Queering Pregnancy: Understanding the Role of Queer Identity in Pregnancy Desires and Decisions

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Abstract

Queer women and gender-expansive individuals assigned female at birth face barriers to achieving their reproductive health and family formation goals. Paradoxically, current literature in this area suggests that while queer individuals face higher rates of unwanted, unintended, or mistimed pregnancies, there are also significant barriers to achieving wanted pregnancies. Informed by principals of reproductive justice, this dissertation study aims to understand collective barriers to family formation, viewing both barriers to wanted pregnancies and barriers to avoiding pregnancy as stemming from similar root causes. This dissertation uses a modified grounded theory approach to examine how queer women and gender-expansive individuals relate and respond to pregnancy, including the role of sexual identity in shaping their experiences. This dissertation is comprised of three papers. The first paper outlines how queer women and gender-expansive individuals consider pregnancy and family planning in the context of their lives and identities and outlines the most salient factors in informing pregnancy desires. The second paper discusses the experiences of queer women and gender-expansive individuals seeking abortion, and the unique ways that queer identity shaped abortion experiences and attitudes. The third paper documents experiences in the healthcare system and the strategies that individuals use to meet their health needs despite barriers to queer-inclusive care. Collectively, these papers discuss the range of pregnancy experiences, the context in which queer individuals are making family formation and pregnancy decisions, as well as the significant influences on pregnancy desires and experiences for queer individuals. Findings from this dissertation have several implications for family planning and social work research and practice, as well as policy implications. Supporting queer individuals in a range of reproductive health and parenting options is vital to full recognition of queer individuals' bodily autonomy, affirming reproductive justice, and supporting participation in a fundamental human experience—family building.

I. Introduction

Queer women and gender-expansive individuals assigned female at birth (AFAB) face barriers to achieving their reproductive health and family formation goals. Paradoxically, current literature in this area suggests that while queer individuals face higher rates of unwanted, unintended, or mistimed pregnancies, there are also significant barriers to achieving wanted pregnancies (Everett et al., 2017; Gregg, 2018; Hayman et al., 2015). Despite pregnancies—both intended and unintended—being a common experience for queer women and gender-expansive individuals, researchers, including family planning and social work researchers, know very little about how these individuals think about and experience pregnancy.

Estimates of the prevalence of pregnancy for queer women vary significantly by data source and method (Stoffel et al., 2017). There are no current estimates of gender-expansive or transmasculine pregnancy rates. Analyses suggest that queer youth are more likely to experience an unintended pregnancy as a teenager than their heterosexual peers, and this disparity persists into adulthood (Charlton et al., 2013; Charlton et al., 2019; Goldberg et al., 2016). Everett et al. (2017) found that adult women with a sexual minority identity were significantly more likely to report a mistimed or unwanted pregnancy (Everett et al., 2017). Research in this area is beginning to document some of the possible sources of this disparity. For example, the health system may play a role, as queer women are less likely to access, use, or be offered reproductive health and family planning services (Agénor et al., 2014; Tornello et al., 2014). Community norms and sexual scripts may also play a role in the likelihood of using contraception (Power et al., 2009). Finally, structural factors contribute to this disparity, as queer women are more likely to be uninsured or low income (Conron, Goldberg, & Halpern, 2018). Relatedly, some researchers have documented the difficulty of achieving wanted pregnancies through assisted reproductive technologies (ART). This literature

documents the logistical and structural barriers, such as cost, lack of insurance coverage for these services, and homophobia and discrimination in the health system, to using ART (Chapman et al., 2012; Gregg, 2018; Hayman et al., 2015).

The queer pregnancy and family planning literatures are limited in three ways. First, studies have yet to consider both the lack of access to pregnancy and the increased risk of unintended pregnancy in this community as related phenomena. There has been little investigation into how queer individuals think about pregnancy, including how sexual identity informs the formation of pregnancy intentions or desires. Second, research in this area uses limited concepts, both in describing pregnancy experiences and identity. The field continues to use incomplete concepts, such as unintended pregnancy, which may or may not be salient to queer women, and limited measures of sexual identity and gender identity. Studies in this area have mostly used limited categories (i.e., gay, lesbian, bisexual) without including other sexual minority identities or measures for fluidity (Diamond, 2008b). Finally, research in this area has only begun to center queer voices, as much of the family planning literature concerning queer women and gender-expansive individuals rely on secondary data analysis, with few qualitative investigations (Higgins et al., 2019; Wingo et al., 2018). This dissertation study intends to fill the outlined gaps and understand queer individuals' barriers to achieving their reproductive goals, such as forming a family through pregnancy, avoiding pregnancy, or seeking abortion.

Concepts in Flux: Sexual and Gender Identity, Sexual Fluidity, and Pregnancy Intentions

In this dissertation, I aim to expand understanding of pregnancy among queer individuals, in part by using challenging traditional conceptualizations of sexual and gender fluidity and unintended pregnancy.

The standard measures of sexual identity, gender identity, and fluidity are limited. Traditionally, sexual and gender identities are understood as fixed identities--once a person identifies as a lesbian, that identity remains static. However, queer theorists posit that sexual identity is instead fluid (Diamond, 2008b). Several empirical studies have validated this. One longitudinal study of sexual minority women shows shifts in identity and attraction over ten years (Diamond, 2008a). These shifts in identity suggest that current data collection strategies and categories are not reflective of the complexity and changing nature of individual identity. Accounting for fluidity may be particularly crucial for understanding reproductive health, as sexual and reproductive health care needs may shift with identity. If providers assume that identity is stable, they may fail to provide needed services. For example, there is evidence that queer women receive contraceptive counseling at lower rates than heterosexual women, even if they recently had sex with a male partner (Everett et al., 2019). In another contraceptive-focused study, researchers collected sexual identity data for all participants. They found that almost 30% of participants identified with a sexual minority identity, and 61% of lesbians reported a male partner in the last 12 months (Everett et al., 2018). Further, it is unclear how sexual fluidity may relate to individuals' ideas or desires around pregnancy. Including fluidity in measurement and the conceptual understanding of sexual identity is essential for accurately understanding both individuals' needs and their realities.

Similarly, researchers typically use binary measurements of gender, even when inclusive of transgender individuals, which may not be representative of a range of gender identities or account for fluidity. Furthermore, sexual identity and gender identity are separate, yet intertwined and fluid identities for many individuals (Butler, 2011; Diamond et al., 2017). Thus, it is often difficult to draw clear lines between individuals who hold a sexual minority identity and

individuals who hold a gender minority identity. For example, in one study of sexual minority individuals assigned female-at-birth seeking sexual and reproductive health care, participants disclosed one identity on the screening questionnaire and another during their interview (Jahn et al., 2019). Thus, to understand the needs of queer individuals assigned female-at-birth, there must be expansive and inclusive measures of gender identity (i.e., not just focusing on cisgender women).

Of note, reproductive health research has not consistently included measures for transgender or gender-expansive individuals. While there has been growing attention to the reproductive health needs of transmen, there is limited data on the number of transmen or gender-expansive individuals who have experienced pregnancy (Light et al., 2018; Light et al., 2014). Most surveys do not include measures for gender identity. To this end, the term "women" in the following sections refers to cisgender women. This study included cisgender women and non-binary, genderqueer individuals or individuals questioning their gender identity. Thus, I describe the sample as "queer cisgender women and gender-expansive individuals" to be inclusive of these identities (Jahn et al., 2019).

Background

As LGBTQ+ individuals gain rights, increasing acceptance, and access to traditional institutions, such as marriage, they are also increasingly starting families. According to one estimate by the Williams Institute, an LGBT-rights focus research institute, 16.2% of same-sex households are parenting a child under the age of 18. Restricting to just female same-sex households, this percentage increases to 23.1%. The majority (68%) of these couples were raising a biological child (Goldberg & Cochran, 2018). Recently, more options for family building have become accessible to LGBTQ+ individuals, given the rapidly changing social norms around

marriage and family building. Many queer individuals and couples are choosing to become parents through adoption, foster care, or assisted reproductive technologies (ARTs) (Family Equity Council, 2019).

Queer cisgender women and individuals assigned female at birth who hold a sexual minority identity, including lesbian, bisexual, pansexual, or queer, share many of the reproductive health needs and goals as their heterosexual peers (Stoffel et al., 2017). However, disparities in reproductive health outcomes remain, and research on family planning and pregnancy has yet to reflect diversity in sexual identities of individuals attempting to get pregnant. Current barriers to family planning care and the invisibility of queer individuals in family planning research motivate this research study.

Much of the research that exists about queer women and pregnancy focuses on Assisted Reproductive Technology (ART), documenting the struggles and barriers of lesbian couples who have already decided to use these services. For example, one study of women seeking ART in Australia documents the homophobia and heteronormativity lesbian couples encounter in trying to get pregnant (Chapman et al., 2012). Further, lesbian couples have particular concerns and decisions related to getting pregnant, such as which partner will carry the child, whether or not to use a known donor, and what ART methods they want to and can afford to use (Gregg, 2018). While this research is valuable and an important perspective on the unique experience of queer women seeking pregnancy, this research is limited in its focus on lesbian couples and the experience once a pregnancy is already desired.

While queer women face barriers to planned pregnancies, they also face barriers to preventing unwanted pregnancies. Extant literature describes reproductive health disparities between sexual minority women (SMW) and heterosexual women, including lower rates of

seeking and receiving care and higher rates of STIs and unwanted pregnancies. Queer women are less likely to receive recommended Pap tests and more likely to have had an STI than heterosexual women (Marrazzo & Stine, 2004; Youatt et al., 2017). A higher likelihood of being uninsured contributes to these disparities (Buchmueller & Carpenter, 2010), though disparities persist even when accounting for insurance status (Everett et al., 2019). Analyses of unintended pregnancy have often excluded queer women, but new research suggests that unwanted pregnancy is common for queer women, and disparities in unintended or unwanted pregnancy persist across the lifecourse (Charlton et al., 2019). Analyses from the United States, Canada, Australia, and New Zealand suggest that the teen pregnancy rate for queer teens is 1 to 4 times higher than heterosexual teens (Saewyc, 2014). A longitudinal analysis using the Nurses' Health Study II and the Growing Up Today Study (GUTS) found that while teen pregnancy rates for queer adolescents have been declining—similar to overall teen pregnancy rates—a disparity persists between queer and heterosexual adolescent women (Charlton et al., 2013). Another study using the National Survey of Family Growth (NSFG) found a similar pattern, with bisexual women being twice as likely to have a teen pregnancy as heterosexual women (Tornello et al., 2014). Studies show that this disparity persists into adulthood. Using the National Survey of Family Growth, researchers found that bisexual women are more likely to report an unintended pregnancy than heterosexual women, heterosexually-identified women who have sex with women (WSW) are more likely to report mistimed pregnancy, and bisexual and heterosexual WSW report lower mean happiness about their pregnancies (Everett et al., 2017).

While unintended pregnancy is a dominant measure of reproductive health, it is an imperfect measure. However, understanding the context of this concept is vital for developing and exploring alternatives that may be more accurate. Researchers have used pregnancy intention as

an indicator of population-level reproductive health since it first emerged as a concept in the United States after World War II (Santelli et al., 2003). Currently, researchers define unintended pregnancy as a pregnancy that is reported as either unwanted or mistimed. Unwanted pregnancies are pregnancies individuals indicate as not ever wanted. Mistimed pregnancies are pregnancies that individuals indicate are desired, but that happened sooner than a woman would have ideally wanted (Finer & Zolna, 2016). The pregnancy literature has evolved to view pregnancy intention as a flawed concept and measure that fails to adequately capture the lived-experiences of trying to achieve, space, and time pregnancies (Santelli et al., 2003; Santelli et al., 2006).

Additionally, there is a concern that intention is not a salient concept to individuals, as individuals may not form intentions before becoming pregnant (Borrero et al., 2015; Sable, 1999; Santelli et al., 2009). Studies have also shown that many women feel ambivalence around pregnancy (Brückner et al., 2004; Zabin et al., 1993). This body of literature has proposed several alternatives, though these alternatives have yet to be adopted by researchers on a large scale. These alternatives include measures of pregnancy acceptability—or assessing how acceptable a pregnancy is to women once it occurs (Aiken et al., 2016)—and reproductive autonomy—or measuring the extent to which women feel in control of their reproductive decisions (Dehlendorf et al., 2018). Further, disparities in unintended pregnancy among queer women often justify the inclusion of queer women in reproductive health research. While this concept is imperfect, it is a key piece of the literature around queer pregnancy. Neither measures of pregnancy intention or the proposed alternatives consider the role of queer identity. This study aims to fill this gap and provide a first step in exploring how queer individuals construct the meaning of pregnancy and pregnancy desires in their lives.

Given the documented disparities in unwanted pregnancies, queer women and gender-expansive individuals may need and seek abortion care. However, data on the sexual identity of abortion patients remain limited, and reproductive health-related studies are only beginning to collect data on sexual orientation and gender identity. A recent study found that while the overwhelming majority of patients included in the Guttmacher Institute's Abortion Patient Survey identified as heterosexual, roughly 5% identified with a queer identity (e.g., bisexual, lesbian, or queer) (Jones et al., 2018). An analysis of Guttmacher's Abortion Provider Census revealed that several hundred trans and gender-expansive individuals sought abortion care in 2017 (Jones et al., 2020). Studies relying on measures of self-reported abortions suggest that abortion is common across queer women's lives (Marrazzo & Stine, 2004). Bisexual adolescents are more likely to terminate a pregnancy than their heterosexual counterparts, a difference that persists into adulthood (Tornello et al., 2014). When examined longitudinally, all sexual minority groups, except lesbians, were more likely than heterosexual women to experience an unwanted pregnancy or terminate a pregnancy (Charlton et al., 2019). While these studies help establish the prevalence of abortion among queer and gender-expansive individuals, studies have yet to investigate how the experiences of considering, seeking, and processing and contextualizing an abortion may differ for queer or gender-expansive individuals.

Several hypotheses about the drivers of these disparities have emerged from these analyses. Possible explanations include inadequate access to services, providers who are uneducated about the reproductive health needs of queer individuals, and discrimination in health settings (Agénor et al., 2014; Greene et al., 2019) Further, qualitative work in this area suggests that heteronormativity and cultural scripts around pregnancy, contraception, and reproductive health may also play a significant role (Carpenter et al., 2019; Everett et al., 2019; Higgins et al., 2019).

Queer women may view pregnancy and contraception as heterosexual concerns. They may be worried about the response from their community if they do engage in sex with men or become pregnant. Structural and social forces not only create barriers to services but may also impact individuals' ability to determine their options, desires, and goals around pregnancy.

This dissertation research examines how queer-identified women relate and respond to pregnancy, including the role of sexual identity in shaping their experiences. This dissertation is comprised of three papers. The first paper, presented in chapter one, outlines how queer women and gender-expansive individuals assigned female at birth consider pregnancy and family planning in the context of their lives and identities and outlines the most salient factors in informing pregnancy desires. The second paper discusses the experiences of queer women and gender-expansive individuals seeking abortion, and the unique ways that queer identity shaped abortion experiences and attitudes. The third paper documents negative experiences in the healthcare system and the strategies that individuals use to meet their health needs despite barriers to queer-inclusive care.

Collectively, these papers have important implications for both social work and family planning research. This research is central to the concerns and approaches of social work, as the social work profession is concerned with the dignity and well-being of individuals and families, addressing social injustice, and centering the voices of the individuals experiencing injustice. Further, this study aims to bridge reproductive justice and social work research. Finding from this study can also inform family planning research and clinical practice about the unique pregnancy experiences and needs of queer individuals. Understanding the role of sexual identity in pregnancy and reproductive health is key to developing queer-informed care and to affirming reproductive justice for queer people.

Reproductive Justice as a Guiding Framework

Reproductive justice is the guiding framework for this dissertation study and informed both conceptualization of the research questions and study design. In using a reproductive justice (RJ) framework, I would be remiss if I did not first address the history of reproductive justice as a framework and a grassroots movement founded by Black and Indigenous women of color (Ross et al., 2016; Ross & Solinger, 2017; Smith, 2005). RJ is a rejection of traditional reproductive health and rights movements that leave out the concerns of women of color (Luna & Luker, 2013). Instead, by illuminating how White women's reproductive concerns overshadow those of women of color in traditional narratives and activism around reproductive rights, RJ reveals the "breadth of reproductive politics beyond abortion provision"(Luna & Luker, 2013, p. 350-351).

Additionally, reproductive justice advocates and reproductive health and rights advocates usually divide down racial and class lines, with women of color concerned for reproductive justice, while White and upper-class women have focused on increased access to contraception and abortion (Ross & Solinger, 2017; Smith, 2005). This history is important for grounding reproductive justice and highlighting the importance of women of color to the movement. Reproductive Justice is a rejection of rights-based or health-based frameworks and focuses on a more holistic view of reproductive autonomy and healthy family formation.

Reproductive Justice guides this study in three ways. The first is the notion that both the choice to avoid having children and the decision to have children are valid, and the ability to make this choice freely is a matter of justice. This tenet of reproductive justice is the impetus for including both queer individuals seeking to become pregnant and individuals who did not want to become pregnant in the qualitative sample. Second, reproductive justice recognizes the range of factors that contribute to safe and healthy pregnancies. RJ insists "on analyzing a range of

policies and practices as part of an interconnected system" extending the focus beyond just the individual, and looking at both the disparities in outcomes across populations and the role of macro factors in shaping outcomes for individuals (Luna and Luker, 2013, p. 329). Thus, qualitative data collection in this study aims to contextualize individuals in their environment and their identity by using a modified grounded theory informed by a constructivist approach. Finally, reproductive justice also informed the process of research. In keeping with a reproductive justice framework, simply using concepts from RJ is not enough. Research must also be carried out in ways that are compatible with reproductive justice, viewing research as the co-production of knowledge with communities most impacted (Gomez et al., 2020). I chose a qualitative study in part to center queer voices and to contribute original research that focused deeply on the experiences of queer individuals. I also centered queer voices in the data analysis process by hiring research assistants who identified as queer. In keeping with principles of economic justice, I paid my research participants for their time and emotional labor, and I paid research assistants a fair wage for their work. I also attempted to maintain connections with my research participants and ensure that they knew what happened with their data by asking participants if they would like to be notified (by email) of research talks or publications that result from the study. An RJ lens will be used to discuss the study findings and implications.

Methods

In each of the three empirical papers, I outline the methods of data collection and data analysis processes used; thus, this section focuses on detailed descriptions of recruitment and data collection, which are common to all three papers.

Given the lack of conceptual clarity around pregnancy desires and experiences in the context of queer women's lives, a grounded theory study is an important first step. According to

qualitative methodologist, John Creswell, grounded theory is an appropriate study design to use when "a theory is not available to explain or understand a process" (Creswell & Poth, 2017, p. 88). Methodologist Kathy Charmaz offers a constructivist approach to grounded theory that emphasizes that social realities are multiple and constructed, contextualizing the researcher in their research, and using iterative data to construct "abstract analytic categories" in the service of theory creation (Charmaz, 2014). Charmaz's approach includes social context, challenges the researcher to address issues related to identity, and offers an inductive and iterative data collection and analysis process.

