

RESEARCH

REPRODUCTIVE HEALTH IN TRANS AND GENDER DIVERSE PATIENTS

Mind the gap: a nationwide audit of LGBTQ+ inclusion in fertility care providers in the United Kingdom

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Abstract

In brief: We describe a first-of-its-kind audit of LGBTQ+ inclusivity in fertility care providers across the United Kingdom. Despite efforts being made to improve LGBTQ+ inclusion in fertility care, our results paint a picture of widespread gaps in clinical and cultural expertise alongside significant barriers to LGBTQ+ inclusion.

Abstract: LGBTQ+ patients comprise one of the fastest-growing user demographics in fertility care, yet they remain under-represented in fertility research, practice, and discourse. Existing studies have revealed significant systemic barriers, including cisheteronormativity, discrimination, and gaps in clinical expertise. In this article, we present a checklist of measures that clinics can take to improve LGBTQ+ inclusion in fertility care, co-created with members of the LGBTQ+ community. This checklist focuses on three key areas: cultural competence, clinical

considerations, and online presence. The cultural competence criteria encompass inclusive communication practices, a broad understanding of LGBTQ+ healthcare needs, and knowledge of treatment options suitable for LGBTQ+ individuals. Clinical considerations include awareness of alternative examination and gamete collection techniques for transgender and gender diverse patients, the existence of specific clinical pathways for LGBTQ+ patients, and sensitivity to the psychological aspects of fertility care unique to this demographic. The online presence criteria evaluate provider websites for the use of inclusive language and the availability of LGBTQ+-relevant information. The checklist was used as the foundation for an audit of fertility care providers across the UK in early 2024. Our audit identified a widespread lack of LGBTQ+ inclusion, particularly for transgender and gender diverse patients, highlighting deficiencies in clinical knowledge and cultural competence. Our work calls attention to the need for further efforts to understand the barriers to inclusive and competent LGBTQ+ fertility care from both healthcare provider and patient perspectives.

Introduction

In recent years, advancements in assisted reproductive technologies (ARTs) and legislative changes have provided new family-building options for the LGBTQ+ community, now one of the fastest-growing demographics in fertility care (Darwin & Greenfield 2019, HFEA 2019). However, studies examining LGBTQ+ experiences within fertility care have revealed significant systemic barriers including cost (Permezel *et al.* 2023), cisheteronormativity (Brown 2023), discrimination (Gato *et al.* 2021), lack of information (Bartholomaeus & Riggs 2020), gaps in clinical expertise and research (Rodriguez-Wallberg *et al.* 2023) and cultural incompetence (Kirubarajan *et al.* 2021).

Studies on the experiences of same-sex couples (SSCs) accessing ARTs have primarily focused on cisgender female SSCs, highlighting heteronormative prejudices and logistical barriers that impact their quality of care and psychological well-being (Rozenal & Malmquist 2015, Carvalho *et al.* 2019, Richburg *et al.* 2022). SSCs often face medical gatekeeping, higher treatment costs, and a lack of knowledge from providers regarding their specific needs (Cherguit *et al.* 2013, Corbett *et al.* 2013). Common issues contributing to patient exclusion include the use of standardised forms designed for heterosexual couples (Rozenal & Malmquist 2015) as well as a lack of tailored information on clinic websites (Jin & Dasgupta 2016, Wu *et al.* 2017). These barriers are compounded by societal stigma, especially for male SSCs, whose experiences are generally less documented (Yee *et al.* 2024). Nevertheless, recent studies suggest that fertility clinics are becoming increasingly inclusive of cisgender SSCs – especially when compared to transgender and gender diverse (TGD) individuals – as the sector catches up with new legislation (Jin & Dasgupta 2016).

