The experiences of women in a same-sex relationship seeking conception services in São Paulo, Brazil

Galdino Cardin de Carvalho, Paula¹
Silva Cabral, Cristiane²
Simone Grilo Diniz, Carmen³

¹ University of São Paulo, School of Public Health, São Paulo./Dept. of Health, Life Cycles and Society, São Paulo, paulagaldino@gmail.com
² University of São Paulo, School of Public Health, São Paulo./Dept. of Health, Life Cycles and Society, São Paulo, cabralcs@gmail.com
³ University of São Paulo, School of Public Health, São Paulo./Dept. of Health, Life Cycles and Society, São Paulo, sidinizg@gmail.com

Abstract: Following the emergence of reproductive technologies (RTs) came an increase of women in a same-sex relationship planning to become parents. This study seeks to examine the experience of women in a same-sex relationship seeking conception services, and to identify gaps for meeting their needs, considering three principles of Brazil’s Unified Health System (SUS) - Universality, Integrality and Equity. Although the purpose was to explore their specific challenges, many of the situations presented could have implications for women using RTs regardless of their sexual orientation. We interviewed 16 women in a same-sex relationship living in São Paulo who already had at least one child for whom they used some RTs to conceive. Public access to conception services remain exclusive to heterosexual infertile couples and, even in these cases, they are extremely overbooked and attends a very limited number of cases. Without legal access to sperm banks, women in same-sex relationships are left to choose between costly medical treatments in the private system or self-insemination with sperm from a known donor. Some use both system and trade-off eggs for treatment. Some participants were alarmed by adverse effects related to assisted reproductive technologies; little information is given on adverse events and overtreatment is the norm. Fertility clinics that offer services to same-sex couples should use inclusive language in documentation and resource materials, include the patient’s partner in all discussions, acknowledge that most same-sex couples are not infertile, and provide more information on options with low-tech interventions and adverse effects associated with RTs.

Keywords: Homosexuality, Female; Reproductive technologies; Public Health; Health Equity; Medical overuse; Brazil.
I. INTRODUCTION

Brazil’s Unified Health System (Sistema Único de Saúde - SUS) is one of the largest public health systems in the world and provides assistance to millions of people, from basic assistance to emergency services and treatments with medium and high complexity. SUS is based on the principles of universality, integrality, and equity. SUS was created in 1988 to meet the Brazilian constitutional guarantee that considers health a right of all and a duty of the State. Universality means that all Brazilian citizens are entitled access to health actions and services free from discrimination. The Equity principle considers that, in a population, people with different needs should be treated differently, with more investments for those who need more. Integrality means that health care includes prevention, treatment and re-habilitation, and their bio-psycho-social dimensions.

The availability of RTs makes it possible for women to conceive without the direct participation of a male figure and the number of women in a same-sex relationship with planned pregnancies is increasing. However, inequalities in access to health services are still common, and many lesbians and bisexual women feel excluded from healthcare, perceiving services as inadequate in their approach and referring to discrimination as a dissuading factor toward accessing health care altogether. Of those seeking health care, about 40% do not reveal their sexual orientation to health professionals. There is also a perception that their needs are not considered by health professionals due to bias, prejudice or unpreparedness. Those considering parenting may face challenges such as: analyzing options for conception, finding a health provider willing to involve their partner in the process, and facing legal implications of same-sex parenthood. Related to the use of RTs, many of the needs of lesbian and bisexual women can be similar to those of heterosexual women, but homophobia and heterosexism may affect their ability to access health services.

RTs include techniques of assisted reproduction, such as artificial insemination (IUI), in vitro fertilization (IVF), and the reception of oocytes from a partner (ROPA). The ROPA involves the participation of both women, wherein one woman provides oocytes that are subsequently inseminated with the sperm of an anonymous donor, and the other woman receives the embryos and can become pregnant. It is also possible that conception is performed using self-insemination (SI), a low-cost insemination in which the woman (or her partner) inserts semen from a known donor into the vagina, without medical intervention. The growing demand for RT services by women in a same-sex relationship shows the importance of discussing this as a Public Health issue.

In this paper, we will examine the challenges and limitations for meeting the specific client needs of women in a same-sex relationship searching for reproductive technologies (RTs). We contrast the actual access women experience, with the three principles of SUS (Brazil’s Unified Health System) - Universality, Integrality and Equity - to make recommendations to overcome the limitations identified.