Sampling Procedures

I used a theoretical sampling technique to recruit twenty-two participants. Theoretical sampling involves allowing the sampling criteria to respond to new themes and requires simultaneous data collection and ongoing analysis of the data as they are collected. This technique results in more precise and specific findings and clarity, and also a more nuanced and complete theoretical understanding of the phenomenon of interest (Charmaz, 2014). To begin, individuals were eligible if they:

- Identify with a sexual minority identity, i.e., queer, lesbian, bisexual, pansexual, fluid,
- Were assigned female at birth (AFAB),
- Are 18 to 40 years old,
- Speak and read in English,
- Are thinking about getting pregnant in the next five years or have already been pregnant.

After conducting the first six interviews, I re-assessed the theoretical categories represented by the data and updated the recruitment criteria to only include individuals who had previously been pregnant, including individuals who got pregnant when they did not want to be or experienced a pregnancy they described as "unwanted" or "unexpected." I had reached theoretical saturation with individuals intending to become pregnant but had additional themes to explore around those who had already been pregnant. Recruitment concluded when I reached saturation, marked by the

emergence of no new themes in additional interviews and sufficient data to support the emerging constructs. (Charmaz, 2014; Starks & Brown Trinidad, 2007).

Recruitment

I employed online recruitment strategies that have been successful in similar studies with queer women, including posts on social media pages and list serves targeting queer individuals (with permission) (McCormack, 2014; Pedersen & Kurz, 2016). In addition to using posts on Facebook and list serves, I had planned to use paid Facebook advertisements to assist with recruitment. However, the response and interest were overwhelming. After my first wave of recruitment, 68 individuals filled out the screening survey, 53 of whom were eligible. In the second wave of recruitment, an additional 17 individuals responded to the screening survey, all of whom were eligible.

Interested participants contacted the study via email or phone (phone call or text message). To allow for secure, accessible communication in several different modes, I obtained an IRB-approved email address using a wisc.edu account, and I set up a Google phone number that forwarded calls and texts to my personal cell phone (but masked my phone number for participants). Once a participant contacted the study, I responded with an eligibility questionnaire via the survey platform, Qualtrics (See Appendix A: Screening Questions). The questionnaire both screened for eligibility and asked demographic questions to assist in the sampling. Depending on eligibility and how their characteristics fit into the theoretical categories of interest, I contacted the individual to schedule an interview.

Once an interview was scheduled, I sent participants an information sheet that outlined the purpose of the study, risks, and benefits of participating, and information on their rights as a participant. This sheet was sent in place of a consent form as the IRB approved a waiver of signed

consent. However, I still began each interview by going over the information sheet and asked for verbal consent.

Final Sample

The final sample included seven individuals who were considering pregnancy but had not previously been pregnant, and fifteen individuals who had previously been pregnant. Of the latter fifteen, eleven had experienced an "unwanted" or "unexpected" pregnancy. In addition to sampling on pregnancy desires, I also attempted to create a diverse sample in terms of sexual identity, socioeconomic status, and racial identity. Using the screening survey, I was able to select interested participants based on these characteristics.

While I was quite successful in obtaining a diverse sample in terms of sexual identity, I was less successful in obtaining a racially diverse sample. Sixty percent (n=15) of my participants were White. The difficulty recruiting participants of color is likely due to the documented whiteness of LGBTQ spaces in general and compounded by the social spaces and networks that I can access (Logie & Rwigema, 2014). Lack of racial diversity is undoubtedly a limitation of my study. The sample was also relatively educationally privileged. Most individuals (n=19) had a Bachelor's degree or higher. Despite high levels of education, roughly half the sample (n=12) self-described as "lower middle class" or "working poor" or experiencing financial hardship in some way. This is in line with patterns of economic inequality in general, as sexual minority women and gender-expansive individuals hold lower socioeconomic statuses and experience higher levels of unemployment and economic hardship than their heterosexual and cisgender peers (Conron et al., 2018).

Individuals who were assigned female at birth and identified as queer were all eligible for the study, meaning some, but not all, participants identified as women. This study included

cisgender women and non-binary, genderqueer individuals or individuals questioning their gender identity. Thus, I describe the sample as "queer cisgender women and gender-expansive individuals" to be inclusive of these identities (Jahn et al., 2019). Individuals who identified as transmen/transmasculine were not included.

Data Collection

Interview Guide

This study relied on in-depth, semi-structured interviews as the primary form of data collection. While grounded theory studies can rely on multiple methods of data collection, because this study is specifically interested in individual experiences and ideas, in-depth interviewing was the most appropriate data collection method. Charmaz (2014) describes an intensive interview as needing to begin with "broad, open-ended questions" and moving to "focus[ed] interview questions to invite discussion" (p.65). The interview protocol for this study contains carefully crafted, non-judgmental, open-ended, and focused questions. The focused questions center around thoughts and feelings about pregnancy, ideas about "ideal" pregnancy or parenthood, resources needed around pregnancy, as well as questions exploring participants' identities. The interview began with targeted questions for women who have been pregnant and women who have never been pregnant. Grounded theory is flexible enough to follow where the data lead, so as themes emerged from data collection, the interview guide was updated to address new information with new respondents.

To ensure the strength of the interview guide, I conducted three pilot interviews (Padgett, 2016). I sought individuals that fit the study criteria but have some amount of knowledge of the field (e.g., queer researchers, advocates, clinicians). For each of the pilot interviews, I conducted a full interview. At the end of the interview, I asked for feedback about the questions and the flow of the interview. These participants were compensated like study participants. I incorporated their

feedback in the final study interview guide, but did not include their data in analysis or include them in the final sample (See Appendix B for the finalized interview guide).

Interview Protocol

I conducted interviews either in person (for participants in the Madison area at a neutral location such as a community library) or virtually, using the platform Zoom. Participants in Madison had the option of either participating in an interview in person or via Zoom, to increase accessibility and comfort with participating. Interviews were recorded, with permission from the participant, and transcribed verbatim by a professional transcriptionist. I also wrote interview notes during the interview and wrote brief memos after each interview.

At the end of each interview, I asked participants if they would be willing to participate in a brief follow-up interview after the initial interview (Padgett, 2016). These interviews took place approximately 2 to 6 weeks after the initial interview. At this time, I asked participants to reflect on the interview experience and share insights that emerged since the interview and to respond to any follow-up questions that emerged based on the analysis. Participants were compensated $30 for completing the first interview and an additional $15 for completing the second interview.

To both increase the credibility of the findings and ensure queer voices were centered in the research, I employed several strategies. First, at the end of the interview, I asked the participants several questions about their desired involvement in the study. I asked participants how they would like the data communicated ("In your ideal world, who would know about this study and what ways would it be communicated?"). One purpose of the interview memos was to debrief the interview experience and to reflect on my internal reactions to the interview (Creswell & Poth, 2017).

Member Checking

In qualitative research, member checking is a strategy for ensuring rigor and trustworthiness of the data (Birt et al., 2016). My original proposal included a member checking protocol that involved sending participants their interview transcripts with codes applied, asking for their feedback. I intended to ask participants if I accurately classified their experiences and if the themes and codes that I developed felt like appropriate representations of their experiences (Harvey, 2015). However, participants did not express interest in being part of this process. Only one participant said they would be interested, and several more said they might be interested. Thus, I decided not to engage in this strategy.

Instead, I was able to use the follow-up interviews for member checking, albeit much less in-depth or rigorous than the original proposal. In addition to asking participants to clarify details or experiences, I also asked them to comment on broader themes. These clarifications played a vital role in either developing themes or providing disconfirming cases. For example, the quote below represents these questions:

> Interviewer: Another thing that I've heard in a lot of my interviews was that people said being pregnant made them "feel straight." Does that resonate with you?
>
> Lynn: Well, it doesn't resonate with me, but I get it because pregnancy is one of those things that mark your life. You graduate. You get your first big job. You get married. You get pregnant. They're life markers. And I think that those life markers are very straight or are very heteronormative. It is what comes along with A very normal, ordinary life. And that' fine. But I don't know that I felt we're straight…I don't really think it did because my wife was with me at all of my appointments and with me all along the way. And I don't know. Just having her there with me in and of itself was not straight.

In this instance, a more nuanced experience emerged, allowing me to refine the emerging theme. I incorporated participants' reactions into my codebook development and analysis. I should note that I was not able the conduct follow-up interviews with all participants, which is a limitation of

this study. In future studies, I would suggest using a systematic approach or designing a focus group for member-checking. Another method could involve presenting findings to a group of four to eight individuals who meet eligibility criteria but were not research participants, and asking for their feedback, and then revising analysis based on their feedback and reactions.

While not related to increasing rigor or validity, member checking also provides the opportunity to inform participants about what happens with their data. At the end of each interview, I asked participants if I could contact them to inform them of presentations or publications resulting from this study. All of the participants agreed to be contacted with this information. While I have not been able to share anything with them yet, I intend to follow up as manuscripts are published.

Data Analysis

Each of the three papers details the data analysis procedures employed for each paper. Thus, this section focuses broadly on the data analysis process, including administrative and logistical details. Four students served as coders for this project. One was an undergraduate student, and three were MSW students. I trained all four students to code and use Nvivo software. I had also intended to ask participants if they would like to be involved in data analysis. Engaging participants in data analysis ended up being much more logistically cumbersome than I had anticipated. I asked the first five participants if they wanted to participate in this way, and only one agreed. Given this lack of interest, I decided member-checking in this way was not feasible.

Interviews were coded using a grounded theory approach (Charmaz, 2014). I used two phases of coding: Open coding and focused coding. One of the research assistants and I coded the first four interviews for codebook development. We met to discuss the initial list of codes, organizing and winnowing initial codes until we reached agreement on the theoretical categories

(Charmaz, 2014). The codes that we developed during the open coding phase laid the foundation for the codebook. Then, the same research assistant and I applied these codes to the first four interviews. The next step consisted of focused coding, taking the initial codes, and refining or expanding them. After this initial open and focused coding of the first four interview transcripts, subsequent transcripts were coded simultaneously with data collection (as opposed to first conducting all of the interviews and then coding all of the interviews) using a method of constant comparison to follow developing themes. If new theoretical categories emerged from subsequent interviews, the coding team went back and re-coded previous interviews to ensure we captured all instances of the new code. At least one additional coder and I coded each transcript to increase the reliability. We met bi-weekly to discuss discrepancies in coding and discussed discrepancies until we came to a consensus. The coding team used the qualitative data analysis software, Nvivo, for all coding (QSR, 2017). Once we began analyzing the data, we used Nvivo to create coding reports of key themes. The summary information in the coding reports helped identify and define the foci of each of the three subsequent chapters. The first paper reflects an analysis of pregnancy desires, including the sub-category of pregnancy desires versus parenting desires. The second presents a targeted analysis of codes related to abortion. The final paper offers an analysis of experiences in the health system.

II. Paper One:

Pregnancy and Parenting Desires for Queer Cisgender Women and Gender-Expansive Individuals Assigned Female at Birth

Abstract

As the LGBTQ+ community gains acceptance in society and access to new institutions, such as marriage, more traditional ways of family building are becoming increasingly possible for LGBTQ people. However, LGBTQ+ family formation and specifically, family formation through pregnancy, is not well understood. This study used a modified grounded theory approach to understand the role of queer identity in pregnancy desires and decisions among individuals assigned female at birth, who identified as queer. Investigators conducted 22 semi-structured interviews with individuals who identified as queer, were assigned female at birth (AFAB), and either had been pregnant or were planning on becoming pregnant in the next five years. Participants described first desiring parenthood, and then choosing pregnancy among the options available for queer individuals to become parents (e.g., fostering or adoption). Individuals seeking parenthood understood their options in relation to alternative paths continuously reassessed their options as they encountered barriers to their family formation goals. Numerous individual, relationship, and structural factors informed pregnancy desires, the choice to seek pregnancy, and experiences with pregnancy. Supporting queer individuals in a range of pregnancy and parenting options is vital to fully recognizing queer individuals as parents and participants in a fundamental human experience—family building.

Pregnancy and Parenting Desires for Queer Cisgender Women and Non-binary Individuals Assigned Female at Birth

As the LGBTQ+ community gains acceptance in society and access to new institutions such as marriage, more traditional ways of family building are becoming increasingly possible. Recent data suggest that 48% of LGBTQ people between the ages of 18 and 35 are actively planning on building families now or in the future (Family Equity Council, 2019). However, LGBTQ+ family formation and specifically, family formation through pregnancy, is not well understood. Research on family building and pregnancy have traditionally not included LGBTQ+ populations, thus not accounting for their unique needs and experiences. Studies that focus on LGBTQ+ individuals focus on the community broadly, which overlooks the unique, nuanced experiences of subgroups within this community. The current study fills these gaps by examining pregnancy and parenting desires of queer cisgender women and gender-expansive individuals assigned female at birth (AFAB).

Parenting among queer individuals is increasingly common. While estimates of LGBTQ+ families remain limited, one analysis by the Williams Institute suggests that 37% of LGBTQ+ adults are parenting a child under the age of 18 (Gates, 2013). LGBTQ+ individuals become parents in a variety of ways. Recently, more options for family building have become accessible to LGBTQ+ individuals, given the rapidly changing social norms around marriage and family building. Many queer individuals and couples are choosing to become parents through adoption, foster care, or assisted reproductive technologies (ARTs) (Family Equity Council, 2019).

Queer women experience both intended and unintended pregnancies.[1] Previous estimates suggest that 80% of bisexual women and 37% of lesbian women will experience pregnancy in their lifetime (Valanis et al., 2000). A recent analysis of the 2014-2016 Behavioral Risk Factors

Surveillance Survey (BRFSS) showed that 3.4% of reproductive age sexual minority women were pregnant, compared with 4.2% of reproductive age heterosexual women (Gonzales et al., 2019). These analyses do not indicate the wantedness or intendedness of these pregnancies, but studies have shown disparities in unintended pregnancy between heterosexual and sexual minority women, in both adolescence and adulthood (Charlton et al., 2013; Everett et al., 2017; Hodson et al., 2017). Recently, some researchers have attempted to understand how queer women conceptualize pregnancy desires. Because queer AFAB individuals experience pregnancies—both intended and unintended—specific, identity-sensitive research on this topic is needed.

Structural factors, including economic and legal constraints, contribute to parenting and pregnancy decisions among queer individuals. In a study examining the use of ARTs, Hayman et al. (2015) found that in addition to financial barriers, women seeking pregnancy also had trouble finding queer-competent providers. Legal constraints around adoption also make adoption a difficult or impossible choice. While technically same-sex couples can adopt in all 50 states, some states allow state and private adoption agencies to decline foster or permanent placements to LGBT parents (Movement Access Project, 2019). Legal, social, and structural barriers shape not only what is possible but what individuals believe is possible for them. While LGBQ+ rights (specifically LGBQ+ individuals, because literature has not fully included trans rights in analyses) have expanded significantly in the past 20 years, the LGBQ+ community still faces legal barriers in building their desired families. Several studies examining options for parenthood find that lesbian and bisexual women are more likely to choose donor insemination, as they view insemination as the least complicated legally (Park et al., 2016; Riskind et al., 2013). Collectively, these findings illustrate aspects of the relationship between structural factors and the ultimate choices individuals believe they have around parenting.

To date, the literature on queer women's experiences pregnancy focuses either on wanted pregnancies using ART or disparities in unintended pregnancy rates, setting up a false dichotomy of these as unrelated phenomena. However, the disparities in unintended pregnancy and the barriers to ART and wanted pregnancies stem from the same causes—inadequate queer health care, discrimination, and stigma (Everett et al., 2018; Higgins et al., 2019; Gregg, 2018). Thus, it is essential to talk about the range of pregnancy experiences together.

Limited narratives of pregnancy exist outside a heteronormative context. Estimates of the prevalence of queer pregnancy have helped challenge the idea that queer individuals either cannot or choose not to become pregnant. Further, queer scholars have interrogated how pregnancy can be both a way of assimilating into heterosexual culture and boundaries (Mamo, 2007). Research exploring pregnancy desires among queer women using contraception demonstrated that while some queer women felt like pregnancy and their identity could not be reconciled, others were more impacted by the perception that pregnancy was a heteronormative experience (Carpenter et al., 2019). Because pregnancy can happen in a variety of contexts, not just heteronormative ones, research needs a framework that pushes our understanding of who gets pregnant, and how pregnancy might fit into queer identities.

The process of becoming pregnant as a queer woman is often profoundly difficult, emotionally, socially, logistically, and financially (Chapman et al., 2012; Kazyak & Woodell, 2016; Renaud, 2007). The goal of this study was to understand how pregnancy fits into the lives of queer cisgender women and non-binary AFAB individuals. This understanding is needed to challenge traditional ideas about pregnancy and to inform healthcare that is responsive to the needs of queer individuals as they consider pregnancy.

Methods and Materials

This study used a modified grounded theory approach to understand the role of queer identity in pregnancy desires and decisions among individuals assigned female at birth who identified as queer. The main research questions were:

1. How do queer AFAB individuals consider pregnancy and family planning in the context of their lives and identities?
2. What is the relationship between their considerations about pregnancy, resources and barriers, and actions they take to achieve pregnancy (or not)?
3. How can clinical and social services be responsive to the specific needs of queer women and non-binary AFAB individuals as they consider pregnancy?

To date, no theory accounts for the role of sexual identity in influencing pregnancy feelings and desires or resulting actions. Thus, a grounded theory approach allows investigators to provide a theoretical explanation of pregnancy desires and the subsequent decisions made by queer AFAB individuals, in the context of their identities and social environment (Charmaz, 2014). This approach facilitated the exploration of pregnancy desires while also allowing additional or alternative conceptualizations of pregnancy experiences to emerge.

Sampling and Recruitment

Twenty-two participants were recruited via targeted posting on social media. For traditionally hard to reach populations, such as LGBTQ+ individuals, social media is an effective recruitment strategy (McCormack, 2014). Per a modified grounded theory approach, investigators used theoretical sampling. Thus, the initial recruitment criteria were broad. As data collection and analysis continued, we narrowed recruitment to be inclusive of specific theoretical categories.

Interested participants were asked to contact the study via email, text, or phone call. Interested participants completed an eligibility survey. The purpose of the survey was two-fold. First, it established eligibility. Second, it aided with theoretical sampling, as it allowed identification of interested participants that fit specific theoretical criteria.

Theoretical sampling was used to understand the diverse range of pregnancy experiences, including both clearly intended and clearly unintended pregnancies, in the context of queer identity. Initially, individuals were eligible to participate if they were between 18 and 40 years old, assigned female at birth, identified as queer (including lesbian, bisexual, pansexual, queer, or any other non-heterosexual identity), and were trying to get pregnant in the next five years or had already been pregnant in order to capture a range of pregnancy desires. After the first ten interviews, we narrowed recruitment only to individuals who had already experienced at least one pregnancy. Through analysis, it became clear that we had reached theoretical saturation with individuals who were planning a pregnancy in the future, but it became clear that we need additional insight into desires and decisions made around a pregnancy that had already occurred. Overall, the goal of this sampling method was to capture a broad range of perspectives, sampled on specific theoretical categories to increase representation of diverse contexts and experiences of pregnancy among queer individuals.

In order to explore pregnancy desires and intentions in the context of queer identity, individuals who were assigned female at birth and identified as queer were all eligible for the study. The focus of this study was sexual identity and sexual orientation; however, these identities significantly overlap with gender identity, and gender identity is often fluid overtime. This study included both cisgender women and also included people who did not identify as women, non-binary, genderqueer, or questioning their gender identity. Thus, the sample is described as "queer cisgender women and gender-expansive individuals" to be inclusive of these identities (Jahn et al., 2019). Individuals who identified as trans men/transmasculine were not included.

