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Lesbian Couples' Assisted Reproductive Technologies Trajectories in Switzerland and Abroad: Navigating Heteronormative Norms and Healthcare Disparities

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Abstract

On July 1, 2022, marriage became legal for same-gender couples in Switzerland, granting married lesbian couples access to assisted reproductive technologies (ART) and recognition of co-maternity from birth. Before this change, lesbian couples had to resort to reproductive travel to access ART abroad. Yet, significant barriers remain. Restrictive Swiss regulations continue to prohibit certain technologies, such as egg donation (i.e., reception of oocytes from a partner), even for married couples. Legal constraints are further compounded by financial inequities: Unlike heterosexual couples, lesbian couples are excluded from insurance coverage for ART because they do not meet the medical definition of infertility. Additionally, Swiss childbirth and parenting culture are deeply heteronormative, and healthcare providers—including fertility clinics—are ill-prepared to welcome lesbian couples. As a result, some couples will continue to turn to reproductive travel, with Swiss health providers involved in their medical care trajectories before and after insemination abroad. Drawing on interviews with Swiss lesbian couples who pursued ART abroad, this article examines their experiences with reproductive travel. How did they access information to select a country and a clinic? And how did they navigate the constraints of reproductive travel alongside work, family, and social obligations? Using a reproductive justice framework, this article analyzes how recent legal changes fall short of ensuring equitable access to parenthood for same-gender couples. It highlights enduring structural inequalities embedded in ART regulations, which intersect with socio-economic norms and disparities in access to medical treatment.

Keywords

assisted reproductive technologies; heteronormativity; minority stress; queer reproduction; reproductive justice; reproductive travel; Switzerland

1. Introduction

Originally designed for wealthy, white, heterosexual married couples, assisted reproductive technologies (ART) emerged in the 1980s in high-income countries as a solution to infertility (Mamo, 2007), reinforcing the stratification of reproduction (Colen, 1995). For decades (1980–2000), access to ART remained restricted to married heterosexual couples, excluding unmarried couples, single women, and LGBTQ+ individuals, who were deemed unfit for parenthood (Gabb, 2017; Golombok, 2015). During this period, lesbian couples relied on community-based resources to conceive (Dempsey, 2008; Dempsey et al., 2022; Mamo, 2007). From the early 2000s onwards, lesbian couples gradually gained access to fertility clinics and ART in pioneering "reprohubs" (Inhorn, 2015), such as California (Mamo, 2007) and Spain (Roca i Escoda, 2015, 2016, 2017).

The reproductive justice movement stresses that some groups face discrimination and inequities based on race, class, gender identity, and sexual orientation in the exercise of their reproductive rights (Ross, 2006; Ross & Solinger, 2017). Over the past decade, reproductive justice has emerged as a critical framework for analyzing the stratification of reproductive rights, highlighting the systemic inequalities embedded in reproductive policies (Briggs, 2018; Haintz et al., 2023). As both a theoretical and epistemological framework, reproductive justice articulates how intersecting systems of oppression—such as racism, classism, homophobia, and transphobia—affect reproductive experiences, including access to care and treatments. Examining these inequalities reveals that ART does not encompass neutral medical tools; rather, these technologies act as instruments of social and moral selection, legitimizing certain forms of family-making while marginalizing others. These dynamics underscore the relevance of the reproductive justice framework in advancing equitable access to ART.

Although an aspect of reproductive justice, queer reproduction also involves specific ethical and justice issues. LGBTQ+ people continue to face systemic barriers to parenthood, particularly concerning unequal access to ART, marriage, and legal parent recognition (Mamo, 2018). As a result, family making is a "legal maze" for most LGBTQ+ parents (Leibetseder & Griffin, 2020, p. 313), and many are forced into reproductive travel, which further stratifies access to parenthood as it requires both financial and time resources (Leibetseder & Griffin, 2018).

Reproductive travel refers to the movement of individuals seeking ART from a place where these services are unavailable, restricted, or unaffordable to a location where they can obtain the desired medical care (Pennings, 2002). This phenomenon is also referred to in the literature as "cross-border reproductive care" (Pennings et al., 2008), a term offering a standardized framing commonly used in clinical and policy contexts. Other scholars have instead used "reproductive exile" (Inhorn & Patrizio, 2009) or "reproductive exclusion" (Desy & Marre, 2022) to emphasize how legal, institutional, and social inequalities compel individuals to travel abroad to exercise their reproductive rights. In this article, we adopt the term "reproductive travel" to foreground the embodied and logistical dimensions of these journeys without assuming a single explanatory frame. Occurring globally, reproductive travel is deeply intertwined with broader reproductive justice issues, as access to ART is shaped by intersecting inequalities related to gender, sexuality, legal status, and economic resources.

Before July 1, 2022, lesbian couples could not marry in Switzerland. Sperm donation is restricted to married couples, so they had to travel abroad to access ART. In 2019, these couples were among the estimated

500 Swiss individuals or couples who traveled abroad for ART, alongside heterosexual couples seeking egg donation and single women (Siegl et al., 2021). However, as Siegl et al. (2021) emphasize, this number likely underestimates the actual scale of reproductive travel from Switzerland, as many cases remain unrecorded. For lesbians specifically, many unrecorded cases exist in which individuals bypassed Swiss medical institutions by ordering sperm directly or using a known donor and performing self-insemination. The legalization of same-sex marriage in 2022 granted married lesbian couples the right to access ART in Swiss clinics and the recognition of co-maternity from birth. Switzerland lagged behind other European countries, legalizing ART for lesbian couples more than a decade after Spain (2005), Denmark (2006), and Belgium (2007; Büchler & Parizer, 2018). Although this legal reform reduced the need for reproductive travel, barriers remain, prompting some lesbian couples to continue seeking treatment abroad.

