ORIGINAL ARTICLE: ASSISTED REPRODUCTION

Utilization of fertility treatment and reproductive choices by lesbian couples

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Objective: To describe intentions and outcomes of lesbian couples requesting reproductive assistance; and report number of cycles needed to achieve a live birth.
Design: Retrospective chart review.
Setting: University-based fertility center.
Patient(s): A total of 306 lesbian couples who sought reproductive assistance between 2004 and 2015.
Intervention(s): Intrauterine insemination or IVF using donor sperm.
Main Outcome Measure(s): Mean age, relationship status, family size, preconception goals, conception attempts, number of cycles to achieve a live birth.
Result(s): Preconception plans were available for 233 couples: 76.4% planned for one partner to conceive and carry (single partner conception); 23.6% planned for both partners to eventually conceive and carry (dual partner conception). Of 306 couples who presented, 85.1% attempted single partner conception, and 68% of these achieved a live birth. Dual partner conception was attempted by 14.9% of couples, and 88.9% achieved a live birth. Of those who conceived with IUI, a mean (±SD) of 3 ± 1.1 cycles were completed. Of those who conceived with IVF, a mean of 6 ± 1.4 IUI and 1.7 ± 0.3 IVF cycles were completed.
Conclusion(s): Lesbian couples may improve their likelihood of a live birth if both partners attempt conception. Further studies are needed to understand why one-fifth of patients did not pursue treatment. (Fertil Steril® 2016;■:■–■. ©2016 by American Society for Reproductive Medicine.)
Key Words: Fertility, lesbian, therapeutic donor insemination, treatment

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Assisted reproductive technology (ART) has made significant technological advances over the past 30 years, and heterosexual couples have reaped the benefits of these advances. Results of a 1985 survey of providers offering therapeutic donor insemination (TDI) demonstrated that only an estimated 0.7% of patients requesting TDI were lesbian couples (1). Current research focusing on lesbians undergoing reproductive assistance is minimal at best, and prior research about same-sex reproduction has mostly focused on the success and well-being of the offspring.

Lesbian couples have been utilizing ART for years, but overall numbers and reproductive decisions are unknown. Anecdotally, some couples have identified one partner who has taken on the role of the genetic mother, providing the egg and carrying the pregnancy. Sometimes the second partner may provide the egg and carry a subsequent pregnancy. Other couples wish to both be involved in the biologic making of the child. The eggs from one woman can be retrieved, fertilized with donor sperm, and the resulting embryo can be transferred into the other woman. This technique has been referred to as "ROPA" (reception of oocytes from partner), intrapartner oocyte donation, shared conception, shared maternity, or shared parenthood (2–4). For the sake of this article, we will refer to this as shared conception.

The lack of research in this area may be due to society's lack of acceptance of lesbian, gay, bisexual, and transgender family building; indeed, some reproductive centers do not treat same-sex couples (5). In 2014 only 235 (60.2%) of the 386 SART clinics reported treating

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female couples, whereas only 178 (46.1%) of the clinics reported treating male couples (6). However, in 2013 the American Society of Reproductive Medicine released a committee opinion stating that access to reproductive technologies should not be restricted on the basis of sexual orientation or marital status (5). Additionally, the US Supreme Court legalized gay marriage across the United States on June 26, 2015 (7), and in Australia and New Zealand the Assisted Reproductive Treatment Act, implemented in 2010, allowed lesbian couples and single women access to fertility treatment (8). These recent opinions and political decisions indicate that society has caught up with technology, and it is therefore important to describe utilization trends and choices by all populations accessing fertility treatment, not just heterosexual couples.

We hypothesized that lesbian couple utilization of reproductive assistance has steadily increased over the past decade as access and societal acceptance has increased. Our study aimed to report the number of lesbian couples seeking reproductive assistance at a single center and to describe the relationship demographics and reproductive choices of those couples. Additionally, we sought to compare actual reproductive behaviors with intentions initially identified by the couple during psychoeducational counseling with the center's clinical psychologist. We also aimed to report the mean number of IUI and IVF cycles needed to achieve a live birth in this lesbian population.

MATERIALS AND METHODS

Study Design

Inclusion criteria for this retrospective chart review included lesbian couples who presented for reproductive assistance between the years of 2004 and 2015. Exclusion criteria included single women without partners or heterosexual couples seeking reproductive assistance.

Data Collection

After obtaining approval from the University of Connecticut Health Center Institutional Review Board, data were collected by performing a chart review of lesbian couples who presented for care at one university-based fertility center. The list of couples was generated through a query in our electronic medical record. The query identified all patients in whom TDI was noted as a potential plan, all patients in whom "donor sperm" was checked off, and all patients who underwent a shared conception cycle type. The inclusion and exclusion criteria were then applied to generate a list of lesbian couples. Progress notes, review of completed cycles, and consult reports from our clinical psychologist were reviewed to find the pertinent information.

At this particular center, all couples or patients utilizing donor gametes or embryos are required to undergo a psychological counseling session before pursing fertility treatment. The vast majority utilize our own clinical psychologist; however, occasionally, a couple has discussed similar topics with an outside psychologist. If the outside psychologist can provide written documentation that meets our psychologist's approval, the couple can forgo the interview with our center's psychologist. All interviews during the study time frame were conducted by our center's one clinical psychologist, with the exception of the above-mentioned scenario and November 2014–February 2015, during which time our usual psychologist was out on medical leave. Our psychologist addresses the same topics with each couple and writes each report in a structured manner.

Outcome Measures

Outcome measures included the percentage of donor sperm users that were lesbian couples, year in which the couple initially entered the program, year in which the couple represented to the program after a successful live birth, number of couples that entered the program but did not proceed with treatment, number of couples that entered the program, started treatment, but dropped out before a successful live birth, number of couples that had one partner carry all pregnancies, number of couples in which the second partner carried a subsequent pregnancy, number of couples that utilized shared conception, discrepancies in planned vs. actual treatment, and if possible, the reason for the discrepancy. Relationship demographics and age of the patients plus whether either partner had prior children was also recorded. Finally, the number of cycles to live birth for each woman attempting pregnancy was recorded, and the mean number of cycles needed to achieve a live birth, as well as the mean number of live births achieved, was calculated.

Data Analysis

Descriptive statistics were used to analyze the recorded data.

RESULTS

Number of Patients and Trends over Time

The query identified 792 female patients in whom TDI was noted as a potential plan, "donor sperm" was selected, or who underwent a shared conception cycle. A total of 352 patients met inclusion criteria, and, after pairing individuals in relationships with other study patients, our population of 306 lesbian couples was identified. Lesbian couples made up 41% of the patients presenting for TDI over the study timeframe, whereas single women made up 29%, and heterosexual couples made up 28%. The mean (±SD) age of lesbian women presenting for TDI was 33.7 ± 2.3 years.

Over the approximate 10-year time frame examined, the number of lesbian couples who presented each year remained fairly stable, with the exception of 2009–2011 when the number of patients decreased; this time frame correlates to a time of economic recession in the United States (Supplemental Fig. 1, available online). Over the study timeframe, overall numbers of new TDI patients presenting to our center each year also remained stable at approximately 50 new patients or couples per year. Interestingly, the overall percentage of reproductive-aged women in the region slightly but steadily decreased from 25.14% of the population in 2007 to 23.65% of the population in 2014 (9).

In Connecticut, civil unions were legalized in 2005, and gay marriage was legalized in 2008 (10). Supplemental Figure 2 demonstrates how the number of patients in civil