If an interested participant was eligible and fit within an open sampling frame category, the lead author contacted them to schedule an interview. Interviews took place via Zoom or in-person

if the participant was local. For Zoom interviews, participants chose whether they wanted to speak via video chat or phone. Local participants chose a convenient, private location (they were provided a list of local libraries or community settings if they were unsure where they wanted to meet). Interviewees were compensated with a $30.00 Amazon gift card for participating in an initial interview and $15.00 for participating in a follow-up interview (explained more below).

Data collection

To ensure the strength of the interview guide, we conducted three pilot interviews (Charmaz, 2014; Creswell & Poth, 2017). These interviews were conducted with individuals that fit the study criteria and have some amount of knowledge of the field (e.g., queer researchers, advocates, clinicians). Pilot interviewees completed a full interview and provided feedback about the questions and the flow of the interview. These participants were compensated like study participants. However, their data was only used to refine the interview guide, not in data analysis.

Interviews lasted between 42 and 90 minutes. The first author, a trained qualitative interviewer, conducted ass interviews using a semi-structured interview guide that included questions on queer identity, pregnancy plans, past pregnancies, and experiences seeking and receiving reproductive health services. Interviews were audio-recorded—with permission from the participant—and transcribed verbatim by a professional transcription service. Identifying information was removed from the transcript. At the end of the interview, the interviewer asked each participant for a pseudonym and their preferred pronouns. All names included in the findings are pseudonyms and pronouns chosen by the participants.

The twenty-two interviewers included in data analysis were asked at the end of the initial interview if they would be interested in brief follow-up interviews. These took place between one

and four weeks after the initial interview, depending on participant interest and schedule. The purpose of the follow-up interviews was to allow participants to reflect on the interview experience, share insights that had emerged since the interview, and to respond to any follow-up questions the researcher had. Additionally, these interviews were an opportunity for participants to clarify responses and the study team to ensure we adequately captured their experiences. Out of 22 participants, all but two agreed to a follow-up interview, and an additional four were lost to follow up. The first author wrote memos after every interview, recording initial impressions, and non-verbal communication from participants.

Data analysis

Interviews were coded using a grounded theory approach in two phases: open coding and focused coding (Charmaz, 2014). Two members of the research team, the first author and a research assistant, conducted independent, open co-coding of the first four transcripts to create a preliminary list of codes. Themes made it onto this list if they either were prominent in more than one transcript or if they were present in all transcripts. Once open coding was complete, codes were applied to transcripts as interviews were completed. Investigators coded transcripts simultaneously with data collection using a method of constant comparison to follow new themes that emerged from the data. If a new theme emerged, coders re-coded previous transcripts to identify those themes in earlier interviews. Theoretical saturation was reached when no new concepts emerged during the interviews. Each interview was coded by two coders independently, the first author and a masters-level graduate student trained in qualitative methods, who then met to discuss any discrepancies. The follow-up interviews were coded using the same codes as the initial interviews. Follow-up interviews focused on the same central themes as the initial

interviews, and thus did not require amending the codebook. All coding was done using Nvivo 12 (QSR, 2017).

For the present analysis, we conducted targeted coding within several larger codes, including parenting desires, pregnancy desires, and queer identity. The interviews presented below offered a rich description of pregnancy and parenting decisions, allowing for selective analyses focused explicitly on pregancy decisions and the context of these decisions for queer individuals assigned female at birth (Charmaz, 2014).

This study was approved by the University of Wisconsin-Madison Institutional Review Board.

Participants

The majority of the participants were in their 20s (n=12), identified as cisgender women (n=15), identified as white (n=15), and had a college degree or higher (n=19). Approximately one-third had never been pregnant, two-thirds had previously been pregnant, and 40% were currently parenting a child that they had given birth to (n=9).

Table One: Participant Demographics (Paper One)

Demographic Characteristics N=22			
Age Range		**Highest Education**	
20-24	3	High school	3
25-29	9	Bachelor's degree	13
30-34	4	Graduate/professional degree	6
35-40	6		
Gender Identity		**Previous Pregnancies**	
Woman/cis woman	15	None	7
Non-binary	3	1	12
Genderqueer	2	2	1
Other[1]	2	3+	2
Sexual Identity		**Partnership Status**	
Queer	5	Not partnered	1
Bisexual	3	Partnered/living together	9
Lesbian	2	Married	12
Pansexual	3		
Queer + another identity (bisexual or pansexual)	9		
Race/ethnicity		**Previous Experience with Abortion**	10
White	15		
Mixed Race	3		
Latina	2		
Native American	2		

Results

Results center around two main themes: (1) Participants described first desiring parenthood and then pursuing pregnancy. Paths to parenthood—e.g., having a biological child through pregnancy, fostering, or adoption—were understood in relation to one another, and were continuously reassessed. (2) Numerous, diverse factors informed pregnancy desires, the choice to seek pregnancy, and experiences with pregnancy. These central themes, elaborated below, are reflective of patterns across interviews. Names presented below are pseudonyms selected by the participants. Participants also indicated which pronouns should be used. Quotes are presented with the participant's age, identities, and experience with pregnancy for additional context.

Pregnancy as one path to parenthood

Participants described pregnancy and parenting as distinct desires and were constantly re-evaluating their path to parenthood. Participants were explicit about how these two concepts were different. Participants were also clear that becoming pregnant in the context of a queer relationship took additional planning and thoughtfulness. For example, Raven (34, lesbian, four previous pregnancies), had two pregnancies in the context of a marriage to a heterosexual man. When asked what it was like to plan a pregnancy in her current partnership with a woman, she said:

> And that was such a different thing because you can't just have a conversation in line for a movie and be like, 'Hey, I think I want another kid'…. And then a month later, be pregnant, which is essentially how it went with my second kid… So it was very different. So it required a lot more research and resources than it had in the past.

Most participants were aware that pregnancy was not the only, or even the obvious, choice for building a family. For example, Isabel (23, bisexual, two pregnancies that ended in abortion) described wanting to have children but being very clear that she does not want to be pregnant again.

For participants in partnerships with individuals assigned male at birth for whom pregnancy was more readily accessible, the process of deciding how to build their families was still thoughtfully considered. Lily (31, bisexual, trying to get pregnant) who partnered with a cisman, was very open to other ways of becoming a parent. She described being clear that she wanted to be a parent but was not sure about the "logistics." She said she "made the decision to be a parent when I was 16 years old, and it's just more, from that point on, just like a matter of when and how." Sylvia (23, bisexual, trying to get pregnant), for example, considered adoption and fostering. She described trying to "break up" or "re-negotiate" presumptive gender roles within her marriage, so building a family through pregnancy was not an automatic choice for her. She attributed this choice to being bisexual and being aware that "things don't have to be this way."

Queer identity added a dimension of thoughtfulness and intentionality even for individuals who identified as queer but were in relationships with cisgender men.

Re-evaluating paths to parenthood

Decisions about how to build a family were not made at one time but were continually re-assessed as participants encountered barriers or gained new information. For example, Amber (28, queer lesbian, trying to get pregnant), and her wife considered the best way to become parents several times. First, after several unsuccessful attempts to become pregnant, Amber took a break because "financially, we just couldn't do it." Then, after several more unsuccessful attempts, her wife decided to start trying to get pregnant, despite not initially wanting to get pregnant because she is "so butch." Lynn (38, queer, one previous pregnancy) and her wife wanted to try to get pregnant, but had they not gotten pregnant, Lynn thought that they would have given up on having a child altogether. Lynn described being realistic about the possibility that she would not get pregnant and that she and her wife may have to make a different choice:

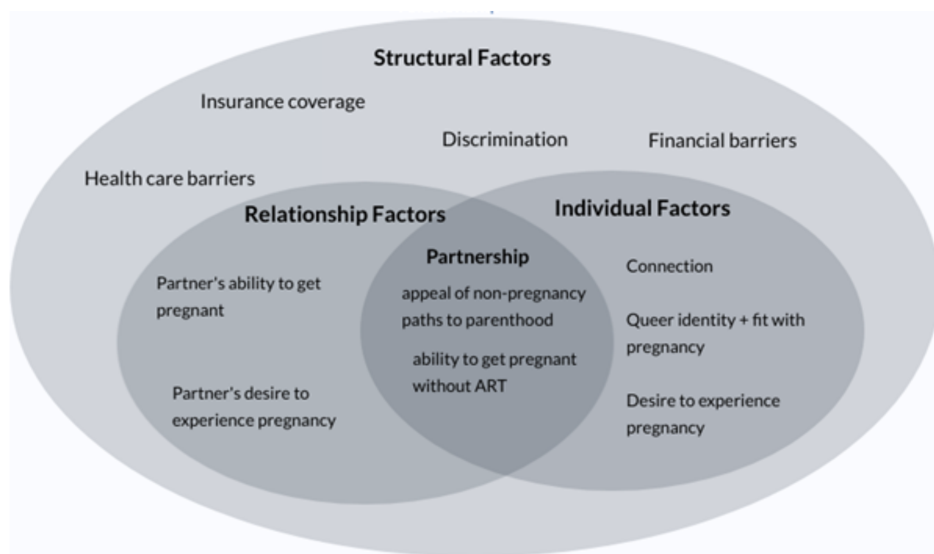
> We decided to do this, and then if that doesn't work, we'll reconsider options. I think adoption was probably one of those, but I don't know if we would have adopted had I not gotten pregnant, ultimately. I don't really know that we would have.

As participants tried to become pregnant and encountered barriers, they reconsidered how and if they should continue their attempts to become parents.

Factors informing pregnancy desires, choice to seek pregnancy, and experiences with pregnancy

Pregnancy desires, the decision to seek pregnancy, and experiences with pregnancy were shaped by individual, relationship, and structural factors. These included participants’ views of pregnancy in the context of queer identity, partner preferences--including their partner’s ability and desire to get pregnant, values around connection, and logistical and financial constraints.

Figure One: Factors informing pregnancy desires and decisions for individuals considering pregnancy in the context of a partnership (Paper One)



Pregnancy in the context of queer identities

Participants' tolerance of pregnancy as a physical phenomenon and view of pregnancy in the context of their queer identity was a key part of sorting through a path to parenthood. Participants who did not want to be pregnant cited the incongruence between their queer identities and pregnancy. Alex (26, non-binary and pansexual, one previous abortion) described several reasons for their abortion, including related to their identity. They said being pregnant felt "wrong" to them as a person who identifies as non-binary. They suspected that had they not had the abortion, they would have felt extremely uncomfortable as a pregnant person. When asked how they were thinking about pregnancy in the future, they responded:

> I think that that piece of it would still be really hard for me, but I do think that I want a family someday. I think that probably adoption would be a better choice for my life and my situation. Regardless of if I'm with someone that I can get pregnant with, I don't think I want to be pregnant again.

While some participants, like Alex, expressed a strong desire to avoid pregnancy because it would be incompatible with their identity, other participants described an intense desire to

experience pregnancy. This phenomenon was connected, in part, to viewing pregnancy in line with their identity. Annie (36, Femme/queer, one previous pregnancy), who had been pregnant previously and gave birth, was very comfortable being pregnant. She described giving birth as "empowering" and wanting to be pregnant again in the future, in part so she could "have that again." Despite also struggling with how "invisiblizing" pregnancy was for her, Annie found comfort in doing "something right":

> I think part of me, even though it was invisiblizing in terms of my identity, my queer identity, felt like I was doing something right for the first time, even though philosophically and theoretically, I totally reject heteronormativity and all that is expected. But it just felt nice to not be the weird one. Or to fit in with everybody in my family. And people know how to relate to you because they were pregnant or have a child.

Jay (27, non-binary and pansexual, currently trying to get pregnant) felt even more so like pregnancy and queer identity were compatible. Jay was excited to turn pregnancy into a queer experience. They were starting to explore gender-affirming care, but held off because they wanted to experience pregnancy and they were worried that they wouldn't be able to get pregnant if they started hormones:

> I think my whole life I've known that I've wanted to have a child and that if I'm able, I want to be pregnant and give birth to that child… I feel excited about being pregnant and having that experience for a lot of reasons… I'm excited for it and kind of wanting to have that experience, integrate it, and continue living my life, and all the things that means.

Many participants talked about the difficulty of being in a same-sex relationship as it related to pregnancy. Annie described how being queer can be limiting while wanting to build a family, and how now that she wants to be pregnant, her queerness is a source of limitation and sadness:

> And then also I feel like totally limited too. I think at this point, I've been out as queer for 20 years or so. I often don't feel shame or sadness about my identity. I mostly just feel confident and excited, and love my queer identity. But I sometimes find myself being jealous of people who can just reproduce without trying.

Similarly, participants voiced frustration with the extra decisions and hurdles they faced in trying to get pregnant that straight couples often do not face.

> Sometimes I feel pretty resentful and frustrated. I am bisexual, so it's not like I always knew that it would have to be complicated to have a child, but also I love my wife, and I'm glad I'm married to her. There's no regret or frustration around that, but it is very inconvenient. There's just a lot of decisions to make that other people don't have to make, and a lot of the financial cost is annoying. I know it's a huge barrier to a lot of people. It's just constantly having to make a ton of decisions that a lot of people take for granted.
>
> (Ava, 28, bisexual/queer, trying to get pregnant)

Partners

Partners also played a significant role in which path to parenthood participants considered, including partners' own relationship to pregnancy, their ability to get pregnant, and their ideas on preferred paths to parenthood. Importantly, most participants were partnered at the time of their interviews, so they could talk about pregnancy and parenting in the context of a specific relationship. Participants considered both their own pregnancy desires and their partners' when making decisions about pregnancy and parenting. For example, Jacqueline (37, lesbian, currently pregnant) and her partner both wanted to be pregnant. Jacqueline described their decision process as "who carries first?" instead of "who carries?" or "how do we become parents?" She explained:

> We actually are both interested in carrying…but I think for the next baby, the plan is for my wife to carry. Certainly, that was a discussion that was who starts first…I think when it came down to it, there was a little bit of a perception that I wanted it more, and that was why we selected me to go first…I think I would have been okay with my wife carrying first, but she was very nervous that I would have a hard time with it…she said, 'You already had a box of children's books. You've wanted this for a really long time.' I think that's why we selected the order of operations.

For others, their partners were either unable or unwilling to carry biological children. For example, Raven and her wife pursued reciprocal IVF, because being biologically connected to her child was important to Raven’s wife, but pregnancy was not something she felt she could tolerate. As Raven described, “my wife has a huge desire to parent, she loves babies, she wants to

parent all day, every day, she would have five billion children if I was willing to give birth to that many. She has no desire to be pregnant." Similarly, Ray's (30, queer and non-binary, trying to get pregnant) partner had no desire to carry a child, which meant Ray would have to be pregnant or they would have to adopt. "I mean they 100% will never use their uterus. So if mine wasn't an option, adoption is the only way."

Participants also voiced interest in building their families in multiple ways to accommodate both partners' preferences. Veronica (31, queer/pansexual, one previous pregnancy) and her wife had one pregnancy and then decided that if they have another child, that they would adopt. Veronica viewed pregnancy and birth as important, but her wife always wanted to adopt, so they planned on building their family in a way that honored both of their wishes.

Maggie's (26, queer, no previous pregnancies) circumstances were unique among the study sample. Maggie's partner is a trans woman who had previously banked her genetic material in order to contribute to a pregnancy in the future. Because of this, Maggie said she would be willing to get pregnant, despite feeling very worried about the risks of pregnancy and the health implications.

> She leans more towards pregnancy. My partner is also a trans woman who has sperm on freeze liquid nitrogen at a facility. So we have the ability to become biological parents with both of our genetic material. It's a question of whether or not using that opportunity would be a waste because it's very fortunate, and it's very nice that she was able to do that.

While many participants were clear about their pregnancy desires independent of their relationship, they filtered these decisions through the context of their current partnerships. Thus, partners' feelings about biology and parenting, as well as their ability and willingness to become pregnant, strongly impacted how participants thought about pregnancy for themselves.

Biological Connection

Values pertaining to biological connection influenced which path to parenthood participants chose. Some participants felt an intense need for a biological connection to their future children. Sylvia described previously feeling much more open to building her family through other ways. However, after her sister's death, she felt much more like she needed a biological connection to her future child: "my sister passed away very suddenly, and so I think the biological component of connection is revealed to me in a whole new way. I don't want to downplay the connections that foster care and adoptions create families, but I think for me right now, that's feeling really powerful." Ava similarly valued a biological connection but was more concerned about what the biological connection would mean for her future children.

> I think if we had chosen to adopt an infant or a small child or a teenager and that was the way that we always chose to parent, I still think that would be distinct from having had a pregnancy and then birth a child just because when you're not the biological parent, even if you are legally and emotionally, there's still always another person who's in that child's mind or body memory.

Others placed less emphasis on being biologically related to a child. Ray, for example, felt as if it simply was not necessary. They understood the draw of pregnancy and biological connection, saying "[it's] a very human instinct to grow a person or have this person that's your own, but it doesn't always have to be like that. **Isn't that what queerness is supposed to teach us**?" Ray's understanding of queerness also pushed them to see a biological component as less critical. Similarly, Maggie thought that it was, in some ways, "selfish" to have a biological child when they could adopt. She said, "It would be nice in some ways to [have a biological child], but it doesn't feel necessary for me to find fulfillment."

Especially for participants in relationships with other AFAB individuals, participants had to consider the role of biology for their partner as well as their desire to be genetically related to their future children. Similarly, partners had varied views on the importance of the biological

connection. While it was a non-factor for many, some participants described their partner's need for biological connection to be a huge factor in how they decided to build their families. For example, Ava and her partner were both planning on being pregnant. For Ava's partner, the biological component felt incredibly strong. Ava suspected her "very butch" partner would struggle with gender dysphoria during pregnancy; however, her desire for biological connection outweighed this concern.

> Yeah. She wants to have a biological child at some point. My parents-in-law, they have two kids, and they thought they were two little girls, and now they have a son, and my wife will probably transition at some point after giving birth...If my wife doesn't have a child, then there won't be any biological grandchildren from that side of the family, and my wife definitely has some kind of drive to see the next generation happen with her genes. She wants to see what her own biological child would be like.

Connection and biological connection became more complicated for the participants of color. All participants of color explicitly expressed the desire to have a child of the same race or ethnicity and viewed this as a consideration. This added challenges for participants attempting to become pregnant. For example, Amber, who is Latina, had difficulty finding a Mexican donor.

> When you're looking for a specific donor, things can be very challenging as well, because we're both Hispanic. My wife is Mexican. I am mixed, and we are looking for a Mexican donor. In cryobank world, that's very rare. There are not a lot of donors who are Mexican identified.

Amber eventually found a known donor, who then left the state, so they had to start the process of finding a Mexican donor over again. Similarly, Ava, who is Native American, struggled with the idea of having a non-Native child. Ultimately, she chose a donor who is not Native American and felt “resigned” to the fact that her future child would be “more white than not.” Despite making that compromise, she still felt a personal and ethical dilemma related to this choice. She went on to say, “It just adds this extra layer of an ethical dilemma of I'm actively choosing to give my child a biological parent who doesn't share this identity that I have. Am I robbing my

future children of this strong identity that I hold?” The lack of racially or ethnically diverse donors created an additional barrier and decision point for participants of color.