Indeed, Switzerland maintains some of the most restrictive ART regulations in Europe (Engeli & Roca i Escoda, 2012). For instance, egg donation is strictly banned, which is legally justified by the prohibited separation of genetic and gestational motherhood, a principle deemed "unnatural" (Bühler, 2014; Mesnil, 2020). This prevents lesbian couples from using the reception of oocytes from partner (ROPA), a technique in which one partner's oocyte is fertilized in vitro and transferred to the other partner's uterus. This method enables both intended mothers to share a biological connection to pregnancy (Roca i Escoda, 2016). Currently, lesbian couples seeking this procedure must travel abroad. As an additional legal restriction in Switzerland, fertility clinics assign sperm donors based on phenotype matching, leaving intended parents with little agency over donor selection.

These legal constraints reflect underlying gender and sexuality norms that shape family policy and reproductive rights in Switzerland. Giraud and Lucas (2009) described this framework as "neo-maternalism," a conservative ideology that reinforces women's primary role in domestic work and childcare (Bornatici et al., 2021; Le Goff & Levy, 2016). Furthermore, childbirth and parenting culture in Switzerland remain deeply heteronormative (Chautems, 2022; Chautems & Maffi, 2021), drawing on hegemonic norms that generate discourses and practices that naturalize and legitimize the heteronuclear family model while marginalizing all other family configurations (Mamo, 2007). Consequently, Swiss healthcare providers are ill-prepared to welcome non-hegemonic couples, including in fertility clinics (Gouilhers et al., 2023).

In addition to legal and cultural barriers, practical and financial obstacles shape ART access in Switzerland for all intended parents, with variations depending on their marital status. Because lesbian couples do not meet the legal definition of infertility, they are excluded from any insurance coverage for ART, making treatment abroad often more affordable than in Switzerland. Single women face similar challenges to those encountered by lesbian couples, as they too fall outside the legal and normative framework of the heterosexual, nuclear family (Belaisch Allart, 2022; Krajewska, 2015; Rozée Gomez & de La Rochebrochard, 2013). Because sperm donation remains restricted to married couples in Switzerland, single women—like lesbian couples before 2022—must travel abroad to access it. These structural inequalities stratify access to reproduction by income and wealth. Married heterosexual couples face high out-of-pocket costs as well. Although some diagnostic tests and up to three cycles of intrauterine insemination may be reimbursed by mandatory basic health insurance (provided the woman is under 40), in vitro fertilization is never covered.

Looking ahead, a new reform is under discussion. In January 2025, the Swiss Federal Council proposed legalizing egg donation and extending ART access to unmarried couples. The Federal Office of Public Health

is currently drafting a revision of the Reproductive Medicine Act, which has regulated ART since 2001. If passed, this reform would allow lesbian couples to access ROPA in Switzerland and remove the requirement of marriage for ART access—two of the key factors currently driving reproductive travel. However, the timeline and outcome of this legislative process remain uncertain.

The focus on lesbian couples in the context of ART is justified by their central role in current debates on reproductive justice, heteronormative family models, and unequal access to reproductive care. Their experiences in fertility clinics reveal how reproduction is structured by inequality: Originally designed for infertile heterosexual couples, ART has long excluded LGBTQ+ people, reinforcing unequal access to parenthood and raising critical issues of reproductive justice (Tam, 2021).

Furthermore, lesbian couples' use of ART challenges dominant heterosexual family norms, questioning the notion that only a father–mother model of parenthood is "natural" or legitimate.

Finally, by focusing specifically on lesbian couples rather than other family configurations, our study offers a unique perspective on the intersection of queer parenthood and socio-legal developments. In several countries, female couples were the first among LGBTQ+ families to benefit from expanded ART policies, though hierarchies of sexuality persist despite these advances. This analytical choice aligns with current debates on stratified reproduction, queer parenthood, and evolving family policies, highlighting how gender and sexual orientation shape access to reproductive rights and redefine family norms.

Based on 22 interviews with Swiss lesbian couples who sought ART abroad, this article explores their experiences with reproductive travel. How did they choose a country and clinic for insemination? How did they coordinate medical follow-ups between Swiss and foreign healthcare professionals? And how did they navigate work absences with their employers and colleagues? Drawing on a reproductive justice framework, we examine how legal changes impact the reproductive choices of lesbian couples in Switzerland. This framework enables us to analyze how Swiss lesbian couples navigate access to ART in a context characterized by structural inequalities and heteronuclear family norms. We also explore how ART regulations shape intended mothers' paths to parenthood, intersecting with socio-economic constraints and disparities in treatment access.

We argue that participants' experiences align with existing research on the discrimination and microaggressions faced daily by sexual minorities. For lesbian couples using ART, the "minority stress" they encounter is closely tied to dominant cultural representations of families, which exclude same-sex parenthood (Haines et al., 2018; Mendez et al., 2016). This exclusion impacts their procreative experiences. Documenting the obstacles they face is essential to addressing gaps in knowledge about the specific healthcare needs of this minority population (Trettin et al., 2006).