TGD individuals also face unique barriers when accessing fertility services. Though gender-affirming hormone replacement therapy (HRT) and gender-affirming surgery can adversely affect fertility, many TGD individuals have aspirations for genetically

related children (Tornello & Bos 2017). Despite this, the uptake of fertility preservation (FP) within this patient group is generally low, with some studies reporting rates of under 5% (Chen *et al.* 2017, Nahata *et al.* 2017, Baram *et al.* 2019). Studies of the experiences of TGD individuals who do access fertility care highlight a lack of appropriate staff training, as well as misgendering and the use of non-inclusive language by staff and in medical records (Hagen & Galupo 2014, James-Abra *et al.* 2015, Ruderman *et al.* 2021). Additionally, some routine examinations can prove distressing to TGD individuals, such as the use of transvaginal ultrasound in transmasculine patients (Armuand *et al.* 2017).

Far fewer studies have been conducted on provider perspectives (Kirubarajan *et al.* 2021) and, to our knowledge, no studies have evaluated the state of LGBTQ+ fertility care at a national level. In this article, we describe the first such effort. Our nation of choice is the UK, which has a relatively advanced fertility care system with provisions for LGBTQ+ patients, including gamete donation, surrogacy, and FP (HFEA 2023). We begin by developing a checklist on LGBTQ+ inclusion in fertility care, co-created with members of the LGBTQ+ community, which then serves as the basis for an audit of fertility care providers across the UK (which we define as a single fertility clinic or group of fertility clinics operating under the same brand).

Methods

Checklist development

A checklist of best practices with regard to LGBTQ+ fertility care was co-created by an interdisciplinary panel of clinicians, researchers, and members of the LGBTQ+ community. An approach of co-creation was taken to ensure that this work was informed by those with relevant lived experience. The panel consisted of four doctors, four clinical embryology staff, four nursing staff, four researchers, two non-clinical clinic

staff, one user experience designer, and six community members not counted in the previous categories. Both SSCs and TGD individuals were represented among the 'community member' and non-'community member' participants. All panel members volunteered and were recruited from personal networks.

The items on the checklist were determined by drawing from a literature review as well as input from clinical and LGBTQ+ lived experiences. From November 2023 to January 2024, multiple meetings were held with various subsets of the interdisciplinary team to iteratively refine the checklist items and, where applicable, their relative weighting. A collaborative document was used for this purpose, allowing all members to contribute and suggest modifications. Ultimately, the items in the final version of the checklist were unanimously agreed upon.

The checklist covered three main areas: cultural competence, clinical considerations, and online presence. The cultural competence criteria covered aspects of inclusive communication, as well as a broad understanding of LGBTQ+ healthcare needs and

knowledge of ART suitable for LGBTQ+ individuals. Clinical aspects covered included knowledge of alternative examination and gamete collection techniques for TGD patients, the existence of specific clinical pathways (which we define as standardised care plans guiding treatment for specific conditions and/or patient populations) for LGBTQ+ patients, and awareness of the psychological aspects of fertility care unique to LGBTQ+ populations. The online presence criteria assessed provider websites for factors such as the prevalence of heteronormative language and the availability of LGBTQ+-relevant information. The full checklist can be seen in [Table 1](#) and the Supplementary Data (see section on [supplementary materials](#) given at the end of this article).

Nationwide audit

Survey for clinic staff

An online survey was used to assess care providers and individual respondents in accordance with the

Table 1 LGBTQ+ inclusion checklist for fertility care providers. This table does not include the online presence criteria, which can be found in the Supplementary Data. Here, 'clinicians' refers to doctors, nurses, and clinical embryologists. 'AMAB' stands for 'assigned male at birth', and 'AFAB' stands for 'assigned female at birth'. Moreover, detailed definitions for 'cultural competence' and 'clinical knowledge' can be found in the Supplementary Data.

