and supporting interpretations with quotes from the data.

Quality and Rigour

Qualitative research is open to judgment and can have 'real consequences' in people's lives (Miles et al., 2014 p. 271). To ensure rigour, merit, integrity, and accountability this research followed Miles et al.'s (2014) practical guidelines for objectivity, reliability, authenticity, transferability, and application. Objectivity was addressed through ongoing personal reflexivity undertaken by the primary researcher, detailed descriptions of the research methods, and regular discussions with the research supervisor. Reliability was supported by aligning the research questions with the study design, the clearly articulated research approach aimed for consistency across participants and data collection, and processes were cross-checked by the research supervisor. To ensure authenticity and credibility the findings are presented with rich, thick descriptions. The plausibility of the accounts undertook careful consideration, and transcripts were reviewed by the research supervisor and participants. Incongruent, uncertain, and alternative findings were discussed. The transferability of the research conclusions is supported through thick descriptions of the participants, as well as connections with prior research and theory. A summary of findings will be made available to interested stakeholders, including participants and the consumer organisation FertilityNZ, and the study will be submitted for publication.

Ethical considerations

Ethical implications were considered continuously throughout the study's stages. The Auckland University of Technology Ethics Committee (AUTEC) granted ethics approval for this research on 25 March 2024, with AUTEC reference number 24/31 (Appendix A).

Informed consent and participant wellbeing

All participants were sent the Participant Information Sheet (Appendix B) via email, which clearly outlined the research's aims and purpose. This information was shared with potential participants following their initial expression of interest in response to the recruitment advertisement. Participants were encouraged to ask questions and seek clarification about the study. They were informed that participation was entirely voluntary and withdrawal from the study would not disadvantage them in any way. It was also emphasised that they could choose to not answer specific questions or pause or stop the interview at any time. This information was reiterated directly before the interview began. To help address any discomfort related to the potentially sensitive nature of the topics covered in this study, the researcher aimed to provide a reassuring and safe setting in which the participants could talk without pressure. Participants were given the opportunity to review and approve their transcripts and to receive a summary of study findings should they wish. Additionally, participants were informed of support available through the charitable organisation FertilityNZ and

the provision of free counselling appointments available to AUT research project participants through AUT Student Counselling and Mental Health Services.

Confidentiality and privacy

Potential participants were invited to contact the primary researcher via email directly. Contact information (i.e. email and/or phone number) was collected at this time in order to send the Participant Information Sheet and Consent Form for review (Appendix B). Potential participants contacted the researcher directly in response to the invitation to participate; their details were not and will not be shared with any third parties. Participants were asked to complete an Oral Consent recorded separately and directly before the commencement of the interview. All consents were recorded and adhered to the oral consent protocol as outlined by AUTEC (Appendix B). The researcher assigned pseudonyms to each participant and all family members. Only the primary and supervisory researchers have access to any data collected at all phases of the research, including analysis and after the findings are produced. In the final report, all personal details and references to people, places, professions, iwi affiliations and organisations have been removed. Interviews were recorded, transcribed verbatim, and deleted once transcription was complete. Deidentified transcripts will be stored on secure AUT OneDrive, protected with multi-factor authentication. Oral consents are stored as mp3 audio files on secure AUT OneDrive, protected with multi-factor authentication, and separately from interview transcripts. All and any other consent and interview recordings have been deleted. All data will be permanently deleted from the AUT OneDrive after six years.

Te Tiriti O Waitangi

To ensure this study adhered to the principles of Te Tiriti O Waitangi the researcher undertook several steps to foster collaboration, protection and respect for all participants. This included offering opening and closing karakia (incantation) for each interview (Appendix B). Additionally, participants were asked if they had any specific requirements to ensure the research process was culturally responsive. The researcher shared some aspects of her own background and story in an act of relationship building. A comfortable and respectful interview environment was created, for face-to-face interviews this included shared food and drinks. Open-ended questions allowed participants to share their experiences and perspectives freely, with a clear option to pass on any questions to ensure participant autonomy. As a gesture of reciprocity participants were given a koha (gift) in the form of a voucher for their time and contribution.

CHAPTER FOUR: RESULTS

Seven themes and associated sub-themes were identified, reflecting the key motivations and experiences of participants who used home insemination and known donors to conceive:

Table 2.

Summary of the themes and sub-themes

Themes	Sub-themes
MOTIVATIONS	
1. Financial factors as motivation: 'inaccessible' clinic costs versus 'getting pregnant for free'	
2. Rejecting the medicalisation of family-building	a. Ease of home insemination, a familiar environment
EXPERIENCES	
3. Choosing the 'ideal donor'	a. Personally connected with us b. Aligned with us c. A good person who is good for our child d. It's tough: 'spreading the net wider' e. There's no handbook 'a stab in the dark'
4. The process	a. Challenging practicalities: how and when? b. It's awkward: navigating logistics c. Lack of information
5. Relationships	a. Not donor dad, but the helping uncle b. Extended family by choice c. Contracting relationality
6. Lack of knowledge and understanding: 'The home experiment'	a. General b. Medical sector (lack of support, inaccessible, uninformed support) c. Family and friends (cautious, uncertain support)
7. Need for resources, support and counselling	

Themes and subthemes related to Motivations and Experiences are presented and illustrated with quotes below.

Motivations

Theme one: Financial factors as motivation – Clinic costs as 'inaccessible' versus 'getting pregnant for free'

Participants were strongly 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. Their reasoning was expressed clearly and unequivocally. Jamie stated, "*Financially it made no sense to try another way."* Two other participants made similar comments:

> *Clinics are extremely expensive and there's no financial help for those… the cost of IVF is quite stifling or inaccessible. (Lily)*
>
> *We don't have tens of thousands of dollars in savings, so we wouldn't… if we had needed to go through a clinic, we'd be saving right now. (Jamie)*

Some participants conceptualised fertility clinics and the associated costs as a backup option if HI failed, whereas, for others, clinics were cost-prohibitive and not an option. Arden framed it by saying, *"If you get pregnant for free then it's a win win, right?"* And Lily commented, *"Don't go straight to a clinic, cause they'll just charge you out the nose".* Jamie, Virginia, and Rina acknowledged that HI was their first option, however, they would have considered paying for clinic services if their HI attempts had been unsuccessful over time. Similarly, Arden conceived using HI, however, after three years of unsuccessful attempts at HI with her partner, Julien, they changed to trying with IVF to complete their family. In contrast, Simone and Frances stated they may have considered the clinical route had they not successfully conceived their first child via HI, however, they will not use a clinic if their efforts to conceive again are unsuccessful perceiving the financial costs to outweigh the chances of success.