2. Methods and Participants

We adopt a qualitative approach based on semi-structured narrative interviews to explore how Swiss lesbian couples navigated access to ART abroad prior to the 2022 legal reform. Framed within a reproductive justice perspective (Ross, 2006; Smietana et al., 2018), we analyze how legal, material, and symbolic factors intersect to shape stratified access to parenthood (Colen, 1995).

The interviews were conducted between April 2022 and November 2023. To ensure diversity while maintaining confidentiality and ethical standards, we employed multiple recruitment strategies. First, we contacted LGBTQ+ parents with whom we had previously collaborated to facilitate access to the field. During this first stage, we used purposive sampling. We then used snowball sampling, a method particularly effective for engaging minority groups (Browne, 2005). Through participant recommendations, we recruited women of various ages, with 70% residing in urban areas and 30% in peri-urban settings.

The final dataset includes 22 interviews with 21 lesbian couples and one single lesbian woman co-parenting with a gay couple, totaling 43 participants. 12 interviews were conducted specifically for this project, whereas 10 interviews drawn from parallel fieldwork were integrated once thematic saturation had been reached. All interviews were conducted in French, and we translated them into English.

All participants were cisgender women aged 31 to 47. Except for two women, all participants were white. They had one or two young children (six months to six years old). The two partners in each couple had comparable levels of education and occupational integration. Out of the 43 participants, 28 held university degrees, and 27 were employed at 80% or more; some individuals may fall into both categories. This is not a sampling bias but a deliberate analytical choice: By neutralizing intra-couple resource asymmetries, we eliminate a variable that could obscure power dynamics and hierarchies within the couple (Digoix, 2020). This allows us to focus on the impact of the socio-institutional framework—legal constraints, medical technologies, and cross-border costs—rather than on economic domination within couples. Indeed, the literature on cross-border reproductive care highlights that the actual ability to travel is already shaped by social selectivity (Inhorn & Gürtin, 2011). 70% of participants lived in urban areas and had diverse ART backgrounds (intrauterine insemination, in vitro fertilization, and ROPA).

2.1. Data Handling: Collection, Protection, and Analysis

The interviews took place in the participants' homes to ensure a confidential setting conducive to intimate narratives. All interviews lasted 60 to 120 minutes and were conducted by the research team. The two partners of each couple were interviewed together, and the single lesbian mother co-parenting with a gay couple was interviewed alone. The interview guide, informed by literature on cross-border ART and reproductive justice, covered five domains: initial motivations, search for information, medical coordination, financial constraints and professional/family organization, and emotional experiences. Two pilot interviews—excluded from the analysis—were conducted to refine the wording of the questions.

Each participant received an information sheet by email outlining the study's objectives, procedures, and confidentiality measures, as well as their right to withdraw at any time. Prior to the interviews, participants signed a consent form guaranteeing the confidentiality and anonymity of their statements. Oral informed consent was then obtained at the beginning of the audio recording. Audio files were immediately encrypted and pseudonymized transcripts are stored on a secure server. All direct and indirect identifiers (such as profession, location, or clinic) were modified or removed. To further protect participants' identities, we followed the recommendations of Béliard and Eideliman (2008). In some cases, we also assigned multiple pseudonyms to the same participant to complicate any attempt at re-identification, particularly within small activist or professional communities where participants may know or work with one another.

The analysis was focused on reproductive pathways and the strategies used to achieve parenthood. Interviews were audio recorded, transcribed, and analyzed using thematic analysis (Beaud & Weber, 2010). Coding was conducted manually using a spreadsheet to identify recurring themes across interviews. A reproductive justice framework informed the creation of coding categories, emphasizing how participants navigated legal, medical, social, financial, and structural barriers; how they accessed or were denied access to ART procedures; and how they articulated their experiences of discrimination, privilege, and the strategies they developed. Codes covered participants' rationales and motivations as well as the challenges encountered throughout the ART process. The resulting categories capture both the diversity of individual trajectories and the shared challenges faced by same-gender couples. Particular attention was paid to the socio-political context shaping the recognition of two-mother families, including their historical development and implications for access to ART.

In the following sections, we unpack the various stages couples navigated, from early information-seeking to the emotional toll of transnational care and public disclosure.

3. Accessing Information: A Laborious Process for "Preconception Mothers"

This section analyzes the documentation and information-gathering work undertaken by intended mothers before even beginning their ART journey. Among our participants, 14 women achieved pregnancy relatively quickly, within one to four insemination cycles. However, eight couples faced greater challenges, requiring three to five years of procedures, multiple techniques, and travel to different countries (Denmark, Spain, the UK, and Belgium). Their choice of destination was influenced by various factors, including language, donor (non-)anonymity, the absence of mandatory psychological counseling for same-sex couples (as required in Belgium), and the perception that procedures in certain locations were easier or less intrusive. While this article focuses on medical pathways to pregnancy, it does not address the issue of donor selection, which warrants a separate analysis. Previous studies have shown that intended mothers choose sperm donors based on various criteria, such as phenotype and racial matching (Dahl & Andreassen, 2023; Nordqvist, 2011, 2012; Roca i Escoda, 2016), or socio-cultural affinities (Côté & Lavoie, 2016; Mamo, 2007).

