ORIGINAL ARTICLE
QUALITATIVE RESEARCH

"It helped that I'm a middle class, educated, White lady": Normative bodies within fertility clinics

Lisa Melville, Te Whare Wānanga o Waikato | The University of Waikato.

ABSTRACT

INTRODUCTION: Fertility clinics, and the assisted reproductive technologies undertaken within them, hold the possibility of creating an eclectic mix of families. Fertility clinics are sites where several fields such as technology, ethics, profit, law, policy, and bodies, intersect with the construction of family. What might the experiences of queer women within fertility clinics in Aotearoa New Zealand indicate about how these fields collude and collide with the notions of the right to have a child, delivering accessible services, and how regulations are applied?

METHODS: This study used a qualitative, multi-methods approach. I conducted 27 face-to-face semi-structured interviews and ran an online survey (88 responses). Questions focused around the decision making and experiences of lesbian women in conception, maternity and family spaces.

FINDINGS: This research found the path to, and through, fertility clinics in Aotearoa New Zealand may be easier for those who embody privilege, that is those who present as white, wealthy, heterosexual, and feminine. Exclusions are practised through policy, wording, inference, and behaviour.

IMPLICATIONS: Fertility clinics demonstrate the inequity of reproductive justice. Normative understandings underpin the right to have a child, accessible services, and the application of regulations. These understandings work to trouble paths to parenthood, not only for lesbians, but for many others within and across a variety of other groups. Access to, and movement through, these spaces can strongly reinforce narrow understandings of family. Fertility clinics not only create families, but also reproduce particular types of family.

Keywords: Heteronormativity; queer; lesbian; family; assisted reproductive technologies

AOTEAROA NEW ZEALAND SOCIAL WORK *35(4)*, 112–124.

CORRESPONDENCE TO:
Lisa Melville
lisamelville@yahoo.com

Fertility clinics are of particular interest when discussing reproductive justice, reproductive health, and reproductive rights, as they are places whose primary concern is to (re)produce families. Fertility clinics are also spaces where a number of fields intersect with the construction of family: technology, ethics, profit, law, policy, and bodies. Practices in fertility clinics are not inert, but are shaped by cultural and kinship ideas and beliefs (Hargreaves, 2006; Michelle, 2006; Nordqvist, 2011; Thompson, 2005). Fertility clinics are therefore spaces that demonstrate what is deemed 'family' and create and reinforce family legitimacy.

Fertility clinics reproduce more than just families. One of the debates around Assisted

Reproductive Technologies (ARTs) is whether they are "innovative ways of breaking free of bondage to old cultural categories of affiliation or whether they are best denounced as part of a hegemonic reification of the same old stultifying ways of classifying and valuing human beings" (Thompson, 2005, p. 177). Theoretically, this question can be easily answered: the technology itself provides for any number of permutations and renditions of family. ARTs procedures can challenge biological essentialism of family through the separation of motherhood through egg, gestation, and biology. Situations that exist in the utilisation of ARTs (such as a woman carrying the embryo of her mother and step-father) also challenge biologically essentialist understandings of (in that situation) daughter, husband, father, grandmothers, aunt, and child (Thompson, 2005). ARTs destabilise assumptions about family and biology (Epstein, 2018).

Fertility clinics have been critiqued, however, for both serving and reproducing a particular *type* of family (see: Lttichau, 2004; Michelle, 2006; Millbank, 1997; Short, 2007; Statham, 2000). They "reproduce more than humans: they reproduce consumer marketplaces, normativities, notions of belonging, and intensifying inequities" (Mamo & Alston-Steppnitz, 2015, p. 521). These normativities have included (and still include in some places) rules around access to fertility clinics (for instance being married; see Lie & Lykke, 2017), conditions for public treatments (for example the use of BMI which is based on a normative White body; see Shaw & Fehoko, 2022), and the expense of private treatment.

Brown and Perlesz (2008) remind us that family "is a culturally dominant idea or world-view that bestows legitimacy, privileges, and resources on some family arrangements, *whilst withholding them from other[s]*" (p. 287, emphasis added). The laws, policies, practices and assumptions of family mean that fertility clinics bestow on some people the ability to create family, while excluding others. Garwood (2016) recognises fertility clinics "have been set up to deal with heterosexual infertility, [and] implement a heteronormative understanding of fertility" (p. 11). Fertile lesbian bodies queer these spaces of infertility, and lesbians utilising fertility clinics can highlight normative assumptions underpinning who is being privileged when considering the rights to have a child, the delivery of accessible services, and how regulations are applied.

There are seven fertility clinics in Aotearoa New Zealand, operated by three different companies, and located in five of the six most populated cities. Repromed, Fertility Plus, and Fertility Associates all have clinics in Auckland (the largest city). The largest company, Fertility Associates, also has clinics in four other cities: Christchurch, Wellington, Hamilton and Dunedin. Fertility Associates also has 11 satellite clinics (which offer consultation services only).