II. METHODS
In this qualitative study, sixteen individual in-depth interviews were conducted with women in a same-sex relationship that had children using to preconception experiences involving the use of RTs, which include assisted reproductive technologies (IUI, IVF, ROPA) and self-insemination with known donors. The women was living in the greater metropolitan area of São Paulo, Brazil. The state of São Paulo has a large and diverse lesbian, gay, bisexual and transgender (LGBT) community, as well as the largest number of same-sex couples in Brazil.

Participants were recruited through a network of contacts (from the internet, social networks, personal references, among other sources). Interviews of couples were prioritized to better analyze how health professionals react when attending women is a same-sex relationship. Therefore, we interviewed women who identified their sexual orientation as other than heterosexual and who experienced preconception, prenatal, birth, and postpartum phases of pregnancy while in a relationship with another woman. Single women and adoptive parents were not of our interest. The couples were interviewed separately and individually. In one couple, one of the partners did not agree to participate, but this was not a reason for exclusion from the other partner. The total number of participants was defined based on the criteria of repetition of the information, that is, theoretical saturation.

Interviews were conducted from December 2015 to January 2017 by the main researcher. They were made in places chosen by the interviewees and lasted around 1h30 to 3h. Using a semi-structured guide, the following topics were explored: personal information, relationship status, reproductive decision-making process, conception, pregnancy and prenatal care, birth, postpartum, breastfeeding and parenting. Participants were also asked if they would choose to do anything differently during the process. Prior to each interview, the participants received explanations about the research objectives, the voluntary nature of participation and the confidentiality terms of the study. After obtaining written informed consent, the interviews were recorded, transcribed, and a thematic analysis of the selected material was performed/carry out.

This research project complies with Brazilian Resolution 466/2012 of the National Health Council of Directives and Norms Regulating Human Research, and was submitted and approved by the Research Ethics Committee of the Faculty of Public Health, University of São Paulo (FSP/USP).

III. RESULTS

The ages of the participants ranged from 27 to 43 years old, with an average of 34 years. Six of the participants identified themselves as lesbian, with the remaining participants identifying as gay or homosexual. There were 11 white women, 4 brown/mixed, and one black woman. Fifteen women had a college degree and one woman had completed high school education.

Based on SUS principles of universality, integrality, and equity, we analyze the data aiming to assess, first, how universal is the access to care and planning for pregnancy; second, how comprehensive (integral) was the care provided for the conception, and third, how equitable was the treatment and the use of reproductive technologies by same-sex couples.

A. “Out-of the protocol”: limits to universality in the access to care and planning for pregnancy
Health treatments related to fertility using SUS resources are limited to a few hospitals in Brazil. The state of São Paulo has a referral service for fertility treatment since 1990. To receive free assisted reproduction services from SUS, the prospective couple must initially go to the Basic Health Unit in order to be referred to the infertility treatment center. After being approved on specific criteria in the center (such as specifications on age and physical factors), the type of treatment is recommended and the tests are requested. All infertility treatments can theoretically be done through SUS, depending on the availability of each health center. However, only heterosexual couples in a civil union or married qualify for this service. Professionals working at one of these hospitals justified their refusal to attend to same-sex couples by citing ethical issues. Even heterosexual couples who meet all criteria for access to services often face several challenges such as: high demand for the program; a lack of information from health professionals about the potential treatments, and the extremely limited number of hospitals in the country that offer these services. 

Six couples went directly to private fertilization clinics and three of them expressed that, at some point in the process, they looked into public services for fertilization treatments. One of these couples went to two public hospitals providing RTs in São Paulo. Both hospitals informed the couple that they were outside the scope of the protocol to receive RT treatment since they were a same-sex couple. This situation represents a kind of failure in terms of SUS’s principle of universality. The implied assumption is that RTs within SUS are primarily intended for those dealing with barriers to heterosexual reproduction, that is, due to the infertility of one or both parents involved. This perspective accounts for the barriers to reproduction for those in a same-sex relationship or for single persons. Within the norms of SUS, infertility seems to be the only qualifying reason for RT treatment. Some of the difficulties encountered by same-sex couples looking for fertility services begin from this understanding that they are inherently excluded from the public system.

B. If health care is not universal: equity and financial barriers

Restricted from accessing SUS’s fertility treatments, the remaining option for women in same-sex relationships seeking to conceive is to choose between costly and medicalized treatments in the private system or self-insemination with a known donor. Both choices have varying pros and cons, as well as legal and financial ramifications to consider.

Private fertility services are usually very expensive, and depending on the reproductive technique used and the number of attempts made, the couples interviewed spent between $3000 and $30,000 dollars until they were able to get pregnant. Therefore, women who opt for the use of these services need to have the financial means to bear the costs of treatment, and this usually requires financial planning for more than one procedural attempt. Social class inequalities and gender hierarchies reflect in the access of groups of the population to medical procedures, being the access to the concepitive procedures of the less favored extracts of the population restricted to the public instance, while groups with greater purchasing power use resources of the private health system.