> *30% chance of conceiving, 30% chance of conceiving and miscarrying, and 30% chance of not conceiving at all and we're like "for* [up to] *$25,000 a pop- nup!" (Simone)*

Theme two: Rejecting the medicalisation of family-building

<u>Ease of home insemination, a familiar environment</u>

For most participants, the perception of HI being an easy procedure was a strong motivation for attempting this method. For example, Julian reflected that *" …the actual insemination is no issue."* And Jamie framed HI as *"…a normal, at-home, non-medical intervention."* This belief was upheld for those who achieved conception through HI within relatively short timeframes.

The rejection of having to engage in medical environments and procedures in order to create a family was a common motivation for HI. This included reluctance to involve medical professionals in the intimate personal process of conception, as well as a desire to claim a sense of involvement in the process for both members of the couple. Participants expressed wanting to conduct the intimate act of

family building in familiar, comfortable environments as opposed to formal medical settings. Lily expressed the desire and the right to have a non-medicalised experience:

> *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*)

Simone described her impression of the clinic as, *"definitely pretty sterile, it's not like you walk in there and it's a laugh a minute".* Home in contrast was regarded as casual and relaxing, where HI could be done at the participant's own pace and on their own terms. Participants described their experiences of HI as more personally meaningful and engaged thus maintaining the motivation to continue HI over choosing a clinical route.

> *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 and it's nice… and there's lots of jokes that come from it as well, so it's quite light-hearted. (Simone)*
>
> *At our place or their place… just relaxing, like, go around and catch up and have dinner. And then, yeah, do the insemination. (Julien)*

Participants' comfort levels engaging with a fertility clinic setting ranged from finding it undesirable but manageable if necessary, to feeling completely uncomfortable and attempting to avoid it if possible. For Kat, this included discomfort with the medical model overall from a te Ao Māori perspective. The undesirability of the fertility clinic setting was a motivation for HI.

Experiences

Theme three: Choosing the 'ideal donor'

For participants, the experience of choosing a donor began with identifying the ideal or preferred criteria they hoped the person would possess.

a. <u>Personally connected with us</u>

For most, the ideal donor was someone they had a personal connection to or someone that they could imagine establishing that connection with. For six couples, this meant that family and friends were the first options explored, related to the concept that friends and family would have aligned values and be known to be 'decent' people.

> *We were kind of on the lookout for a known donor. And we kind of asked a few friends jokingly… and it was just a running joke for a little while. We wanted someone that we knew, that felt really odd to us – to have an unknown donor… and we have kind of decent-ish friends, it feels like our criteria for friends is quite nice (laughs). (Jamie)*
>
> *We knew his personality in lots of ways, like we knew him as a single guy, know him as a partner, know him as a father. (Rina).*

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 a meaningful connection could be built. These

couples considered potential donors found through the internet and hoped to spend time getting to know them.

b. Aligned with us

Participants prioritised finding a donor whose values they perceived as being aligned with their own, a preference often referred to as relating to trust:

> *People that I respected and trusted their integrity and …that I felt like their values kind of were intertwined enough that, you know, I could consider approaching them. (Kat)*
>
> *If someone had said that they had donated 36 times, I'd be like "Ohh, that is amazing, that is so awesome that you are doing that for those families" – but that is not for us. (Anne)*

For some, the requirement for a personal connection and aligned values contributed to the rejection of seeking a clinic donor. Parents 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, like their personality or what they like or anything. And well, actually… we do 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).*

For some, personal connections were favoured and sought with attention given to genetics, whereby, the DCP would resemble the couple physically through the process of donor matching.

> *I think definitely the genetic side, the look of the person. I think it was important they resembled us. (Julien)*
>
> *…probably going back to the idea of wanting someone who looked fairly similar to us. Had our donor been a seven-foot-four Nigerian man, you know, that might have been different. (Rina)*

For two of the three Māori participants, finding a Māori donor was either highly desirable, as in the case of Lily and Remy, or essential for Kat, who stated, *"Yes, I absolutely had criteria, Māori… all five,* [potential donors] *had Māori whakapapa."* For these couples, genetic considerations extended to genealogy, with a strong preference for a Māori donor as part of a culturally informed approach to donor matching that included ongoing connections to whakapapa (whānau, hapu, and iwi). This was the case for Lily, *"I'm Māori and we really wanted to find a Māori donor and continue that."*

> *You know, when we first started, we were like, it would be great to have someone that we know, who's Māori… and we can build family that way. (Remy)*

For others, donor matching was insubstantial and secondary to the donor being a decent person who would be involved.

c. A good person who is good for our child

When considering a donor participants prioritised the wellbeing of the DCP, their motivation for seeking a known donor was informed by wanting to find someone perceived as a good person, who would be good for their child in the longer term. Simone shared, "*For me, knowing that Brendon was a decent person..."* and Arden commented, *"Yeah and not like a crazy serial killer."* All parents emphasised the importance of the donor being accessible to the DCP throughout their lives. Julien stated, *"It's actually quite important for them to have the option of…the donor being in their lives."* Rina 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."* For most parents, donor accessibility was closely tied to the hope that knowledge of their origins would help give the DCP a sense of identity:

> *It's important for our children to know where they whakapapa back to and when they are older and they want to visit their marae that they can. (Rina)*
>
> *We wanted 'future child' to have that kind of sense of identity that you get from knowing where you come from. (Simone)*

d. It's tough: 'spreading the net wider'