Barriers

The barriers participants faced as they explored their options shaped their experiences and decision. These included financial, legal, and healthcare-related barriers. Finances often played a role in how participants were thinking about pregnancy. While getting pregnant was costly, adoption could be equally expensive. Participants sometimes weighed their options to decide which path to take. For example, Jacqueline and her wife chose pregnancy, in part because that was the path they preferred, but in part due to cost.

> For us, I think it was always we would like to get pregnant…I think we just always had that, I mean independent of one another always had that vision for ourselves, specifically because we both wanted to carry. Honestly, I think part of it is also cost. As expensive as this has been to try to get pregnant, it is still cheaper than a lot of other options, or more affordable. I hate to say cheaper when we're talking about people, but the legal fees and the whatnot for adoption and all of that are astronomical. As hard as this has been, it seemed easier.

For others, finances were the difference between trying to build a family or not. Gail (32, pansexual, one previous pregnancy) had a child with her ex-husband before she came out. Once she re-married, she wanted to have a child with her wife, but they have not pursued it seriously because of cost. She said that if they could get pregnant as she did in her previous marriage, she absolutely would. Like other participants, Gail and her wife were sorting through all their options. "So we kinda roll around with the thought of adoption or fostering. It's just the price tag on having a child is the bigger issue". Similarly, Amber and her wife decided to take a break in trying to get pregnant because they "just couldn't do it financially." Finances played a significant role in decisions around pregnancy and parenting.

Legal and structural barriers also played a role in pregnancy decisions. Raven had two children from a previous marriage to a cisgender man and a third pregnancy with her current wife.

She described not only the difficulties related to getting pregnant but in being recognized as a family:

> We had to actually look at what sort of rights we had. We ended up moving out of the state that we were in because at that time our marriage wasn't legal in that state and [my wife] couldn't be on the birth certificate…and so we moved out of state, to a state where I could deliver and she could be on the birth certificate. So there was just a lot of hard sort of decisions that we had to make, that I don't think that other people even really think about unless they're pregnant and in the queer community.

Participants also cited the lack of providers and their limited options for care as a barrier to getting pregnant. No participants had health coverage that could cover the cost of ART fully, and the few participants that had coverage were restricted to one or two providers. Participants also relied on fertility clinics, many of which were not equipped to treat queer patients. For example, Raven said that she and her wife chose the clinic that was the "cheapest." She described: “it was just like horrible. It was disorganized. There was no communication. There was no education about what to expect or when to do what.” Given the financial restraints, Raven and her wife felt like they were “stuck” using that clinic, despite the “horrible” care they received. Similarly, Robyn (26, lesbian, trying to get pregnant) described the fertility clinics as an “assembly line” and suspected that these clinics could “get away with anything” because queer patients trying to become pregnant had limited options. Veronica described the bias she encountered in the health care system while she was trying to become pregnant. Specifically, she felt like health care providers perceived her “identity as a bad choice I made” and that providers viewed her queerness as a limitation to getting pregnant that she could control. Being queer added discrimination and bias to the process of family building, adding both emotional and logistical barriers.

Discussion

This study aimed to understand how pregnancy fits into the lives and identities of queer individuals assigned female at birth. Ultimately, findings point to the ways that queer individuals AFAB conceptualize pregnancy distinctly from parenthood and how they consider options around building a family. Queer individuals sort through multiple paths to parenthood and re-assess these paths as they gain more information or encounter barriers. Additionally, participants seeking to become parents weigh individuals, relationship, and structural factors. We wish to highlight two important contributions to the current pregnancy intention and LGBTQ+ family formation literature. First, this study expands on currently known factors shaping pregnancy decisions and experiences and expands on previous literature focused on lesbian or same-sex couples by including diverse identities within the queer community. Second, the study pushes the pregnancy intention literature by focussing on how queer identity may shape pregnancy intentions, desires, and decisions.

New Factors Shaping Pregnancy Desires, Decisions, and Experiences

Findings are in line with previous work that suggests structural barriers shape LGBTQ+ individuals' perceptions of what is possible for family formation, as well as their actual ability to pursue the option they desire (Park et al., 2016; Riskind et al., 2013). Findings from our study reinforce this phenomenon while also identifying specific factors related to choosing pregnancy. In a previous study of lesbian couples in Australia, Hayman et al. (2015) found that lesbian couples made a series of decisions in their "journey to motherhood." That study, however, focused exclusively on pregnancy and conception and included couples who had already decided to try to get pregnant. While Hayman et al. identified factors that shaped experiences with conception and pregnancy, we found that many of these factors often influenced the decision to try to conceive at all.

Diversity of Experiences among Queer AFAB Individuals

Many previous studies focused exclusively on lesbians or same-sex couples. The current study fills an important gap by examining pregnancy experiences among diverse sexual identities, gender identities, and partnerships. This diversity revealed myriad experiences even within the queer community. To date, the literature has not examined pregnancy decisions and desires for queer individuals with different-sex partners. Even among couples for whom pregnancy could be achieved without ARTs, ideas about family building and formation were filtered through a queer lens and thus made to challenge heteronormative narratives of family formation. Additionally, participants who identified as non-binary expressed concerns regarding gender identity and compatibility with pregnancy. Similarly, participants of color faced added struggles in trying to use donor sperm of their same race/ethnicity and trying to maintain a connection to their culture while pursuing ART. The diversity of experiences among queer individuals highlights the need for incorporating intersectional frameworks to examine how identities influence individuals' experience and the context in order to gain a holistic view of pregnancy and parenting decisions for queer individuals.

Pregnancy Intentions and Desires

Previous research on pregnancy intentions and desires have not explicitly included individuals who identify as queer. The current study highlights the way that queer partnerships and queer identity play a role in shaping pregnancy desires. While pregnancy intentions and desires are multifaceted for most women, being queer brings added layers of complexity and additional dimensions to these desires. For example, partners play a significant role in happiness about pregnancy, and women often consider their partner's feelings in decisions related to pregnancy. One mixed-methods study of pregnant women seeking prenatal care found that partners' attitudes

and desires significantly impacted women's own experience of pregnancy wantedness (Kroelinger & Oths, 2000). Studies that include partners directly have found that men also have their own desires, including ambivalence, around pregnancy (Lewin et al., 2014; Waller & Bitler, 2008; Zabin et al., 2000). Similarly, a nationally representative study found that women who report that having a child is important to their partner are more likely to be trying to get pregnant, regardless of her own feelings about pregnancy (McQuillan et al., 2011). However, much of the previous literature on pregnancy intentions focused on heterosexual couples. Our study emphasized that queer couples have specific considerations that shape both individual pregnancy desires and desires within partnerships, such as how difficult it will be to become pregnant, compatibility with queer identity, and economic barriers. For example, one factor identified by Hayman et al. (2015) was the incompatibility with pregnancy and one partner's gender identity. The current study expands on participants' consideration of their own and their partners' feelings regarding identity and pregnancy and found that many more masculine-presenting partners were willing to try to conceive if the other partner was unsuccessful. Of note, all participants in this study were partnered, so able to make decisions in the context of their current partnership. Pregnancy and parenting desires of queer AFAB individuals may shift as they enter new partnerships and seek to integrate their own and their partners' desires.

Limited research on pregnancy desires and queer identity has found that queer women experience both intended and unintended pregnancy but have yet to examine how queer identity shapes these constructs in family planning traditionally used in family planning research (Everett et al., 2017; Gonzales et al., 2019). We found queer identity played a significant role in shaping pregnancy desires, and queer individuals may conceptualize pregnancy desires differently than heterosexual women. For example, some individuals were willing to become pregnant even when

it felt incompatible with their identity or delay gender-affirming care because they wanted to experience pregnancy. Our study also highlights the ways that pregnancy might be compatible with queer identity. This study adds to our understanding of how queer identity shapes pregnancy desires and decisions.

Limitations

This study is not without limitations. First, the majority of the study participants were White. Previous literature suggests that Black sexual minority women face specific barriers related to pregnancy as well as conceptualize their identity and pregnancy in different ways than white sexual minority women (Reed, Miller, & Timm, 2011). As our study demonstrated, queer individuals of color may have additional concerns, including the availability of donors that share the same race or ethnicity or concerns about not sharing a racial/ ethnic identity with their child. There may be additional dimensions to pregnancy and parenthood not represented in this study as a result.

An additional limitation relates to recruitment methods. Participants were recruited by social media posts. Thus the sample is limited to social media users and those who learned about the study through others who use social media. There may have been overlap in the social networks of participants. Investigators tried to limit this possibility by posting in a wide array of social media groups and encouraging re-posting. Finally, several participants did not participate in the follow-up interviews. Especially for early participants, investigators did not have the opportunity to ask about themes that emerged after the analysis progressed.

Implications and Future Directions

Findings highlight that queer AFAB individuals struggle through many decision points and barriers to meet their family formation goals. There are multiple intervention opportunities for

healthcare providers and support workers during the perinatal period. Most importantly, findings highlight the need to recognize family formation and pregnancy outside a heteronormative context and adapt support services to these contexts. While there is no “right” way for queer AFAB individuals to achieve their pregnancy and parenting goals, providers can incorporate relevant factors—physical tolerance of pregnancy, partner preferences, and potential structural barriers—into their assessments. Additionally, services should carefully consider the diversity of experiences within the queer community.

Additional research is needed to advance knowledge in this area further. First, the majority of participants indicated that their partners had unique experiences around pregnancy and often were invisible in the process. Thus, future research should examine the experiences and needs of non-pregnant partners as they support their queer AFAB partners and become parents. Research could also examine the perspectives and experiences of both non-partnered individuals and individuals in non-monogamous relationships to gain a better understanding of how queer AFAB individuals consider pregnancy in a range of partnership arrangements. Finally, gender identity should be further explored as a factor influencing pregnancy. As the focus of the current study was sexual identity, often gender identity was not deeply explored with participants. Future work should be inclusive of both sexual and gender identity but do so with attention to honor the difference between gender and sexual identity and how different dimensions of marginalization influence pregnancy experiences differently.

Supporting queer individuals in a range of reproductive health and parenting options is key to full recognition of queer individuals as parents and their participation in a fundamental human experience—family building. More research on the nuanced experiences of queer family building is needed to fully and respectfully support queer individuals to form their families. This study is a

critical first step in understanding the numerous individual, relationship, and structural factors informed pregnancy desires, the choice to seek pregnancy and experiences with pregnancy for queer AFAB individuals and more fully understand their family formation goals in the context of queer identity.

III. Paper Two:

"It's Isolating to have an Abortion, and to be Queer and have an Abortion is Even More So:" Abortion Attitudes and Experiences Among Queer Individuals Assigned Female at Birth

Abstract

Context: Abortion research has traditionally overlooked sexual and gender identity, assuming that all abortion seekers are cisgender and heterosexual. Emerging evidence is beginning to challenge that assumption and suggests that individuals of all sexual and gender identities experience unwanted pregnancy and may seek an abortion. Greater understanding of the abortion experiences of queer individuals is needed.

Methods: This study is part of a larger project using a modified grounded theory approach to understand the role of sexual identity in pregnancy decisions and desires. Investigators conducted in-depth interviews with 22 queer individuals assigned female at birth who had been pregnant or were considering pregnancy. For the current study, investigators conducted selective analysis focusing on experiences with abortion. Two researchers independently coded transcripts using inductive coding.

Results: Findings reveal that queer cisgender women and gender-expansive individuals assigned female at birth seek abortion care for multiple and complex reasons. Queer identity shapes abortion experiences in two ways: First, queer identity shaped engagement in abortion care. Second, queer identity shaped how individuals process or contextualize their abortion. Participants translated their experiences into recommendations for improving abortion care to be more inclusive of queer individuals.

Conclusions: Compassionate and inclusive care requires enhanced recognition of diverse sexual identities in family planning research and clinical practice. Improvements to abortion care that include sexual and gender identity will improve the abortion experiences and outcome of all abortion patients and all sexual and gender identities.

"It's Isolating To have an Abortion, and to be Queer and have an Abortion is Even More So:" Abortion Attitudes and Experiences Among Queer Individuals Assigned Female at Birth

Until recently, abortion research has overlooked sexual and gender identity, assuming that all abortion seekers are cisgender and heterosexual. Emerging evidence from both unintended pregnancy and abortion literature is beginning to challenge that assumption and suggests that individuals of all sexual and gender identities experience unwanted pregnancy and may need abortion (Jones et al., 2018; Jones et al., 2020). However, data on the sexual identity of abortion patients remain limited, and reproductive health-related studies are only beginning to collect data on sexual orientation and gender identity. A recent study found that while the overwhelming majority of patients included in the Guttmacher Institute's Abortion Patient Survey identified as heterosexual, roughly 5% identified with a queer identity (e.g., bisexual, lesbian, or queer) (Jones et al., 2018). An analysis of Guttmacher's Abortion Provider Census revealed that several hundred trans and gender-expansive individuals sought abortion care in 2017(Daniels et al., 2015). Studies relying on measures of self-reported abortions suggest that abortion is common across queer women's lives (Marrazzo & Stine, 2004). Bisexual adolescents are more likely to terminate a pregnancy than their heterosexual counterparts, a difference that persists into adulthood (Tornello et al., 2014). When examined longitudinally, all sexual minority groups, except lesbians, were more likely than heterosexual women to experience an unwanted pregnancy or terminate a pregnancy (Charlton et al., 2019). While these studies help establish the prevalence of abortion among queer and gender expansive1 individuals, studies have yet to investigate how the experiences of considering, seeking, and processing and contextualizing an abortion may differ for queer or gender-expansive individuals.

Queer patients navigate stigma, discrimination, and bias, both in their everyday lives and in health care encounters (Meyer, 2016). Discrimination and stigma in sexual and reproductive health care are well documented and can impact patients' health-seeking behaviors and health outcomes, such as increased risk of cervical cancer, lower use of preventive services, and increased risk of unintended pregnancy (Agénor et al., 2015; Everett et al., 2018; 2019; Greene et al., 2019; Higgins et al., 2019). Recent attention to the role of sexual identity in contraceptive care has shown that the lack of queer-specific healthcare and experiences of discrimination contribute to a higher risk of unintended pregnancy, as queer women are less likely to seek contraceptive care and may not be counseled on their contraceptive options (Greene et al., 2019; Higgins et al., 2019). Queer patients' own internal discord between being queer and being at risk of unwanted pregnancy—for example, not viewing oneself as a contraceptive user or not perceiving a risk of pregnancy—also contributes to lower use of contraception (Everett et al., 2019). At the same time, queer identity shapes pregnancy desires, including how queer individuals process unwanted pregnancies and pregnancy ambivalence (Carpenter et al., 2019). This evidence suggests that queer individuals, much like straight and cisgender women, engage in complex decision-making about their reproductive health trajectories and that queer identities add an additional layer of complexity. However, no prior qualitative studies on queer individuals and their reproductive health experiences have focused explicitly on abortion.

Experiences of abortion stigma loom large over individuals seeking abortion, regardless of sexual or gender identity. Kumar et al. (2019) define abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (P.625). Experiences of abortion stigma are marked by isolation, feelings of shame and guilt, and poor psychological outcomes post-abortion (Kumar et

al., 2009). Importantly, the abortion literature consistently finds stigma is a mediating factor—that is, abortion does not lead to poor outcomes by itself, but rather, experiencing abortion stigma leads to adverse outcomes, such as experiencing depression, post-abortion (Biggs et al., 2017). Because abortion stigma is socially produced and varies across place, time, and contexts, and, queer patients already experience marginalization in the health system, experiences of abortion stigma may differ for queer individuals, marked by both stigma associated with abortion and stigma related to queer identity (Young et al., 2005; Norris et al., 2011). Furthermore, the field's current understanding of abortion stigma presumes that all individuals who have had an abortion self-identify as a woman and as heterosexual, and focus on heterosexual womanhood. Thus, this current definition may be limited in describing queer individuals' experiences, or the multiple layers of marginalization individuals may experience being both queer and seeking abortion.

While it is clear that queer and gender-expansive individuals need access to abortion care, little is known about the role of queer identity in shaping abortion experiences. To address these gaps, we conducted a study with twenty-two individuals who identified as queer about their experiences with pregnancy, including unintended pregnancy and abortion, and the ways their experiences are shaped by queer identity.

Methodology

Overview

The current study focuses on queer individuals' experiences with unintended pregnancy and/or abortion. Data come from a larger, modified grounded theory study designed to understand the role of sexual identity in pregnancy desires and decisions among individuals assigned female at birth who identify as queer (Carpenter & Niesen, 2019). Individuals were eligible to participate if they were between 18 and 40-years old, they were assigned female at birth and identify as queer

(including lesbian, bisexual, pansexual, queer, or any other non-heterosexual identity), and they planned on trying to get pregnant in the next five years or had already been pregnant.

While the larger study focused on the role of sexual identity in pregnancy desires and decisions, sexual identity and gender identity are separate, yet intertwined and fluid identities for many individuals (Butler, 2011; Diamond et al., 2017; Scheffey et al., 2019). Thus, some participants identified as queer cisgender women, but other participants held more expansive gender identities. Additionally, some participants indicated that they identified as women in the initial screening questionnaire, but indicated they were non-binary or genderqueer during the interview. To respect and include the identities of all participants, we describe the sample as queer cisgender women and gender-expansive individuals or simply queer individuals (Jahn et al., 2019).

Participants were recruited via targeted posting on social media. For traditionally hard to reach populations, such as LGBTQIA+ individuals and communities, social media is an effective recruitment strategy (McCormack, 2014). Investigators engaged in targeted advertising to increase the likelihood of recruitment of participants who had previously had an abortion, such as posts in LGBTQ+ social groups. Online recruitment methods secured participants from both the PI's local area and across the U.S.

Data collection

Interviews took place between November 2018 and June 2019 via Zoom —a web-based video conferencing platform—or in-person for local participants, per their preference. For Zoom interviews, participants chose either the video chat option or the audio-only feature. Local participants chose a convenient, private location for their interview, such as a private room in a local library. Interviewees were compensated with a $30 Amazon gift card for participating in

an initial interview and $15 for participating in a follow-up interview. At the end of the interview, the interviewer asked each participant for a pseudonym and their preferred pronouns; pseudonyms and pronouns chosen by the participants are used throughout this paper.

Initial interviews lasted between 42 and 90 minutes and follow up interviews lasted between 18 and 45 minutes. All interviews were conducted by the first author, a trained qualitative interviewer with significant prior experience with primary qualitative data collection. Interviews drew on a semi-structured interview guide that included questions on queer identity, pregnancy plans, past pregnancies, and experiences seeking and receiving reproductive health services. At the end of the initial interview, participants could opt-in to a brief follow-up interview. Of the 22 total participants, ultimately, 13 participants participated in a follow-up interview. Two did not agree to be contacted for a follow-up interview, and the other seven were lost to follow-up. Follow-up interviews were scheduled between three weeks and two months after the initial interview, depending on the participant's availability. The follow-up interviews allowed participants to reflect on the interview experience and share insights or responses that had emerged since the first interview. All interviews were audio-recorded--with permission from the participant--and transcribed verbatim by a professional transcription service. Investigators then removed all identifying information from the transcript. This study was approved by the University of Wisconsin Education, Social, and Behavioral Institutional Review Board.