C. Integrality of care and achieving conception: the problem of overtreatment
Most female couples looking for RT services have no infertility problem and only need access to safe, anonymous semen. However, many couples who use RT treatments undergo the same procedures as infertile women, that is, with the use of hormones and invasive procedures\textsuperscript{13}.

It’s not uncommon for couples of women to make multiple attempts and/or try multiple techniques in order to get pregnant. Only three of the couples in this study got pregnant on their first try (two couples by way of the ROPA method, and the third couple by using IVF). Between the other couples, two became pregnant after several attempts of SI, and one couple became pregnant after two IUI attempts followed by one IVF attempt. Three couples performed SI, IUI, and IVF before achieving a pregnancy; in fact, one of these couples tried IUI twice and IVF five times before finally becoming pregnant. As mentioned before, women with more financial resources can opt for the methods offered by private clinics. However, these methods can still result in complications or side effects. Several women reported the limited and biased information received and many participants were negatively surprised by the degree of insecurity, risk and adverse effects related to RT.

In this study, two couples endured ovarian hyperstimulation during the IVF process and two couples encountered twin gestation. In one case, one of the babies developed a congenital diaphragmatic hernia during pregnancy, surviving the resulting surgery after being born. This scenario shows the importance of providing personalized information about all available procedures, highlighting options involving less interventions, and offering psychosocial counseling to people using RT, being they heterosexual or homosexual couples, or single persons.

The notion of equity is a key concept to problematize the obstacles that impede or delay the achievement of universality and integrality, aiming at overcoming inequalities in access and care\textsuperscript{14}. This principle also guides health policies, recognizing the needs of specific groups and acting to reduce the impacts of social determinants on health to which they are subjected. The inequities that exist as part of Brazil’s reality must be tackled with actions that propose to revert frameworks of exclusion and violation of human rights in different social groups\textsuperscript{15}.

Promoting health equity in a population means that people with different needs should be treated differently, investing for those who need more\textsuperscript{16}. Demographic aspects such as race, social class, age and sexual partnership can determine the social acceptance of their maternities, and their experiences. Non-reproductive sex and reproduction resulting from sex partnerships with less social acceptance are subjected to discrimination\textsuperscript{17}. Optimal care practices and treatment for women in a same-sex relationship can be incorporated into existing fertility services with minor adjustments made by clinicians and providers; for example: attention to how the couple is treated; involve all parties requested by the patient, including partners and coparents; use gender-neutral language (e.g. “parent” instead of “mother” or “father”); adapt language in written materials; educate medical and office staff about the changes in policy and address any discomfort or concerns they may have; provide cues that the service is lesbian and bisexual positive; acknowledge and accept the role of non-biological parents; and recognize the diversity of same-sex parented families\textsuperscript{18}. 


\textsuperscript{17}Fernández, P. (2019). The role of equity and social determinants in assisted reproduction: A content analysis of the experience of assisted reproduction in Spain. *Fertility and Sterility*, \textbf{111}(6), 921-928.

This paper addresses some key questions in relation to Brazilian context and the demand for RT from same-sex couples of women. This study is primarily represented by women with high levels of education and middle socioeconomic conditions, we found that women with higher income tend to resort to private clinics, where IVF and ROPA are used, while those less wealthy resorted to self-insemination by a known donor. To decrease costs, women use a combination of public and private sector, and trade-off eggs for treatment. Couples seeking fertility services may be exposed to unnecessary technologies with high levels of interventions and side effects. Overtreatment is the norm, with limited information of low-tech alternatives, or about the potential adverse events in RT (Machin & Couto, 2014). Women in a same-sex relationship may also be subjected to homophobia in services, that do not take into account aspects such as the inclusion of partners, the absence of infertility between the couple, and non-use of forms and heteronormative communication.

There is a number of impediments to meeting the universal access guarantee such as political, geographical, structural, and funding challenges of SUS. The current government recently approved the Proposed Amendment to Constitution 55/2016, which limits increases in public spending to variations in inflation. With this legislation, fewer investments will likely be made in the health arena, in turn leading to further decline of services offered by SUS and privatization of the public health system. In the midst of budget restrictions and limited investments being put into health care, it may be challenging to think about expanding on same-sex couples’ right of health and access to fertility services. The restricted financial investments put into the public health system are one of the main challenges that SUS faces in attaining its principles.

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