Participants expressed that in reality finding the ideal donor was 'tough'; as time stretched out the lack of options became overwhelming, and choosing a donor who fit their initial criteria gave way to the practicalities of finding any available person who fit their now more basic requirements. As Remy and Lily explained, *"We had had a lot of criteria in mind."(Remy) …yeah, which had basically gone out the window." (Lily)*. The lack of choices was commonly described as restrictive and distressing:

> *It wasn't like we were kind of browsing through a catalogue of potential known donors, he was the only option. (Jamie)*
>
> *It was hard because the more we looked and the more we couldn't find someone, the more desperate we got. (Lily)*

When faced with limited or no choices, parents reached out to their extended networks, as was the case for Kat, "*And so I said OK, I'm just going to spread the net wider."* And Remy, *"We were basically going through friends of friends of friends."* For one couple, this included eventually expanding the search to the previously unexplored and undesirable 'dark place' of internet-based sperm donor groups. Lily, *"We also were using the Facebook sperm donor groups, which are 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. Some criteria were held onto as Anne clearly states, *"We wanted like an Uncle-like figure… we weren't prepared to compromise on it."*

e. There's no handbook - 'a stab in the dark'

Couples often felt uncertain about how to approach a potential donor. As Lily put it, *"it was kind of a stab in the dark, just reaching out to people who potentially might want to."* Remy explained,

"There's no kind of handbook on how to ask people to be a donor…" and Anne said, *"I wish it* [finding a donor] *was a little bit easier."*

Theme four: the process

a. Challenging practicalities: how and when?

The experience of performing HI required the couples to navigate practical challenges that often involved time-sensitive procedures and unknowable timeframes necessitating the requirement for flexibility, rapid decision-making, and persistence. Couples expressed the timing of ovulation, the donor's availability and location, and getting the sperm from donor to recipient as difficult:

> *So my ovulation hit early…we messaged our donor "What are you up to?" He's like "Ahh, I'm in…* [location 4-hour drive away]." *So we finished up working and drove up there* [to inseminate]. *(Anne)*
>
> *He started work at six o'clock in the morning…so he came at five. (Kat)*

For some couples, 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)*

Often these practical challenges created an environment of pressure that pervaded the couple's experience. The act of trying to conceive became logistical rather than personal and the practical challenges required physical and emotional resources.

> *I feel like the intimacy around home insemination can be a bit challenging because you've got to get it in fast so there's not a lot of time, you know? (Frances)*
>
> *We know that we need to do it tonight but like we are both emotionally and physically exhausted… (Remy)*

In contrast for some the process was easy and effective. Virginia explains:

> *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 for her. Virginia*

b. It's awkward: navigating logistics

The actual 'doing' of HI brought about awkward practical interactions that had the potential to be uncomfortable for both the donor and the couples. For many, this awkwardness 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 just like, yeah, I know you guys, but this just feels a little weird, you know? (Anne)*
>
> *You kind of need to orgasm just before you put them* [sperm] *in but then you've also got a stranger… well someone, wanking in your bathroom. (Simone)*

The discomfort was often managed with humour but for some, the effects caused distress, 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)*

Jamie and her partner realised their donor had initially misunderstood the intended insemination process:

> *He hadn't quite grasped the home donor situation, which was quite funny because he was just assuming, you know, clinic and stuff and " it won't be awkward because I just hand it to the doctor." (Jamie)*

c. Lack of information

Couples often felt uncertain about how to navigate the processes. Many expressed that practical information on when and how to perform the specific steps of sperm collection and insemination was difficult to find and could be ambiguous or conflicting:

> *I guess you know that 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. If you know what I mean, I'm like, do you keep it warm? (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, like, 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)*

In some cases, participants were unaware of their options:

> *I genuinely thought that [IVF] was like the only way for like a same-sex couple other than like adoption or something but like to have your own baby in the same-sex relationship…that's all I'd ever heard... (Julien)*

Theme five: Relationships

a. Not donor dad, but the helping uncle

All the couples clearly stated it was never the intention for the donor to play a "dad" role in the DCP life. Anne explains, *"Well, we don't refer to our donor as 'Dad', that's probably a biggie for us."* Similarly, Jamie stated, *"Like he's not Dad. That was… very clear."* Instead, most couples contextualised the donor's role as that of a helper. As Virginia put it, *"He helped us have you, but he's not your dad."* Simone described the donor's role, "*I can help you make a family and here you go."*

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. So we had an expectation of that you would be involved in our family. (Anne)*
>
> *My ideal was to have a known donor who was going to have like, an active role in their lives. Yeah, not as a parent, but actually as a like a kind of an Uncle. (Kat)*

The "uncle" role was seen as a meaningful one, not focused on biological connections but valued for its unique, non-parental quality, and allowing for a degree of involvement. Jamie relayed conversations shared with her donor-conceived child, *" Uncle Ben helped us conceive you."* Simone described the connection, *"It's a sweet relationship."*

b. Extended family by choice

For four of the couples, engaging in donor conception involved the choice to build an extended family network, whereby, donors (and their families) became connected. Arden 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 an extended family. 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)*
>
> *It's a connection of choice… just nice extended whānau. (Lily)*

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)*
>
> *We kind of have that mutual agreement that our children can refer to each other as siblings and kind of treat it that way. (Lily)*

c. Contracting relationality

All of the couples had some form of written agreement in place with their donors before attempting insemination. Half of the couples engaged a lawyer to review their contracts, as was the case for Virginia, "*We spoke to lawyer,"* and Rina, "*We did get everything drawn up legally."* Lily and Remy expressed an understanding as to 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 at least. (Lily)*

The other four couples used written agreements, often generic forms downloaded from the internet. These agreements were 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 just kind of gave it to him and said like, "Ohh, are we on the same page?' and they read it, and they were like, "Yes, this sounds good." And they were like, "OK, good. Excellent." Carry on! (Jamie)*

For other couples the agreements were more in-depth and considered, Kat explained, "*We've got a written agreement with them, it's quite detailed."* The agreements cover a range of future possibilities, establish boundaries, and indicate considerations have been made for the donor, parents and DCP:

The thing that they stipulated was that our kids would have no claim to their … any Māori lands claim. … and we put in the agreement that they didn't have to have any financial input at all. (Kat)

[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, yeah. (Anne)*

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 couples and donor. Regardless of the approach, all couples acted to formalise the conception arrangement. Overall, these agreements were founded on a desire to establish understanding, set expectations, and create a protective framework for the future.

