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Doing Pregnancy Without Doing "Womanly" : Non-Conventionally-Feminine Gender Expression and the Provision of Pregnancy-Related Medical & Midwifery Services

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by

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Under the Direction of Wendy S. Simonds, PhD

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ABSTRACT

There is a long and pervasive history of conflating “womanhood” and “motherhood” in the United States (U.S.). Expectations (and privileging) of particular gender identities and expressions and “what it means to be a woman” leads to a narrow depiction of how pregnancy (and those who do and don’t go through it) should look. What happens when those identities and expressions diverge from the generally expected standards? Anecdotal evidence and prior research on pregnant lesbians suggest the potential for backlash and poor medical experiences. There has been little attention to pregnant sexual and gender minorities (SGMs) and their medical and/or midwifery care experiences. Invisibility, health care that isn’t caring, and fear of backlash and/or violence are known drivers of health disparities and poorer health outcomes in other populations, including LGBTQ+, BIPOC, and LGBTQ+ BIPOC peoples.

The overarching goal of this research is to bring to light the experiences of individuals who do not embody or identify with “the "normal" look of a pregnant woman” (@domo.crissy.15, 2017). I employed mixed-methods research and modified-grounded theory methods (mGTM) to analyze surveys completed by 51 non-conventionally-feminine (NCF) and pregnant individuals (or individuals who had previously given birth). I also conducted paid, follow-up interviews with eight of my survey participants. I illustrate how essentialist views of gender intersect with dominant discourses regarding the pregnant body and how these discourses can cause harm to pregnant and birthing people who do not embody the gendered expectations. When medical providers take steps to affirm these individuals’ identities, they can help prevent further medical-related trauma and related health issues (Roberts 1997; Ross and Solinger 2017). This work contributes to current understandings and constructions of gender and the medical treatment of differently gendered and sexed bodies. Not all birthing bodies display include the conventions of

femininity and/or *mother*hood. Further, these persons and identities should be met with affirmation and equitable care, not differential treatment, nor through a lens of pathology. With this work I seek to inform (and improve) medical and midwifery services to gender-diverse populations.

INDEX WORDS: Gender, Gender Hegemony, Gender Expression, Pregnancy, Birth, Medical care, OBGYN, Obstetrics, LGBTQ+ Health

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DEDICATION

I dedicate this work to the amazing individuals that shared their stories with me for this project. Thank you, from the bottom of my heart, for not only helping me make this important research happen, but for being who you are. Y'all are living proof that your gender identity and/or expression does not a birthing body—or a mother, father, parent, etc.—make. You are also proof that the bounds of gender are limitless, and that, is a beautiful thing. I worked hard to preserve your voices and I promise my best efforts to make your voices heard and used, to improve and sustain health services for all those whose gender (or any other part of who they are) has ever called into question their right, and capacity, for good health.

This dissertation is also dedicated to two amazing women: Caroline Wall and Bernadette Patterson, both of whom I lost during this educational journey. I never thought the version of me that would finally finish their PhD would be one in a world in which you are both gone. I don't even know how to put in words what you both mean to me, especially when I haven't even truly come to terms with that fact—but what I do know is that I'm not alone. So this is also dedicated to all the people out there that have, whether partially or completely, had to put their grief on hold not just to survive, or to get through the work day, but because sometimes you feel like if you don't, you'll be six figures in debt with nothing to show for it.

Bernadette—I have and will continue to devote my career to preventing doctors from ever treating patients the way I watched them treat you. You deserved better. I love you.

Figure 0.1 Zoe and Bernadette Faceoff for Control of the Party Jams

This photo was taken in 2015 at Mary's in East Atlanta, where myself and friends gathered to celebrate my successful master's thesis defense. Thanks, Bernadette, for always supporting me and my, "sociology crap or whatever."