The study

This article draws from my PhD research (Melville, 2021) where I examined how lesbians' experiences of conceiving, being pregnant, birthing (and also sometimes not conceiving, not being pregnant, and not birthing for one partner) and mothering both reinforce and trouble the normative gendering of bodies and spaces. I conducted 27 face-to-face, semi-structured interviews, 16 with one person (either a sole-parent or one partner from a couple) and 11 with couples. The interview questions focused on how people started their families, how they decided who the donor was going to be, and their experiences with fertility and maternity services. I also ran an online survey at the same time, based around the same lines of inquiry, with 88 responses. The study received ethical approval from the Waikato University Ethics Committee on 12 January 2016.

I used the term *lesbian* when recruiting for the participants, however, not everyone

in the research identified as a lesbian. In terms of sexuality, over half of respondents I interviewed (52%) self-identified as 'lesbian' while another quarter (24%) self-identified as 'gay'. The remainder (24%) self-identified as 'queer', 'mostly lesbian', or 'queer/lesbian'. In terms of gender, everyone self-identified as female. These, then, are not the stories of non-binary or gender diverse people. They are the stories of some lesbian and gay and queer women, and I use the terms 'lesbian' 'queer' and 'gay' throughout, not because they are interchangeable, but because if I use the term 'lesbian' as an umbrella term for them all, I obscure some voices, which are already marginalised. By using the different descriptors, I pay homage to people's different identities, as well as acknowledging people may choose to identify differently at different times and in different spaces, and perhaps direct attention to the fluidity of sexuality.

Discourse analysis and thematic analysis were used for analysis. Both of these types of analysis are not about uncovering *the truth* but more about the way participants construct their own realities and identities. I utilised three different types of themes: literature-based, question-based, and emergent. Before undertaking the interviews, I created documents based on common themes from relevant scholarship (literature-based themes). I also created documents based on themes derived from the interview and online questions (question-based themes). Lastly, during the interviews I added themes that were data driven—commonalities that arose across discussions with participants (emergent themes).

Examining bodies

Human Geography is a field which recognises bodies can be used to "highlight relationships between power, knowledge, subjectivities and spaces" (Johnston, 2005, p. 106). This interaction between bodies and the spaces they move through can expose power and privileges that exist. Spaces are not inert but are produced and maintain cultural norms, with many geographers focusing particularly on the assumption of heterosexuality (see: Browne & Nash, 2010; Butler, 1990; Hubbard, 2008) and how the realities of bodies demonstrate the gendering and heteronormativity of spaces (see: Johnston, 2016; Longhurst, 2001; Watson, 2005).

Heteronormativity is the assumption that heterosexuality is the only sexuality. However, heteronormativity also promotes one particular heterosexual norm, which marginalises many other heterosexual identities and practises (Richardson, 2004, 2005). Although geographers may focus on the heteronormativity of space, Valentine (2000) reminds us that spaces are produced in a variety of ways and "the identity of spaces, like the identities of individuals, are always cross-cut with multiple contradictions and tensions" (p. 5). A space is not just 'heteronormative' or 'queer', just as "masculinities are culturally constructed in relation to femininities and other social identities (class, race, sexualities)" (Gorman-Murray, 2008, p. 368).

This crossing and combinations of identities ties into *intersectionality*, a term coined by Crenshaw. Crenshaw (2017) defined intersectionality as:

> a lens through which you can see where power comes and collides. It's not simply that there's a race problem here, a gender problem here, and a class or LBGTQ problem there. Many times that framework erases what happens to people who are subject to all of these things.

Intersectionality recognises unique oppressions exist, and also they change when in combinations. A second aspect of intersectionality that Crenshaw mentions is that it "is not only about multiple identities but is about relationality, social context, power relations, complexity, social justice and inequalities" (Hopkins, 2019, p. 937). Similarly, in discussing hegemonic heterosexuality Allen and Mendez (2018) also took into account spheres of ability, class,

ethnicity, nationality and race. Specifically focusing on fertility clinics, Gabb (2004) suggested ethnicity, wealth and geographical location could impact on the choices of lesbian couples wanting to have children.

Paying attention, not only to the spaces of insemination, but also to the bodies involved in insemination may reveal new ways of knowing and understanding, as well as problematising boundaries and binaries. Examining lesbians' experiences within fertility clinics, developed to recreate the normative heterosexual family, may expose underlying assumptions about family, about mother, and about bodies (Longhurst & Melville, 2020). Geography also works from a strength rather than a deficiency approach, allowing for the possibility that these families might have much to offer understandings of family and kinship.

Findings

Queer women often find fertility clinics to be awkward spaces. The normativity clinics both ensconce and are ensconced within, make it difficult for people to create alternative family formations. I examine four aspects that create a path of privilege through the clinic: wealth, definitions of infertility, gender normativity, and definitions of family. Lastly, I look at how privilege is extended to the families that are created in fertility clinics.