Data Analysis

The PI and a team of research assistants trained in qualitative coding used a modified grounded theory approach to analyze the interview transcripts. Coding involved two phases: open coding and focused coding. Investigators coded transcripts simultaneously with data collection using a method of constant comparison to follow new themes that emerged from the

data. First, during open coding, the lead author and a research assistant compiled a list of themes. After a final list of themes was developed, roughly halfway through data collection, the lead author and research assistant met to discuss and winnow the list of themes and create the codebook based on remaining themes. The lead author and research assistant then applied these codes to the transcripts independently and met to discuss discrepancies and to reach consensus. Because interviews were ongoing during the coding process, the study team amended the codebook and re-coded prior interviews as new themes emerged. After all initial interviews were complete, final codes were applied to all transcripts. While coding the follow-up interviews, the study team amended the codebook with new themes that emerged during follow-up interviews, which were only applied to follow-up interview transcripts. All coding was done using Nvivo 12 (QSR, 2017).

A prior, more general qualitative investigation used these data to examine pregnancy desires and experiences among queer individuals (Carpenter & Niesen, 2019). The current, more focused analysis examines attitudes towards abortion in the sample more broadly, as well as experiences with abortion through targeted coding of a sample of 12 individuals who considered abortion (10 who had obtained an abortion and two who had experienced a pregnancy they described as unplanned but ultimately carried to term). During the selective analysis process, the study team identified subthemes related specifically to the choice to seek abortion (or not), with the goal of understanding the intersection of queer identity and abortion experiences. The subthemes below emerged as participants spent time describing their experiences with abortion and articulated how their identity related to their abortion experience. These sub-themes are described below.

Participants

Of the 22 participants, ten participants had an abortion. Two additional participants had experienced an unintended pregnancy but ultimately decided not to have an abortion. The majority of the participants were in their 20s (n=12), identified as cisgender women (n=15), identified as white (n=15), and had a college degree or higher (n=19). Most participants identified as queer (n=15), with participants also identifying as bisexual, pansexual, or lesbian. Participant demographics are displayed in Table Two. The ten participants who had an abortion were demographically similar to the full sample. Of the participants that had an abortion, most did so because they did not want to be pregnant, though two participants had conceived using assisted reproductive technologies and needed an abortion for health reasons.

Table Two: Participant Demographics (Paper Two)

Demographic Characteristics(N=22)			
Age Range		**Race/Ethnicity**	
20-24	3	White	15

25-29	9	Mixed Race	3
30-34	4	Latina	2
35-40	6	Native American	2
Gender Identity		**Highest Education**	
Woman/cis woman	15	High school	3
Non-binary	3	Bachelor's degree	13
Genderqueer	2	Graduate/professional degree	6
Other	2		
Sexual Identity		**Partnership Status**	
Queer	5	Not currently partner	1
Bisexual	3	Partnered + living together	9
Lesbian	2	Married	12
Pansexual	3		
Queer + another identity	9		
Time Since Abortion (n=10)			
Within the last year	2		
Within two years	3		
Within five years	4		
Within ten years	1		

Results

Findings reveal that queer cisgender women and gender-expansive individuals assigned female at birth seek abortion care for multiple and complex reasons. Queer identity shapes abortion experiences in two ways: First, queer identity shapes experiences in abortion care. While seeking an abortion, participants encountered barriers to access shared by many individuals seeking an abortion, such as parental notification laws. Unique to queer individuals, their identity shaped participants' experiences in the health system and seeking care. For example, study participants cited a lack of queer-competent providers. Second, queer identity shaped individuals' ability to process or contextualize their abortion. For example, some participants reported stigma and isolation associated with both being queer and having an abortion. These themes will be discussed more thoroughly below. In addition, participants translated their experiences into recommendations for improving abortion care to be more inclusive of queer individuals, and these recommendations are discussed below.

Queer identity shapes individuals' experiences with abortion care

Participants discussed barriers that all abortion seekers can experience, such as having to travel long distances, as well as barriers specific to being queer, such as the inability to find queer-sensitive providers or encountering bias while seeking an abortion. Sequoya (pansexual and genderqueer, they/them), who obtained an abortion when they were sixteen and still in high school, described barriers to access that were similar to those described by heterosexual cisgender women in numerous studies. They reported that their most significant barrier to getting an abortion was the parental notification requirement in their state. Similarly, Lynn (pansexual, she/her) described having to go to another town to obtain an abortion as a barrier. Though notably, she commented, "it was hard then, but nowhere near as difficult [as] now," showing an awareness of the increasingly restrictive abortion laws.

However, even the participants who knew how to access abortion care struggled to find abortion care that was queer-inclusive or had queer-competent providers. Barriers to inclusive care ranged from feeling invisible in clinical settings to experiencing bias and stigma from providers. Most participants reported that staff at the abortion clinics they went to did not ask about their identity. In addition to the lack of recognition, some participants experienced stigmatizing comments from providers. For example, Zoey (bisexual and nonbinary, they/them) described being routinely misgendered and having their partner be misgendered. They drew a direct line between this experience and the difficulty of their abortion experience:

> It almost feels like a fantasy at this point. Like, wow, to be gendered correctly and have a sensitive experience, I don't even expect that, at all. I just sort of brace myself, and it would be great to live in a reality where I could expect [something] different… I mean, I wish they were more sensitive about [my identities], for sure. It would have made a very traumatic experience slightly less traumatic.

Collectively, these barriers to inclusive care compound the difficulty of obtaining abortion care for queer individuals and can increase the negative impact of these experiences.

Queer identity shapes processing and contextualizing abortion experiences

Many participants described how having an abortion could work against their queer identity, struggling to reconcile being queer and needing an abortion, or worrying they would no longer be perceived as queer. For example, Isabel (bisexual, she/her) described that having an abortion made her less sure of her queer identity. Even though she had identified as bisexual for several years before having an abortion, she felt like having an abortion "solidified [me] more as a straight person," because being bisexual and having an abortion felt incompatible to her. Additionally, Isabel did not disclose her abortion to anyone at the time, in part because she was worried that they would then see her as straight. Sequoya expressed a similar sentiment. They had recently come out and were trying to integrate into the queer community, so if anyone found out about their abortion, "the jig would be up that I was not really a lesbian." Participants described the ways in which having an abortion may be incompatible with both their ideas of queer identity and others' perceptions of their identity.

There were also ways in which participants interpreted their abortion as a positive experience related to their queer identity. In processing their abortions, several participants indicated that having an abortion ultimately affirmed their queer identity. Lynn, who had an abortion in college, expressed that having an abortion allowed her to have a more "fulfilling" life and explore her sexuality. Similarly, Adrienne (pansexual and femme, she/her) said that her abortion "just really solidified for me that I wanted to have a more queer life." Having faced the possibility that she would get "stuck" in a straight relationship, she was now grateful that she could fully explore her identity. Both of these participants relayed acceptance of, and even gratitude for, their abortion experiences, as having an abortion allowed them to affirm their identity.

Mental health concerns

One specific way in which queer identity shapes processing and contextualizing abortion manifested in participants' discussions of mental health. Participants described mental health concerns related to both coping with an unintended pregnancy and the ramifications of having an abortion. These concerns ranged in nature and in intensity but were amplified by experiences of both abortion and identity-related stigma. Many participants described the process of getting an abortion as extremely emotionally difficult. The difficulty stemmed from the lack of support that they were receiving at the time of their abortion. Many participants did not tell anyone that they were getting an abortion for a variety of reasons. Isabel, who self-managed (induced an abortion at home with pills she acquired) two abortions as a teenager, said: "I didn't tell anybody. I didn't tell my partner, I didn't tell my parents, I barely admitted to myself, like…wow. I was actually pregnant. I just told myself, 'you dealt with your problem.'" Alex (pansexual, they/them) also didn't tell anyone about their abortion, as they were sure that their queer friends "just couldn't relate" to the experience of needing an abortion, and also felt as if their straight friends wouldn't understand their experience. The stigma associated with abortion, and specifically with being queer and having an abortion, prevented participants from seeking support.

Importantly, not all participants who had an abortion did so because they had an unwanted pregnancy, which had additional implications for their ability to process and contextualize their experience. Raven (queer/lesbian, she/her) had an abortion at 20 weeks for health reasons. She relayed that she and her wife had "invested all this emotional and financial effort" into getting pregnant. Raven described her abortion as a "loss." However, despite the different circumstances leading to her abortion, Raven described similar feelings of isolation and lack of support as Alex and Isabel but stemming from different causes. Raven felt that by not

asking about or acknowledging her identity or how she got pregnant, the clinic did not understand how painful the procedure was on her. As she described:

> I mean it really did, [the abortion] felt like grieving, it felt like somebody had died. And I think that wasn't something anybody acknowledged or understood; they just assumed that I didn't want to be pregnant anymore and so I should be happy.

Raven felt as if there was no “space” for her or what it meant to have an abortion in the context of a planned and wanted pregnancy. However, she worried voicing her concerns might make her seem anti-choice.

> I don't want to mandate counseling, a woman should be able to just make that decision, go in, get it done, and be done. I totally agree with that, and that's absolutely what I would vote for. But having gone through it, I think that some people would benefit from being able to sort of cry or talk or vent.

Raven feared that voicing this nuance would make her appear anti-choice, which kept her from reaching out for support to process her complicated feelings around choosing to have an abortion.

Participants also described dealing with mental health challenges following their abortions. While no participants reported feeling regret after having an abortion, they had to process the stigma and the isolation that resulted. Jay (pansexual, they/them) could not recall most details from their abortion. They attributed the memory loss to not processing the abortion or their feelings at the time: "I feel there's lots of phases of my life that I don't remember clearly because I never provided myself with the opportunity to process them in the moment." Alex described a similar feeling:

> People sometimes don't really remember it [having an abortion] super well for multiple reasons. They're just trying to block it out or just trying to not think of anything more...But I think one of the contributing reasons why I don't remember that specific day[is]because I didn't really feel like a lot of that stuff applied to me. I didn't really feel like I was represented in the people that worked there [or] the way the counselor talked to me.

Alex’s interview highlights how much having an abortion in the context of heteronormative standards of care can impact mental health. They went on to say that discussing

abortion is difficult for most people, given the social stigma associated with abortion. However, for queer patients, there were added layers of difficulty related to identity, leaving them feeling more isolated and stigmatized.

While most participants described stigmatizing and difficult experiences with their abortions, Adrienne described a positive and affirming experience, leading her to have very different outcomes than the ones described above. Specifically, she felt like the counselors and providers were non-judgemental and affirming. She described:

> The woman who had to ask me about my sexual history and my sexual partners, she was amazing. It was actually the first time in my life that felt like my relationship status was validated in a medical context. She was actually asking me did I have multiple partners. She didn't assume that all of my partners were male. She didn't assume that my other partner had no other partners. She just acted like it was all normal.

The interactions with the physician she saw were similarly affirming:

> I know that I absolutely felt like my sexual orientation was being validated by the people whom I worked with at [Clinic Name] like it was being acknowledged and validated. That, to be honest, meant a lot to me at the time.

Adrienne had a medication abortion—the only method available in her area— and had support throughout the process. Her experience was much different from other participants who did not talk about their experiences or seek support from their social network. Adrienne described having practical and emotional support from several friends and financial support from the partner that got her pregnant.

> Again, I feel so lucky…in terms of emotional support or community…My best friend, he came in from Oklahoma, which is a nine-hour drive, to be there with me for my abortion. My other best friend bought me groceries the morning of … So when I actually took the second pill…, it was seriously almost like a party. My roommate had her boyfriend there. My friend, whom I had done the pregnancy test with [was there].

Adrienne's experience highlights the ways that abortion stigma can be mitigated by affirming clinics and providers, as well as social support.

Recommendations from participants for queer affirming and inclusive care

At the end of each interview, participants were asked how they would design abortion care to be inclusive of queer patients. While they had no shortage of ideas, participants' responses clustered around three main themes: increase abortion providers' knowledge about queer identity, update clinical procedures to be queer-informed, and improve access to care.

Increase provider knowledge about queer identity.

Many participants believed that if their providers knew more about the queer community, they would be less likely to make harmful assumptions and more equipped to provide affirming care. As Sequoya said:

> [As abortion providers,] you're not just providing services for straight women; you're providing services for very differently gendered people, who also have different experiences, in terms of their sexuality, and a plethora of other social identities that [providers] should at the very least be competent in. [Try] to check your own personal biases or understandings and try to come into a new understanding of what pregnancy and abortion look like for all people. It's really changing the narrative, the cultural narrative…and trying to reconceptualize how we understand those services and who's accessing them.

There was a sense that integrating this understanding would make providers more comfortable with queer patients and more able to ask "neutral" questions and avoid assumptions about patients, as described by Adrienne:

> Honestly, it sounds kind of stiff, but I feel like if they just have a prescribed list of questions that they ask every single person…compared to people just making assumptions about my sexual orientation or my partners. I mean, people do make assumptions based on the way that I look. I feel like that gets in the way of good healthcare.

Participants described the ways they wished providers were both more knowledgeable about diverse sexual and gender identities and able to integrate that knowledge into their practice. Participants were also clear that providers' lack of knowledge, as Adrienne said, "gets in the way of good health care."

Queer-informed practices

Beyond providers being knowledgeable about queer identity, participants wanted clinics to integrate clinical care that was informed by and sensitive to queer identity, including trauma-informed care. Participants voiced a need for queer-informed practices both in interactions with patients and structurally throughout the clinic. Queer-informed practices include visually signalling safety and inclusion for queer patients in waiting rooms with representation of queer individuals in pamphlets or hanging pride flags, having staff wear pronoun buttons, providing gender-neutral bathrooms at the clinics, and having queer and trans staff working at the clinics. It was important to participants that the whole clinical experience is designed to be inclusive of queer patients. Participants also described how these practices would improve the clinical experience in a meaningful way. For example, Alex believed that hiring staff that represented diverse sexual and gender identities might translate into improved care.

> Honestly, hire a bunch of queer people and have the patient populations served by people that look like and act like and talk and think like them. If you hired people that reflect your patient population, you're going to have better patient care every time. I think that a lot of the other issues would just go away if you had people that already [know how to incorporate queer identity] in their everyday conversations.

Giving patients the ability to drive the conversation about identity was understood as an important part of meaningfully incorporating queer-informed practices. While most participants wanted their providers to ask them how they identified, they recognized that it was not always safe to disclose their identity, and some patients may not be ready to come out to their providers. This idea is captured by Raven:

> I love the idea of [disclosing your identity] being a part of intake paperwork and having the option to not answer if you don't want to. So that it's written and it's sharing ourselves versus being asked directly. And maybe there could something on there, where it's like, 'are you comfortable with the provider bringing this up or discussing the way that your gender and identity and sexual orientation align with your health?'

Participants also recommended that providers incorporate trauma-informed practices. Seeking health care as a queer person can feel like a vulnerable experience, and given the high rates of sexual violence experienced in the queer community, having providers trained in trauma-informed practices could improve care. As Zoey said:

> The first thing that comes to my mind [to make abortion care more inclusive] is consent-based work with reproductive care. And understanding that, at least for gynecology and things like that, if you have to physically put your fingers in someone else's vagina, that could cause gender dysphoria, perhaps… it could bring up memories of sexual assault, all these things.

The recommendations related to queer and trauma-informed practices require that providers are both knowledgeable about queer identity and committed to incorporating queer and trauma-informed care across clinical practice. Importantly, participants believed care that was sensitive to their identities would help all patients, regardless of their identity. As Ray (queer, non-binaryish femme, she/they) said: "bring in queer-centered practices, and they're going to help everyone."

Improve access to affordable abortion care

Finally, participants recommended that abortion care should be more accessible for low-income patients. While many of the participants knew where to go or could afford an abortion, they were aware that many in their community could not. Thus, they recommended removing cost barriers to abortion:

> Planned Parenthood is amazing, but of course, they keep getting shut down…Just more cheap or free resources because tons of people in the queer community are low-income, or below the poverty live. Lots of people are homeless, and they need access to these resources, too...the fact that a lot of these things are so expensive makes them impossible to access. (Isabel)

Participants displayed an awareness of the barriers to abortion care that most abortion seekers face. Similar to the recommendations related to improving clinical care, removing cost barriers to

abortion would benefit all people who need abortion care, regardless of their sexual or gender identity.

Discussion

This study is the first to document the role of queer identity in shaping abortion experiences. Through in-depth interviews with twenty-two, queer individuals about pregnancy experiences more broadly, and with ten individuals about abortion attitudes and experiences, specifically, we found that queer individuals seek abortion care for complex reasons. Queer identity plays a distinct and unique role in the barriers queer individuals face and their interpretation of their experiences. Some participants experienced their queer identity as incompatible with needing an abortion, while others felt that having an abortion affirmed their identity. Further, the experience of double marginalization as a queer individual seeking an abortion loomed large and had deleterious effects. Finally, results indicate a set of changes that queer people would like to see in order to make reproductive health, specifically abortion care, more suitable for queer patients. This study enhances the family planning field's understanding of queer-specific barriers to abortion care and adds urgency to efforts to promote queer-inclusive care. This study reveals the ways queer patients are harmed by multiple layers of stigma and structural barriers to inclusive care.

A key finding is that abortion care, as it stands, is not structured to be inclusive of sexually and gender diverse populations. As a result, most participants in this study described difficult experiences of abortions—and in unique ways from cis straight women who get abortions. Some faced explicit bias from clinics or providers. However, even the participants who did not face explicit bias suffered from the implicit ways that sexual and gender identity are left out of abortion care. For example, they felt they had to suppress or hide part of their identities in order to get

through the abortion. Despite the negative experiences, participants did not express regret about their abortions, and many said that they were fully able to live their lives—including their development as queer or gender-expansive individuals—as a result of their abortion.

Much of what participants described related to abortion stigma. Numerous studies have established that abortion stigma is harmful and leads to worse outcomes post-abortion for women generally (Kumar et al., 2009; Norris et al., 2011). However, the current definition of abortion stigma is rooted in the assumption that all individuals who have had an abortion self-identify as a woman and as heterosexual. Findings from this study suggest that holding a stigmatized identity, such as being queer, may alter or compound experiences of abortion stigma. Along these lines, this study adds a new layer to the literature on abortion stigma and underscores how multiple marginalized identities and experiences can work synergistically to negatively affect people's experiences of abortion. Participants in this study experienced isolation because they felt not only that they could not talk about their abortion with their support network, but also they could not talk about what it meant to be queer and have an abortion. Because abortion stigma is socially produced and varies across culture, space, and time, this study suggests that as our understanding of *who* needs abortion evolves, our understanding of who is experiencing abortion stigma and how that stigma manifests should also evolve.

Study findings suggest several implications for clinical care, most of which stem directly from participants' needs and desires. Importantly, participants were clear about what would make health care better for them. Increasing provider knowledge of sexual and gender identities would help providers avoid assumptions and begin to see that their patients may hold diverse sexual and gender identities that will have implications for their care. However, knowledge of queer identity is not enough, and improving care for queer patients requires structural shifts across clinical

practice, such as hiring more queer people, updating patient intake forms, and signally inclusivity. Importantly, participants experienced abortion in a variety of contexts, ranging from abortions in high school without telling parents or partner, to abortion of a planned pregnancy in the context of a marriage. Thus, both healthcare and support needs will vary widely among queer individuals. Queer-informed care needs to encompass recognition and respect for widely varying circumstances among queer individuals, including varying gender and sexual identities, as well as age, partner support, future pregnancy plans, etc. The family planning field has shown a small but growing awareness of these issues, as evidenced by an increasing number of panels and papers on this topic. The current study underscores the importance of such work to improving patient-centered reproductive health care and increasing attention to identity in family planning clinical care and research.