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The "somehow I finished this" can be explained via the endless love and support of my wife, Marjorie Freggens. Linda from Bob's Burgers said it best: "Thank you for loving me. Thank you for being there. Thankin' you, for thankin' me, thankin' me, for lovin' youuuuu." Similarly, I couldn't have gotten to this finish line without the help of my parents, Mary Ellen Riddle and John Scott Fawcett, as well as my brother and sister, (and baby nephew), Chris Riddle, Sarah Riddle, and August Lee Riddle. And of course, to my amazing in-laws: Don and Lisa Freggens, Libby and Bo-LeBlanc, and "the boys:" Boyd, Max and Drew; thank you for always believing in me. I'm so lucky to call you family. Last but not least, my ride or dies, Bronte Emery and Dara (Webb) Ramstein—whom other than my biological family—I've known the longest. Thank you for always being there for me, at my best, and my worst. I couldn't have finished this without y'all. And Bronte—I'm gonna pay you back one day. (U.S. Department of Education—that's a different story. We both know I am never going to pay you back in full—but thank you for loaning me a buttload of money over the years to pay for this degree.)

I'd also like to thank Lindsey Johnston, who was my therapist in 2020 and 2021. Lindsey—you are very literally the reason I finished my dissertation proposal. I was psychological dreckitude when I first entered your office, and when I re-enrolled in my PhD program in 2020, I realized I was facing an insurmountable barrier in the form of a dissertation proposal. You helped me find the strength and tools to overcome that barrier and get one major step closer to finishing this degree. I cannot thank you enough, for both helping restore my sanity after I quit my job, and for helping me get to a place where I could move forward with my education—and my life.

I also owe a very special thank you to my committee: Wendy Simonds, Elisabeth Burgess, and Katie Acosta. I feel extremely privileged and honored to have been granted your time, energy, and guidance on this project. Wendy—you've taught me so much. Thank you for never giving up on me. And for your patience. If I had a dollar for how many times I've told you, "I just need a little more time," I'd be rich—but you never made me feel bad for the time I needed to finish this. Thanks for believing in me. And for always reminding me that my work getting rejected or delegitimized along the way just means I must be doing something right.

Finally, this dissertation is for all the folks that didn't finish (or even start) their graduate degrees—more specifically, for those that chose (or were forced to choose) their mental and physical health (and/or a better paying job)—over an overpriced, albeit useful, status symbol. In many ways—you are stronger and wiser than I. Without all those I mentioned above, as well as other friends, mentors, and administrators within my department(s) and life that have been rooting (or cooking) for me for the past eight years, there is literally no way I'd have survived, let alone graduated. Erin and Jim—while in your roles as graduate director—you helped me to continue moving forward in my program after my leave of absence, when I decided I was ready to "come back." You both provided me with support I desperately needed during those times. Thank you for seeing potential in me and for helping me carry on.

Similarly, I feel that it is important to state for the record that it would have been OK if I hadn't finished my PhD. Let me say that again: It is OK when people don't finish a degree. It would have been just as valid a decision (and wouldn't mean I'm any less smart and capable) had I decided that it was too much for me to handle. Because honestly, overall, it *was* too much—and I never would have managed it had I truly been on my own. Most importantly: My value and worth as a human being are not determined by a doctorate degree. No one's value is.

Academia, and those in power within academia, need to do better. I didn't do this to join that racist, sexist, classist, xenophobic, homonegative, transphobic, cult that is the ivory tower. I may have started this degree with a hell of a lot to prove—but I finished this degree for myself. And for my family. And so people (well, some people) will take me seriously just long enough for me to get in the door. I just want to use what I've learned to help make more equitable the institutions on which we rely—not only to survive, but to thrive.

Oh, and thanks to my cats. They can sense when you're having a hard time and always jump at any chance to provide cuddles and support. Even sometimes at the detriment of your focus. (They just LOVE keyboards, y'all.) To Keeks (~2000-2015)—thanks for being with me to kick off two big life events: Y2K and graduate school.

P.S.

To the reviewer that "didn't see the point" of my dissertation research and felt it seemed, "more like advocacy than scholarship,"—I'm sorry your interpretation of science is so archaic and epistemologically drab that you can't even imagine it helping anyone. That's a bummer for you. Also—you're wrong, because advocacy and scholarship are not mutually exclusive. When you typed those words about my work—you did more than "provide feedback" to a PhD student asking for financial assistance. You revealed that you've taken an unfortunate stance—a stance that attempts to silence the voices and experiences of the amazingly strong and courageous human beings that gave their time and emotional labor to this project. And I simply won't stand for that.