Interestingly, most participants were initially reluctant to pursue ARTs. Because they did not have fertility issues, they perceived the medicalization of the process as a significant constraint. Many first explored alternative solutions, such as mutual aid and self-insemination at home, either with sperm from a known donor (sometimes as part of a co-parenting arrangement) or with sperm ordered online and delivered by mail. However, these initial attempts often proved unsuccessful, eventually leading them to seek more structured assisted reproduction procedures.

In neoliberal regimes, people are expected to inform themselves about health risks and implement good practices (Rose, 2006). This is even more the case for LGBTQ+ parents. They must possess extensive "cultural health capital" to access information (Shim, 2010) in a heteronormative reproduction culture in which fertility treatments are medically and legally designed for heterosexual couples. These constraints deepen inequities between intended parents and reinforce stratification in care access. In our study, most participants held a higher education degree, facilitating access to information and health literacy.

Nevertheless, during the preconception stage, participants could not rely on healthcare providers or Swiss fertility clinics for information in the same way heterosexual couples typically do (Bize et al., 2022). Instead, they had to independently research their options or seek guidance from LGBTQ+ associations for (intended) parents to identify which country, clinic, and techniques would best meet their specific needs.

In this way, long before conception, the couples who participated in the study showed a strong commitment to their parenting project, aligning with an "intensive parenting culture" (Faircloth & Gürtin, 2018). This trend, documented since the late 1990s in high-resource countries, primarily targets mothers, pushing them to meet increasingly high expectations to ensure their child's optimal development (Lee et al., 2014). In this context, parenting begins even before pregnancy. For lesbian couples, it involves extensive planning and decision-making—a process during which they become what we refer to as "preconception mothers." This theoretical framework is reflected in the lived experiences of the couples in our study, who had to navigate legal, medical, and social barriers and constraints to make informed decisions.

Camille and Justine were in their late 30s. Camille worked in marketing and Justine worked in digital advertising. Both held higher education degrees. When they decided to start a family, they attended a local LGBTQ+ association meeting for prospective parents. There, they met a lesbian couple who had been to a fertility clinic in Copenhagen. The two mothers were invited to share their experience. Inspired by their story, Camille and Justine decided to go to the same clinic: "We listened to several testimonials, including one from two girls who seemed really cool, and it went really well for them….They told us how they did it. They said the gynecologist [from the Copenhagen clinic] was very nice."

Camille and Justine also selected their obstetrician in Switzerland based on a list of "safe" practitioners recommended by the association.

Like Camille and Justine, other participants relied on community-based knowledge from LGBTQ+ associations' meetings for prospective parents, as well as from friends and online support groups. Although these resources provided initial guidance, participants still needed to cross-check the information online—not only on fertility clinic websites but also on forums and other sources.

After conducting some preliminary online research, Diane and Isaline decided to pursue ART in Spain. They later participated in an event organized by an LGBTQ+ association for prospective parents, which reinforced their decision, especially because they had found a clinic where they could communicate in French. They had already arranged their first visit, including flights and accommodation, when Diane began to feel uncertain. She conducted additional research online, which led her to question their plan:

> I did some research afterward and found that British law was, in fact, the closest to Swiss law when it came to ART for heterosexual couples. And I said to Isa…I was assuming that Swiss law would eventually evolve—sooner or later—and that if it did, it would likely align with British law. With that in mind, we started looking in London and found a clinic….So we thought, well, let's go and take a language course.

They eventually proceeded with insemination in London, selecting the clinic based on online research. This situation is emblematic of couples' commitment to their parenting project, as they invested significant time in gathering information from various sources—even learning a new language—to navigate the process.

Some couples gathered information exclusively from the internet, becoming largely self-taught. This was the case for Alison and Daniela. While researching ART options for lesbian couples, they came across an interview with a professional soccer player who had used the ROPA technique to start a family with her partner. She mentioned in the interview the clinic where they had undergone treatment in London. Alison and Daniela then searched for information on the clinic and ultimately decided to go there. Before settling on London, they briefly considered Denmark and Spain, gathering information and reaching out to clinics via email:

> In Denmark, we were told no [for ROPA], so we moved on. Then we considered Spain, but as soon as the first clinic said, "No, you must be married," we moved on. And then, shortly afterwards, we found the clinic in London.

Overall, all couples devoted a significant amount of time to online research, exploring techniques, prices, and regulations such as donor anonymity while also assessing clinics' reputations in terms of healthcare and fertility treatments for LGBTQ+ intended parents. They had to untangle complex information, simultaneously weighing different options and demonstrating extensive planning, budgeting, and communication skills—often in a language other than their first. This process required not only significant time and effort but also a great deal of emotional and intellectual investment, as the couples had to navigate a range of complex and often contradictory information. These efforts, while essential for making informed decisions, also highlight the burdens placed on LGBTQ+ parents in a system that privileges heterosexual norms and expectations.

4. Reproductive Travel and Medical Coordination

Accessing and gathering information is a crucial first step, but lesbian couples also face significant challenges in coordinating medical care and traveling for treatment. Before the 2022 legal reform in Switzerland, they were entirely excluded from access to ART and legally recognized paths to parenthood, forcing them into reproductive travel. This form of exclusion from reproductive rights (Desy & Marre, 2022; Inhorn & Patrizio, 2009; Zanini, 2011) reflects deeper structural inequalities and a system of governance that fails to recognize lesbian family formation. The experiences discussed in this article were shaped by a complex interplay of medical, logistical, and social barriers that demanded high levels of coordination and resilience. This section examines how these mobilities are shaped by structural constraints and strategic agency as couples navigate legal restrictions and logistical uncertainties, including those heightened by the Covid-19 pandemic, as many participants resorted to ART abroad during this period (Tsakos et al., 2020).

