‘Dealing with sperm’: Comparing lesbians’ donor conception processes inside and outside reproductive health clinics

Petra Nordqvist, University of Manchester
Petra.Nordqvist@Manchester.ac.uk

Post peer-review version of article published in

Nordqvist, P. (2011) ‘Dealing with sperm: comparing lesbians’ clinical and non-clinical donor conception processes. *Sociology of Health and Illness*, 33(1): 114-129. DOI: 10.1111/j.1467-9566.2010.01279.x

Please refer to the published version for citations.

This article draws on Petra’s PhD research into lesbian couples’ experiences of donor conception. For more information about other articles published by Petra about lesbian donor conception and assisted reproduction more broadly, please visit http://www.manchester.ac.uk/research/petra.nordqvist/

Petra’s most recent project ‘Relative Strangers’ (2010-2013) (with Carol Smart) explored the impact of donor conception on family life among heterosexual and lesbian couples. The research explored parents as well as grandparents’ experiences of donor conception in their families. The findings from this project are available in the book ‘Relative Strangers: Family Life, Genes and Donor Conception’. If you are interested in reading more about the project and see our videos, please visit http://www.socialsciences.manchester.ac.uk/morgancentre/our-research/kinship-and-relatedness/relative-strangers/

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Abstract

A growing body of literature investigates heterosexual donor conception and there is now also a small body of work which investigates the experiences of single women and lesbian couples. Both of these focus on a clinical setting. Women, notably single and lesbians, also undertake non-clinical donor conception, and insufficient consideration has been paid to these reproductive practices, and how they may compare to the clinical ones. Seeking to fill this gap, this paper explores women’s experiences of accessing donor sperm inside and outside reproductive health clinics by drawing on a qualitative interview study with 25 lesbian couples in England and Wales with experiences of jointly pursuing donor conception. The paper explores the differences embedded in the two conception routes with regards to donor recruitment, access to donor sperm over time, space and the management of sperm as a bodily fluid. Utilising the framework of ‘ontological choreography’ developed by Thompson (2005), as well as Douglas’s (1966) work around bodies, dirt and disgust, the paper argues that the clinic functions as a containment for legal as well as practical and bodily dimensions of donor conception, and this in turn shapes practices and perceptions of self-arranged conception.

Keywords

Bodily boundaries, clinical donor conception, donor insemination, lesbian, ontological choreography, self-arranged donor conception, sexual boundaries

Abstract word count: 194

Main paper word count: 8266

Introduction

There has been a growing interest in the experiences of heterosexual couples who conceive using donor sperm (e.g. Becker 2000, Burr 2009, Grace and Daniels 2007, Haimes 1992, Hargreaves 2006). There are also women, notably single women and lesbians, who seek to access donor sperm, not as a remedy for male infertility, but as a route to conception.[i] There is now a small body of work which investigates the reproductive practices of women in these groups. This research focuses on women's motivations and experiences when accessing licensed donor sperm in reproductive health clinics (Donovan 2008, MacCallum and Golombok 2004, Murray and Golombok 2005). However, there is considerably less research into the experiences of women who pursue donor conception outside the clinical context and who attempt to conceive in self-organised donor arrangements. Their experiences are important to consider because they do not benefit from what private clinics or the National Health Service (NHS) have to offer, they may be exposing themselves to health risks, and they also encounter legal uncertainties over parenthood. We know almost nothing about these women's experiences, what processes they undergo, or how their reproductive processes compare to the clinical ones. We thus have very limited insight into what the different routes entail, and how they are differently experienced.

Social, cultural and legal frameworks heavily constrains women's 'choices' of reproduction and it is particularly timely to compare the processes involved in clinical and non-clinical donor insemination given that the new Human Fertilisation and Embryology Act 2008 will keep in place the distinction between the two routes made in the previous Human Fertilisation and Embryology Act 1990. This means that non-clinical donor conception remains excluded from the regulatory framework (Human Fertilisation and Embryology Authority 2009). One particularly important aspect of

this exclusion is the difference in regulation governing the status of the donor as a parent in clinical and non-clinical donor conception. Clinical donors are anonymous to couples and children, and such donors are not considered the legal father of the child (but children conceived after 1 April 2005 can access information about their donor at the age of 18[ii]). However, for couples who self-arrange donor conception the donor is considered in law to be the 'natural' father of the child, and as such, he can claim parental responsibility. We know very little about how this legal distinction impacts on the lived experience of pursuing donor insemination inside and outside clinics.