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LIST OF ABBREVIATIONS

AFAB : assigned female at birth
LGBTQ+ : lesbian, gay, bisexual, transgender, queer, plus
PLWH : people (or person) living with HIV
SGM : sexual and gender minority
TGE : transgender, nonbinary, and gender expansive (people)
GD : gender diverse
DEI: Diversity, Equity, and Inclusion
CDC : Centers for Disease Control
SOGI : Sexual Orientation and Gender Identity
ODPHP : Office of Disease Prevention and Health Promotion
HHS : Department of Health and Human Services
PRIDE (study) : Population Research in Identity and Disparity for Equality
NCF : non-conventionally-feminine
SES : socioeconomic status
POC : people (or person) of color
WoC : woman (or women) of color
PCP : primary care provider
FQHC : federally qualified health center
EQI : Equitas Health Institute
SCA : structural competency assessment
EMR : Electronic medical record
EHR : Electronic health record
UME : undergraduate medical education
ACGME : Accredited Council for Graduate Medical Education
mGTM : modified-Grounded Theory Methods
GTM : Grounded Theory Methods
HF : hegemonic femininity
HM : hegemonic masculinity
CAQDA : computer assisted qualitative data analysis
ART : assisted reproductive technology
NASS : National ART Surveillance System
IVF : in vitro fertilization
IUI : intrauterine insemination
WSW : Women who have sex with women
AMAB : Assigned Male at Birth
MSM : Men who have sex with men
BIPOC : Black, Indigenous, and Other People (or person) of Color

1 INTRODUCTION

This research sheds light on gender-diverse individuals who get pregnant and give birth. This project seeks to understand better the medical experiences of *non*-hegemonically feminine *individuals* going through a hegemonically feminine *process*. I explore what it's like for non-hegemonically-, or non-conventionally-, feminine individuals to biologically reproduce, an act and experience that has long been considered a hallmark of femininity and womanhood. Via an in-depth original survey and a small sample of follow-up interviews, I had the privilege of gaining insight into an array of emotional, physical, social, financial, and medical experiences of an understudied subsample of pregnant and birthing individuals. I sought to hear from any pregnant and/or birthing folx that saw themselves (or felt they were seen by others) as *non-conventionally-feminine* (NCF) in terms of their gender identity and expression. Whether or not they identified as a woman, or a mother, was largely irrelevant (in terms of eligibility). This project acknowledges (and supports) the fact that women, men, as well as people who identify as non-binary, agender, genderqueer, or trans, etc. desire to (and do) get pregnant and give birth as a means to expand their family. While there is more gender diversity in pregnancy and birth than generally recognized or represented in most literature, based on existing yet limited research on sexual and gender minority (SGM) and lesbian, gay, bisexual, transgender, queer-plus (LGBTQ+) health and health disparities, I hypothesized the pregnancy and birth experiences of those outside the gender (and/or sexual) binary would differ from those who identify as (or are read as) cisgender,[1] particularly in terms of the medical services they receive(d). The purpose of this project is to examine how gender-diverse or gender-non-conforming individuals navigate the hyper-gendered and frequently heteronormative practice of having kids.

[1] Cisgender: from the Latin term *cis*, meaning on the same side; an individual whose gender identity aligns with their assigned sex at birth. For example, a baby assigned Female at birth that also identities their gender as a woman.

I employed a modified-grounded theory methods (mGTM) approach to analyzing my data. LaRossa states that while there is variety in potential frameworks one can use in grounded theory methods (GTM), "a theoretical perspective that places language at the nucleus of the analysis is critical" (2005:846). I aim to both keep the respondents and their language "at the nucleus" of this work (LaRossa 2005:846). Specifically, I shed light on the experiences of individuals who satisfy both of the following two requirements:

(1) Are currently pregnant and/or have given birth previously,

and

(2) do not (or did not at the time of their pregnancy/birth) typically ascribe to hegemonic or "traditional" constructions of "femininity" or "womanhood," or "motherhood," including, but not limited to, masculine women, butch women, 'studs,' 'tomboys,' 'STEMs' (combination of stud/fem), non-feminine women, gender-nonconforming individuals, non-binary individuals, trans-masculine individuals, individuals whose gendered self-expression is not typically feminine, or more broadly, (non-feminine) transgender individuals in general.

In the pages to come, I illustrate how essentialist views of gender intersect with dominant discourses regarding the pregnant body in medicine and medicalized experiences. My work will include how the medical community's treatment of these individuals can harmfully reinforce those ideals and lead to poor(er) health outcomes (Roberts 1997; Ross and Solinger 2017). I also discuss how these individuals (actively or passively) resist dominant discourses regarding pregnant bodies and their treatment in medical or midwifery contexts.