Patient Group	Priority	Items
Same Sex Couples	High	<ul style="list-style-type: none"> Clinicians have been trained to work with same-sex couples (cultural competence) Clinicians have been trained to work with same-sex couples (clinical knowledge) Non-clinicians (including administrative staff) have been trained to work with same-sex couples (cultural competence) Specific clinical pathways exist for same-sex couples
	Medium	<ul style="list-style-type: none"> Forms and paperwork are inclusive of same-sex couples (e.g. uses 'parents' rather than 'father/mother' or offers 'mother/mother' and 'father/father') Patient guidance is inclusive of same-sex couples
Transgender and Gender Diverse Patients	High	<ul style="list-style-type: none"> Clinicians have been trained to work with transgender and gender diverse patients (cultural competence) Clinicians have been trained to work with transgender and gender diverse patients (clinical knowledge) Non-clinicians (including administrative staff) have been trained to work with transgender and gender diverse patients (cultural competence) Specific clinical pathways exist for transgender and gender diverse patients Process for recording name and pronoun preferences Gender-neutral treatment spaces and waiting rooms as a default (including for gynaecology and andrology services) Alternatives to transvaginal scans offered for AFAB transgender and gender diverse people (e.g. transrectal/transabdominal) Alternatives to masturbation offered for AMAB transgender and gender diverse people (e.g. electroejaculation/surgical sperm retrieval/at-home production)
	Medium	<ul style="list-style-type: none"> Forms and paperwork are inclusive of transgender and gender diverse people, including individuals with gender diverse identities outside of 'man' and 'woman' (e.g. does not misgender them) - unless totally unavoidable for legal reasons. Patient guidance is gender-neutral where possible and/or there is specific patient guidance for transgender and gender diverse patients Branding of same-sex fertility services is inclusive of couples that include transgender and gender diverse partners (e.g. a couple consisting of a cisgender woman and a transgender woman may be referred to as 'shared motherhood', but a couple comprising two transgender men ought not to be)

checklist. The survey came in two parts. The former was completed by all respondents and concerned cultural competence as well as provider-level practices. The latter was only completed by doctors, nurses, and clinical embryologists (who, in the UK, are all patient-facing and involved in clinical decision-making) and assessed awareness of relevant clinical aspects of LGBTQ+ fertility care.

To reduce the time required to complete the survey, we primarily used multiple-choice questions with sparing use of free-text answers. Questions regarding care provider practices were formatted as Yes/No/Don't Know questions, with the Don't Know option accounting for respondents who might not be aware of their clinic's processes (which itself highlights a gap in knowledge). Questions about whether individual respondents received training were simply formatted as Yes/No questions (as respondents would know if they have undergone training). Confidence levels of individual respondents as well as doctors, nurses, and clinical embryologists' awareness and understanding of clinical aspects were measured using Likert scales.

Despite the emphasis on multiple-choice questions, certain checklist items necessitated free-text responses to assess knowledge without leading the respondent. For instance, a question examining whether doctors, embryologists, and nurses were aware of the discomfort or reluctance of TGD patients to be examined required a free-text response. Additionally, three questions aimed at assessing knowledge of referrals and two questions regarding alternative uterus examination and sperm retrieval processes for transmasculine and transfeminine patients, respectively, also used free-text answers.

UK fertility care providers were assessed using the survey (live from 08 January 2024 to 26 January 2024, advertised through social media, email, and the national Fertility 2024 conference). Multiple survey respondents were allowed from each provider, with a provider-level consensus being calculated from modal responses. The full survey can be seen in the Supplementary Data.

Website audit

Websites were audited according to a rubric based on the checklist items to ensure a consistent evaluation process. Each website was assessed in a blinded fashion by two independent reviewers. Following the individual assessments, the reviewers engaged in a discussion to reach a consensus on the evaluation of each website. This approach ensured that the assessments were thorough, with any discrepancies resolved through collaborative discussion. Providers without websites were excluded from the website audit. The rubrics used to assess the inclusion of SSCs and TGD patients on care provider websites can be seen in the Supplementary Data.

Statistical analysis

Statistical analysis of survey responses was conducted using the Pandas package (v1.3.3) in Python (v3.8.10). To compare dichotomous variables, we utilised two-tailed Fisher's exact tests. Thematic analysis was conducted on the open-ended survey questions.