Seeking to fill this gap, I compare in this article women's experiences of donor conception inside and outside reproductive health clinics by drawing on a study of lesbian couples' experiences. Lesbians' experiences are important to consider in their own right and yet their choices and experiences may also speak to a larger group of women whose reproductive choices and considerations we know very little about. These are women who want to have a baby, who may find that 'time is running out', and who are not in a heterosexual couple relationship. What do women in this situation do, and what do their conception practices and considerations look like? Although this paper does not comment directly on the experiences of these women, it explores experiences which may be indicative of them. This is because women, regardless of sexuality, who want to have a baby outside a heterosexual relationship have to, to some extent, tease out the building blocks of conception that are culturally assumed and 'hidden'. They have to consider questions such as: How does a woman choose and recruit a donor? How does she know that he is sexually healthy? Does she have sexual intercourse with a man? How does she gain access to donor sperm over time (since she may not conceive on the first attempt)? How does she find a place to

do the insemination? How does she feel about preparing the semen sample, the bodily fluid, of a probable stranger? Seeking an answer to these questions, I shall first outline the conceptual framework of the paper, and I then go on to introduce the study. Thereafter, to ease comparison and to provide a holistic understanding of these processes, I have structured the body of the paper in two sections exploring, first, clinical conception and then non-clinical conception. In both of these sections I use sub-headings (guided by the questions above) to direct the reader. Finally, I discuss the emerging findings.

Conceptual framework

As a route to conception, donor insemination transgresses conventional discourses around conception, and also discourses around parenthood, family structure and kinship connectedness. Moreover, it enables reproduction beyond conventional gendered and heterosexualised reproductive regimes. As such, it raises a number of challenges to conventional social, cultural and legal discourses, many of which have been notably explored elsewhere, theoretically and empirically (Becker 2000, Donovan 2006, Franklin 1993, 1997, Haimes 1992, Haimes and Daniels 1998, Lasker 1998, Thompson 2005, Strathern 1992). Also explored elsewhere are the issues raised by lesbian donor insemination with regards to fatherhood (Haimes and Weiner 2000). Building on, and adding to, these bodies of work the task of this particular paper is specifically to compare the processes involved in clinical and non-clinical experiences and explore the relationship between the two, and therefore it does not provide a further summary to these broader debates.

The paper draws in particular on two conceptual frameworks. First, it utilises Thompson's (2005) concept 'ontological choreography' developed through her ethnographic work in infertility clinics. Thompson argues that clinical assisted

conception is a highly organised process in which aspects of conception which are of different ontological orders are separated out and brought into a carefully managed and negotiated in coordination with each other. This means that the potential transgression of traditional family, parenthood and kin discourse embedded in new reproductive technologies and assisted conception is carefully managed through a range of techniques which coordinate medical and scientific issues with the legal status of parenthood, and also discursive gender and kinship assumptions. This 'ontological choreography' enables the social, cultural and legal construction and recognition of the couple who pursue clinical assisted conception as the (proper) parents of the conceived child.

The second framework that the paper utilises is that associated with the work of Mary Douglas (1966) and concerns how sperm raises social anxieties to do with margins of the body and the way in which donated sperm transgresses social and cultural classification and boundaries. Douglas (1966: 36) argues that notions of dirt and impurity emerge around practices which are likely to confuse and transgress upheld social and cultural boundaries and classifications. Dirt, she argues, triggers 'pollution behaviour', and gives rise to symbolically loaded rituals which 'neutralise' it and also neutralise the overstepping of social boundaries. These rituals are particularly associated with the margins of the body and bodily fluids such as semen.

Douglas' approach has informed previous work around donor conception. For example, Donovan (2006) indicates that the UK Human Fertilisation and Embryology Act 1990 attends to the threats of semen as a bodily fluid and the fact that this is a fluid in transition (it has the potential to life), by creating boundaries around fatherhood which reinstate the heteronormative family model. Kirkman (2004) and Burr (2009) attend to understandings of the sperm donor in the context of

heterosexual couples' donor insemination, and demonstrate that donors are ambiguously perceived with gratitude but also resentment, embarrassment and anxiety. Adding to this body of work, I explore the particular anxieties that donated sperm raises in the context of lesbian donor conception, and how the clinical and non-clinical context constitute different frameworks for 'dealing' with these anxieties.

The study

The study is based on qualitative in-depth interviews with 25 lesbian couples in England and Wales who have jointly pursued donor conception. As noted in previous studies of non-heterosexual life experience, same-sex couples constitute a 'hidden' population and a hard-to-reach group (Dunne 1997, Weeks *et al*. 2001), meaning that random sampling is not an option. A purposive sample based on self-selection was employed in the study, and couples were primarily recruited using online gateways[iii]. Both the sample size and the method of recruitment meant that the couples in this study were unlikely to be a representative cross-section of the population of UK lesbian couples. Themes that emerged from the interviews, however, were likely to have generalisability beyond the sample from which they were drawn as the data offered in-depth understandings suggestive of the ways in which these processes are experienced by others (Mason 1996: 93).