This research will be foundational in that almost no existing literature highlights these numerous intersections while also situating the research from the standpoint of the group in

question. Theory and research on female masculinity and non-feminine women do exist; however, much of it is situated firmly within the context of lesbian culture and lesbian gender identity (Halberstam 1998, Epstein 2002, & Ryan 2013). To look at those identities in tandem has largely made sense for feminist theorists and scientists, both historically and contemporarily. Gender and sexuality are nonetheless different aspects of identity, and I aim to reduce a common tendency to conflate gender and sexuality. I prefer to provide my respondents the opportunities to make those connections or distinctions themselves in the survey and/or interviews. Nonetheless, existing knowledge and evidence pointed to the likelihood that many of my participants would hold one or more LGBTQ+ identities (Halberstam 1998; Epstein 2002; Trebay, 2008; Ryan 2013).

While my participant outreach certainly included various LGBTQ+ spaces, at no point was this project inherently limited (or advertised as limited) to only LGBTQ+-identified individuals. I acknowledge that while sex, gender, and/or sexuality are often connected in some way (for individuals personally and/or in language), that I, nor this work, intend to imply the categories share a causal relationship—nor that they are "supposed to" or "have to" be in any particular form of "alignment." That intent should become abundantly clear in the pages to come, however I wanted to mention it here explicitly because the (real and/or perceived) relationships between these categories have long interested me. More specifically, I've noticed in my studies, my professional life, and even many individual level interactions that there is very often an assumption that *gender diversity* doesn't really exist outside *sexual diversity*. Typically gender and/or sexuality scholars at least understand and acknowledge that the opposite—that sexual diversity doesn't exist outside gender diversity—is not a universal truth; for example, a person

can be gay (sexuality) and a cisgender woman (gender), and thus, not necessarily identifying as both a sexual *and* gender minority.[2]

For these and other reasons I will discuss further, I knew it was necessary that I take an intersectional approach in my efforts to understand how these expressions, identities, and choices are situated within U.S. society's dominant gender framework. My research supports and expands upon previous empirical findings that gender identity and sexuality can affect a person's health, receipt of medical services, and ultimately, their health outcomes.

1.1 Medical "Care"

The biomedical model prevails in the U.S., and while biomedicine and biomedical practice are supposed to be held to the strictest standards and codes of empiricism and ethics in research and practice, agents of biomedicine and medicalization routinely apply outdated and/or simply inaccurate concepts of sexual dimorphism and gender binarism in their approaches to research, pathology, and service to non-binary bodies. What happens when patients (or clients)[3] confront their providers with an unknown-- with bodies or behaviors that conflict with their belief systems? How do providers respond? And what impact do their subsequent actions have on their clients?

Even when a provider is "just following protocol" and/or has no apparent biases or cultural differences impacting their provision of care, they can nonetheless do damage to their clients. There is no expectation of perfection; we are all human, and even the best-intentioned medical experts can and do make mistakes. Honest mistakes, however, do not account for, nor excuse, the staggering amount of health inequity in the U.S.

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[2] I also acknowledge that some theorists of gender hegemony might disagree based on a rigid interpretation of Connell's model of hegemonic masculinity and how it includes opposite sex attraction as an integral component.

[3] Going forward I will use *client* or *clients* instead of "patient" or "patients," unless I'm referring to someone else's research, in which case I will use/defer to their language/definitions, etc.

Scads of research on health disparities and health inequities provide significant evidence that there is no "one size fits all" approach to medicine. Similarly, there is no "one size fits all" approach to "doing no harm." Contrary to popular belief, in the U.S. there is currently no universal or formal rule wherein all medical practitioners are required to take an oath to "do no harm." Still, I argue there is significant evidence pointing to a problematic norm in which medical providers can and do harm their clients. For many groups, there is a lack of trust of medical professionals and often even the expectation of a bad experience.