ART treatments often involve extensive pretreatment medical testing—such as hormone assessments, sexually transmitted infections (STIs) screenings, and fallopian tube examinations—along with consultations to determine appropriate treatment options, such as intrauterine insemination or in vitro fertilization. These tests, often conducted in the home country and sent abroad, require significant logistical coordination and planning. Our interviews reveal that, in the absence of institutional support, participants often had to assume the role of medical coordinators themselves, acting as intermediaries between their Swiss healthcare providers and foreign clinics. This placed the burden of medical administration and communication on the couples themselves, who had to arrange medical examinations, transmit test results, and schedule treatments—often on short notice. Many participants also highlighted the additional emotional strain of having to coordinate their own care in the absence of institutional support.

The experience of Aurore and Clarisse is particularly illustrative. Their ART journey spanned three years and included 16 insemination attempts, a miscarriage, and an unexpected change in treatment protocol before they finally became pregnant. Clarisse recalled the relentless demands of medical coordination:

> Lots and lots of medical appointments, lots of expenses, lots of attendance. And then, every time we did these tests, we had to send them to Belgium. And then, all of a sudden, we had to make ourselves available. I think I spent half an hour every other day on the phone to Belgium for two or three years.

Many participants emphasized how acting as intermediaries between Swiss healthcare providers and foreign clinics had significant emotional impacts on their journey. Urgently performing tests, sending results to clinics, waiting for feedback, and then rushing to the clinic at the right moment of ovulation is an exhausting process. In the same interview, Aurore emphasized the urgency and unpredictability of the process:

> We had to go and take blood samples early in the morning to make sure the results were sent in time for them to analyze in Belgium. Then we'd be told, "Well, you'll have to come tomorrow," or "Tomorrow you'll need another blood test or ultrasound."

Clarisse and Aurore's experience echoes that of Laurène and Amélie, who also traveled to Belgium. They described the rigid medical scheduling they had to follow, coordinating ultrasounds with clinic requests and embarking on a 5-hour drive overnight to arrive on time:

> Peak ovulation lasts a certain amount of time. You really have to be on that schedule….When they [the clinic] tell me at 5:30 pm that we have to be there at 1:30 pm the next day and not at 4 pm, then I have to be there at 1:30 pm. It's because they've really calculated that we'll be at the top of our game and we're putting all the chances on our side.

The precision required in this process added significant stress, as couples had to ensure they could travel within narrow time frames. The pressure of potentially missing this critical window created an ongoing sense of urgency, amplifying the emotional burden of reproductive travel.

Despite meticulous planning, schedules could easily be disrupted by unexpected logistical setbacks, which could derail entire cycles. Morgane and Léa shared the emotional toll of the practicalities of travelling abroad by plane during their first attempt in Denmark, which was derailed by unforeseen travel delays:

> The first attempt was in September 2016. But we didn't leave in September. We had prepared everything. The plane was late—so late that by the time we arrived in Denmark, the clinic was closed. And it was ovulation day. We called them, and they said, "It's too late." We cried in that airport. We really felt our wings being clipped right from the start.

Beyond the logistical and emotional toll, border crossings carried additional stress for lesbian couples, especially concerning anxieties around parental rights. Before Switzerland granted access to marriage and ART to lesbian couples, the non-gestational mother had no legal recognition and had to adopt the child, a process often described as intrusive and discriminatory (Carri & Boulila, 2022). This lack of legal status created ongoing anxieties for families traveling abroad, especially when seeking ART for a second child.

For instance, while the adoption process for their first child was still underway, Diane and Isaline were already seeking ART abroad for a second child. This ongoing legal uncertainty compounded the stress of their reproductive journey. Isaline, the non-gestational mother, described the distress of crossing borders while lacking formal parental recognition. She recalled the unease of traveling back to Switzerland alone with their child, knowing she had no legal rights:

> The other aspect that was quite complicated was that I had no rights over [child's name]. It was always stressful to return alone with her if Diane had to stay an extra day. Crossing borders without being the legal parent—it was nerve-wracking.

The Covid-19 pandemic further exacerbated these challenges, forcing couples to navigate up to four border crossings due to rapidly changing travel restrictions. Amélie and Laurène had initially planned to travel through France to go to Belgium, but they had to adjust their itinerary as multiple European borders closed. They were forced to take a detour through Germany and Luxembourg while ensuring their journey aligned with the precise timing of ovulation. Laurène described how this socio-political situation added "enormous stress to the project," and Amélie highlighted the overwhelming logistical and emotional burden:

> We were keeping abreast of the news, news from all three countries, in fact. To see how things were going, the exchanges, the transits of people, simply because, in fact, we also passed through Luxembourg. But you have to think about it. There are four countries to cross.

Not only did couples have to coordinate medical care and contend with legal uncertainties, they also had to navigate unpredictable border policies, shifting restrictions, and the looming threat of being turned away at any point. This added layer of stress further underscores the emotionally exhausting nature of their journeys.