Fieldwork took place from September 2007 to March 2008. Semi-structured, theme-based narrative interviews where conducted and included questions around the experience and understanding of planning conception, doing the insemination, becoming and being a family. Couple interviews were conducted where possible and altogether 45 women took part. All interviews were recorded and transcribed verbatim and the data were thematically analysed using a narrative-holistic approach (Lieblich *et al*. 1998: 13) which was conducted using graphic elicitation and event-state

networks (Miles and Huberman 1994: 115f.). From these networks codes and also themes were derived. The study design raised ethical issues around topic sensitivity and researcher's safety in online recruitment, and the study was ethically approved by the Centre for Women's Studies Ethics Committee, University of York.

Twelve of the 25 couples actively pursued, or had conceived, using clinical conception, while eleven had pursued non-clinical conception. Around a third of all couples (9) had at some point in their conception journey tried both routes. No couple in the study saw having sexual intercourse with a man as a viable option to conceive, nor had they used this method.

Nine of the twelve couples who went to clinics self-funded treatment while three had gained access to treatment in an NHS clinic. For most couples in the study the NHS had proved an impossible route; a majority of the couples in the study reported having been denied access as lesbians to NHS clinics, or chose to access private clinics because they believed that they would be denied access (because of their sexuality), or that they would face homophobia in the NHS. Private treatment was entirely self-funded, but the few couples who did access NHS treatment also self-funded part of their treatment, for example, they had to pay for the vials of sperm.

The women were between 23 and 56 years of age (median age 33.5 years). Thirty six percent had left school at 18 whilst 64 percent had a higher education qualification. Names, places and identifying details in the interview extracts have been altered to protect participants' anonymity.

Negotiating clinical donor insemination

The choice between clinical or non-clinical conception shaped significantly how the couples negotiated and experienced the process of trying to conceive. Depending on which pathway they chose, the key issues of the process such as recruiting and

choosing a donor, being able to get access to donor sperm several times, accessing a place where they could inseminate, and also preparing the sample of semen, were differently negotiated and experienced. Focusing now on how these aspects were negotiated in the clinics, I shall start by exploring processes to do with finding a donor.

Donor selection and recruitment

By accessing a reproductive health clinic, lesbian couples gained access to an existing pool of donors and access to donor sperm. The couples did not meet or communicate with the donors as the contact was mediated through clinical staff. So, for example, one couple known here as Frances and Jane, the parents of one child, sought access to and information about donors through the embryologist at the clinic where they conceived:

> The embryologist who actually spoke to us was able to say, I know who this person is [...] I've met him, you know. What's written down on this piece of paper is really what he is like. […] So, yeah, they kind of… they do all that job for you, don't they? (Frances, 34,)

The couples became part of a process in which the clinic recruited donors. As a result, the donors were anonymous to the couples throughout the conception process. This organisation was structured by the law governing clinical donor conception which stipulated that the donor is anonymous to the conceiving couple. This anonymisation of the donor enabled the construction of the couple as the sole parents of the conceived child, thus protecting the normative discourse that a child has (exclusively) two parents. In this way, the practicalities of clinical donor recruitment were aligned with laws governing parenthood (Thompson 2005).

As Frances' account indicates, the clinic staff recruited donors on behalf of the couples: 'they do all that job for you'. Behind this 'job' were regulatory practices through which clinics recruited and selected donors based on, among other things, age and medical history. The clinic vetted the donor sperm and the donor was required to produce a semen sample for testing. He was physically examined and a urine and blood sample was taken and screened for sexually transmitted diseases (STDs) such as Chlamydia and HIV. To carry out health checks, the vials of donor sperm were frozen and quarantined for 6 months before they were used (e.g. London Women's Clinic 2008).

While the couples who accessed licensed donor sperm were not involved in recruiting donors, they did select which donor to use from the donor 'pool' available at the clinic. The couples reported that they were typically presented with a sheet of paper giving information about the donors based on their height, eye colour and hair colour. Jane and Frances, who undertook clinical conception, knew of another lesbian couple who had done so and, in the interview, they recounted a conversation with these friends. Although this is a recollection of a conversation about another couples' perceptions, it shows a way of conceptualising and perceiving a specific value in donor sperm in clinics which was common among the couples in my study. As with many others, these friends were unhappy about the choice of donors available to them in the clinic:

Jane They were complaining about the sperm available to them which was… well, there was no choice, was there?

Frances No, they didn't have any choice.

Jane So they felt he was a bit short and they felt that…

Frances His hair wasn't blonde enough. His hair wasn't blonde enough and perhaps he wasn't sporty enough. […] (Jane, 35 and Frances, 34)

Although there is a sense of humour implicit in the recollection of this conversation, it nevertheless indicates the considerations that this lesbian couple engaged in, and the understanding that couples can reject donors based on perceptions of undesirable characteristics. As Holly's and Carol's account illustrates, donors with red hair could be negatively perceived:

> We felt awful, because she [the clinician] said, is there anything you really don't want? And we said red hair, like, not being horrible. (Holly, 28 and Carol, 32)

The couples in my study commonly wished to find 'matching' donors, i.e. donors with physical characteristics similar to those of the mothers, thus mirroring what is already established practice in heterosexual donor conception and cultural norms around family likeness. I explore the meaning of 'matching' of physical resemblance in a lesbian context elsewhere (author, *forthcoming*), while here I shall focus solely on how desires for particular donors were conceptualised in ways which related to the clinic set-up and framework.