Findings from this study regarding negative experiences in the health system are in line with other studies focused on sexual and gender identity in reproductive health care (Greene et al., 2019; Light et al., 2014). Reproductive health care was not designed for individuals with diverse sexual or gender identities. However, findings from this study also demonstrate that inclusive healthcare can mitigate the negative experiences of being queer and having an abortion. One of the participants, Adrienne, describes a very inclusive experience of abortion care—providers asked about identity, did not make assumptions about identity or partners, and were non-judgmental and respectful. Thus, Adrienne had a positive experience, and none of the deleterious effects other participants reported. Adrienne's experience suggests that health care, specifically queer-inclusive and non-judgmental abortion care, can be an intervention for abortion stigma for patients regardless of their sexual or gender identity. While abortion stigma is a cultural and structural phenomenon that requires structural changes, it can be mitigated through inclusive healthcare.

Limitations

One limitation of this study is the homogeneity of the sample. The sample was approximately two-thirds White and two-thirds cisgender, and it did not include trans men. Given systemic racism and bias related to race and reproduction, it is reasonable to assume that queer individuals of color seeking an abortion may face additional challenges related to abortion stigma. An additional limitation of the study is attrition. While 60% of participants agreed to a follow-up interview, losing the others meant that the study team could not engage in member-checking or clarify new themes with all participants. Finally, sexual identity and gender identity, while overlapping and interrelated, are not the same. In order to better understand the experiences of gender diverse, and specifically transmasculine individuals, future studies require dedicated attention to gender identity.

Conclusion

To our knowledge, this is the first study to explicitly focus on the abortion experiences and attitudes of queer individuals. Findings reveal the complex nature of abortion care among queer individuals and highlight the ways that queer individuals face particular barriers, including additional stigma, while seeking an abortion. This study has important clinical implications for improving abortion care for queer patients, including improving provider knowledge and explicitly recognizing sexual and gender diversity in abortion care. While further studies are needed, changes to abortion care that attend to sexual and gender identity will improve the abortion experiences and outcome of all abortion patients with all sexual and gender identities.

IV. Paper Three:

"The Health System Just Wasn't Built for Us:" Queer Cisgender Women and Gender-Expansive Individuals' Strategies for Navigating Reproductive Health Care

Abstract

Background: The LGBTQ health disparities literature documents barriers to comprehensive and queer-inclusive care. Queer cisgender women and gender-expansive individuals assigned female at birth (AFAB) experience myriad health disparities related to reproductive health, in part due to

the healthcare system. However, few studies have examined how queer individuals cope with and overcome barriers to queer-competent reproductive health care. This study aims to understand the strategies queer cisgender women and gender-expansive individuals use to meet their reproductive health needs.

Material and Methods: Using a modified grounded theory approach, investigators conducted interviews with 22 queer cisgender women and gender-expansive individuals AFAB about their experiences seeking reproductive health care services. We used inductive coding to identify themes related to meeting reproductive health and healthcare needs.

Results: Findings highlighted the prevalence of negative and harmful experiences while seeking reproductive health care. In response to these negative experiences, individuals developed active strategies to meet their health needs, including seeking information and community, seeking alternative models of care, and managing identity disclosure. Importantly, these strategies varied in effectiveness, depending on participants' social and economic advantage.

Conclusions: Queer individuals face numerous barriers to queer-competent reproductive health care when seeking reproductive healthcare. While queer patients are often resilient and creative, developing strategies to get their needs met, the presence of such strategies highlights the need for structural changes in the health system to better serve queer patients.

"The Health System Just Wasn't Built for Us:" Queer Cisgender Women and Gender-Expansive Individuals' Strategies for Navigating Reproductive Health Care

Queer women and gender-expansive individuals assigned female at birth are more likely than their heterosexual and cisgender peers to encounter stigma and bias in health settings (IOM, 2011). Negative encounters are associated with a reduced likelihood of returning to care, increased mistrust of the health system, and reluctance to disclose their identity to providers, which in turn, may lead to poorer health outcomes (Conron et al., 2010). Extant literature regarding queer women

and gender-expansive individuals seeking reproductive health care has demonstrated that bias and misinformation lead to less frequent STI screenings and cervical cancer screenings, reduced likelihood of receiving appropriate contraceptive counseling, and may explain some—but not all—of the disparities in contraceptive use and unwanted pregnancies (Grant et al., 2010; Higgins et al., 2019; Wingo et al., 2018).

While the role of the healthcare system in contributing to health disparities for the LGBTQ+ populations in general, as well as queer cisgender women and non-binary individuals specifically, is well established, little is known about how individuals interpret and then overcome the healthcare system barriers (Conron et al., 2010). One major area of focus has been identity disclosure. Recent evidence suggests that patients are strategic about their disclosure. Greene et al. (2019) found that in the context of contraceptive care, sexual minority women assess for the safety of disclosure and weigh the costs and benefits of disclosing their identity to their providers. Additionally, previous negative experiences influence whether or not patients reveal their identity. Similarly, a qualitative study of transmasculine patients who had been pregnant found that patients often made a conscious choice to conceal their identity in order to avoid transphobia and stigma from their OB/GYN providers (Hoffkling et al., 2017). While disclosure management is one strategy patients may use to navigate the health system and mitigate the potential for a negative or harmful experience, there may be other strategies sexual and gender minority patients use that have not yet been identified.

To address the gaps in understanding of how queer women and gender-expansive individuals assigned female at birth navigate reproductive health-related care, this study aims to 1) identify the experiences or structural barriers to reproductive health care among queer women and gender-expansive individuals assigned female at birth, 2) understand the strategies these

individuals used to meet their reproductive health needs. This study advances our understanding of queer and gender-expansive AFAB patients as active navigators of the healthcare system. It will suggest structural solutions to common negative and harmful experiences in the healthcare system that require the development of such navigation strategies.

Methods and Materials

Overview

Data for the current study come from a larger, modified grounded theory study designed to understand the role of sexual identity in pregnancy desires and decisions among individuals assigned female at birth who identified as queer, and the role of health and social services in shaping pregnancy decisions and experiences (Carpenter & Niesen, 2019). Individuals were eligible to participate if they were between 18 and 40-years old, they were assigned female at birth and identify as queer (including lesbian, bisexual, pansexual, queer, or any other non-heterosexual identity), planned on trying to get pregnant in the next five years or had already been pregnant. Sexual identity and gender identity are separate, yet intertwined and fluid identities for many individuals (Butler, 2011; Diamond et al., 2017; Scheffey et al., 2019). Thus, some participants identified as queer cisgender women, but other participants held more expansive gender identities. Additionally, some participants indicated that they identified as women in the initial screening questionnaire, but indicated they were non-binary or genderqueer during the interview. To respect and include the identities of all participants, we describe the sample as queer cisgender women and gender-expansive individuals or simply queer individuals (Jahn et al., 2019).

Participants were recruited via targeted posting on social media. For traditionally hard to reach populations, such as LGBTQIA+ individuals and communities, social media is an effective recruitment strategy (McCormack, 2014). Investigators engaged in targeted advertising to ensure

the recruitment of participants who had previously had an abortion, such as posts in LGBTQ+ social groups. Online recruitment methods secured participants from both the PI's local area and across the U.S.

Data Collection

Interviews took place via Zoom —a web-based video conferencing platform—or in-person for local participants, per their preference. For Zoom interviews, participants chose either the video chat option or the audio-only feature. Local participants chose a convenient, private location for their interview, such as a private room in a local library. Interviewees were compensated with a $30.00 Amazon gift card for participating in an initial interview and $15.00 for participating in a follow-up interview. At the end of the interview, the interviewer asked each participant for a pseudonym and their preferred pronouns. All names and pronouns included in the findings are pseudonyms and pronouns chosen by the participants.

Interviews lasted between 42 and 90 minutes. The first author, a trained qualitative interviewer with significant prior experience with primary qualitative data collection, conducted all interviews. Interviews drew on a semi-structured interview guide that included questions on queer identity, pregnancy plans, past pregnancies, and experiences seeking and receiving reproductive health services. Questions aimed at understanding experiences in the healthcare system included: 1) ”Please tell me about a recent reproductive health care encounter” with prompts for experiences of bias, satisfaction with care, and responses to providers, 2) “What changes would you like to see in the health system?” and 3) “What advice do you have for providers caring for queer patients?”

At the end of the initial interview, participants could opt-in to a brief follow-up interview. Of the 22 total participants, 13 participants participated in a follow-up interview. The follow-up

interviews allowed participants to reflect on the interview experience and share insights or responses that had emerged since the first interview. All interviews were audio-recorded and transcribed verbatim by a professional transcription service. Investigators then removed all identifying information from the transcripts.

Data Analysis

The larger study used an inductive approach to understanding the role of queer identity in pregnancy desires and decisions. The first author and a team of research assistants trained in qualitative coding used a modified grounded theory approach to analyze the interview transcripts. Because interviews were ongoing during the coding process, the study team amended the codebook and re-coded prior interviews as new themes emerged. While coding the follow-up interviews, the study team revised the codebook with new themes that emerged during follow-up interviews, which were only applied to follow-up transcripts. All coding was done using Nvivo 12 (QSR, 2017). From the larger study, investigators identified structural problems and navigating health care as key themes, which became the basis for the current analysis. The coding team engaged in a targeted coding process of the established "experiences in the health system," the "suggestions for improvements in the health system," and "navigating health care" codes and then organized common experiences and responses to experiences. Through analytic memo-writing and discussions among the research team, we refined and clarified new-subthemes, which form the basis of the results presented.

This study was approved by the University of Wisconsin-Madison Education and Social/ Behavioral Science Institutional Review Board.

Sample

The majority of the 22 participants were in their 20s (n=12), identified as cisgender women (n=15), identified as white (n=15), and had a college degree or higher (n=19). Most participants identified as queer (n=15), with participants also identifying as bisexual, pansexual, or lesbian. Participant demographic characteristics are displayed in Table Three.

Table Three: Participant Demographics (Paper Three)

Demographic Characteristics N=22			
Age Range		**Race/ethnicity**	
20-24	3	White	15
25-29	9	Mixed Race	3
30-34	4	Latina	2
35-40	6	Native American	2
Gender Identity		**Highest Education**	
Woman/cis woman	15	High school	3
Non-binary	3	Bachelor's degree	13
Genderqueer	2	Graduate/professional degree	6
Other[1]	2		
Sexual Identity		**Previous Pregnancies**	
Queer	5	None	7
Bisexual	3	1	12
Lesbian	2	2	1
Pansexual	3	3+	2
Queer + another identity (bisexual or pansexual)	9		
Previous abortion experience	10		

Results

Results below detail the strategies that participants developed in response to negative experiences and barriers to inclusive, queer-competent health care. Nearly every participant had a story about a negative encounter while seeking reproductive health care services (e.g., fertility treatments, contraception, abortion, or prenatal care). Experiences varied in severity and nature. Most commonly, participants reported experiences or fearing bias and discrimination from providers. As Bella (she/her, bisexual, 27) said: "I was [scared] I didn't want people to find out [I was

bisexual] and treat me worse during that time… medical care, in general, can be scary to LGBT people because they are just discriminated against for a lot of different things." Participants also reported receiving inaccurate information or seeing providers who lacked knowledge about their specific reproductive health needs. As one example, Sylvia (she/her, bisexual, 24) asked her provider about her STI risk with her female partner. She described the following: "there was an obvious shock that went across my provider's face…looked around for dental dams, couldn't find any, and was generally confused... I feel like healthcare providers don't think about two cisgender women having sex and what the healthcare implications are." While there were obvious incidences of bias, ignorance, and lack of knowledge, participants more generally described the ways that it was obvious to them that the health system "just wasn't built for us" (Ray, they/them, queer, 31). Participants felt the impact of small reminders that they were not normative and the compounding of these instances over time:

> They just didn't know what to do with us. Even though I was a patient there for almost a year and a half, every time I called, I needed to re-explain our situation and the fact that we were two women... It felt like if we were a straight couple, it felt like we wouldn't have to do the rundown every single time...It felt like there was some kind of amnesia because we were slightly different. I feel like good care would involve fewer times that the patient needs to remind the provider why they're there. (Jacqueline, she/her, lesbian, 38)

Despite encountering these negative experiences and barriers to queer-competent care, participants displayed resilience and creativity by developing strategies to get their reproductive health needs met. These strategies are detailed below and include seeking information and community, seeking alternative care, and managing disclosure. Out of necessity, participants devised strategies to get their reproductive health needs. The results below are illustrative examples of such strategies.

Strategy One: Becoming Experts in their Own Care and Creating Community

Participants noted a profound lack of information about queer-specific reproductive health and faced multiple gaps in access to relevant health information. In response, participants sought out information from a variety of sources, both to assist them in becoming better advocates for their health needs and to combat feelings of isolation. As Gail (she/her, pansexual, 31) commented: "You can't just raise your hand in 8th-grade health class and say 'I like chicks and I wanna have kids, can you tell me how to do that?'" For example, Zoey (they/them, bisexual, 25) sought information about queer individuals seeking an abortion and said:

> I feel like it can feel really isolating, especially when you look it up online and can't find anything. When the internet doesn't have answers for you, that's when you know you are in some deep territory.

In response to this lack of information, participants filled their information gaps and sought to become "experts" in their healthcare and health needs. Robyn (she/her, lesbian, 29), for example, reported spending time seeking information from "Online, books, YouTube, other people's experiences yeah...everywhere...now I'm always educating people because nobody has done the research that I have." Not only did Robyn spend a significant amount of time and energy collecting information, but she then felt compelled to share it with others in similar situations. Participants commented about the vast information networks, fueled by people like Robyn, who shared their research and experience. Given the additional concerns around queer pregnancy, such as how to get pregnant, where to seek services, legal complications, etc., participants found themselves in need of specific information that clinics could not provide them. Raven (she/her, queer/lesbian, 34) described the informal network this way:

> There's no education...we, as a community, figure it out in our own right, through talking to each other in Facebook groups or Googling or Wikipedia articles or whatever. But it's not like when you go to a fertility clinic, they have some sort of workshop where they explain all of that to you.

In filling their information gaps, participants found community in other queer people seeking healthcare, especially those who were trying to get pregnant. This helped participants both

practically, in finding the information they needed, but also emotionally by helping to make them feel less isolated. As Amber (She/her, queer lesbian, 28) describes:

> I think [online communities] are really important because you will open up an entire world of people who are in a similar situation with you. Finding community that way, you can also find information about which healthcare providers you should be looking at in this area or recommendations or learning about the experiences of a person.

Similarly, Ava (she/her, queer bisexual, 28) conveyed that she was “I have found that I've been seeking out community more now… I don't think it makes us feel more ready, but it makes us feel like we're not the first to do what we're doing." Online communities played an important role in filling information gaps, sharing knowledge, and providing support.

Strategy Two: Alternative Care and Demedicalizing Care

Participants described seeking alternative care for two main reasons: to increase the likelihood of access to queer-informed providers and to gain control over their care. Many participants described intentionally seeking queer providers (or known queer or queer-friendly providers) and seeking care outside the mainstream healthcare system, including homebirth midwives and doulas, for both pregnancy and abortion care.

Seeking care from providers that are known to be queer-friendly or are queer themselves gave participants a sense of comfort and safety. For example, Ray talked about the benefits of "shared understanding" because queer providers have a sense of the "unspoken norms and assumptions [within the queer community] that allow you to get better care… I prefer it that way because I just don't have to explain myself in the same ways." Similarly, Sylvia (she/her, bisexual, 24) intentionally sought out care from Title X clinics and Planned Parenthood because she felt that they saw more queer patients, and they were more equipped to care for her. Per her description, "These people actually care. They're doing this because they care about me, and not because they're

trained to make money." Participants worked to find providers who were informed and comfortable working with queer patients.

Participants also sought providers outside mainstream healthcare for similar reasons. For example, Veronica (she/her, pansexual, 31) and her wife sought out a fertility clinic that was outside their care network and wasn't covered by their insurance because it was specifically dedicated to helping single individuals and queer couples become pregnant. In addition to seeing more queer patients, participants were attracted to the models of care offered by midwives. As Jay (they/them, pansexual, 29) described:

> [there is an] overlap between the queer understanding of what it means to be in a body and to have bodily autonomy and the midwifery model. That because there are all these parallels like queer birthing people can really lead the way on here's how to stand up for yourself. Here's how to be autonomous. Here's how to have the birth you want.

Jay's choice to seek a midwife was based both in their expectation that a midwife would be more informed about their needs and more in line with their preferences.

Others viewed their choice of providers as a way to have control over their care. As one example, Ava's (she/her, queer bisexual, 28) primary care physician (PCP) wanted to refer her for infertility testing. Instead, she chose to start seeing a midwife who "starts with the mindset that [I am] capable of getting pregnant, and it's a normal thing for your body to do." By choosing a midwife, Ava said she and her wife were "taking a little bit of power back in the situation" by resisting her PCP's recommendations and instead of seeing a provider who was more in line with her values.

Relatedly, participants were interested in demedicalizing the process of getting pregnant, both for emotional and logistical reasons. Participants sought providers that would facilitate this preference. Amber and her wife intentionally sought a midwife who would allow them to do intrauterine inseminations (IUIs) at home. This felt like a way to involve her wife, and to "be in

your own home, in your own bed.” Ava and Amber’s preferences represent a desire to have more control and comfort during an otherwise stressful process.

Strategy Three: Managing Disclosure

While the previous two strategies reflected participants' choice about how and where to seek information and care, the final strategy reflected an approach to interacting with providers. The most frequently identified strategy was managing identity disclosure. Disclosure management happened in two ways: allowing providers to make assumptions or simply not disclosing queer identity and lying to providers about their identity. Disclosure management stemmed from a fear of discrimination or bias, emotional self-protection, and the desire to get the healthcare they need.

Managing disclosure was one tactic participants used to (attempt to) avoid discrimination from their providers. As Sylvia said: “coming out [to a provider] I’m just exposing myself to more stigma and discrimination.” Importantly, participants were in different places regarding disclosure, both in and out of the healthcare system. For example, Bella (cisgender and bisexual, 27) was not out to many people in her life ("I've always kind of hid my sexuality, especially when I go to the doctor or anything like that... because I felt I guess like I'd be judged"). Bella lived in a small rural town and described her provider as "very conservative." Bella highlights the ways that discrimination and queer-phobia more broadly shape expectations about healthcare. Because she experiences discrimination in her everyday life, she expects that to translate into her healthcare.

Beyond protecting themselves from discrimination or bias from providers, participants also made choices about identity disclosure to protect their emotional wellbeing and mental health. For example, Jay said that often it is “just easier to let [providers] make assumptions,” meaning that it was less emotionally taxing for them. Jay went on to say that they would rather not disclose their identity than disclose it and not have the provider follow up, recalling a time recently where the

paperwork they filled out had a blank box for both sexual and gender identity. Despite disclosing their identity on the form, the provider did not acknowledge the disclosure or signal that she was using it in her approach to care, which Jay viewed as more harmful than if the provider had made assumptions. Jay demonstrates that while creating space for disclosure may be important, a lack of follow up or inability to respond may be damaging.