Theme six: Lack of knowledge and understanding 'The home experiment'

a. General lack of awareness:

Participants described a general public lack of knowledge regarding HI, which then often manifested as a lack of support. For example, Lily sums up their experience by saying, "*No one had any faith that it would work at all. It was like it was like a home experiment."*

b. Medical sector (lack of support, inaccessible, uninformed support)

Participants encountered differing degrees of understanding from the medical sector. Healthcare professionals often appeared unfamiliar with the nuances of HI as it was outside of their understanding of conventional practices:

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

None of them [GP, obstetrician, nurses], *have understood that donor conceived is not just IVF and none of them know what home insemination is. Umm yeah, it's just obviously not common. (Lily)*

In some cases, the same-sex status of the relationships meant couples experienced higher barriers to receiving fertility clinic support. Remy and Lily, for example, considered that they might need additional support to negotiate both social and medical fertility barriers. Their experience demonstrated inequity in access to procedures and a lack of support for options that aligned with their needs, preferences, and resources:

I think before we even started we were really wanting some help from clinics with ovulation induction. But kept hitting a bit of a wall with that. …none of the clinics offer ovulation induction to same-sex couples – if you're not doing IUI… (Remy)

The disparity in clinic requirements for proof of unsuccessful attempts to conceive was explained by Jamie:

> *...it was just that you had to pay for six in-clinic rounds as a lesbian couple, whereas as a heterosexual couple, you just have to try for 12 months, not through them. (Jamie)*

In contrast, sometimes it was the participants themselves who had limited information; in some cases, options were able to be clarified and supported by practitioners:

> *Yeah, we went to see a guy at [fertility clinic] asking about IVF, he was like "Why don't you just do IUI?" And we're like, "What's an IUI?" (Julien)*
>
> *She* [GP] *was like, "Do you guys know how to get pregnant?" And I was like, "Yeah." It turns out that actually, like, I probably didn't know the ins and outs. (Frances)*

Family and friends (cautious, uncertain support)

Participants were supported by friends, family and chosen networks. For some, the support offered was cautious and therefore at times inadequate to meet the individual's needs:

> *I definitely have* [felt supported] *in different ways and the family initially were supportive, but they couldn't do the same sort of support… 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 you know, because they didn't have to go through it, you know, it wasn't a lived experience for them. Anne*

Theme seven: Need for resources, support, and counselling 'We didn't know what we didn't know'

Participants in this study consistently highlighted gaps in accessible, informed resources to support their conception journeys. Rina, who is rurally located, commented on the availability of informed counselling for HI, *"Absolutely not. No."* Her comment underscores the difficulty of accessing appropriate services in remote areas. The lack of locally relevant, inclusive resources had emotional implications, Lily explained her experience of seeking information and support online:

> *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 social infertility. They made me feel 100 times worse, so all our information, I would feel, because 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 which spoke to their desire to be more informed, as Frances put it, "*Yeah, we did that* [counselling] *because we didn't know what we didn't know."* In some incidences, the support was well matched as Jamie explained, "*He 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 what was described to be a tight-knit community. The desire for cultural competence of providers added a layer of complexity:

> *I think that's really hard to find counsellors and therapists that are… Well, at that time, I think it was really hard to find it, 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 that's able to… and not having to educate them. [and] Yeah, I mean trying to find Māori therapists is… yeah. (Kat)*

For the participants in this study, their journeys to parenthood through privately arranged donor conception involved careful consideration and decision-making. Decisions were grounded in personal values and a desire for agency. The couples initial motivations and ideal scenarios often required compromise in the face of practical, emotional, and social challenges. The desire for an ongoing connection with their donor, the creation of extended families, and consideration for the DCP remained central. Participants commonly navigated their experiences with inadequate information, resources, or support.

CHAPTER FIVE: DISCUSSION

The purpose of this qualitative study was to explore the motivations and experiences of same-sex and gender-diverse couples who use known sperm donors and self-insemination methods to conceive in Aotearoa. The results contribute to the limited body of knowledge in this area. Few studies have investigated the decisions and choices these couples engage in, the factors influencing these choices, and their consequent experiences. This 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 ongoingly from birth. As suggested by (Haimes & Weiner, 2000) in same-sex family building the 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 multiple factors. Personal values, a desire for agency, and a commitment to achieving the best outcomes for the DC child grounded the decisions. Personal ideology, structural constraints, and cultural positioning further guided their decision-making processes. The findings and implications of this study are discussed in the context of the limited existing literature. The strengths and limitations of this study, along with suggestions for future research directions are presented.

Consistent with existing literature (Bree, 2003; Hayman et al., 2015), the socially infertile status of the same-sex couples in this study meant they were required to consciously and deliberately plan their methods of conception. As previously acknowledged (Goldberg & Scheib, 2015; Hayman et al, 2015; Kelly, 2020; McNair et al., 2002; Shaw & Fehoko, 2023), the high costs of fertility clinic procedures were found to be a key motivation to seek alternative pathways to conception for all couples except for one. Most couples acknowledged that HI was their first option and conceptualised fertility clinics and the associated costs as a backup option if HI was unsuccessful. These findings align with Hayman et al. (2015), whose research found that medicalised clinical procedures were typically used only after other methods were unsuccessful. However, for two couples clinic interventions were not an option due to financial restraints.

Further, for some participants clinic processes were seen overall as the unnecessary medicalisation of a natural process, that of conceiving, and the issue was not financial but rather ideological. In regard to donor recruitment, the clinical route was seen as incongruent with the requirement for the DCP to have ongoing connections to whakapapa and knowledge of their genetic origins from birth. This belief reflects the Aotearoa context of this study, where negotiating customary rights to genealogy for DCP is a cultural principle (Covington, 2022; Glover et al., 2009; Ruru, 2005; Shaw & Fehoko, 2023).