"Money is a deciding factor. And that sucks"

Eligibility for free public funding for fertility treatment is based on the scoring system Clinical Priority Assessment Criteria (CPAC). One of the requirements of CPAC differs depending on sexuality. Heterosexual couples must have been trying to get pregnant unsuccessfully for one year. Like heterosexual couples, lesbian couples must also have been trying unsuccessfully for a year, however six months must be within an authorised fertility clinic. Lesbians therefore need to be able to cover the costs of six months of treatment before they can access state funding. One month of Intrauterine Insemination (IUI) (the cheapest form of assisted reproductive technology offered) costs NZ$1720, plus NZ$0-500 for medication (Fertility Associates, 2020). (There are also additional costs such as appointments, sperm storage, blood tests, travel to and from the clinic, which are not considered here.) While funding is never guaranteed, heterosexual couples can be expected to be assessed, whereas lesbian couples require at a minimum NZ$10,320 before they can get to this initial stage.

Paula (queer Pākehā in her late 30s and mother of one[1]) mentioned this injustice:

> There's a real base line frustration, the whole thing that basically you have to pay thousands of dollars for a privilege that heterosexual couples at least get a head start. It doesn't work for all of them, and I don't make assumptions about fertility in that way, but at least they get to have a head start and so it kind of feels a bit "on the nose" [unfair] I think … it does grate a little bit that you have to pay from the get go for a process that you physically, mechanically you can't do.

Kelly (a lesbian Pākehā in her late 30s and mother of one) mentioned how much the basic cost of the clinics cost their family:

> Going down that track is very financially costly. [Our child] owes us heaps of money. We've got all the bills so we're gonna give them to him when he's 21 and say guess what mate [laughter]. $28,000 [approximately US$19,000] thanks very much.

Megan (a Pākehā/New Zealand European/New Zealander in her late 40s and mother of one) also mentions the cost for her family:

> The criteria for getting funded fertility help are atrocious for lesbians. We took seven years to get pregnant, and spent $30,000 [approximately US$20,000] before we were eligible for funding. … Given

> that women are generally paid less than men, I think that lesbian couples are probably less wealthy than heterosexual couples, and so this requirement to spend so much money on self-funded inseminations discriminates against us.

The intersection of sexuality, financial resources, and gender (through the gender pay gap) all impact on disadvantaging queer women seeking to create a family.

Kelly jokes about being unable to get pregnant, as many of the women did: "We've been trying for five years, it hasn't worked, I don't know why [laughter]." But she also recognises the social injustice of this distinction between queer and straight couples:

> We did feel a bit ripped off about not being able to get funded in the same way that a straight couple would. So that was one thing that I just thought "oh this doesn't seem fair to me". It should be funded for lesbian or gay men at the same as it is for straight people who are not able to conceive a baby because I'm not able to conceive a baby with a female partner. It's impossible so I should be able to get funding to do that, the same way as a straight couple.

Kelly and her partner Shannon eventually did get public funding. The reason for their funding had nothing to do with a system recognising inequity or seeking to counter-balance the impact of intersectionality:

> We actually had to say that Shannon had been trying with her ex-partner who is a man and that what's got us [the funding].

Kelly and Shannon received public funding to create their family because of Shannon's prior relationship with a man. Being heterosexual outside the clinic is rewarded inside the clinic.

Queer couples therefore have financial considerations that most straight couples do not. Their available financial resources impacts on their decision making about how they might create their families. Although Catherine (a gay Pākehā in her early 30s) and her partner Margaret (a gay Māori in her early 30s) initially considered a clinic, they did not use one:

> … and so we started to look at different ways of having children and cause we were students at the time, or I was working fulltime and you were still studying? We were really poor, well that's ridiculous, we were just, we didn't have a lot of spare money and so going through [a fertility clinic] just seemed so expensive to us.

Catherine acknowledges the use of "really poor" was an incorrect framing of their financial situation, highlighting that if fertility assistance was beyond the financial means of a family who have some discretionary income, then fertility assistance must be out of reach for a vast number of people.

Many women seemed very aware of the consequences of the cost, not just for them, but for others wanting a family. Paula realises it would affect some heterosexual couples, but not to the same extent:

> [Money] is a similarly limiting factor for some [straight] couples but I guess because they can get pregnant outside of the clinic, the people who are being disadvantaged, [it] is a much smaller proportion of them.

Paula acknowledges that financial resources affect people's choices in how they create their families: "money is a deciding factor. And that sucks." She continues, recognising both the emotion involved in creating families and her privilege:

> I mean Susan and I are incredibly fortunate that … you know we earn generous salaries but actually I don't think it's right. I know how gut

> wrenching it is to be able to afford this and to do it, and just know that it's your biology and your chances and your rah de rah de rah that affect the outcome. For me to have considered that money might be a limiting factor, that would just be devastating.