Results

A total of 50 responses (seven doctors, six nurses, 26 clinical embryologists, two andrologists, nine patient support/admin/other) were collected from 29 care providers. This represented a 43% response rate among fertility care providers registered with the Human Fertilisation and Embryology Authority. Of these providers, 18 were fully private, 11 accepted NHS patients, and 14 were London-based. Seven of the care providers comprised multiple (often 'satellite') clinics under the same brand name. Results from the survey can be seen in Tables 2, 3 and 4, along with our definitions of 'minimal' cultural competence and clinical knowledge. Results from the website audit can be seen in Table 5. In the following sections, we discuss some of our main findings.

Gaps in clinical and cultural competence

While most respondents reported confidence in their ability to work with SSCs (47/50) and TGD patients (36/50), fewer than half of the respondents reported receiving minimal cultural competence training (15/50 SSC, 13/50 TGD). Confidence in treating TGD patients was associated with cultural competence training ($P=0.010$), but this association was not observed for SSCs ($P=0.545$).

Clinical knowledge of TGD patients varied, with only 4/7 doctors, 2/26 embryologists, and 0/6 nurses meeting the minimum criteria. Moreover, only 16/29 providers were reported as having policies detailing alternatives to transvaginal ultrasound scans (such as transabdominal or transrectal) for transmasculine patients, and 13/29 had alternatives to masturbation (such as electroejaculation, surgical sperm retrieval, or at-home collection) for transfeminine patients. This lack of alternatives poses a barrier to TGD populations as many standard procedures used in fertility treatment have the potential to trigger psychological and physical discomfort (Baram *et al.* 2019, Nadgauda & Butts 2024). When asked why a TGD patient may be reluctant to be examined, gender dysphoria featured in 17/50 responses, previous negative experiences with healthcare professionals in 11/50, and embarrassment in 9/50. However, only 2/50 respondents – one doctor and one embryologist – identified pain as a potential factor causing reluctance to be examined, with only the embryologist identifying a possible link to HRT.

Table 2 Care providers meeting different criteria based on survey responses.

Criterion	Patient group	Count meeting criterion	Proportion meeting criterion (95% CI)
Clinical pathways available for..	SSCs	23/29	0.79 (0.60, 0.92)
	TGD patients	17/29	0.59 (0.39, 0.76)
Inclusive patient guidance for...	SSCs	27/29	0.93 (0.77, 0.99)
	TGD patients	19/29	0.66 (0.46, 0.82)
Policies detailing alternatives to transvaginal ultrasound	Transmasculine patients	16/29	0.55 (0.36, 0.74)
Policies detailing alternatives to masturbation for transfeminine patients	Transfeminine patients	13/29	0.45 (0.26, 0.64)
Use of gender neutral HFEA paperwork	-	24/29	0.83 (0.64, 0.94)
Mixed-sex waiting spaces for all services	-	24/29	0.83 (0.64, 0.94)
Use of correct names and pronouns	-	27/29	0.93 (0.77, 0.99)

SSCs, same sex couples; TGD, transgender and gender diverse.

Greater inclusion of same-sex couples than transgender and gender diverse patients

Most providers were reported to be using gender-neutral HFEA paperwork (24/29) and having mixed-sex waiting spaces for all services (24/29), benefiting both SSCs and TGD patients. However, while 23/29 providers had clinical pathways for SSCs, only 17/29 had pathways for TGD patients. In the same vein, while 27/29 providers had patient guidance inclusive of SSCs, this fell to only 19/29 for TGD patients. These findings, along with the previously noted lack of TGD-specific clinical and cultural competence among many respondents, suggest that TGD patients may experience poorer care compared to SSCs.

Inclusivity in websites does not reflect inclusivity on the ground

Few websites scored over 70% on inclusivity criteria for SSCs (9/24) and TGD patients (7/24), which we consider the minimum score for a website to be deemed 'inclusive'. As websites are often the first port of call for prospective patients, the lack of LGBTQ+ inclusivity may deter LGBTQ+ patients from engaging with providers, potentially contributing to poorer healthcare outcomes.