Donor 'matching' draws on discourses to do with family resemblances and kinship, and the fact this framework structured the clinic process meant that ideas of kinship and connectedness were build into the organisation of the clinic. Following Thompson (2005), properties of kinship were brought into coordination with the legal, medical and technical dimensions of clinical donor conception. Jane and Frances' friends' disappointment in not managing to find a donor who met their expectations was shaped by an understanding that the clinic would provide a range of donors of such varied characteristics that they would meet the individual desires of all couples.

Negotiating frequency of access

It was rare that the birth mother became pregnant at the first insemination cycle of intrauterine insemination (IUI) (and also in vitro fertilisation, IVF), and she often had to undergo a number of cycles, thus requiring a number of vials of donated sperm. The majority of the couples wanted to use the same donor in the course of a series of cycles (which related to their desire for a donor of particular characteristics). Furthermore, many couples wanted to conceive bio-genetically related siblings, and therefore wanted to use the same sperm donor for successive pregnancies. The issue of gaining access to donated sperm from the same donor several times was therefore important to many of the couples interviewed. Linda and Annette were one of the few couples who conceived through a NHS hospital. They discussed the lack of choice of donors and how they eventually found one that 'was perfect', and whose sperm they wanted to use for successive pregnancies. The expectation of and desire for 'choice' in clinics structures their account:

Linda The pool had… there was nobody in it, we literally had no choice [at first]. [But then] they phoned, they gave me these two people over the phone […] I called Annette very quickly. I said, look, there's two and one of them was perfect which was… happened then the one we got pregnant with because he was… Yeah, he wasn't very tall. He's 5'8". He had brown hair, blue eyes, he's a research scientist, yeah, our child is going to have some brains. He had very similar hobbies to us.

Annette He liked to cook, he liked wine.

Linda Very, very similar things and we just went, yeah, him and bingo! [laughs] So we were, like, he's good stock. Let's put some on ice for the next one. So last time, when we went in a few months ago, we took our child with us and we said, "Right, this is one we made earlier. We'd like another one please, just like this one [laughs]". (Linda, 39 and Annette, 33)

Linda and Annette's story about their experience of choosing and storing donor sperm is told tongue in check. It was usual for couples to use humour in the interviews as a way of conveying the choices of donors that they made. Nevertheless, there was a serious undertone to these accounts. Linda and Annette purchased more sperm which they 'kept on ice'. They jokingly indicated that they saw this as 'good stock' to keep for the conception of future siblings, thus ironically mobilising a discourse of animal husbandry. The couples who conceived in clinics had the option to store sperm for future use by buying a number of vials of donated sperm which were kept frozen at the clinic for the cost of a yearly storage fee. This can be understood as creating a property relationship between the couple and the sperm (Waldby 2006: 63), which meant that links were forged in clinics between consumption, reproductive fluids and properties of kinship. The couples' accounts indicate that they perceived donor sperm as a product, the value of which was measured in its promise to produce particular kin characteristics, and avoid others, in the child (see also Almeling 2007).[iv] Following Thompson (2005), aspects of consumption and aspects of technological advancement (being able to freeze sperm) were brought into coordination with aspects of kinship (family resemblances, biogenetically connected siblings) in ways that enabled the couples to conceive a particular child.

Negotiating place

The coordinated legal, medical, kinship and technological aspects of the clinic were further coordinated with issues to do with place. The donor sperm was collected and stored at the site of the clinic. At the time when the birth-mother underwent treatment, IUI was performed at the clinic by a nurse or, in the case of IVF, in operation-like procedures performed by medical staff. Thus, the actual place of the clinic also constituted the physical site of conception. For couples, this meant that for every

cycle they underwent, they needed to travel to the clinic. For Caroline and Gillian, who undertook IUI, being at the clinic at the time of treatment represented a positive memory:

> We always seemed to have the last appointment, so they would just leave us in the room and said, it's free over lunchtime and take as long as you want. […] And it was nice. It was a very gentle. (Caroline, 30)

Caroline and Gillian felt that being in the space of the clinic, and the way in which they had access to it, shaped their experience positively. Gillian described in the interview that the clinic felt 'more like a house' as there were places to sit, a bed, and the couple was given time to relax together afterwards. Although some couples experienced the clinic space in more negative terms, for all the couples who went down a clinic route, the clinic provided a 'space of conception'.