Couples sought meaningful and intimate conception experiences without the involvement of medical professionals or clinical settings preferring to conduct insemination in familiar, comfortable

environments. They wanted to maintain agency in the process of family building as a right, this included the desire for the non-gestational parent to perform an integral role in conception procedures, claiming a sense of involvement for both members of the couple. As Nordqvist (2012) states, active participation in insemination is enacted to legitimise the non-birth parents' role in the family-building process. Overall, fertility clinic environments were conceptualised as cost-prohibitive, transactional, sterile, and for some culturally undesirable; the home setting was seen as favourable.

While fertility clinics were considered as a second option for some couples, participants expressed feeling disadvantaged by the disparities in access to clinic procedures and funding between heterosexual and homosexual couples. This was demonstrated by the proof required to qualify for funded treatment (as outlined above) and through higher barriers to accessing clinic procedures. Specifically, while heterosexual couples can receive clinic-assisted ovulation stimulation and attempt to conceive at home, these options were unavailable when requested by one couple in this study. Additionally, some participants reported facing a lack of understanding from healthcare professionals in general regarding the process of HI when seeking advice or support. As identified in previous studies (Gregg, 2018; Hayman et al., 2013), participants were frequently required to explain their circumstances and educate healthcare providers regarding donor conception via HI. Participants' experiences highlighted the psychosocial strain of sexual minority stress (Holley & Pasch, 2022), as they navigated heteronormative environments and faced heterosexism related to family building.

These findings align with barriers identified by Shaw and Fehoko (2023), who state that obstacles to accessing reproductive pathways in the form of policy, law and practice, financial insecurity, gender identity, and sexuality can render individuals socially infertile. In the context of this study, participants' sexuality along with heterosexism in clinic policies, impacted their accessibility to funding and procedures, thereby narrowing choices and experiences. Therefore, this study supports the notion that a range of barriers exist in pathways for non-heterosexual couples seeking conception, with a lack of sperm being just one of the obstacles; these circumstances are not a matter of choice that can be opted out of in order to conceive (Covington, 2022; Shaw & Fehoko, 2023). Additionally, infertility may also be contributed to by ideological factors including how an individual negotiates any incongruence between socio-cultural norms and their autonomy in family-building decisions. Therefore, participants' motivations need to be contextualised as being informed by the limited options available brought about by their sexual minority status. Notably, reproductive choices become increasingly complex when social infertility is compounded by medical infertility. This highlights the need for equitable and non-discriminatory access to clinical procedures, funded reproductive care, and informed support, that meets specific needs when required (e.g. support in preparing for home insemination).

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. This meant identifying ideal and preferred donor criteria. For most, family and friends were the first options as they were deemed to have aligned values and could be known to be ‘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 and physical characteristics. However, the couples’ initial motivations and ideal scenarios often required compromise in the face of practical, emotional, and social challenges. As reported in other 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.

In addition to the difficulty of finding a suitable donor, for some, the practicalities of HI could be difficult with interactions between donor and recipient uncomfortable, further complicating the process. Some participants found the ease with which HI could be performed and their own rates of success were motivating factors to continue pursuing HI, similar to other studies whereby knowledge of others' success with HI was a motivating factor (Haimes & Weiner, 2000). For others, however, as timeframes stretched out the logistics of HI became more challenging. As reported by Nordqvist (2012) and Hayman et al. (2015), when HI was unsuccessful over extended timeframes intimacy was reduced and the process became mechanical and perfunctory. Repeatedly asking the donor to undergo the process of being available and donating on demand for each cycle created strain, and the ongoing persistence required depleted emotional resources. Recurring unsuccessful attempts to conceive caused self-doubt and for some, a lack of clear guidance had the potential to add stress and complexity to the process. This demonstrates the need for accessible, evidence-based self-insemination information and practical support to remove uncertainty and address stress.

All couples, except one, set out to build a two-parent family and donors were contextualised as playing a ‘helper’ role. Consistent with Nordqvist (2012), the donor's role was most commonly likened to that of an uncle, with the terminology of ‘dad’ being firmly rejected. Unlike Côté and Lavoie (2019) there were no third (or fourth) parents and no relatives who were donors. Furthermore, most of the couples sought to build extended family networks with the donor, for some, this included donor sibling connections and in two cases wider whānau and iwi connections. These extended families by choice were favoured for the ability to offer the DCP a wider familial network.

All couples in this study created some form of written agreement 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 were aimed at fostering and clarifying a sense of 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, as well as their consideration for the future needs of the DCP. Without established precedents or family models to refer to, donors and couples were left to figure out agreements on their own in an attempt to safeguard the wellbeing of all involved. However, these agreements are not necessarily legally enforceable.

Participants commonly navigated their experiences with inadequate or inaccessible information and resources. 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 of this was that they were vulnerable to being uninformed and unsupported both in the planning stages and throughout the family-building journey, indicating a need for informed resources and access to reproductive care.

Implications and recommendations

The unwelcoming and inequitable environment, coupled with the high costs of fertility clinics, has the potential to exclude same-sex couples from accessing clinic-based procedures. While medical interventions may not be desired for those opting for self-insemination, this research highlights the need for more welcoming and inclusive non-medicalised clinical support for HI. In particular, there is a need for informed, accessible, evidence-based information and support in the preparatory and procedural phases of conception via HI. The inability to access such support throughout these phases of DC means exclusion from the safety of an established protective framework. Beneficial support would include providing readily available 'how-to' information therefore reducing the potential for error, uncertainty, and the associated stress. There is a need for practical assistance with HI, such as facilitating donor health screening, offering guidance with timing and cycle monitoring, the provision of informed counselling, and clinic procedures that support HI when required. Accessible counselling related to HI would help couples and donors consider a range of potential outcomes and scenarios, aid the establishment of relationships based on informed mutual understanding, and support both the immediate and long-term needs of the DCP. This would include awareness of the legal and legislative context, ultimately supporting the rights and needs of all stakeholders. Additionally, discriminatory inequities in the access to ART funding and procedures require addressing.