While most websites had pages targeted at SSCs (20/24) and TGD patients (14/24) deemed to be similarly accessible when compared to their pages aimed at a cisgender heterosexual demographic, fewer offered

Table 3 Survey respondents meeting different criteria for cultural competence.

Criterion	Patient group	Count meeting criterion	Proportion meeting criterion (95% CI)
Self-perceived confidence working with...	SSCs	47/50	0.94 (0.83, 0.99)
	TGD patients	36/50	0.72 (0.58, 0.84)
Received training on different sexual orientations*	-	21/50	0.42 (0.28, 0.57)
Received training on different gender identities†	-	19/50	0.38 (0.25, 0.53)
Received training on inclusive terminology*†	-	20/50	0.40 (0.26, 0.55)
Received training on effective communication strategies to make LGBTQ+ patients feel comfortable (including when referring to body parts of TGD individuals)	-	12/50	0.24 (0.13, 0.38)
Received training on specific healthcare needs of...	SSCs*	21/50	0.42 (0.28, 0.57)
	TGD patients†	16/50	0.32 (0.20, 0.47)
Received training on assisted reproductive technologies suitable for LGBTQ+ individuals*†	-	23/50	0.46 (0.32, 0.61)
Received training on the health disparities and challenges faced by LGBTQ+ individuals in reproductive healthcare	-	13/50	0.26 (0.15, 0.40)
Received training on relevant laws and regulations related to LGBTQ+ health care rights and protections	-	21/50	0.42 (0.28, 0.57)
Received training on relevant administrative procedures and paperwork relating to parenting rights	-	28/50	0.56 (0.41, 0.70)

SSCs, same sex couples; TGD, transgender and gender diverse.

* indicates that a specific criterion is included in the definition of 'minimal' cultural competence training for working with SSCs.

† indicates the same for working with TGD patients.

Table 4 Doctors, nurses and clinical embryologists meeting different criteria for clinical knowledge.

Criterion	Count meeting criterion	Proportion meeting criterion (95% CI)
Awareness of surgical procedures TGD people may undergo ⁺	28/39	0.72 (0.55, 0.85)
Awareness of variations in anatomy that may be seen in TGD patients during examination ⁺	22/39	0.56 (0.40, 0.72)
Understanding of the impact that hormone replacement therapy medications may have on gametogenesis and the ability to prognosticate/adjust medications in fertility treatment accordingly ⁺	15/39	0.38 (0.23, 0.55)
Aware of the different medications TGD individuals may be on and how they may affect or interact with fertility medications ⁺	10/39	0.26 (0.13, 0.32)
Understanding of the implications of ovarian stimulation for TGD patients assigned female at birth ⁺	24/39	0.62 (0.45, 0.77)
Aware of the psychological aspects of fertility treatment in LGBTQ+ patients ⁺	23/39	0.59 (0.42, 0.74)

TGD, transgender and gender diverse.

⁺ indicates that a specific criterion is included in the definition of 'minimal' clinical knowledge.

detailed content describing available treatments. Inclusive language appeared on 17/24 websites for SSCs and 11/24 for TGD patients. Moreover, about half of the clinics explicitly claimed to be inclusive of SSCs (15/24) and TGD patients (11/24). Notwithstanding, there was a notable lack of positive testimonials from LGBTQ+ patients, with only 6/24 sites featuring SSC testimonials and just 1/24 including TGD testimonials.

We found no significant association between website inclusivity and the existence of clinical pathways for both SSCs ($P > 0.5$) and TGD patients ($P > 0.5$). Among the nine providers with SSC-inclusive websites, two did not have clinical pathways for SSCs. Conversely, 12/15 providers without SSC-inclusive websites did have such pathways. Similarly, for TGD inclusivity, only 5/7 providers with TGD-inclusive websites had

clinical pathways for TGD patients, while 10/17 providers without TGD-inclusive websites had pathways.