This lack of choice to use fertility assistance is not limited to gay women, but these comments show how lesbian couples' access to fertility clinics is limited through their gender, and therefore potentially receiving less in wages due to being women, as well as their sexuality, where the privileges of heterosexuality outside the clinic are also rewarded inside the clinic.

Kelly also discussed how money impacts decision making:

> It means that people that don't have the resources can't make the same choices that I can, as someone who is fortunate enough to have resources. It's stink. … Because then you're probably more likely to put yourself in a difficult position perhaps than if you do have the you know you might end up who knows you could do all sorts I'm sure you understand what sort of things [laughter]. And then you get yourself in trouble … As I said having a child is complicated enough as it is without anything else going haywire.

Kelly highlights the point that the clinic can be a safe space for creating a family and removing the clinic as a choice potentially places people who want to create a family in more dubious spaces and situations.

Examining medical infertility

Teresa (a mix of four Eastern and Western European identities in her early 50s and mother of one) said online she "resented having to pay when straight couples who lacked viable sperm didn't". Heterosexual women in a relationship with someone whose sperm is not viable do not usually have to pay for the service. Women in a relationship with another woman (who, it can be argued, also does not have viable sperm) have to pay for the service. Teresa is calling into contention the distinction between 'medical infertility' (for instance a physical condition such as low sperm count), and 'social infertility' (an outcome of life chances and circumstance).

'Medical infertility' is not an objective medical term or biological definition, but "equally a socially constructed phenomenon existing within a complex matrix of historical and socio-cultural specificities" (Statham, 2000, p. 136). For instance, the factors or causes of infertility are often unexplainable as "many couples will not have a clear-cut infertility diagnosis—over 50% in fact" (Fertility Associates, 2019). So even though access to fertility treatment is often framed under a rhetoric of medical infertility, which works to easily exclude gay and single women, straight couples are given access even though under the criteria for medical infertility, more than half of them are not eligible.

Analysing court cases in Australia, Statham (2000) made the same point that infertility is a fluid construction, and not based on the biological capabilities of the body but rather the context of the body. She examined two examples: firstly, where a heterosexual woman had an infertile male partner, and secondly, a woman with a female partner who was seeking sperm.

> In either case, the "medical (in)fertility" status of the recipient, considered as an individual, is identical. The telling difference, however, is that infertility is (socially) constructed so as to legitimate and protect the integrity of the exclusive couple relationship in the former case (the heterosexual couple is infertile) but not in the latter (the lesbian woman is not). (p. 138)

Infertility is not therefore solely an embodied medical condition. In the scenario above

the straight married woman's body is fertile, as in the lesbian woman's body. The medical condition of both bodies is the same. Due to the combination of legal and sexual privilege, one body is given access to fertility treatment, and one body is not. The difference between infertile and fertile bodies is therefore not simply an easy medical distinction.

"They don't look like the mother role."

Gender normativity means ascribing to the body and actions of one of the binary genders—male or female. As people tend to interact with clothes on, it is the outward portrayal of male or female—people's appearances—that provides the information to pigeonhole someone as male or female. Within the context of Aotearoa New Zealand looking 'female' can cover a wide range of appearances but within the space of a fertility clinic this idea of 'female' is closely interwoven with ideas of 'mother'. For instance, a lesbian who adapts appearances that would score highly on a 'feminine' scale (i.e., who wears lipstick and frocks), seems to have no problem moving through the fertility clinic. A lesbian who adapts appearances that wouldn't score highly on a 'feminine' scale (i.e., wears trousers, has short hair) or would score on a 'masculine' scale (i.e., wears a tie, is muscular or bulky) may encounter more resistance.

Vanessa (a lesbian NZ European in her early 30s and mother of one) and her partner Cassandra had an easy experience within the fertility clinic. As a queer woman, she thought this was due to them both being gender normative:

> We've had really good experiences as a lesbian couple in general because we're not stereotypical. Visually we're not [identifiable as two queer women]. People are often surprised, so I could say probably quite confidentially that we've had pretty good experiences because of that.

Similarly, Kitty (a lesbian Western European/Pākehā New Zealander in her late 30s and mother of one) says that she is "reasonably feminine, and yeah, could pass as straight". Kitty and her partner Polly found their journey through the fertility system reasonably straight forward. In comparison, friends of theirs, who present as "quite butch", were finding the clinic quite difficult. Kitty muses:

I do notice there is often a bit of distinction between how people generally treat women who present as quite feminine. … versus those that present as really quite masculine and butch. And I have noticed, not just with parenting or anything, but generally, the more sort of the butch ones get a rawer deal you know.

She continues:

> I mean it's a totally uninformed opinion, but I wondered if, I don't know, maybe that's part of the cold shoulder [my friends are] receiving from [the fertility clinic]. [They] don't look like the mother role.