Preparing the sample for insemination

The clinic process was further organised so that the clinic staff prepared the sample of sperm for insemination. Many of the couples reported that they felt relieved by the fact that they did not prepare the sperm themselves. Linda says:

> It was quite impersonal at the hospital which is good whereas it all coming in fresh [in non-clinical conception], it's something… it makes it all a bit more squeamish, if you know what I mean, when you have to deal with it yourself. [Y]ou've got this sperm in a vial and you have to then go and deal with it yourself. I don't know, there's something about it being done in a hospital that sort of takes all of that nastiness… I think, being a lesbian, it's the last thing you really want to be involved in, isn't it? That's why you're gay, to be honest with you. You don't want to be dealing with sperm at all. Let somebody else deal with it. (Linda, 39)

The ambiguities recorded in studies of heterosexual women dealing with sperm (Kirkman 2004, Burr 2009) are magnified in this context due to the transgression of sexual boundaries. Linda says '[as a lesbian] you don't want to be dealing with sperm at all'. Linda's account evokes a sense of sperm as something which is distasteful and unpleasant to handle. This reflects findings made in sociological research on the body, outlining the embarrassment and disgust felt in handling (other peoples') bodies, bodily fluids and sexuality, and how this requires careful social management (e.g. Lawler 1991, Twigg 2000). Drawing on Douglas (1966) the sperm transgresses social boundaries, and is therefore perceived as a polluting substance. Importantly though, Linda's account indicates that the hospital clinic provided a setting which allowed Linda, and also others, to distance themselves from the dirt and pollution associated with the sperm. The account suggests that because the staff handled and prepared the sperm, this lessened the threat of it for the lesbian couples: 'there's something about it being done in a hospital that sort of takes all of that nastiness away'. This brings to mind Twigg's (2000) findings, in her study of managing bodies and bathing, that surgical gloves provide an intermediary which detaches bathing in health care from intimacy, and thus maintain social boundaries. Dealing with sperm outside of that clinic framework, and without these intermediaries, was however perceived as 'nasty'. This was also reflected in my interview with Gillian who stated that she preferred clinical conception as self-arranged conception was 'almost like using a penis' and that it was therefore 'a bit seedy'.

In conclusion, the women who accessed clinics engaged in processes in which a set of practices (technical, medical, technical, temporal, commercial and kinship) were linked together and brought into coordination with each other (and this extended to NHS clinics). This structure linked in with the legal regulations of donor conception

which stipulated that the donor was anonymous to the couple and that he was not legally considered the father of the child. In addition, the clinics purified the sperm and made it a less polluting substance for the lesbian couples to deal with. I now move on to explore how self-arranged conception was experienced.

Self-arranged donor conception

Donor selection and recruitment

In contrast to women who accessed licensed donor sperm, women who self-arranged conception had to recruit their donor themselves. And rather than having an embryologist who 'did all that job for them' according to certain criteria, they had to design their own recruitment process.

Because self-arranged conception is not included as donor conception in English law and the donor is legally regarded as the father of the child, the couples and donors who took part in non-clinical donor insemination were exposed to the risk of loosing, acquiring and sharing legal responsibility. The 'informal' donor could claim parental responsibility for any child conceived with his sperm, meaning that the lesbian couple could risk losing autonomous control over the child's upbringing. Equally, a lesbian couple could claim child support from an informal donor. Both scenarios have been known to happen (e.g. McCandless 2008).

The vast majority of the lesbian couples in this study experienced this as a very serious threat, and therefore many of them attempted to define parental arrangements through agreements and contracts, although such arrangements were recognised as precarious and uncertain as they were known to be legally unenforceable. While an anonymous relationship between a couple and donor was built into the clinic setting and where English law automatically excluded the donor from any parental rights,

couples who self-arranged had to negotiate and define for themselves the type of parental relationship they wanted with the donor.

The overriding concern with regards to recruiting and choosing a donor in self-arranged conception was therefore finding someone who agreed with the couples' vision of parenthood. As a first step, this involved asking the man if he was interested in donating in principle, a conversation which many experienced as sensitive, embarrassing and difficult. The couples then had to try to come to an agreement with the donor over parental responsibilities. Kim and Nicola approached a close friend about a possible donation:

> [I]nitially we just had to have him say, yes, I am interested in theory, and then we set about this rather long, difficult process of hammering out between the four of us [the lesbian couple, the donor and his partner] what it might mean and how we might all relate to each other within the set-up. (Kim, 30, expecting a baby together with Nicola, 41)

The process of 'hammering out' the parental involvement of the parties was difficult. It took place before Kim and Nicola entered into a civil partnership. Kim sought legal advice, and a lawyer helped her draw up a contract for everyone to sign. The lesbian partners wanted to be the parents, and the contract stipulated that the donor would not be named on the birth certificate because that would make it harder for Nicola, the non-birth mother, to adopt. The couple insisted that the child would know the donor as 'dad', but he would not be a 'full-time' caring parent and he would not be involved in the child's upbringing. The donor agreed to this. But when it came to actually providing sperm he had changed his mind and decided that he wanted more involvement with any child who might be conceived. As a result, Kim and Nicola called off the arrangement. Many of the couples had similar experiences. Although

they sought, and reached, agreements with donors they ran the constant risk that the donor, either before conception or after birth, would change his mind and seek parental responsibility. For these couples, the issue of parental responsibility and legal parenthood was endlessly unfixed and uncertain, and it also shaped other aspects of their conception process.