Provider location and funding not associated with inclusivity

We found no significant associations between whether a provider was based in London (the UK's capital city, with one of the highest proportions of LGBTQ+ residents in the country ([Government Equalities Office 2018](#)) and the existence of clinical pathways for SSCs (9/14 had pathways, $P > 0.5$) or TGD patients (7/14 had pathways, $P > 0.5$). Furthermore, we found that providers that were fully private were just as likely to offer clinical pathways for SSCs (9/11, $P > 0.5$) and TGD patients (6/11 had pathways, $P > 0.5$) as providers accepting NHS patients. These findings suggest

Table 5 Results from the website audit. Care providers without websites were excluded from this part of the audit.

Criterion	Patient group	Count meeting criterion	Proportion meeting criterion (95% CI)
Information on the website about relevant services is equally as accessible as those for cisgender/heterosexual services	SSCs	20/24	0.83 (0.63, 0.95)
	TGD patients	14/24	0.58 (0.37, 0.78)
There is content on the website that details and explains available treatment plans for...	Female SSCs	18/24	0.75 (0.53, 0.90)
	Male SSCs	13/24	0.54 (0.33, 0.74)
	Transmasculine patients	12/24	0.50 (0.29, 0.71)
	Transfeminine patients	11/24	0.46 (0.26, 0.67)
Language on the website is inclusive of...	SSCs	17/24	0.71 (0.49, 0.87)
	TGD patients	11/24	0.46 (0.26, 0.67)
Language on the website regarding TGD patients is up-to-date (e.g. 'transgender' rather than 'transgendered')	-	12/24	0.50 (0.29, 0.71)
Website explicitly mentions that the care provider is inclusive of...	SSCs	15/24	0.63 (0.41, 0.81)
	TGD patients	11/24	0.46 (0.26, 0.67)
Website content mentions staff training, awareness or readiness to work with...	SSCs	14/24	0.58 (0.37, 0.78)
	TGD patients	11/24	0.46 (0.26, 0.67)
Website has easy-to-find positive testimonials from...	SSCs	6/24	0.25 (0.10, 0.47)
	TGD patients	1/24	0.04 (0.00, 0.21)

SSCs, same sex couples; TGD, transgender and gender diverse.

the level of LGBTQ+ inclusion to be consistent across the UK, as well as across the NHS and private sector.

Poor awareness of LGBTQ+-competent external services

A patient's fertility journey extends beyond the fertility clinic, often necessitating referrals to external services for antenatal care, legal advice, and mental health support. Despite this, we observed a lack of awareness surrounding LGBTQ+-competent providers of these services. Although six respondents mentioned referring patients to LGBTQ+-competent legal services, none were aware of external LGBTQ+-competent antenatal care providers. While not directly within the control of fertility care providers, a lack of competent antenatal care providers may hamper LGBTQ+ parenting aspirations (Permezel *et al.* 2023).

When asked about referrals to LGBTQ+-competent mental health services, two respondents mentioned referring patients to Mermaids (a charity supporting transgender youth aged 20 and under), while another mentioned referring to Stonewall. Neither organisation, however, is a mental health care provider.

Discussion

Our audit revealed a lack of LGBTQ+ inclusion across UK fertility care, a finding that broadly aligns with existing studies into patient perspectives within the UK (Cherguit *et al.* 2013, Tasker & Gato 2020, Brown 2023) and internationally (Corbett *et al.* 2013, Bartholomaeus & Riggs 2020). Moreover, we found that this lack of inclusion was more severe for TGD patients than SSCs, which again comports with previous works (Jin & Dasgupta 2016). Our results suggest that these deficiencies are systemic, with the lack of inclusion consistent regardless of location or funding source.

Deficits in clinical knowledge

This lack of inclusion is particularly concerning as one way it manifests is through deficits in clinical knowledge, potentially resulting in LGBTQ+ patients not receiving the same standard of care as their cisgender heterosexual counterparts. This lack of knowledge was particularly pronounced among nurses and embryologists, though even among doctors, only half met the minimal criteria for LGBTQ+ inclusive care. This is problematic as (in the UK) doctors, nurses, and embryologists are all involved in clinical decision-making and the planning of treatment, which requires all parties to have a full picture of a patient's condition and medical history.