Kitty suggested that being lesbian and not gender normative may present roadblocks within fertility clinics, where heteronormative ideas of women, femininity and motherhood are interwoven. Michelle (2006) argued that while ARTs can broaden new territories for mothers, regulations reinforce particular interpretations of bodies by

> … attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are judged and against which they police themselves. (p. 26)

Bodies themselves are not impartial, but spaces of cultural interpretation which privilege different representations, depending on gender norms. As McDowell (1995) pointed out: "masculine characteristics and attributes have different meanings

depending on their embodiment in male or female bodies" (p. 71), so having short hair or wearing a suit often elicits different understandings depending on whether the person is male or female. Johnston (2016) called for more recognition of where the privileges of being-cisgender are played out, and Kitty and Vanessa highlight fertility clinics as one such place.

Kitty and Vanessa's experience also demonstrate how access to ARTs can work to ensure gay and lesbian families reproduce dominant behaviours of heteronormative families (Jones, 2005), and this reduces their ability to deconstruct or broaden notions of family. Therefore, homonormative lesbian couples who may be given access are

> … conforming as closely as possible to dominant ideals of the family as a middle-class, self contained economic unit, perhaps even mimicking the traditional division of domestic labour in which one partner works while the child bearer is a stay-at-home mother. (Michelle, 2006, p. 28; see also Dempsey, 2004)

In this way, lesbian families may become "families in drag" (Malone & Cleary, 2002, p. 274). This performance actively "serves to both reinforce familial ideology and further marginalise those unable or unwilling to conform so successfully due to their socio-economic class, ethnicity, lifestyle choices, or political beliefs" (Michelle, 2006, pp. 28–29). Heteronormativity provides a particular heterosexual norm, which marginalises many heterosexual identities and practises (Richardson, 2004) and also imposes particular gendered identities and practices, which marginalise many heterosexual women who do not subscribe to these notions of 'femininity' (Rich, 1980). Heteronormativity also marginalises men who do not subscribe to notions of hegemonic masculinities.

Queer families and their use of ARTs can also be regarded as transgressive:

> As a route to conception, donor insemination transgresses conventional discourses concerning conception, and also those concerning parenthood, family structure and kinship connectedness. Moreover, it enables reproduction beyond conventional gendered and heterosexualised reproductive regimes. (Nordqvist, 2011, p. 115)

That is, as well as disrupting heteronormative understandings of family, queer families also disrupt gender roles within families. Similarly, heteronormativity is maintained by not recognising lesbian and gay families as 'family', and so situating both heterosexuals and queer families within 'family' consequently broadens understandings of family.

Within fertility clinics then, queer families are "enabled by both complicit acceptance and active negotiation of these structures" (Mamo & Alston-Stepnitz, 2015, p. 521). Just as ARTs can be used in a way that is normative and a way that is transgressive, when queer families utilise ARTs they can similarly be regarded as both normative and transgressive.

Intersectionality can be seen operating in fertility clinics, where different axes of embodied subjectivity intersect to give rise to a wide range of experiences for lesbian mothers. Lesbians are a "doubled subject" (Johnston, 2005; Probyn, 2005), in that their bodies are an intersection of both gender and sexuality. However, some lesbian women utilising fertility clinics recognised that although they are queer, other embodied identities provided privilege that helped them pass through the fertility system more easily. Danielle (a lesbian New Zealander/European in her early 40s and mother of one) was aware that her embodied subjectivity impacted on her experience of becoming a mother:

> It helped that I'm a middle class, educated, White lady so I kind of just shuffled along, and I'm a New Zealander so I sort of shuffled along in that general group pretty well.

Fertility clinics are spaces where embodiment impacts on experiences, or even the possibility of receiving treatment.

"They count lesbian families as two families."

Within Aotearoa New Zealand sperm from one donor is generally allocated to a maximum of five families. Fertility Clinics in Aotearoa New Zealand have different slightly different wording and forms for those donating sperm. Below are examples from two clinics:

> My sperm may be used for … (*maximum of five*) families.
>
> I request that the maximum number of families that may be created from my donations is: … (Maximum number of families allowed is 5).

The way these statements are worded situate the sperm donor as the creator of families. The sperm is centralised in the making of families and the inference is the sperm is making the families. There are alternative ways that an agreement can be phrased, that instead gives the sperm to the families, and leaves the making of families up to them. Examples I can think of include:

> My sperm may be given to … (*maximum of five*) families.
>
> I request that the maximum number of families that my donations can be given to is: … (Maximum number of families allowed is 5).

Using this language, the sperm is being given to other families (queer, straight, single, partnered) to be used by them to create their families, marginalising the sperm donor and centring those who will be named on the birth certificate.

The way in which "five families" is interpreted and applied within fertility clinics is heteronormative. While the language can seem clear, the application of this policy shows the tendency or the ability to interpret so the policy supports heteronormative definitions of family, as Kitty discovered:

> And we had to get a special compensation. We were the 5th and the 6th family 'cause they count lesbian families as two different families, which is bizarre.