Importantly, in this research DC was viewed as a relational rather than a medical process. The ability to build personal connections and maintain agency when choosing a donor is not readily attainable in traditional clinic settings. Evidence suggests there is a need for a more relational process in clinic environments whereby couples can more readily meet donors and establish meaningful connections. This approach would facilitate access to a choice of safe and appropriate donors, enabling couples to build connections and allow for more agency in the donor selection process. The ability to establish connections with donors and therefore have knowledge of genealogy prior to conception may contribute to more culturally acceptable processes. To ensure effective interactions,

healthcare professionals and clinic staff need to be better informed in relation to non-clinical same-sex DC and the needs and experiences of the people involved. Furthermore, there is a clear need for legislative frameworks that recognise diverse family forms and that protect the rights of all parties involved. This includes the ability for DCP conceived outside of the formal fertility framework to have their details recorded on the HART register (2004).

Recommendations for future research

Further research is needed that explores 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 over time, 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, and how the donor's role compares to initial expectations. 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 they work with. Additionally, future studies could explore the negotiation of sibling and whānau relationships within these family structures, in order to more deeply understand the complexities and dynamics unique to families formed in this way.

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. Recruitment through community pages may have primarily reached people with similar perspectives, 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 couples seeking to conceive using HI and a known donor, particularly individuals who are more private and conservative regarding their sexual identity. An additional limitation of this study is that two of the couples had not yet become parents at the time of interviews, as one member of each couple was pregnant. Although these participants had navigated the processes up to conception, they had not yet experienced parenthood. Moreover, there was the potential for social desirability response bias due to the relatively small size of the LGBTQ+ community in Aotearoa and the minimal degrees of separation between the researcher and participants. Responses may have been influenced by the desire to present themselves in a socially acceptable light, particularly due to the sensitive nature of the topic. Notably, due to the variability and differences in legislation across jurisdictions globally, this research may have limited applicability beyond Aotearoa’s unique cultural and legal context.

Conclusion

This study explored the motivations and experiences of same-sex couples who use known donors and HI methods to conceive in Aotearoa. Understanding the experiences and implications of

this type of DC is important for promoting the wellbeing and for conceptualising and addressing the rights of all stakeholders. Therefore, participants' motivations 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. The 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. Central to this process is the desire for agency, a commitment to the DCP future wellbeing, the intention to establish ongoing connections with the donor, and the consideration of culture. 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, 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 and informed fertility support. There is a need for informed, accessible, culturally responsive, and evidence-based information and resources regarding HI options and processes, as well as the ability to be included on the HART register (2004), to increase choices and protect the rights, health, and safety of parents, donors, DCP, and their families.

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APPENDICES

Appendix A. Ethics approval

Auckland University of Technology Ethics Committee (AUTEC)

9 April 2024

Sonja Goedeke
Faculty of Health and Environmental Sciences

Dear Sonja

Re Ethics Application: **24/31 Home insemination: the motivations and experiences of same-sex couples using known sperm donors and self-insemination methods to conceive in Aotearoa New Zealand**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 8 April 2027.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz
(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: yzz8218@autuni.ac.nz; Elizabeth du Preez

Auckland University of Technology, D-88, Private Bag 92006, Auckland 1142, New Zealand.
T: +64 9 921 9999 ext. 8316: E: ethics@aut.ac.nz: www.aut.ac.nz/researchethics

Appendix B. Tools

Interview guide

Background and context (how did you prepare)

- How did you arrive at the decision to build a family?
- How did you decide who would be the gestational parent?
- How many children have you/ your partner had via home insemination/donor sperm?
- Did you use the same or different donors?
- Were any cultural or spiritual beliefs and considerations taken into account when choosing your conception route, your donor, or the method of conception? How important was this to you?
- What were the main challenges?
- What were the main successes, and benefits?

Donor

- Can you please explain how you decided who would be your donor?
- What factors influenced this/your choice of donor?
- How did you find your donor? How long did this process take?
- How did you approach your donor?
- What are the reasons you chose a known donor/home conception versus clinic-facilitated? Known donor versus unknown donor?
- Did you have any thoughts/expectations of the donor and the role they would perform in the child's life? Has this changed over time?
- And what role has the donor played in the child's life/ in your family?
- What are the contact arrangements? (if any)
- What is the relationship like between yourself and the donor? *Past/current*
- What is the relationship like between the child and the donor? *Past/current*
- Has your broader 'family' been supportive of your conception journey? *Past/current*
- Have you had support from people along the way? Who has supported your journey?

Agencies and processes engaged with

- What are your impressions of the fertility clinic environment? Was a fertility clinic ever considered? Reasons for not proceeding with a clinic? *(asked sensitively)*
- Did you seek any counselling or professional (psychological) advice in regards to building your family? at what point? who engaged with this process? (donor, either or both parents, other 'family' members or support people)?

- What aspects of this professional service did you find helpful? Unhelpful?
- Was there any agreement or contract discussed or drawn up between you and your donor? What type of topics did this cover? What were your beliefs around this contract?
- Did you seek/receive any legal advice prior to proceeding with insemination? Afterwards?

Experiences of the donation

- How did you prepare for the donation, the process, and practical aspects of home insemination?
- How many cycles did you try home insemination?
- Were there any challenges you faced?
- Has your sperm donor donated to anyone else – that you know of? Do they plan to donate to any others?
- Do you know anyone else who has conceived using self-insemination and a known donor to conceive?
- What advice do you have for other same-sex couples considering home insemination with donor sperm?

Language

- What does/will your child call you and the other parent?
- What language do you use to refer to your donor?
- How does your child refer to the donor?
- What language do you use for describing the procedure of home insemination?
- Is there any language related to creating your family that you prefer/dislike?
- Is there anything else you would like to add, any questions or comments?

Demographic questions *to be asked at the end of the interview*

- age, gender identity, married or domestic partnership status, ethnicity, religion, spirituality, education, occupation, income bracket,
- age when first attempted home insemination? age when gave birth?
- how many children are in your care?
- how many of these are you the gestational parent?
- Would I be able to email you any follow-up questions afterwards?