Several factors may contribute to the lower levels of knowledge. First, there may be wider gaps in medical

education (Arthur *et al.* 2021) and research related to LGBTQ+ healthcare (Feldman *et al.* 2016). In the UK, standard medical curricula and teaching lack sufficient incorporation of LGBTQ+ healthcare needs (Barber *et al.* 2022), impacting clinical literacy and future preparedness to treat patients. Nevertheless, a body of literature and practice is emerging around fertility treatment for LGBTQ+ patients (Yan *et al.* 2021, Mattelin *et al.* 2022, Stark & Mok-Lin 2022). Thus, while it is important to acknowledge the areas where further research is needed, it is not only possible, but also crucial for clinical staff to be acquainted with the best knowledge available. The lower levels of knowledge may also stem from a lack of hands-on experience necessary to effectively treat these patients. This lack of experience is likely exacerbated by the fact that fewer LGBTQ+ and, in particular, TGD individuals access fertility care due to barriers such as cost and fear of discrimination (Chen *et al.* 2019, Permezel *et al.* 2023).

Irrespective of its cause, a lack of clinical knowledge of LGBTQ+ patients can be harmful to patient outcomes, especially for TGD patients (Moseson *et al.* 2020). Lack of awareness of current best practices in transmasculine stimulation may translate into excessively cautious or aggressive stimulation protocols, suboptimal oocyte yields, and avoidable discomfort to patients (Leung *et al.* 2019, Tordoff *et al.* 2023). Furthermore, the lack of knowledge of alternative examination and gamete retrieval techniques – or even the rationale behind their necessity – can result in discomfort or distress for TGD patients. This is particularly problematic for transmasculine patients, for whom routine vaginal examinations may be distressing owing to psychological factors such as gender dysphoria and past sexual trauma, as well as physical factors such as vulvovaginal pain associated with testosterone use (Tordoff *et al.* 2023). This is compounded by a lack of awareness regarding variations in anatomy, which is crucial for clinicians performing examinations. Inadequate knowledge in this area not only poses risks of physical harm but can also erode trust between patients and healthcare providers.

Deficits in cultural competence

We identified notable deficits in cultural competence training, which can contribute to negative experiences for LGBTQ+ individuals accessing fertility services (Kirubarajan *et al.* 2021). Moreover, a lack of knowledge regarding referrals to LGBTQ+ competent mental health and antenatal care may pose a barrier to LGBTQ+ patients, leaving them unsupported for a major proportion of their fertility journey. Inappropriate referrals (such as to organisations like Mermaids for mental health support) may also negatively impact the patient experience and erode trust in the competence of the referring healthcare professionals.

Nonetheless, the task of developing integrated LGBTQ+ competent reproductive care pathways extends beyond the fertility sector alone, likely requiring collaboration across multiple services.

A particularly interesting finding was the gap between clinics' online marketing towards LGBTQ+ patients and the reality of the services provided on the ground. This discrepancy suggests that some clinics may be promoting their services as LGBTQ+ inclusive without possessing the necessary competence to deliver appropriate care. Such a mismatch can undermine trust within LGBTQ+ patient populations, especially if a clinic appears welcoming and affirming online but fails to meet expectations in practice. Care provider marketing teams should thus be mindful to ensure that clinic websites are accurate in their claims of LGBTQ+ inclusivity. Our checklist may be helpful in such cases, as it would allow care providers to specify the exact measures taken to guarantee inclusion.

Limitations

This work carries a number of limitations inherent in its design. Firstly, the collection of survey data on self-reported practices across fertility care providers may not be as reliable as a traditional external audit due to factors such as social desirability bias. Moreover, the use of convenience sampling meant that the audit did not cover all UK fertility care providers and saw a disproportionate number of responses from embryologists. However, given the constraints of our work, especially in the absence of support from regulatory or influential bodies, avoiding convenience sampling is challenging.