Within the clinic environment, the word 'family' is used. However, as Kitty's experience exposes, the word 'family' has a working definition that is very heterosexual. The clinic actually means five women:

> I think in the initial consultation they explained that you could only do five families per donor and that there were four already. And I don't recall exactly what they said but I think the message was, because you're two women, two separate bodies, two wombs, you count as two families.

Kitty felt heteronormative definitions and practises of family were presented as status quo, which excludes her and her partner from being acknowledged as a family. It would be interesting to know whether a transgender man/woman couple, for example, would be subjected to this 'two wombs' application of family and be considered to be two families.

Hayley (a lesbian Pākehā in her early 40s and mother of one) also mentioned not being recognised as a family, and the financial implications of being classified as two families:

> I guess one thing that really got to me [about the fertility clinic] was this whole idea about what constituted family. So a sperm donor can only give to five women, but they use the word "family". And I challenged them on that, cause we have to pay for sperm for both of us. We had to pay twice because we were two women.

Hayley and her partner Kelsey, and Kitty and her partner Polly, are not a family within a fertility clinic. They are two families. Not only are their relationships being denied, in a place designed to create families, they are also financially penalised, needing to pay twice as much as a straight couple (if a straight couple is even needing to pay for treatment).

Dunne's (2000) study with lesbian mothers showed that there was the expectation from others that if the relationship broke up then "each [mother] will depart into the horizon with her own child" (p. 23), and this is also what Hayley experienced. As Hayley mentioned, she queried why she and Kelsey had to reserve two lots of sperm.

> The explanation [the nurse] gave was if we broke up, my child that I gave birth to would go with me and not with my partner.

This again demonstrates an understanding that lesbian families are not a family, with a potential mess if the parents separated. Instead, the assumption is biology creates an unbreakable familial unit between one woman and child, and denies any contribution from, or even the existence of, Kelsey.

"It seemed good from a legal perspective."

Given lesbians have other options for creating families why would they chose to use a fertility clinic, if they have to pay, and if they are not accepted as a family, and if their journey into and through fertility clinics may not be as smooth as that for normative bodies?

Reasoning is often related to seeking normativity, in order to have the privileges that heteronormativity imbues upon families. Luzia (2013), in her seminal work on lesbian-led families in Sydney Australia, found that these families had to work harder, not to be a family, but to be recognised and protected as one. In a review of literature about LGB families in Australia, Perales et al. (2019) reported that "the most prominent challenge reported by lesbian mothers was a lack of legal and social recognition of their status as a family, particularly the status of the non-birth mother" (p. 7). Allen and Mendez (2018) acknowledged that some people "now do family, gender, and sexuality in ways akin to heteronormative prescriptions, benefiting from social and legal progress" (p. 74) and Hubbard (2008) pointed out that "conforming to a heteronormative ideal may create any number of emotional and physical anxieties, therefore, but is associated with certain material privileges as well as political rights" (p. 643). Fertility clinics not only help to create families, they also legitimise families.

One privilege of heterosexual families is that the two parents are recognised, and these rights (and responsibilities) cannot be challenged by others claiming to be parents. For two-parent lesbian families, who have used donor sperm, but live in a society where biology is often regarded as the determinant of 'real' parenthood, the fertility clinic is a space that provides this privilege of undisputed parenthood. When Rebecca (a lesbian NZ European in her early 40s and mother of two) talks about the reasons they used the clinic, she mentioned the clinic as a space of distancing the donor from parental legal status: "it also seemed good from a legal perspective that [the clinic] recorded that they were donors not parents".

The protection the clinic provides is demonstrated through a court case in Australia. Lesbian parents were seeking to reduce the sperm donor's access to their child, and so the sperm donor bought the case to court to prevent this happening. Where the insemination took place was an influencing factor on the result of the case, and the judge not only denied the parents' request but increased the amount of contact the sperm donor was allowed. According

to Dempsey (2004), part of the judgement rested on the fact the insemination was not done within the space of a clinic, and therefore the donor was not given:

> … the opportunity to be counselled and to overtly consent to the relinquishment of both the assumptions of kinship and parental rights and responsibilities. (p. 97)

Because the donor did not explicitly opt out, the judge reasoned, he had opted into fatherhood. The emotional impact such decisions can have should not be ignored either. Four months after this ruling, one of the mothers and the child were found dead in their home, in a presumed murder-suicide.

The clinic space not only works to situate the two mothers as parents, but also operates to exclude the sperm donor, on a number of levels. The physical presence of the person who donated sperm is removed, as well as any legal rights or responsibility. Queer mothers utilise the clinic space in order to be included within normative understandings of 'family' – that of having two, and only two, parents. In this way, the sperm donor is excluded from the family. Nordqvist (2011) argued that "clinics provided a framework of cultural legitimacy" (p. 127), conferring legal status on the queer couple and thereby recognising them within a heteronormative understanding of 'family'. Queer women conceive within a fertility clinic to ensure the recognition of both mothers as legal parents and to exclude the possibility of the sperm donor being included. This desire for legal recognition as a mother to your own child should not be underestimated as a factor in decision making.