One such aspect had to do with sexual health, and the risk of contracting serious sexually transmittable diseases (STD's) from the donor's semen. While this was built into the clinic context, couples who self-arranged conception had to manage it themselves. It was difficult to negotiate, first, because screening was only valid on the day it was carried out (or in the case of an HIV test it was only valid up to three months before the test) and second, couples had little knowledge of or control over the donor's sexual practices.

The difficulties associated with obtaining reliable sexual health checks were amplified by the lack of legal regulations of parenthood, and the risks that the couples felt were embedded in the parental arrangements with donors. Some couples conceived using the sperm of a male friend. It was felt that this could help protect the birth mother's health and the parental agreement because the couple knew and trusted him. However, there was also another group, representing the majority in this group, who used the sperm of a donor who they knew very little about, and who in return knew little about them. These donors were often contacted through the Internet, and related to the couple in what can be best described as an arms-length relationship (I call them 'stranger' donors). It was felt that this kind of arrangement had protective qualities for the women because their identities (i.e. their full names and addresses) could be kept secret which meant that the donor could not trace them and seek parental responsibility. However, this made it inherently difficult for the couples to

know whether the donor was trustworthy, and thus, whether his claims about his sexual health were reliable. This uncertainty is illustrated in Laura and Victoria's account about their conception with a 'stranger' donor:

> Laura He had a HIV test, didn't he?
> Victoria There was something about the HIV wasn't there, that came up.
> Laura He showed us the piece of paper that said the results of his HIV test and all the other hepatitis and stuff. But something came up in a conversation further along that led us to believe that they weren't monogamous in their relationship. (Laura, 33 and Victoria, 47)

The interviews indicate that couples who undertook self-arranged conception developed strategies to manage the contradictory and serious risks embedded in the arrangements. One the one hand, the couples sought to arrange and maintain distance to the donor. Hanna and Anne conceived with a donor they met online. They knew him by his first name and had an e-mail address, but nothing more. Hanna states:

> As much as I can say oh he seems really genuinely trustworthy a really honest guy, otherwise we wouldn't have used him as a donor. But there is always that niggling doubt in the back of your mind. Hence we haven't given him our personal details, that's why he knew our first names only. (Hannah, 23, mother of one together with Anne, 34)

Controlling personal information was a common method used to maintain this arms-length relationship, but of course, the notion of 'distance' was always precarious as they ultimately had to meet up with donors in order to retrieve the sperm.

Although many couples wanted a distant relationship with the donors, it was also commonly recognised that they needed to trust him, not least because of the risks associated with sexual health. This made the desire for distance more complex. The couples, including these who sought to control personal information like Hannah and

Anne, often arranged to meet up with donors at an early stage to assess whether they were trustworthy. In doing so the couples subtly but carefully sought to make 'stranger' donors more known to them. Several of the couples talked of needing to be a good judge of character; any gap in the donor's display of trustworthiness was taken very seriously and often resulted in that the couples ceased to pursue that contact.

These conditions of non-clinical conception meant that the recruitment of donors was undertaken through a different logic than clinical conception. Women in clinics conceptualised choosing a donor through a discourse of 'choice'. In contrast, I argue that the non-clinical process was shaped through an economy of trust which involved a careful working out of the relationships involved. This is illustrated in Elaine's account:

> I felt it was a two-way thing in that they were trusting us that we wouldn't name them on the birth certificate and we wouldn't chase them for any payment [from the Child Support Agency], so therefore I was prepared to trust them that they didn't have anything [e.g. an STD]. (Elaine, 36, mother of one together with Carrie, 36)

Elaine's account illustrates how self-arranged conception was managed through a system of reciprocal trust between couples and donors. Both participated in practices through which they became exposed and vulnerable. This mutual sensitivity was directly shaped by the way in which self-arranged donor conception was (not) legally regulated.

Because the relationships between couples and donors were primarily based on trust, this meant that couples' choices of donors were very limited. Although these couples often expressed desires for particular characteristics, just like the clinic

population, they often experienced that issues of trust overrode requirements for particular physical characteristics:

> [At first we felt that] everyone had the wrong colour hair and wrong colour eyes and it was the wrong kind… But you realised [after a while] that this is not actually the most important thing. The important thing is to find a donor that you trust. (Hannah, 23, mother of one together with Anne, 34)

A result of self-arranged conception being risky and a difficult process to manage, kinship discourses of physical resemblance shaped, but less prominently so, the selection of donors in this context.