Furthermore, our audit only provides a snapshot of LGBTQ+ inclusion in UK fertility care providers in early 2024, and thus our results are not generalisable to other countries. For instance, one particular point of difference between the UK and many other countries is the more patient-facing role that embryologists have. Finally, while we somewhat cover TGD SSCs in our checklist, this does not fully appreciate the fact that the intersection occupied by TGD SSCs can present its own unique barriers, on top of the compounding factors of being both TGD and SSCs.

Moreover, our survey did not explicitly mention that SSCs may include TGD partners, which may have led to respondents assuming questions only ask about cisgender SSCs. Our survey also did not include some demographics under the LGBTQ+ umbrella. These include intersex people and people in polyamorous relationships who may also face barriers to inclusive care (Jones 2020, Campbell *et al.* 2023). Nonetheless, despite these limitations, we view our work as an important preliminary step in initiating a broader dialogue about national and international standards for LGBTQ+ fertility care.

Future work

There are evident gaps in both clinical knowledge and cultural competence that need to be addressed to ensure LGBTQ+ inclusive care. To better understand and meet the specific needs of LGBTQ+ patients, further research is essential, potentially conducted in collaboration with or led by the LGBTQ+ community itself. Such collaborative approaches may help ensure that the research is more aligned with the actual lived experiences and needs of this demographic. Moreover, to drive meaningful change, continued audits and possibly regulatory pressure may be necessary to hold clinics accountable and ensure that competent and inclusive care is available to all LGBTQ+ patients.

Conclusion

In this work, we have presented a first-of-its-kind audit of LGBTQ+ inclusion in fertility care across the UK. Though our results are limited by survey biases such as sampling, response, and social desirability biases, our findings, which capture a snapshot of the sector in early 2024, paint a picture of widespread gaps in clinical and cultural expertise alongside low levels of inclusion in fertility care. These gaps are likely exacerbated by a lack of access to education and learning resources for clinical staff.

Our work highlights the need for further research to understand the barriers to inclusive and competent LGBTQ+ fertility care from both healthcare provider and patient perspectives. These barriers may be reinforced by deficits in clinical knowledge and research (Nadgauda & Butts 2024). The low levels of awareness seen in our audit may indicate a wider lack of LGBTQ+ health focus in medical education and research.

Our findings call attention to the different experiences of SSCs and TGD patients in fertility care, supporting the case for collecting disaggregated data on both SSC and TGD outcomes in fertility services. Moreover, overlaps between SSCs and TGD patient groups should be accounted for in future research due to intersecting and complex barriers facing these patient demographics (Gato *et al.* 2021).

Our best-practice checklist, co-created with the LGBTQ+ community, provides a useful springboard for clinics considering improving inclusion as well as future audits. Moving forward, it is essential for healthcare providers, researchers, and members of the LGBTQ+ community to collaborate in fostering inclusive fertility care for all.

Supplementary materials

This is linked to the online version of the paper at <https://doi.org/10.1530/REP-24-0173>.

Declaration of interest

CHe receives PhD funding from Apricity. CHe and NA are co-founders of Sapphic Bison. JS, IM, RH, CJ, TF, and DE are employed by Apricity. DN and ST are employed by CRGH. TP is employed by Avenues. CHI is the founder of Avenues and IVF Professionals. CHI is co-founder of Ovom Care.

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Author contribution statement

CHe, NK, CHI and FV contributed to the conceptualisation and design of the study. CHe, NA, MF, JS, IM, NK, RH, RD, SS, LS, ST, DN, DE, CJ, and CHI contributed to the checklist and website audit. CHe, NA, MF, JS, IM, and CHI contributed to the survey design. CHe, IM, NK, SS, LS, ST, DN, DE, CJ, TF, TP, and CHI contributed to publicising the survey. CHe, NA, and MF conducted the website audit. CHe, NA, MF, and NK contributed to the survey analysis. CHe wrote the code for data and statistical analysis. CHe, NA, MF, JS, RH, SS, LS, TF, TO, and TP contributed to the interpretation of the results. CHe and NA wrote the manuscript. CHI and FV supervised the project. All authors contributed to the final review of the manuscript.

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