5. Financial Costs, Medical, and Insurance Coverage Exclusion

Beyond the logistical and legal hurdles of reproductive travel, lesbian couples also face barriers within medical settings, further complicating their access to ART and reproductive care. LGBTQ+ individuals often experience discrimination in healthcare, limiting their access to reproductive and sexual health services (Béziane et al., 2020; Conron et al., 2010). This section emphasizes how financial constraints and medical and insurance exclusions further reinforce existing inequalities and shape lesbian couples' reproductive journeys.

One of the major obstacles participants in this study faced was financial. At the time of the interviews, Swiss health insurers did not cover ART for lesbian couples on the grounds that they were not considered medically infertile (Gouilhers et al., 2023). This exclusion forced couples to bear the full cost of treatment themselves, a burden compounded by the uncertainty surrounding reimbursement for initial medical tests conducted in Switzerland. Fearing rejection, some couples hesitated to submit claims to their insurance, while others found themselves abandoned by their gynecologists, left to navigate the medical process on their own. Isaline described how she and her partner Diane, had to monitor ovulation cycles without professional guidance:

> The second time, my gynecologist didn't agree to do the monitoring. Even though I paid for it, telling myself that the insurance companies wouldn't understand if we booked more appointments. So, I had

> to trust only my cycle, as I was very regular. I would say, "Okay, we'll book in London for such and such date, and it'll be fine."

Beyond medical expenses, the financial burden extended to the cost of travel itself. Given that ART procedures require precise timing, couples often had to book last-minute flights within a 24–36-hour window after ovulation triggering, significantly increasing travel costs. Daniela and Alison, who traveled to London for ROPA, estimated that their expenses for one cycle amounted to approximately 15,000 Swiss francs—more than twice the median Swiss pretax monthly income (Office Fédéral de la Statistique, 2022)—with additional attempts costing around 5,000 francs each time. These figures illustrate the financial barriers that limit access to ART, making reproductive travel an option only for those who can afford repeated trips and associated costs.

Legal restrictions also interacted with medical discrimination, further marginalizing LGBTQ+ individuals in reproductive healthcare. Beyond the outright exclusion from ART in Switzerland, participants often encountered resistance when seeking medical support for their treatment abroad. Existing research has shown that medical professionals may be reluctant to assist patients undergoing ART in another country (Culley et al., 2011), but for lesbian couples, this reluctance was compounded by potentially stigmatizing attitudes. Some obstetricians discouraged them from seeking ART altogether, emphasizing its illegality, while others exerted pressure through intimidation. Aurore and Clarisse, for instance, faced a particularly hostile response from a doctor when they attempted to submit pretreatment medical expenses to their insurance. They recounted that the doctor warned them: "If the insurance asks, I will say that you are a couple of women. I will say that you did this." This reaction illustrates how legal and financial restrictions created a context where some practitioners not only denied care but also actively contributed to a stigmatizing environment.

Despite the numerous constraints research participants faced, their experiences highlight the stratified nature of reproduction and their agency within these limitations. Although they successfully navigated complex legal and medical systems, demonstrating that reproductive travel is not only a forced structural constraint but also a way of asserting reproductive rights (Bergmann, 2011; Zanini, 2011), agency was not equally accessible to all; it was contingent on social and economic resources, such as financial stability and cultural and health capital. These findings align with existing literature highlighting the stratified dimension of reproductive travel (Deomampo, 2019; Miner, 2021; Payne, 2013), demonstrating how exclusion from reproductive rights in one's home country and forced mobility abroad structure shape access to ART and reproduction. Together, these financial, legal, and medical barriers underscore how reproductive travel reflects and reinforces stratified access to fertility care, deepening existing inequalities among intended parents.

6. Navigating Professional Negotiations and Forced Coming Out

This section explores how reproductive travel and ART procedures placed participants in complex situations at work, where communication became a critical concern. Reconciling medical needs with professional life requires a degree of flexibility that is difficult to achieve. This involves justifying frequent absences, which can lead to fear of judgment or prejudice. As a result, participants may feel forced to "come out" to their superiors and colleagues, as it becomes difficult to take unannounced absences without explanation. They

often had to reveal not only their ART project but also their sexual orientation—an experience commonly felt as a double exposure. Often perceived as involuntary, it forces individuals to share an intimate part of their lives at work. When met with support, it can foster trust, yet it is rarely free from intrusive questions or inappropriate remarks. Conversely, a negative reception can create tension or even jeopardize the parenthood project. Couples who approach the topic with equanimity usually benefit from a flexible work environment, sympathetic employers, or financial resources that enable them to manage the unexpected. In all cases, their experiences highlight the extent to which pursuing ART is closely linked to workplace negotiation possibilities and society's representations of same-gender families.

As shown in the previous sections, the need for precise medical coordination while traveling creates a tight time frame and the financial burden of purchasing last-minute tickets, often conflicting with professional obligations. While navigating these demands, participants encountered remarks, misunderstandings, or, conversely, seemingly polite but subtly ambiguous reactions, all of which contributed to minority stress related to their parental aspirations (Amodeo et al., 2018).