Participant Information Sheet

Participant Information Sheet
6 March 2024

Project Title
Home insemination: the motivations and experiences of same-sex and gender diverse couples who use known sperm donors and self-insemination methods to conceive in Aotearoa New Zealand*

** including gender diverse, transgender, and non-binary identifying people*

An Invitation

Kia ora! My name is Angela.
I am the mother of twin boys (Ngāpuhi, Te Rarawa) who were donor-conceived within my same-sex relationship. I am interested in child and parental well-being, alternative pathways to parenthood, and diverse forms of family building. I am an Honours student in Psychology at AUT and I am keen to explore the motivations and experiences of same-sex and gender diverse couples using known (e.g., family member, friend, acquaintance) sperm donors and self-insemination methods to conceive and build their families. Couples may include (cis) women, gender diverse, transgender, and non-binary identifying people. If you or your partner conceived using a known donor and 'home' insemination (not within a fertility clinic), between the years of 2004 - 2024, in Aotearoa New Zealand I would like to invite you to participate in this research.

This involves taking part in an interview at a time (and place) convenient to you. The interview can be either face-to-face (if it's in the Auckland area) or via online media or telephone. The interview is expected to take approximately 1 to 1 ½ hours of your time.

What is the purpose of this research?
The aims of this research are to:

- develop a better understanding of the motivations of people who use known (e.g., family member, friend, acquaintance) sperm donors and home-insemination methods to conceive in Aotearoa New Zealand
- explore the experiences of diverse family building outside of a clinical environment (e.g., a fertility clinic)
- understand the challenges faced by same-sex and gender diverse couples who conceived 'at home' using donor sperm from a known donor

This research will explore your experience, including how you made choices along the way, the social or cultural considerations that played a role in your journey, how you decided on and approached your donor, what role the donor has in your lives, the types of relationships that exist between you (as parents), your donor, your child, and your extended family. By exploring your experiences, a broader understanding of same-sex and gender diverse couples lived experiences of family building outside of a clinical environment will be gained. The research findings may help to anticipate the needs of and provide appropriate support

for parents, donors, donor-conceived people, and their families who conceive outside of a clinical framework in Aotearoa New Zealand. The findings of this research may help inform and guide practice (e.g., counselling approaches) and may be used for academic publications and presentations. The research will also form part of the research requirements that are a component of Auckland University of Technology's postgraduate Bachelor of Health Science Honours qualifications.

How was I identified and why am I being invited to participate in this research?

You have responded to an advertisement posted on either Fertility New Zealand, Rainbow Community websites, social media, or via word of mouth inviting people who have become parents using self-insemination and a known sperm donor (outside of a clinical environment) to participate in this research. We are aiming to interview approximately 6-8 individuals (either the birth or non-birth parent) who conceived via 'home' insemination with donor sperm from a known donor in Aotearoa New Zealand. Participants must be fluent in English and have conceived in Aotearoa New Zealand. Once we have a sufficient number of participants, we will close the recruitment.

How do I agree to participate in this research?

People interested in participating are invited to make direct contact with me, Angela Fyfe, via email (see below). I will address any questions you may have about the research, and if you agree, will arrange an interview at a time and place convenient to you. Interviews can be conducted online via Zoom or similar media or by phone if you prefer. Only my supervisor and I will have access to your contact details. You will be asked to complete a Consent Form immediately before beginning the interview. If the interview is via Zoom or phone, a verbal consent will be recorded directly prior to the start of the interview as evidence that you agree to participate. This consent will be recorded. Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you agree to participate, the research will involve an interview at a time and place convenient to you. Where this is outside of Auckland, you have the option of being interviewed via Teams or similar media, or via phone. The interview is expected to take approximately 1 to 1 ½ hours of your time.

What are the discomforts and risks and how will these be alleviated?

I aim to provide a comfortable and safe environment in which you can talk. You can choose to stop the interview at any time or choose to stop talking about any issue about which you feel uncomfortable. In the event that you experience discomfort related to the research, further information and support may be accessed at no cost through the consumer organisation, Fertility New Zealand www.fertilitynz.org.nz , Ph. 0800 333 306.

AUT Student Counselling and Mental Health is also able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9292.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student- life/student-support/counselling-and-mental-health

What are the benefits?

You will have an opportunity to share your experience of using a known donor and 'home' conception methods to conceive and build your family. This research may be useful to other individuals and couples who are considering or have undertaken self-insemination using known donor sperm. This research will be of interest to counsellors working with the rainbow communities in the donor conception field. The research will also contribute to my postgraduate Bachelor of Health Science Honours qualifications. A koha in the form of a $30 voucher will be offered at the conclusion of the interview.

How will my privacy be protected?

You will be asked to provide a pseudonym by which you will be known in the study, or we can choose a pseudonym for you. All references made during the interviews to names of other people (e.g., donors, children, partners), place names and organisations, or any other details that could compromise confidentiality will either be deleted or altered to protect confidentiality as much as possible. Only the researchers will have access to data during the data collection and analysis stage. Only the project supervisor, Sonja, will have access to the data after the final reports are produced. Audio recordings of interviews will be destroyed following transcription. Transcripts and consent forms (both oral consent recordings and paper forms) will be stored separately and electronically, for the duration of six years, on the secure AUT OneDrive protected with multi-factor authentication.

What are the costs of participating in this research?

There are no costs to you other than your time. We anticipate that the interviews will be approximately 1 to 1 ½ hours in duration and that you may spend approximately a further hour in reviewing your transcript should you wish to do so.

What opportunity do I have to consider this invitation?

The invitation asks those interested in participating to make direct contact with me, Angela Fyfe, within a two-week time period. If insufficient participants have been recruited, the posting will be made again. From receipt of this information, you will have a minimum further two-week time period to confirm your interest.

Will I receive feedback on the results of this research?