Negotiating place and time

In clinics sperm samples were frozen and then thawed and prepared by clinical staff and did not require the donor to ejaculate on that particular day. In contrast, in 'fresh' donations the ejaculation and insemination had to take place in quick succession as sperm was only motile for one-two hours after ejaculation (Insemination for lesbians and single women 2008). These conception practices did, furthermore, not have a designated 'place' where the donation and the insemination could take place (such as a clinic space), but the couples/donors had to arrange to meet up somewhere for the handover. Couples who conceived with the sperm of a 'friend' donor could inseminate in the comfort of their own homes because the arrangement built on a geographical and/or personal closeness between the donor and couple. For couples who conceived with 'stranger' donors, the desire for a 'protective' distance from the donor often meant long journeys and no access to a 'home' space. This meant that the handover of the donation and the insemination of sperm could become, and often were, a logistically difficult process to manage. This is illustrated in Sue and Trish's account:

Trish We went and got a sample off a [stranger] donor […] about 60-70 miles away. We had to go straight to work afterwards and we were literally like down to the minute so we got this sample, […] this cup of sperm.

Sue The original theory, as well, our car is the big black one out there. It's a huge 4x4 and it's got blacked-out windows. So the original theory was, we put the back seats down, you can get a mattress in there if you want, but she could lay down in there with a blanket, no one can see in and I can just drive round a car park or something, nobody would know. No, our car breaks down, so we're left with her mum's very little Nissan Micra, which is open for everyone to see, very low down. So where did we go? Morrison's car park. [laughs] Find the furthest spot away that you can. So I found it. She's only halfway through putting this cup [similar to a diaphragm] in and all of a sudden this trolley bloke comes walking our way. I'm going to move the car. She said, "Don't, I'm going to spill it, don't go round the corner". (Trish, 31 and Sue, 34)

Many couples in the study had similar experiences suggesting that undertaking self-arranged conception was often potentially demeaning and unpleasant. This grimness was commonly managed through humour, illustrated in this account. The couples had to negotiate the logistics of retrieving a sperm donation repeatedly at every cycle as, unlike in the clinic, these women could not buy a stock of frozen sperm.

Preparing the sample

Embedded in self-arranged conception was also that the couples had to prepare the sample of sperm themselves:

> I get the taking [up] and the smell and the putting it up the syringe, and it's gloopy and it's stringy. And also I think because I did live a straight life when I really didn't want to be and I did, that is one thing that's always

> repulsed me more than any... So I'm there actually close up, syringing it up. (Sue, 34)

Like Sue, many of the women saw sperm as 'repulsive' and handling it was experienced as unpleasant. Many couples who pursued self-arranged conception stated that they preferred this route (e.g. because it was cheaper), however, they felt that it was regarded as a less acceptable route to conceive compared to clinical conception. Wendy and Penny self-arranged conception and Wendy theorised about why she thinks this route is perceived differently from clinical conception:

> I think somehow going to the clinic, where there's doctors and there's stirrups and someone goes like that with the plunger and [laughter] and the sperm just goes there, and that somehow… somehow that's okay, clean. Whereas a man arriving with a pot and you sucking the sperm into the syringe yourself and putting it into your own vagina, or your partner doing it, and doing that is somehow dirty. And it's like same thing actually. (Wendy, 36, mother of one together with Penny, 36)

The clinical route was perceived as a 'clean' route to conceive while preparing the sperm yourself represented a 'dirty' route. In self-arranged conception, the rituals that were part of the clinic context, and which were perceived as purifying the sperm, were removed. Wendy's account suggests that this raised the social anxieties around the donated sperm. I argue that this relates to the fact that the sperm in self-arranged conception could not (as easily) be detached from the donor, his body, or his sexual practice of masturbation compared to clinic conception. The women who self-arranged conception therefore faced difficulties in neutralising the donor sperm, and also experienced it as a less legitimate route to conceive. This is illustrated by the fact that Wendy and her partner, although critical of the notion that there would be any major difference between inseminating inside or outside the clinic, kept the self-

arranged conception a secret from family and friends. Hannah and Anne made a similar choice:

> I think it's been easier to tell people we went to a clinic even if we didn't truth be known. I think it is easier. Even to friends we say yeah we went to a clinic […] and paid X amount of money, then this happened. […] That is what I told my parents anyway and that's the story I'm sticking to. (Hannah, 23, mother on one together with Anne, 34)

Hannah and Anne wanted to avoid what they felt was others' unwelcome questions about the procedures involved in self-arranged conception. Their account indicates that they perceived clinical conception, in contrast to self-arranged conception, as a socially acceptable route that could legitimately explain their conception to friends and family.

DISCUSSION

In this article I have compared the reproductive processes involved in clinical and non-clinical conception as experienced by lesbian couples. I now want to pick up on the differences between clinical and self-arranged conception, the relationship between the two, and also the ways in which the distinction between the clinical/non-clinical context impacted on the management of sperm as a bodily fluid.