Several women shared that they had exhausted all their vacation time, leaving them "drained" by the end of the year. Isaline confided: "It swallowed up all my vacation time, and I ended up without a single day off. All my vacations had been spent on unsuccessful trials, so by the end of the year, I was exhausted." This prolonged fatigue is often compounded by anxiety, as the work organization must constantly adapt to an unpredictable biomedical calendar. When employers are accommodating and colleagues are supportive, the pressure is alleviated. Many women emphasized that the success of these professional negotiations depends on their work environment, the hierarchy in place, and the nature of their job. However, even in favorable workplace environments, the emotional burden remains high (Rozental & Malmquist, 2015). The fear of a negative reaction from an employer due to frequent absences weighs heavily on couples navigating this process.

Some couples described themselves as "lucky" to have flexible working hours, understanding management and the complicity of colleagues who "have their back." However, flexibility largely depends on the nature of the activity. Aurore expressed it bluntly: "We have privileged jobs. Someone who works at Migros [a Swiss supermarket], that's just not possible." Her comment highlights how the ability to navigate the demands of ART is closely tied to one's social and professional capital (Bourdieu, 1986). Most of our participants held skilled positions that granted them a degree of negotiating power with their employers, making it easier to take time off. As one interviewee explained: "I'm lucky that my colleagues have always covered for me. We have intellectual jobs, so we can afford to talk to our bosses and explain what's going on." Camille and Justine also claimed that they have "privileged jobs." Camille, for instance, highlighted the solidarity of a supportive team, which made it much easier for her to take last-minute leave. However, in the past, Justine recalled that "it was only possible because I wasn't working. And when I was working, I was calling in sick."

Even in privileged positions, it is important to remember that the interviewees belong to a double minority that is often discriminated against in the labor market, particularly as women and as lesbians. The involuntary disclosure of sensitive personal information in the workplace, such as maternity plans and medical procedures like ART, can constitute indirect discrimination under EU law (Council Directive 2000/78/EC, 2000). Seemingly neutral workplace policies can, in practice, compel employees to reveal private information, disproportionately affecting individuals based on their sexual orientations. Had these

couples been able to access ART in Switzerland without the need to resort to reproductive travel, this "coming out" situation would not have been necessary. Moreover, few LGBTQ+ individuals in Switzerland choose to come out in the workplace for fear of discrimination and stigmatization (Lloren & Parini, 2017).

Participants' stories reveal a structural inequality: the ability to pursue ART abroad is closely tied to an employee's level of recognition and negotiating power in the workplace. This raises questions about how the professional sphere reinforces a heterocentric family model in which non-normative pregnancies—both due to same-gender parenting and the need to seek care abroad—compel employees to disclose intimate details that heterosexual couples can more easily conceal or present as a routine request for time off.

6.1. Exposing Oneself and One's Intimacy

Several participants expressed discomfort with being forced to disclose aspects of their private lives. Laurène, for example, described the discomfort of explaining her family project in a predominantly male environment where the concept of a two-mother family was unfamiliar: "It was sharing something very, very intimate with people." She referred to the "Swiss politeness" of her colleagues, glossing over possible judgments. However, this "politeness" did not prevent feelings of intrusion for Laurène, who was also forced to disclose her partner's ovulation schedule in order to negotiate time off work for ART-related travels.

Some participants preferred to inform only their immediate superior to maintain discretion, as Maude explained:

> I told my boss, but not my colleagues, because I prefer to tell them later. And then if I'm pregnant, people ask fewer questions. But in your case [directed to her partner], you were going to be a mother without being pregnant, and people don't understand.

In such situations, non-gestational parents often must justify themselves and explain their path to same-gender parenthood, resulting in an involuntary and abrupt "coming out." Léa recalled having to inform her manager and then witnessing the surprise of her colleagues when they discovered a birth announcement in the cafeteria featuring two women's names instead of a "father." This example highlights how the disclosure of a same-gender family challenges cisheteronormative representations of parenthood.

Participants also emphasized the importance of a supportive family environment, including siblings or grandparents. Parental stress is influenced by the desire to become a parent in a societal context dominated by heteronormative representations of family and parenthood.

Some participants found themselves having to explain the ART process in detail to uninformed relatives. This leads to questions about donor identity, which mother will carry the child, or the future roles of each parent—questions that would not arise in a heterosexual context.

The identity and status of the donor are sensitive issues. In several accounts, family members spontaneously referred to the donor as "the father," implicitly assigning him a parental role within a two-mother family—an assumption that participants experienced as an additional burden.

Furthermore, the need to travel abroad for ART makes the preconception process more visible. Many couples described not only having to negotiate time off with their employers but also feeling the need to justify themselves to family and friends. This dual exposure at work and in their personal circles adds to the stress already inherent in the medical process, a phenomenon characterized as minority stress (Amodeo et al., 2018; Luxion, 2020; Scandurra et al., 2019; Wheeler et al., 2018).

Some participants chose to keep their parenting projects confidential during the preconception stage to avoid potential negative reactions from family and friends. Camille explained:

> We decided not to tell our family. Justine isn't close to hers, so it wasn't even a question. As for me, I didn't want to create false hopes….They still hold prejudices like "gay people don't have families."…I didn't want to feel pressured to justify our decision to my family.

Camille's testimony aligns with studies on ROPA, which highlighted how fear of judgment leads many couples to keep their plans private (Golombok et al., 2023; Roca i Escoda, 2016). The concept of "sharing motherhood"—one mother providing the oocytes while the other carries the child—directly challenges dominant notions of kinship, which remain largely rooted in cisheteronormative frameworks. Aurore and Clarisse, for example, chose to hide that they had undergone a ROPA from Aurore's father, convinced he would not approve.