Allen and Mendez (2018) noted how "some groups previously demarcated as 'deviant' are now do family, gender and sexuality in ways akin to heteronormative prescriptions, benefiting from social and legal progress" (p. 74). This demonstrates the fluidity of boundaries—what was previously 'heteronormative' has expanded, and a lesbian couple may benefit from heteronormative privilege of family. For instance, in Aotearoa New Zealand a lesbian couple can both go on the birth certificate and therefore be granted the privileges of their heterosexual counterparts—which is not problematic unless the sperm donor is not just a donor but also a (third) parent.

Another aspect that is distanced in fertility clinics is sperm. The body the sperm came from is absent, and the sperm itself is contained within vials and handled by professionals with gloves. Discussing why they chose the clinic, Rebecca says "we thought it'll just be less icky [laughter]". Nordqvist (2011) recognised that the clinic is different to the space of home when it comes to the presence of sperm: "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" (p. 126).

Many stories of home insemination mentioned dealing with sperm were told with much laughter, as demonstrated by this conversation between Stacey and Kerry:

> Kerry It was fun for you dealing with sperm wasn't it?
>
> Stacey Oh it was disgusting [laughter]. It traumatised me … Yuck! No questioning my sexuality there whatsoever [laughter].

The clinic space therefore also offers lesbians, whose sexuality generally provides distance from sperm, a less hands-on approach to insemination.

Conclusion

Although not identical in their operations and services, fertility clinics in Aotearoa New Zealand are conducive to a normative body, one that is White, wealthy, straight, and gender normative, and this privileging of embodied subjectivities which support narrow understandings of heteronormativity make parenthood more achievable for

particular bodies. Fertility clinics, and the normativity they both ensconce and are ensconced within, make it difficult for people to create alternate family formations, particularly safely and legally.

My research shows that lesbian, queer and gay women in Aotearoa New Zealand who used fertility clinics often found them heteronormative spaces. Consequently, clinics presume, and privilege, normative bodies and families and ignore other possibilities. Many of the lesbians I talked to were "White, middle class, educated" and could therefore choose to access and negotiate the clinic, even though the clinic itself often denied they were a family.

Fertility clinics are an example of a space where reproductive justice, reproductive health and reproductive rights are not universal, but instead operate as spaces of exclusion. The presence of lesbian bodies within fertility clinics highlights how notions of reproductive rights are not simplistic. Privilege and exclusion operate on a variety of levels (e.g., inference, behaviour, policy) and across many subjectivities (e.g., gender, sexuality, ethnicity). It was recognised both by those who used clinics and those who didn't that inequitable access was a social injustice, denying people a physically safe and legally clear way to create a family, and also denying others a chance of children. The paths to parenthood into, and through, fertility clinics are often troubled, not only for lesbians but for many others within and across a variety of other groups with non-normative and therefore non-privileged bodies.

Received: 2 March 2023

Accepted:21 July 2023

Published: 18 December 2023

Note

[1] These descriptors throughout are based on the definitions participants provided of their ethnicity, sexuality and number of children.

References

Allen, S., & Mendez, S. (2018). Hegemonic heteronormativity: Toward a new era of queer family theory. *Journal of Family Theory & Review, 10*(1), 70–86.

Brown, R., & Perlesz, A. (2008). Not the "other" mother: How language constructs lesbian co-parenting relationships. *Journal of GLBT Family Studies, 3*(2), 267–308.

Browne, K., & Nash, C. (2010). *Queer methods and methodologies: Intersecting queer theories and social science research*. Taylor and Francis Group.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. Thinking Gender. Routledge.

Crenshaw, K. (2017). Kimberlé Crenshaw on intersectionality, More than two decades later. *Columbia Law School*. https://www.law.columbia.edu/news/archive/kimberle-crenshaw-intersectionality-more-two-decades-later

Dempsey, D. (2004). Donor, father or parent? Conceiving paternity in the Australian Family Court. *International Journal of Law, Policy and the Family, 18*(1), 76–102.

Dunne, G. (2000). Opting into motherhood: Lesbians blurring the boundaries and transforming the meaning of parenthood and kinship. *Gender & Society, 14(*1), 11–35.

Epstein, R. (2018). Space invaders: Queer and trans bodies in fertility clinics. *Sexualities, 21*(7), 1039-1058.

Fertility Associates. (2019). Infertility explained. Fertility Associates. https://www.fertilityassociates.co.nz/understanding-your-fertility/infertility-explained/

Fertility Associates. (2020). Treatment costs valid from 1st April 2020. Fertility Associates. https://www.fertilityassociates.co.nz/treatment-costs-and-payment-options/costs/

Gabb, J. (2004). Critical differentials: Querying the incongruities within research on lesbian parent families. *Sexualities, 7*, 167–182.

Garwood, E. (2016). Reproducing the homonormative family: Neoliberalism, queer theory and same-sex reproductive law. *Journal of International Women's Studies, 17*(2), 5–17.