Similarly, Alex (they/them, pansexual, 26) saw not disclosing their identity as a way to protect themselves. During their experience getting an abortion, they said: "I just ignore that part of my identity for the time it took to take care of [my abortion]."Alex's quote demonstrates both a choice not to disclose and also an attempt to cut themselves off from their identity. Alex's most pressing concern was getting an abortion, so they were less concerned with identity-affirming care in the moment. However, upon reflection, Alex attributed struggling emotionally post-abortion to the fact that they did not receive queer-informed or affirming care. "I feel like there was a lot of dissociation related to not being heard and feeling the system wasn't seeing me." While not disclosing their identity was helpful in the short-term, the lack of affirming care had long-term consequences.

Beyond just allowing providers to assume they were heterosexual and cisgender, participants often felt the need to lie if they were asked how they identified. For example, Adrienne (she/her, queer, 27) said that she would often lie about her identity and her behavior to her providers:

> I realized I lie to most of my medical providers if I think that I need to get the type of medical care that I need. I've definitely told people, 'Nope, not sexually active right now.' I will really play up my white, straight, middle-class persona… because it feels like I have to in order to get them to take me seriously.

Adrienne's quote highlights that she views lying as an act of self-advocacy, as she did not believe she could get the healthcare she needed if she did not lie. However, she sees this as problematic:

> It is messed up that I'm not honest with my own doctors... I just felt like it wasn't an option if I wanted to, I don't know, get the kind of care I wanted, and not be written off. Even though I was seeking reproductive health, I was downplaying the fact that I'm sexually active, and not disclosing that I was bi, not disclosing that I was poly, not disclosing that I had had an abortion.

Perceiving providers as queerphobic or sex-negativity prevented participants from accessing comprehensive reproductive health care.

Robyn revealed that she lied to her providers about her relationship status. She and her wife decided to use a close friend as their sperm donor. Once they learned that to use donor sperm, they would have to take "extra steps" (i.e., the sample would have to be quarantined, and their insurance did not cover donor insemination, but a donation from a spouse would be), Robyn decided to pretend that her close friend was her husband.

> It's been awkward, and I shouldn't have to do this. I feel like there shouldn't be so many obstacles. For me, I didn't want to have to go through all of the expenses, and the time it would require, so I opted not to. It's a shame… I shouldn't have to.

Disclosure management was an important strategy that participants developed to overcome structural barriers and meet their reproductive health goals.

In contrast, some participants felt safe to disclose their identity. This was usually because they lived in a more progressive city or area of the country. As Annie (she/her, queer, 37) stated:

> In terms of gender and sexuality for white people, it's very progressive. Everyone is non-monogamous and poly and trans and non-binary and every iteration of gender expression. It feels like people are used to seeing people who might describe themselves as not on the binary gender spectrum… I was like, it's going to be okay with me and my partner.

Participants who saw queer providers also felt safe and comfortable disclosing their identity. As mentioned in the second strategy, seeking alternative providers was a way to ensure participants could receive queer-competent care. Given the "shared understanding" that queer providers offered their patients, participants often felt the trust and comfort required for identity disclosure.

Strategies in the Context of Systemic Barriers

Importantly, the strategies discussed above were more successful for some participants than others. For example, many participants commented that they *wished* they could have sought alternative care but were unable to seek out providers who met their preferences due to geographic, insurance, or cost barriers. For example, Gail (she/her, pansexual, 32) lives in a rural town and is unsure if she will try to get pregnant while living in her rural town: "If I lived in a more blue state, I feel like the options would be broader… It wouldn't be a roll of the dice… how are we going to be treated?" Gail's options for providers are already limited, and even more so, by trying to find a queer-friendly provider. Similarly, both Raven (she/her, lesbian, 35) and Robyn said they chose the fertility clinics they did because of cost. Without insurance coverage, they had to choose the affordable option, rather than the clinic they thought would provide the best care. Raven described her experience with the clinic as "uncomfortable, insensitive and lacking awareness about [queer patients]." Robyn described her clinic as "a factory…a factory assembly line." For Robyn and Raven, financial circumstances and lack of insurance coverage constrained their choices.

Disclosure management was also more possible for some participants than others. Many of the participants who mentioned not disclosing their identity, allowing providers to make assumptions, or lying about their identity, were able to do so because they “passed” as heterosexual and cisgender. Maggie (she/her, queer, 26) described effortlessly passing in health settings:

> I think [providers] just go 'she's probably a straight woman.' So it's not a conversation that I would plan on engaging with the doctors or whatever. I am a pretty queer-looking woman, but in a way that I guess it's signaling to queer women and other queer folks, but not necessarily straight folks.

While most participants described the ability to “pass” if necessary, they also recognized this ability as “passing privilege” (Amber).

Further, participants who felt most comfortable disclosing were located in more liberal areas of the United States or had more choices in terms of providers. In contrast to Annie, who described her city as progressive and most providers having some familiarity with sexual and gender identity issues, Bella lived in a small, conservative town, with only one provider within driving distance. The lack of alternatives compounded Bella's fear of discrimination. Geographic, cost, and insurance barriers related to provider availability allow more economically and socially privileged individuals to access more inclusive and appropriate care and highlighting systematic barriers that are easier for some individuals to overcome than others.

While participants described the strategies that they used to get the reproductive health care that they needed, it was apparent to them that these strategies were in response to a system that was not inclusive of queer patients. Navigating this system took a toll on emotional wellbeing. Jacqueline commented that "I think how complicated the strategies can get…Having to navigate those things...can be overwhelming." Both Robyn and Adrienne vocalized how problematic it was that they felt lying to their providers was their only avenue to proper healthcare. Other participants commented on the myriad ways that they were not included in healthcare and how frustrating that was. There was a recognition among participants about the structural barriers to queer-competent healthcare, as exemplified by Ray: "just the way that large systems try and care for people leave most people out…[queer people] just work in a framework that isn't for us." Further, these systematic barriers can be overcome by individuals with resources while exacerbating barriers for queer-inclusion for others.

Discussion

This study documented queer cisgender women and gender-expansive individuals' experiences navigating reproductive health care, confirming previous studies focused broadly on

LGBTQ+ health, that report experiences of bias, stigma, misinformation, and improper healthcare (Conron et al., 2010; Graham et al., 2011). This study then documented the strategies that individuals developed to meet their reproductive health care needs in the face of the many barriers they report. Queer patients have developed a variety of approaches, including seeking information and community, seeking care in alternative settings, and managing identity disclosure. Importantly, this study highlights the ways in which some individuals have more ability to overcome systemic barriers through the use of these strategies than others.

Findings from this study are consistent with previous studies that identified identity disclosure and managing disclosure as essential processes for queer individuals seeking healthcare more generally. Given the push to collect SOGI (sexual orientation and gender identity) information on electronic medical records, it is crucial to see disclosure as a conscious choice made by patients, depending on both their previous healthcare experiences and the information they have gathered about the provider (Cahill & Makadon, 2014; Greene et al., 2019). Our findings also highlight that an individual's decision not to disclose their identity may be an attempt at emotional self-preservation, like in the case of Alex who believed it was just easier to cut themselves off from their identity, or a strategic calculation about how to get the care they need, like in the case of Adrienne who would "play up [her] white, straight middle-class persona." Healthcare settings must create an environment where disclosure is both comfortable and safe. However, we should not view non-disclosure as non-compliance or a problem, but rather a strategy that developed as a response to negative experiences or fear of discrimination.

Our study also expands previous literature around disclosure strategies by emphasizing additional strategies queer patients use outside of disclosure management. Becoming “experts” in their own health needs was one strategy patients developed. Importantly, for many, attempts to

become experts in their health needs stemmed from an inherent distrust of providers and the health system. In general, patients should be empowered to advocate for their needs, though they should be able to do so in partnership with their providers, not despite their providers. Further, we see the ways that queer individuals seek support outside the health system to become a more effective advocate and consumers of healthcare. By sharing their experiences, joining online communities, and crowdsourcing information, participants felt less isolated and were able to make more informed choices about their care. The other strategy, seeking queer providers or care from alternative sources, did alleviate many of the concerns and negative experiences participants described. However, this strategy should be interpreted in context, as many participants did not have access to alternative providers given their income, insurance coverage, or geographic location.

This study advances our understanding of how queer patients navigate reproductive health care. However, a few limitations should be noted. First, while 60% of participants participated in follow up interviews because we lost participants to follow-up, we could not ask all participants about emerging themes or confirm the researchers' interpretations about their experiences. Interviews focused broadly on the experiences with reproductive health care and did not distinguish between settings or types of providers. Future research should explicitly focus on diverse care contexts, including OB/GYNs, midwives, etc. The sample was mostly white and mostly well-educated. While this did not always translate to economic stability, as eight participants described themselves as lower-middle class or working poor, this was a sample with relative privilege. Given additional barriers to healthcare for racial minorities and low-income individuals, it is possible that these results do not capture the experiences and strategies of more marginalized queer patients. Finally, while the sample included individuals who were not

cisgender (i.e., assigned female at birth but did not identify as a woman), the sample was not inclusive of transmasculine individuals or trans men. Transmasculine individuals have additional barriers to adequate reproductive health care, such as insurance denying claims due to their sex-marker, high rates of discrimination, and gender dysphoria in women-centered spaces (Hoffkling et al., 2017; Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Future studies of queer patients should be more inclusive of diverse gender identities, and there should be dedicated studies to the unique experiences of gender-expansive, including transmasculine, individuals.

Implications for Policy/ Practice

Results from this study suggest several intervention points for improving queer-competent reproductive health care. Reproductive health care could be improved for queer women and gender-expansive individuals by creating and distributing queer-competent and queer-specific reproductive health information so that patients do not bear the burden of informing themselves or educating their providers; ensuring all clinicians and clinical staff are prepared to care for their queer and gender-expansive patients appropriately; and enacting policies, procedures, and provider training that ensures that patients feel safe disclosing their identity to their providers (Cahill & Makadon, 2014; Klein et al., 2018). Furthermore, providers must appropriately respond to the disclosure. As discussed in the results section, participants found an inappropriate response to disclosure to be more harmful than not being asked about identity. Thus, providers must receive proper training in how to respond when patients disclose their sexual or gender identity and how to follow up on disclosure respectfully. Additionally, because disclosure is a strategic decision, and safety is not guaranteed, providers and clinics must respect patients' right to make the disclosure decisions most comfortable to them, including whether or not to disclose their identity, when to disclose, and to whom they disclose.

However, the very fact that participants used complex and varied strategies to get their reproductive needs met demonstrates the underlying structural barriers in the healthcare system that leave queer and gender-expansive patients distrustful of and harmed by reproductive health care. The well-resourced participants and participants with "passing privilege" had a greater ability to overcome barriers, especially to seek out different sources of care. In contrast, others were significantly limited by financial limitations and obstacles to access. Equitable care requires that all patients, regardless of income or location, have access to information, queer-competent providers, and inclusive clinical practices. The health system is not outside the social world but rather is shaped by it. Thus, findings from this study also underscore the urgent need to address queerphobia and systematic barriers to LGBTQ equality, both in and out of the health system, to truly address the persistent barriers in queer cisgender women and gender-expansive individuals' reproductive health care outcomes.

V. Conclusion

Each of the three papers included in this dissertation aimed to discuss a unique aspect of pregnancy for queer cisgender women and gender-expansive individuals assigned female at birth. In this section, I will briefly describe the main findings of each of the three papers individually and as a whole, discuss practice and policy implications of the three papers, describe limitations of this research, and discuss ideas for future research.

Paper One: Pregnancy and Parenting Desires

The first paper describes pregnancy desires and the multi-level factors that influence pregnancy desires. An important finding from this paper is that pregnancy desires could not be disentangled from parenting desires. Participants described first desiring parenthood, and then choosing pregnancy among the options available for queer individuals to become parents (e.g., fostering or adoption). For example, some individuals felt very clear that they wanted to parent a child, and they wanted to become a parent through pregnancy. Others felt discomfort with pregnancy, often due to their belief that pregnancy was incompatible with their queer identity. Other participants saw pregnancy as the "least complicated" option for becoming a parent and thus were willing to become pregnant to meet their family formation goals.

Another key finding is that individuals seeking parenthood understood their options in relation to alternative ways of becoming parents and continuously reassessed their options as they encountered barriers to their family formation goals. Participants were willing to consider alternative paths when they encountered obstacles, such as healthcare barriers, financial barriers, or were physically unable to become pregnant. Importantly, numerous individual, relationship, and structural factors informed both pregnancy desires, and the options participants pursued to become pregnant.

One participant, Amber (28, queer lesbian, Latina), highlights these findings particularly well. At the time of the interview, She and her partner had been actively trying to become pregnant for approximately a year. She was unable to become pregnant after five attempts with intrauterine inseminations (IUIs). Thus, she and her wife decided to stop trying and save money. They also moved to a new city, losing access to their queer-friendly midwife, and their donor was deployed. Because it was important to Amber and her wife to have a child that shared their racial identity, they had to find a new Latino donor. These barriers prevented them from resuming attempts to

become pregnant. When they did continue, after more unsuccessful IUIs, Amber and her wife decided that her wife should start trying to become pregnant instead of Amber. However, her wife identifies as "super butch" and had complicated emotions about being pregnant. Amber reported that they would stop or consider adoption if they continued to be unsuccessful.

Amber and her wife highlight the complicated path that queer individuals and couples walk in trying to build families. In their story, we see consideration of several factors in becoming pregnant, including a desire to share a racial identity with their future child and considering a pregnancy's impact on queer identity. We also see the financial component influencing when, if, and how many times they could attempt to become pregnant. Finally, we see Amber and her wife deviate from their desired path to parenthood, for Amber to carry their biological child, as they encountered financial and logistical barriers.

This paper highlights that pregnancy desires are both a distinct desire (the desire to physically experience pregnancy) and a complicated piece of parenting desires (perhaps the most feasible or acceptable option for becoming a parent). The broader pregnancy intention literature implicitly conflates pregnancy and parenting. My study argues for the importance of making the distinction between these two desires and experiences, especially for queer individuals sorting through complex decisions. Findings from this paper emphasize the importance of recognizing the complexity of pregnancy and parenting and the barriers queer individuals face in family formation. Further, social workers and healthcare providers must incorporate this understanding into their work—for example, counseling queer individuals about pregnancy should include an assessment of the many factors influencing pregnancy desires. Supporting queer individuals in a range of reproductive health and parenting options is key to full recognition of queer individuals as parents and their participation in a fundamental human experience—family building.

Paper Two: Abortion Attitudes and Experiences Among Queer Individuals Assigned Female at Birth

The second paper identifies the queer-specific factors that shape abortion experiences and care. Until recently, abortion research has overlooked sexual and gender identity, assuming that all abortion seekers are cisgender and heterosexual. Emerging evidence from both unintended pregnancy and abortion literature is beginning to challenge that assumption and suggests that individuals of all sexual and gender identities experience unwanted pregnancy and may need abortions (Charlton et al., 2019; Jones et al., 2018; Jones et al., 2020). This paper intended to be the first qualitative investigation into how queer identity, and specifically how the stigma of being queer, interacts with abortion stigma.

Findings reveal that queer cisgender women and gender-expansive individuals assigned female at birth seek abortion care for multiple and complex reasons. Queer identity shapes abortion experiences in two ways: First, queer identity shaped engagement in abortion care. Second, queer identity shaped how individuals processed or contextualized their abortion. Participants translated their experiences into recommendations for improving abortion care to be more inclusive of queer individuals.

Adrienne (she/her, 27, queer, white), provided an account of her abortion experience, involving inclusive and queer-informed providers, access to financial assistance, and social support both in making the decision and through the abortion process. Her account could be viewed as the goal for all individuals seeking an abortion. Her friends drove her to the clinic and stayed with her until she had to take the second of two pills involved in a medication abortion. As she described, "it was almost like a party." In reflecting on her experience, Adrienne is grateful to have had an abortion and believes this is the experience that allowed her to live "a fully queer life" in a

way that she could not have if she had a child. Adrienne describes the financial, emotional, and logistical resources required to make a decision, a community that helped mitigate abortion stigma, and a sense of empowerment from her decision. Adrienne's experience provides us with a model to work towards for all individuals seeking abortion care.

There are two broad implications of this paper. First, this paper outlines the nuances and complexity of seeking an abortion as a queer woman or gender-expansive individual. This complexity plays out in a variety of ways, including the decision to have an abortion, the experience with abortion care, and the stigma associated with abortion. For example, most participants experienced an unwanted pregnancy, but two participants needed an abortion for health reasons in the context of a very wanted pregnancy. Queer identity also interactions in the health system. While some participants had positive interactions with abortion providers, others described encountering bias and harmful heteronormativity from providers. Finally, queer identity interacts with abortion stigma to amplify mental health consequences post-abortion. To be clear, these are not consequences caused by the abortion, but rather by the inability to process having an abortion and the isolation that abortion stigma causes. In particular, several participants felt like they could not talk to their queer friends about their abortions, and thus never discussed their experience. In contrast, several participants described positive experiences seeking an abortion. Understanding the common experiences of queer individuals seeking abortion care expands our narrative of the people who need an abortion.

Second, implications from this paper highlight possible improvements to abortion care to be inclusive of queer patients. I intentionally highlighted participants' recommendations for improving care, as they so clearly could articulate what they needed to feel cared for and safe in seeking abortion care. These suggestions ranged from improving provider knowledge and pushing

the narrative about a "typical" abortion patient to more structural interventions, such as increasing the number of providers who identified as queer and decreasing financial barriers to abortion. Importantly, these improvements would help all individuals, regardless of sexual or gender identity, access more compassionate abortion care.

The first paper explained the importance of understanding pregnancy and parenting in the context of queer identity and removing barriers to desired family formation as key to affirming reproductive justice for queer individuals. In the second paper, I built on this concept and argued that improving abortion care so that it is accessible and inclusive, and allows individuals control over their bodily autonomy, is also crucial for advancing reproductive justice.

Paper Three: Queer cisgender women's and gender-expansive individuals' strategies for navigating reproductive health care

The third paper in this dissertation focused on the healthcare system. I chose to focus the last paper on the healthcare system and the strategies individuals employ to meet their needs, because respondents consistently reported encountering healthcare barriers to reaching their reproductive health and family formation goals.

Participants talked about the ways that it was evident to them that the healthcare system "just wasn't built for us" (Ray, they/them, queer, 31). Nearly every participant had a story about a negative encounter while seeking reproductive health care services (e.g., fertility treatments, contraception, abortion, or prenatal care). However, despite experiencing bias and discrimination, participants displayed resilience and creativity by developing strategies to get their health needs met. These strategies include seeking information and community, seeking alternative care, and managing disclosure. Results detail the strategies participants used to navigate reproductive health care. First, some participants became "experts" in their own care and sought community. Second,

participants discussed intentionally choosing providers, including alternative healthcare providers (midwifery clinics or doulas) or queer providers. Finally, some participants managed their identity disclosure, from not disclosing to intentionally identifying as straight to their providers.