Access to ART is both a highly stratified and stratifying process (Barnes & Fledderjohann, 2020; Tam, 2021). Lesbian couples face intersecting forms of oppression, including homophobia and heterosexism (Short, 2007), as members of minority groups. ART remains shaped by heteronormative family norms, reinforcing structural barriers to access. Beyond the medical and legal dimensions, ART also raises symbolic and social issues, exposing persistent resistance to same-gender parenting and the enduring influence of traditional family models. More broadly, it reflects the weight of family norms and the challenges faced by lesbian couples, who often have to justify the legitimacy of their families. These narratives highlight how lesbian couples must navigate a double layer of exposure in professional and personal contexts as they pursue parenthood through ART. Whether negotiating with employers or responding to family expectations, participants are often compelled to disclose and defend the legitimacy of their parenting project. This dual burden of visibility and justification amplifies existing inequalities and adds emotional weight to an already demanding process. The case of ROPA exemplifies how lesbian couples challenge normative assumptions about biology and kinship. As Nordqvist (2014) argues, their parenting projects confront dominant social representations of family, highlighting the ongoing struggle for recognition among two-mother families.

7. Conclusion: A Path Fraught With Obstacles

Lesbian couples' reproductive travel is costly and imposes an additional burden on couples already facing minority stress factors (Wheeler et al., 2018). The "minority stress" they experience is closely linked to the lack of access to ART in their home country, a situation that affects their desire to become parents (Scandurra et al., 2019). The concepts of parental stress (Luxion, 2020), parenting desire, and minority stress (Amodeo et al., 2018) are especially relevant here, highlighting the risks associated with clandestine procreation in terms of health and safety (Peleg & Hartman, 2019). Couples must manage not only the medical and logistical aspects of ART but also the psychological and emotional implications of their situation (Rozental & Malmquist, 2015).

The obstacles lesbian couples face in their ART journey are not limited to medical challenges. They encompass logistical, legal, financial, and psychological difficulties, exacerbated by minority stress and clandestine situations. These combined factors profoundly impact their path to parenthood, their health, and their well-being. The medical process of ART follows a very rigorous timeline that involves repeated tests, ovulation monitoring, and the need to leave the same day as ovulation triggering. However, this temporal rigor conflicts with the mobility inherent in reproductive travel. Couples often must cross one or more countries' borders, adding the stress of distance to geographical and legal obstacles. Acting clandestinely—exacerbated by Covid-related mobility restrictions and professional constraints—further complicates this journey.

Integrating the critical perspective of reproductive travel as "reproductive exile" (Inhorn & Patrizio, 2009) further highlights the role of social inequalities and prevailing gender norms in shaping lesbian couples' ART experiences. This can be understood as a form of double discrimination based on both their sexual orientation and their relationship status, forcing them into costly "reproductive exile" in order to pursue their parenthood project. The systemic discrimination embedded in heteronormative medical and legal frameworks not only deepens social inequalities by disproportionately burdening lesbian couples financially and emotionally but also reinforces traditional gender norms by implicitly positioning heterosexual couples as the normative standard for access to ART. Such structural inequalities underscore the urgency of redefining ART access and related policies through a reproductive justice lens that can acknowledge and mitigate these gendered and social inequalities in care.

Our study shows that the experiences of lesbian couples undergoing ART abroad go beyond logistical and legal challenges. It is also shaped by microaggressions and reinforced by enduring heteronormative biases in healthcare facilities, as highlighted by previous research on LGBTQ+ patients' healthcare experiences (Kirubarajan et al., 2021). These everyday microaggressions, though often subtle, build up over time and play a significant role in the minority stress these couples experience, potentially impacting their mental health and well-being (Nadal, 2019). It is therefore essential for medical institutions to adopt a fully inclusive approach. A key lever for enhancing care equity and the experience of LGBTQ+ couples on their path to parenthood is training healthcare providers to recognize and prevent microaggressions while implementing affirming and respectful practices.

Fieldwork insights also suggest that adopting a reproductive justice approach could more effectively address lesbian couples' needs (Stacey, 2018), encouraging policymakers to raise awareness among healthcare providers about the specific legal, medical, and social vulnerabilities LGBTQ+ families face. It also emphasizes the importance of acknowledging the diverse profiles of patients seeking reproductive care. Tailoring ART protocols to better align with the specific needs and lived experiences of lesbian couples can help foster more inclusive, safer, and equitable pathways to parenthood. Collaboration with LGBTQ+ associations offers valuable insights in this regard. Further research is needed to explore how the principles of reproductive justice can concretely inform policy development and clinical practices.

The legal reform of 2022, which extended ART access to married lesbian couples in Switzerland, marks a significant shift in LGBTQ+ reproductive rights. Although this change has removed one major structural barrier, drawing on previous studies in perinatal care settings, Swiss reproductive and parenting culture remains strongly cisheteronormative (Chautems, 2022; Chautems & Maffi, 2021; Gouilhers et al., 2023).

In this context, the reform must be understood as a step toward reproductive justice, but not as its full achievement, as significant inequalities persist. Some of these inequalities also apply to other non-heteronuclear intended parents, such as single women. Future studies should investigate how this legal shift has shaped the care experiences of lesbian couples and whether it has led to meaningful improvements in their reproductive journeys or merely changed the terms under which existing inequalities are negotiated.

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Conflict of Interests

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