All participants who would like a copy of the results will receive a summary report via email at the end of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Sonja Goedeke, Email: sonja.goedeke@aut.ac.nz, 09 9219999 ext. 7186
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Email: ethics@aut.ac.nz, Ph: (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet for your future reference. Once signed you will be offered a copy of your consent form. You are also able to contact the research team as follows:

Contact Details

Project Supervisor: Sonja Goedeke, Email: sonja.goedeke@aut.ac.nz, 09 9219999 ext. 7186
Researcher: Angela Fyfe, Email: angela.fyfe@aut.ac.nz, Ph: 022 301 2033

Approved by the Auckland University of Technology Ethics Committee on 25 March 2024 AUTEC Reference number 24/31

Advertisements

Did you or your same-sex partner (past or current) use a known sperm donor and 'home' insemination methods to conceive?

Kia ora, my name is Angela.
I am the mother of (donor-conceived) twin boys (Ngāpuhi, Te Rarawa) and I am interested in child and maternal well-being and alternative pathways to parenthood. If you or your partner conceived using a known donor and 'home' insemination (not within a fertility clinic), between the years of 2004 - 2024, in Aotearoa New Zealand I would like to invite you to participate in this research.

This involves taking part in an interview at a time (and place) convenient to you. The interview can be either face-to-face (if it's in the Auckland area) or via online media or telephone. The interview is expected to take approximately one hour of your time.

The project aims are to:

- develop a better understanding of the motivations of same-sex and gender diverse couples who use known (e.g., family member, friend, acquaintance) sperm donors and home-insemination methods to conceive in Aotearoa New Zealand
- explore the experiences of same-sex and gender diverse family building outside of a clinical environment (e.g., a fertility clinic)
- understand the challenges faced by same-sex couples who conceived 'at home' using donor sperm from a known donor

The findings of this research may help to anticipate the needs and provide appropriate support for same-sex couples, donors, donor-conceived people, and their families who conceive outside of a clinical framework in Aotearoa New Zealand. The findings of this research may help inform practice (e.g., counselling approaches). This research will also form part of the research project requirements that are a component of Auckland University of Technology's postgraduate Bachelor of Health Science Honours qualifications.

If you are interested in participating or have any questions, please contact me:

Angela Fyfe Email: angela.fyfe@aut.ac.nz

Thank you for your contribution!

This study is conducted by Angela Fyfe, Bachelor of Health Science Honours in Psychology, Auckland University of Technology under the supervision of Associate Professor Sonja Goedeke, Associate Professor in Psychology, Auckland University of Technology.

Approved by the Auckland University of Technology Ethics Committee on 25 March 2024 AUTEC Reference number 24/31

Rainbow Families Aotearoa Facebook post artwork

Consent Forms

Consent form for in-person interviews

Project title: *Home insemination: the motivations and experiences of same-sex couples using known sperm donors and self-insemination methods to conceive in Aotearoa New Zealand*

Project Supervisor: ***Associate Professor. Sonja Goedeke***

Researcher: ***Angela Fyfe***

- I have read and understood the information provided about this research project in the Information Sheet dated 6 March 2024.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, the removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

Date:

Note: The Participant should retain a copy of this form.

Approved by the Auckland University of Technology Ethics Committee on 24/31 AUTEC

Reference number 30032024

Oral Consent protocol form for videoconference interviews

Project title: *Home insemination: the motivations and experiences of same-sex couples using known sperm donors and self-insemination methods to conceive in Aotearoa New Zealand*

Project Supervisor: ***Sonja Goedeke***

Researcher: ***Angela Fyfe***

The participant joins the videoconference directly prior to interview

- Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated, and they will be asked the following:

- Have you read and understood the information provided about this research project in the Information Sheet dated 6 March 2024?
- Do you have any questions about the research?
- Do you understand that notes will be taken during the interviews and that the interview will also be audio-recorded and transcribed?
- Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?
- Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.
- Do you agree to take part in this research?
- Do you wish to receive a summary of the research findings? (please tick one): Yes No
- Do you want me to send you a copy of the audio recording for this consent? Yes No
- Please confirm you name and contact details

Participants Name : .....

Participants Contact Details (if appropriate) :

.....

.....

.....

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 24/31 AUTEC Reference number 30032024

Letter of support from FertilityNZ

fertility
NEW ZEALAND

22 February 2024

RE: 'Home insemination: the motivations and experiences of same-sex couples using known sperm donors and self-insemination'

Fertility New Zealand Inc (Fertility NZ) is a nationwide registered charity. Our mission is to walk alongside all people facing fertility challenges and it is our vision that everyone gets the support they need during their fertility experience. Fertility NZ has supported New Zealanders with fertility issues for over 30 years and we are therefore familiar with the challenges faced.

Many members of our community use donors with the aim of creating a much longed for baby. This includes same sex couple using known sperm donors and self-insemination. We provide specific support to these people through our Donor Conception and Surrogacy Network as well as our range of other support, information and advocacy services. Participants of this study are encouraged to reach out to Fertility NZ if required.

The research, 'Home insemination: the motivations and experiences of same-sex couples using known sperm donors and self-insemination', led by Angela Fyfe at the Auckland University of Technology, is of great relevance and interest to our community.

This letter constitutes our endorsement of the abovementioned work.

I am happy to further discuss and can be contacted as below.

Yours faithfully,

Lydia Hemingway
CEO

Fertility New Zealand
lydia@fertilitynz.org.nz
+64 21 577442

Opening Karakia

Whakataka Te Hau

Ngāti Apa (1855)

Whakataka te hau ki te uru
Whakataka te hau ki te tonga
Kia mākinakina ki uta
Kia mātaratara ki tai
E hī ake ana te atakura
He tio, he huka, he hau hū
Tīhei mauri ora!

Cease the winds from the west
Cease the winds from the south
Let the breeze blow over the land
Let the breeze blow over the ocean
Let the red-tipped dawn come with a sharpened air.
A touch of frost, a promise of a glorious day.

Closing Karakia

Karakia Whakamutunga – To End

Unknown origin

Whakamaua te kōrero
Whakamaua te wānanga
Whakamaua ki a Ranginui e tū iho nei
Whakamaua ki a papatuānuku e takoto ake nei
Whakatina ki te tumu o te māramatanga kia tina
Tina, Hui E, Taiki E

Affirm these discussions
Affirm these learnings
Affirm them before Ranginui above
Affirm them before Papatuānuku below
Bind them firm
Let us be one
We have united in conscious thoughts