Gorman-Murray, A. (2008). Masculinity and the home: A critical review and conceptual framework. *Australian Geographer, 39*(3), 367–379.

Hargreaves, K. (2006). Constructing families and kinship through donor insemination. *Sociology of Health & Illness, 28*(3), 261–283.

Hopkins, P. (2019). Social geography I: Intersectionality. *Progress in Human Geography, 43*(5), 937–947.

Hubbard, P. (2008). Here, there, everywhere: The ubiquitous geographies of heteronormativity. *Geography Compass, 2*(30), 640–658.

Johnston, L. (2005). Man: Woman. In P.J. Cloke and R. Johnston, eds. *Spaces of geographical thought: Deconstructing human geography's binaries* (pp. 105–123). Sage. https://doi.org/10.4135/9781446216293

Johnston, L. (2016). Gender and sexuality I: Genderqueer geographies? *Progress in Human Geography, 40*(5), 668–678.

Jones, C. (2005). Looking like a family: Negotiating bio-genetic continuity in British lesbian families using licensed donor insemination. *Sexualities, 8*(2), 221–237.

Lie, M., & Lykke, N. (Eds.). (2016). *Assisted reproduction across borders: Feminist perspectives on normalizations, disruptions and transmissions*. Taylor and Francis Group.

Longhurst, R. (2001). *Bodies: Exploring fluid boundaries.* Routledge.

Longhurst, R., & Melville, L. (2020). Embodiment: Lesbians, space, sperm, and reproductive technologies. In A. Datta, P. Hopkins, L. Johnston, E. Olsen, & J. Maria Silva (Eds.), *Routledge handbook of gender and feminist studies* (Ch 13). Routledge.

Lttichau, I. (2004). "We are family": The regulation of "female-only" reproduction. *Social & Legal Studies, 13*(1), 81–101.

Luzia, K. (2013). "Beautiful but tough terrain": The uneasy geographies of same-sex parenting. *Children's Geographies, 11*(2), 243–255.

Malone, K., & Cleary, R. (2002). (De) Sexing the family: Theorizing the social science of lesbian families. *Feminist Theory, 3*(3), 271–293.

Mamo, L., & Alston-Stepnitz, E. (2015). Queer intimacies and structural inequalities: New directions in stratified reproduction. *Journal of Family Issues, 36*(4), 519–540.

McDowell, L. (1995). Body work: heterosexual gender performances in city workplaces. In D. Bell and G. Valentine (Eds.), *Mapping desire: Geographies of sexualities* (pp. 67–84). Routledge.

Melville, L. (2021). "It was kind of awkward and kind of special all at once": Lesbians' experiences of conception, maternity and family spaces [Doctoral dissertation, University of Waikato.] Research Commons.

Michelle, C. (2006). Transgressive technologies? Strategies of discursive containment in the representation and regulation of assisted reproductive technologies in Aotearoa/New Zealand. *Women's Studies International Forum*, *29*(2), 109–124.

Millbank, J. (1997). Every sperm is sacred. *Alternative Law Journal, 22*(3), 126–129.

Nordqvist, P. (2011). "Dealing with sperm": Comparing lesbians' clinical and non-clinical donor conception processes. *Sociology of Health & Illness, 33*(1), 114–129.

Perales, F., Reeves, L., Plage, S., & Baxter, J. (2019). The family lives of Australian lesbian, gay and bisexual people: A review of the literature and a research agenda. *Sexuality Research and Social Policy, 17*(1), 43–60.

Probyn, E. (2005). *Blush: Faces of shame*. University Minnesota Press.

Rich, A. (1980). Compulsory heterosexuality and lesbian existence. *Signs: Journal of Women in Culture and Society, 5*(4), 631–660.

Richardson, D. (2004). Locating sexualities: From here to normality. *Sexualities, 7*(4), 391–411.

Richardson, D. (2005). Desiring sameness? The rise of a neoliberal politics of normalisation. *Antipode, 37*(3), 515–535.

Shaw, R., & Fehoko, E. (2022). Epistemic injustice and body mass index: Examining Māori and Pacific women's access to fertility treatment in Aotearoa New Zealand. *Fat Studies*, 1–15.

Short, L. (2007). Lesbian mothers living well in the context of heterosexism and discrimination: Resources, strategies and legislative change. *Feminism & Psychology, 17*(1), 57–74.

Statham, B. (2000). (Re) producing lesbian infertility: Discrimination in access to assisted reproductive technology. *Griffith Law Review, 9,* 112–115.

Thompson, C. (2005). *Making parents: The ontological choreography of reproductive technologies*. MIT Press.

Valentine, G. (2000). Introduction: From nowhere to everywhere: Lesbian geographies. *Journal of Lesbian Studies, 4*(1), 1–9.

Watson, K. (2005). Queer theory. *Group Analysis, 38*(1), 67–81.