Comparing the processes embedded in the two routes, the experience of the lesbian couples' who accessed clinics suggest that embedded in the clinic route was an ordering, organisation and aligning of various practical, medical and legal aspects of reproduction. Building on Thompson's conceptual framework, the narratives of the women in this study indicate that the clinic setting functioned as an organisational hub that assembled and organised the fractured and multilayer processes of donor conception for them. Legal regulations (of donor anonymity and the absence of a legal

father) were aligned with practical procedures carried out by clinic staff (such as recruiting donors, sampling sperm, screening, freezing, storing, and preparing the sperm). What we see here is a containment of donor conception. The clinic 'contains' not only the practical implications of donor insemination, but also the legal management of the donor as a non-parent.

The accounts of non-clinical donor insemination highlighted just how contained and restrained these processes were in clinics. The experiences of couples who arranged non-clinical donor conception demonstrate the literal but also figurative boundaries of the clinic. These couples were outside the geographical, medical and economic space of the clinic, but also its legal containment regulating the position of the donor as a non-parent. They had to manage and coordinate multiple interlinked stages, such as asking a man to make a sperm donation, negotiating parental responsibilities, health checks, managing place, time and sample preparation; many of which were both uncertain and difficult to negotiate.

While I do not wish no minimise the risks and constrains encountered in the clinic process (Becker 2000, Franklin 1997), I want to explore in particular the relationship between the non-clinical experience and the clinic 'containment' of donor conception. I argue that the uncertainties and complexities embedded in self-arranged conception, which I have outlined here, are linked to the fact that its counterpart, clinical donor insemination, is coordinated through an ontological choreography (Thompson 2005). The legal distinction between the position of the donor in clinical and non-clinical conception *added* hurdles to non-clinical conception and *increased* the vulnerabilities and uncertainties for women who took this pathway. The interviews with women who took the non-clinical route demonstrate that the fact that the donor was legally considered a father in these arrangements amplified and heightened the hurdles and

risks experienced in self-arranged conception. For example, many of the couples took the decision to conceive with a distant 'stranger' donor because it was perceived that this enabled more (although not total) control of his parental involvement. But distance also meant increased difficulties in securing sexual health checks and, furthermore, it made organising donations logistically difficult.

It is likely that women will have to negotiate the difficulties, complications and risks embedded in self-arranged conception also in the future as many cannot negotiate access to reproductive health clinics. For example, women of lower socio-economic backgrounds find it hard to negotiate access to clinical treatment due to its high costs (Bell 2009). It is therefore particularly problematic that the current legal framework of the Human Fertilisation and Embryology Act 2008 continues to separate between clinical and non-clinical conception.

The clinical coordination also shaped the way in which the couples perceived 'dealing with sperm'. The accounts suggest that clinical conception and self-arranged conception had different discursive power to purify (in Douglas' terms) the 'dirt' of sperm, and the social anxieties associated with sperm donations. The clinic provided a context in which the polluting potential of sperm was seen as managed and even neutralised, and it provided a set of intermediary rituals which restored social boundaries around lesbianism and also intimacy and bodily boundaries. Thus, the clinic did not only contain the practical and legal dimensions of donor conception, but it also stopped it from spilling over intimate, sexual and bodily boundaries. In contrast, non-clinical conception was seen as more 'dangerous', and also experienced as less legitimate. Thus, there was a morality of clean/dirty and right/wrong associated with the distinction between clinical and non-clinical donor conception. Drawing on, but also adding to, Thompson's conceptual framework, I argue that the 'ontological

choreography' of the infertility clinics provided a framework of cultural legitimacy in ways which directly related to and even shaped the way in which non-clinical conception was perceived as a more questionable and less legitimate route to conceive.

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[i] Donor insemination was developed as a 'treatment' for male infertility (Haimes and Daniels 1998). This has been the dominant legal and social discourse governing these technologies, and also constitutes the rationale to limit, until recently, access to heterosexual couples, often framed through notions of 'social' and 'medical' infertility (Dempsey 2006). Lesbian and single women utilise it as a pathway to conceive in ways totally unrelated to male infertility (Bateman Novaes 1998), and thus in ways which transgress conventional, medicalised understandings of the context in which couples access donor insemination.

[ii] From 1st October 2009 this was lowered to 16 years of age for non-identifying information.

[iii] Online recruitment primarily took place using online message boards for gay and lesbian parents. The following five sites were selected: 'Rainbownetwork' (www.rainbownetwork.com, now www.gaydarnation.com); 'Stonewall' (www.stonewall.orgo.uk); 'LGBT parents' (www.lgbtparents.proboards74.com); 'Gingerbeer' (www.gingerbeer.co.uk); and 'Lesbian Insemination Support (http://groups.msn.com/LesbianInseminationSupport).

[iv] The concept of 'promise' has been explored in the context of umbilical cord blood banking (Brown *et al*. 2006).