The case of Robyn (she/her, 29, lesbian, Latina) demonstrates these findings well. She and her wife wanted to become pregnant using their close friend as the donor. When she discovered the initial financial costs associated with using a known donor versus a donation from her male partner, she decided to lie to the clinic and represent the donor as her partner. This choice certainly had implications for the relationship with her provider and the clinic, and also precluded Robyn's wife from being involved in the conception process. It also left Robyn angry, constantly reminded that she is not "normal" and experiencing the effects of discrimination. Of course, her case also brings up ethical questions about lying to providers and possibly committing insurance fraud. From Robyn's perspective, the system created so many barriers to her family formation goals, that she had no other option. There need to be significant improvements to the healthcare system, including insurance coverage and equitable policies regarding queer fertility, so that the healthcare system becomes a facilitator for, rather than a barrier to, queer reproductive health and family formation.

Findings from this paper highlight the structural nature of barriers to queer-inclusive healthcare. The presence of these complex strategies demonstrates underlying structural barriers in the healthcare system that leave queer and gender-expansive patients distrustful of and harmed by reproductive health care. Additionally, findings from this paper demonstrate the ways that individuals are informed and active participants in their care. Participants developed strategies to meet their health needs, despite the barriers they faced to compassionate, queer-inclusive reproductive health care. While these strategies show resilience and resourcefulness, the need for such strategies is that the healthcare system is failing queer individuals seeking reproductive health

care. Instead of encouraging and relying on these individualized strategies, we should be addressing structural problems in the healthcare system that provide the barriers that required such strategies in the first place.

While the first two papers focused on individuals' experiences concerning pregnancy, the third focused on the healthcare system, which is integral to individuals meeting their reproductive health and family formation goals. Dismantling structural barriers to reproductive health care and family formation is key to affirming reproductive justice.

Collective Implications

Collectively, these papers discussed the range of pregnancy experiences, the context in which queer individuals are making family formation and pregnancy decisions, as well as the significant influences on pregnancy desires and experiences for queer individuals. Importantly, the three papers address decisions to become pregnant, decisions to avoid pregnancy, and decisions to terminate a pregnancy. As discussed in paper one, decisions about when and how to become pregnant and decisions about seeking abortion were often influenced by the same factors, including the intersections with queer identity or partners. As discussed in paper three, the healthcare system played a significant role in how easily individuals were able to seek the care they needed and make these decisions.

Additionally, viewing these two seemingly opposite decisions as related, we can see that the barriers to wanted pregnancy and the increased rates of unwanted pregnancy stem from many of the same causes—including a lack of queer-informed healthcare providers, limited narratives about who needs reproductive health care, and queerphobia more broadly. Talking about these decisions as related instead of disparate challenges the dominant paradigm set up in the queer pregnancy literature. This approach also brings a reproductive justice lens to this work, by focusing

on both the right to have a child and to not have a child as equally valid and vital for affirming queer family formation and bodily autonomy.

Each of the three papers focuses on the healthcare system. While paper three pays the closest attention to the role of the healthcare system and the ways that queer individuals interact with this system, both papers one and two also include the healthcare system. Queer individuals making pregnancy decisions are primarily reliant on the healthcare system to meet their reproductive health goals. Thus, participants' experiences mainly focused on their engagement with, and satisfaction, or dissatisfaction, with this system. While I did prompt my participants for information about other systems, such as social services or public benefits, most were much more concerned with the healthcare system. Each paper produces distinct, yet related, recommendations for providers working with queer patients and improvements to the healthcare system so that queer individuals can more easily make decisions around pregnancy and have affirming and inclusive experiences in the healthcare system.

Finally, each of the three papers speaks to the underlying homophobia and heteronormativity shaping individuals' experiences. Ranging from small insinuations that they are not "normal," to the impacts of isolation and stigma, to overt structural barriers to their family formation goals, individuals make pregnancy decisions in the shadow of homophobia and heteronormativity. Participants felt these forces in varying degrees and different ways. Given that pregnancy, especially unwanted pregnancy, is viewed as a "straight" experience, participants expressed a heightened sense of awareness of heteronormativity around pregnancy. As Annie (she/her, 36, queer, white) expressed: "... I've been out as queer for 20 years or so. I often don't feel shame or sadness about my identity," but when she was pregnant, "it was weird because I'm queer and people think I'm not queer... I [couldn't] wait to not be pregnant so people can stop

assuming that I'm heterosexual". Annie is one example that highlights the ways in which participants, regardless of their specific circumstances or decisions, felt the pervasiveness of heteronormativity. Homophobia, or overt discrimination and bias, also loomed large, shaping not only the services individuals had access to but also how they could engage in those services. The influence of heteronormativity and homophobia is an important theme across the three papers, speaking to the need to address structural homophobia and create social environments supportive of queer individuals more broadly.

Implications for practice, policy, and research

Findings from this dissertation have several implications for family planning and social research, as well as policy implications. One goal of the study was to understand, from the perspective of queer individuals, how to improve clinical and social services to be responsive to the specific needs of queer individuals. Participants were asked what changes they wanted to see, what they wish service providers knew, and what they wish people more broadly knew about queer individuals and reproductive health and family formation. Answers clustered around three main themes: more inclusive narratives around pregnancy, both in general and in the health system, increasing provider knowledge, and structural changes. Many of these solutions are discussed in depth in paper two. Uniquely, these solutions are both a finding and an implication of this dissertation.

Current narratives around pregnancy are largely heteronormative. The lack of inclusivity has implications both for individuals as they contextualize their pregnancy desires and experiences and a variety of health and social services. The lack of queer-inclusive narratives left many participants feeling isolated or experiencing internal discord between their identity and desire to be pregnant. Increasing awareness and expanding the narrative of who gets pregnant or who seeks

abortion care may help alleviate isolation, as well as shift healthcare practices. As Sequoya (they/them, pansexual and genderqueer, 28, Cherokee) posited, providers would be less likely to make harmful assumptions and more equipped to provide affirming care: "It's really changing the narrative, the cultural narrative…and trying to reconceptualize how we understand those services and who's accessing them."

Family planning and social work researchers play a crucial role in promoting queer-inclusive narratives by continuing to build on preliminary efforts to collect data about sexual orientation and gender identity, especially around more heteronormative experiences like pregnancy and family formation. Researchers play a crucial role in defining the scope of social phenomena. By counting the number of queer individuals experiencing pregnancies and abortions, we not only have evidence of the phenomenon, but play a role in reinforcing the normalcy of including queer individuals in our assessment of pregnancy and abortion.

Findings from this dissertation also highlight the importance of increasing knowledge about queer identity and ensuring that healthcare providers, social workers, and others involved in interventions during the perinatal period, are educated about the specific needs of queer individuals. Working with queer individuals around pregnancy should be normalized for providers. Queer individuals face barriers to accessing queer-informed providers, and thus both provider education and clinical practices should be improved to include queer individuals. The queer-inclusive healthcare practices my participants advocated for reflected principles of patient-centered care, trauma-informed care, and evidence-based care. As Ray said: “bring in queer-centered practices, and they're going to help everyone."

Finally, structural barriers play a significant role in shaping the experiences of queer women and gender-expansive individuals around pregnancy. Healthcare systems must address

structural barriers to queer-inclusive healthcare, as well as barriers to affordable care. Participants cited the ways that the "health system wasn't built for us" as a barrier to family formation or reproductive health goals. Participants also cited economic barriers to both wanted pregnancies and to avoiding unwanted pregnancies. Policies such as ensuring access to health insurance coverage for ARTs as well as abortion, including ending bans on using Medicaid funds for abortion care, would help to promote queer reproductive justice.

Because health and social services reflect patterns of inequality and discrimination more broadly, social workers must be advocates for queer-inclusivity and equity more broadly (Meyer, 2016). Social workers play a crucial role in promoting reproductive health and wellbeing through individual and community practice, program implementation, and policy advocacy. Further, social workers have a unique skill set that can help ensure that marginalized identities are not overlooked or underrepresented in reproductive health-related work. Social workers can and should play a role in advocating more broadly for systems and policies to promote LGBTQ+ equity, as well as appropriate, accessible, and affordable healthcare to support queer individuals' family formation and reproductive health goals (Begun et al., 2016; Bird et al., 2016).

Limitations

This study is not without limitations. First, the majority of the study participants were White. Previous literature suggests that Black sexual minority women face specific barriers related to pregnancy as well as conceptualize their identity and pregnancy in different ways than white sexual minority women (Reed, Miller, & Timm, 2011). As my study demonstrated, queer individuals of color may have additional concerns, including the availability of donors that share the same race or ethnicity or concerns about not sharing a racial/ethnic identity with their child.

There may be additional dimensions to pregnancy and parenthood not represented in this study as a result.

An additional limitation relates to recruitment methods. Participants were recruited by social media posts. Thus, the sample is limited to social media users and those who learned about the study through others who use social media. There may have been overlap in the social networks of participants. Investigators tried to limit this possibility by posting in a wide array of social media groups and encouraging re-posting. Finally, several participants did not participate in the follow-up interviews. Especially for early participants, investigators did not have the opportunity to ask about themes that emerged after the analysis progressed.

Future Research Directions

This dissertation was an innovative investigation into how queer individuals relate and respond to pregnancy and navigate systems to meet their family formation and reproductive health goals. However, this study sparked several new questions, some of which can be answered with additional analyses of the data I collected, while others will inform future research.

Especially for participants seeking desired pregnancies, the role of their partners could be further explored with the data collected. Many participants voiced concerns about their partners (the non-birthing partner) feeling left out of the process. Limited narratives about queer pregnancy extend to the non-birthing partners as well. Several participants suggested this as an important topic for future research. Further exploring partner involvement could be an additional analysis using data from this study. I asked participants about their partners, including their perceptions of their partners' experiences and the negotiations between partners. This would include both monogamously partnered couples and individuals with multiple partners.

Additionally, mental health was a pervasive theme, and thus an additional possible analysis would be the role of mental health in influencing pregnancy decisions and experiences. Given the high rates of mental health concerns in the queer community and the evidence of the impact of stigma present from the current findings, this analysis would have clear implications for both mental health practice and research and family planning research and clinical care (Frost et al., 2011).

Future research needs of the field

In addition to the possible analyses from this dissertation's qualitative data set, there are additional family planning and social work research needs. Researchers need to include more accurate and in-depth identity measurements, including integrating a range of gender identities, in all studies pertaining to reproductive health. Better integrating gender identity would allow future research to explore the unique needs of transmasculine individuals and focus more specifically on gender-expansive individuals. Additionally, family planning researchers must continue to collect data on sexual identity and gender identity when studying pregnancy prevention, abortion, and pregnancy plans. Such data allows the field to fully understand who is seeking family planning care and continue to expand understanding of queer-specific family planning needs.

Given the finding in paper one that pregnancy is one path to parenthood and often considered in conjunction with other routes to parenthood, we need future research about the experiences of queer individuals with adoption and fostering agencies. Alternative routes to parenthood are especially relevant given the Supreme Court Case, *Fulton V. The City of Philadelphia* (2020), which will determine adoption agencies' ability to discriminate against queer couples in adoption or foster care placement (*Fulton V. The City of Philadelphia*, 2020). Further

understanding the structural barriers to all paths to parenthood in relationship to one another is needed.

Finally, in general, we need more considerable attention to queer individuals as actively making and achieving family formation and reproductive health goals. Until queer individuals are consistently and accurately represented in the literature around pregnancy, abortion, and family formation, both social work and family planning researchers will continue to perpetuate heteronormative narratives about pregnancy and family formation.

Conclusion

This dissertation attempted to understand the role of queer identity in shaping pregnancy desires and decisions. Informed by principles of reproductive justice, this study challenged dominant paradigms related to queer individuals and pregnancy. My findings that queer individuals hold a range of pregnancy desires challenge the idea that queer women either experience very wanted pregnancies using ARTs or constitute a demographic at risk of unintended pregnancy. Pregnancy desires are much more nuanced and complex and are informed by a range of interpersonal, relationship, and structural factors. This dissertation also demonstrates that barriers to wanted pregnancies and risk factors for unwanted pregnancies stem from the same causes—inadequate healthcare, heteronormativity in reproductive health care, and queerphobia more broadly. Supporting queer individuals in a range of reproductive health and parenting options is critical to full recognition of queer individuals' bodily autonomy, affirming reproductive justice, and supporting participation in a fundamental human experience—family building.

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Appendix A: Screening Questions

Screening Questions

Potential participants will fill out this brief survey on Qualtrics. The purpose of the study will be to 1) determine eligibility for the study and 2) help with the theoretical sampling.

If they are eligible and meet the dimensions for participants that I am looking for, I will contact them.

Demographics:
How old are you? (*text box*)
Were you assigned female at birth? (*Y/N*)
How do you describe your sexual orientation? *(Open-ended text box)*
How do you describe your gender identity? *(Open-ended text box)*
How do you describe your race/ethnicity? *(Open-ended text box)*

Highest education? (*Open-ended text box*)
How would you describe your class/ socioeconomic status? (*Open-ended text box*)
What city and state are you currently living? (*open-ended text box*)

Relationships:
What is your current relationship status?
(Open-ended text box)

Pregnancy:
Have you ever been pregnant? (*Y/N)*

If yes:
How many times?
Did you plan to get pregnant when you got pregnant? (Ask for all pregnancies)

Have you ever terminated a pregnancy or had an abortion? (*Y/N)*

Do you want to become pregnant…

In the next year?
Five years?
Ten Years?
Undecided
I never want to be pregnant
I don't want to be pregnancy again

Are you actively taking steps to try to become pregnant? (*Y/N)*

Are you actively taking steps to prevent pregnancy? (*Y/N)*

Appendix B: Interview Guide

Interview guide

Thanks so much for taking the time to speak with me today! I am so grateful to learn from you and to hear your thoughts. For your protection as a research participant, I have to go over a few things with you before we begin…

Your participation in this study is completely voluntary. You can end the interview at any time. You can also skip any of the questions I ask you. If you'd like to skip a question, simply say "pass" and I will move on.

I take your privacy and confidentiality very seriously! Interviews will be recorded and transcribed, however, all identifying information will be taken out during transcription. At the end of this interview, I will ask for a pseudonym. Any information that you've provided

me will be kept on a password protected server or in a locked filing cabinet. All audio recordings will be destroyed at the end of the study.

You will be compensated $30 for this interview. At the end of the interview, I will ask you if you would be willing to participate in a brief follow-up interview. If you agree and complete another interview, you will be compensated an additional $15.

Do you have any questions about being a research participant?

Okay great. The purpose of this study is to understand what queer-identified folks are thinking about pregnancy and having a family. I know that this is a personal topic. I appreciate your time and emotional labor and your contributions to our understanding of this topic!

I know that language around identity is really personal, so I will try to use the language you use and I want you to use the identifying terms that feel most comfortable to you.

Is It okay if we get started?

Question	**Purpose/Sensitizing Concept/ Notes**
What comes to mind when you hear sexual identity and pregnancy?	rapport building/ easing into the interview
Identity	
Can you tell me a little bit more about how you identify in regard to your sexual orientation? How has your identity changed over the course of your life? How does your sexual orientation/identity influence your daily life? Are there other identities that feel important to you? How do these identities influence your life? *(Prompt if needed: race, ethnicity, religion, socioeconomic, status etc.)*	Sexual identity + role of sexual identity
Pregnancy	
Thanks for that. Now I'm going to ask you some questions about pregnancy and how you are currently thinking about pregnancy or getting pregnant.	Pregnancy desires and dimensions of desire.

Can you say a little bit more about how you are thinking about pregnancy? (*Prompt if needed: what types of things are you thinking about?)* If partnered: Can you tell me about how your partner is influencing your thinking around pregnancy? *(Ask a similar question about other dimensions of interest: life stage/economic stability, resources, other family, health/mental health)* How has your sexual identity played into your thoughts/ feelings about pregnancy in the past?	
Pregnancy Cont. (for participants who have been pregnant)	
The next few questions are directed towards participants who have been pregnant… Skip ahead if they have never been pregnant. *This section is about your previous pregnancy(cies). I'm going to ask you a couple of questions about each pregnancy. Let's start with your most recent pregnancy.* *(Repeat for every pregnancy)* Can you tell me what was happening when you got pregnant? What was happening in your life at that time? What were you thinking about? *Prompt for:* *Partners* *Finances* *Other family* *Friends/ community* *Accessibility/ ease* *Mental health* *Political implications* Were you trying to get pregnant? How did you feel about the pregnancy?	Pregnancy desires and dimensions of desire.

How did these feelings change across the pregnancy? How did your sexual orientation/ identity play into your pregnancy?	
Health Services + Other Social Services (Skip if participant had an abortion)	
Can you tell me about navigating the health system as a pregnant queer woman? What about as a queer woman trying to get pregnant?	Facilitators to pregnancy
Can you tell me about any struggles or obstacles you had to get the services you needed?	Barriers to pregnancy or reproductive health care Purposefully vague—trying to get at the services they wanted/ wished they had had trying to achieve pregnancy/terminate pregnancy.
Abortion (Only for participants who indicated they had an abortion)	
If the participant indicated they had an abortion. First ask if it is okay to ask questions about abortion experience. I just want to remind you that it is okay to skip questions is needed. Can you walk me through what you were thinking about when you made the decision to have an abortion? What was that process like for you? Can you tell me about navigating the health system to get an abortion as a queer woman? What support did you have while seeking an abortion? Can you tell me about any struggles or obstacles you faced getting the services you needed? *(Prompts if needed: Was it difficult to get an abortion)* What support do you wish you had during that process?	Process and facilitators and barriers

How did your sexual identity impact your decision to have an abortion? Were there ways that your abortion impacted your identity?	
Health Services	
Skip to here if the participant has never been pregnant. *This next section is about your experience seeking reproductive health services more generally. By reproductive health services I mean health services like contraception, ART, STI testing and treatment.* Can you tell me a little bit about your experience seeking reproductive health services*? (If necessary, prompt for contraceptive counseling or pre-conception counseling*) Can you think of a specific example? In general, have providers talked to you about your sexual identity? Can you think of a specific time when they asked about your sexual identity? Did you choose to disclose? How did that go? Do you think it is important for reproductive health providers to ask you about your sexual orientation/identity? IF YES: How would you like providers to talk to you about your queer identity? How do you want providers to respond to you disclosing your identity? IF NO: Why don't you think providers should ask about your sexual identity? What is your health insurance situation? How does your coverage impact the services you use?	

Community	Social narratives about pregnancy
What is it like to talk about pregnancy with people in your immediate community? (*Prompt if necessary: what's it like to talk about pregnancy or thinking about pregnancy with your friends? Or ask the participant to clarify who they mean by their community)* What about in the LBGTQ community in general? How do you think being in XXX city impacts your experience? (*Prompts if necessary: large LGBT community, political climate, accessibility of health care, etc).*	
Wrap up questions	
What advice would you give to a friend in a similar situation? What advice would you give to reproductive health care providers? What do you wish people knew about pregnancy for queer women? (society-at-large)	
How would you like to see this study communicated with the world? In your ideal world, who would hear about these findings?	
Would you be interested in participating in the analysis? This would involve reviewing your transcript with codes applied. Would you like to be notified about research talks or any publications that come out of this study?	
Are you interested in participating in a second follow-up interview? If you are willing, we would schedule it for 1 to 2 weeks from now and I would ask some follow-up questions as well as give you space to reflect on this interview. You will be paid $15 for the second interview if you choose to participate, but agreeing to it or not has no impact on your getting paid for this interview.	