The majority of LGBTQ+ individuals report having had negative healthcare experiences because of their identity; they are less likely to go to the doctor again as a result of those experiences (Lambda Legal 2010; Brenick et al. 2017; Boyd-Barret 2018; Seelman et al. 2018; Wolstein et al. 2018) Research has shown, for example, that lesbian and bisexual women are less likely to engage in breast cancer screenings (Boehmer and Elk 2015; National LGBT Cancer Network 2021). Similarly, LGBT people are believed to have "both greater cancer incidence and later stage diagnosis" (National LGBT Cancer Network 2021). For this population to be engaging in these screenings less often is of particular concern because they are already at higher risk for breast (and other) cancer(s) (Quinn et al 2015; ACS 2021). It is important to note, however, that their sexual identity does not cause their higher risk. Being LGBTQ+ does not cause cancer. Rather, lesbian and bisexual (LB) women have a "dense cluster of risk factors, significantly raising their risk of developing breast cancer as well as several other types of cancer" (National LGBT Cancer Network 2021). For example, LB women (have at least historically) been statistically less likely (than straight women) to give birth (and thus lactate/breast/chest feed, a risk-reducing factor) (Boehmer and Elk 2015; ACS 2021). Additionally, they are more likely to be overweight and/or cigarette smokers (risk-increasing

factors) (Quinn et al 2015; ACS 2021; National LGBT Cancer Network 202). Scholars attribute higher rates of these behaviors in this population to minority stress. Also, alcohol and tobacco companies have been known to market heavily to the LGBTQ+ community (Washington 2002; Spivey, Lee, and Smallwood 2018; California Department of Public Health 2021). Some of the reasons LB women get screened for breast and cervical cancer at lower rates include fear of discrimination, low rates of insurance coverage, and negative experiences with providers (ACS 2021).

While individual differences and myriad intervening variables at the interpersonal level will always exist and allow for some unpredictability in experience, the systemic problems associated with biomedicine and medical institutions in the U.S. are not beyond fixing. Approaches to medical *care*[4] that acknowledge context and directly seek to combat medical mistrust, disparity, and inequity do exist. Research and education in these areas (and on those most affected) illuminate the potential for a new praxis of medicine and medical service—one that connotes *and* denotes the provision of health*care*.

Trauma-informed care and *culturally humble* care are two such approaches to providing *care* that is medical. "Trauma-informed care seeks to: Realize the widespread impact of trauma and understand paths for recovery; Recognize the signs and symptoms of trauma in patients, families, and staff; Integrate knowledge about trauma into policies, procedures, and practices; and Actively avoid re-traumatization" (Tello 2018; Trauma-Informed Care Implementation Resource Center 2021). Simply put, consider the following (plausible) hypothetical example: a patient presents with an issue that requires a provider to physically examine them. The patient

[4] Unless specific to language within a source I am referencing or critiquing, I will typically refrain from using the language "health*care*," opting instead for "health services" or "medical services." Health services are not *caring* for everyone. Not all people receive *care* from medical professionals.

has a history of one or more forms of intimate partner violence (IPV) that for myriad reasons is neither known to the physician nor explicitly documented in their chart. The patient explains their presenting concern (i.e. back pain) while the provider sits/stands across from the patient (at approximately eye-level), asking clarifying or follow-up questions as needed. Based on the patient's description and symptoms, the provider suspects the patient might have Ailment X, but won't know for sure without visual and digital confirmation. The provider explains why and how they need to examine the patient in Part X of their body (i.e. their lower back). The provider outlines the exam and any risks before asking the patient for their consent. The patient consents. The provider may mention how they will verbally inform the patient of their movements as they proceed through the exam (i.e. "I will now lift your shirt…"), and then asks whether or not the patient has any questions before they get started. The provider verbally prefaces all physical touch as promised and whenever possible provides the patient with advance warnings of potential discomfort or other jarring sensations. The provider completes the exam gently, effectively, and efficiently. Upon finishing the exam, the provider confirms for the patient the exam is complete and returns to face the patient to discuss the situation further.

In this scenario the provider's methods served multiple functions, all of which served the patient. The provider was not aware of their patient's history of sexual violence, but they were aware of the prevalence of such violence (and commonly associated issues like PTSD[5]) among a population to which the patient belonged. The provider also knew that physical touch can sometimes trigger stress, pain, or even retraumatize those that have experienced/survived such violence. The provider's trauma-informed approach to the physical exam also can serve to ameliorate the burden on the patient to disclose their history of violence. This burden routinely

[5] Post-Traumatic Stress Disorder

falls on survivors/people that have experienced trauma and it is not always clear who and/or what they do or don't need to rehash in order to achieve the best outcome for themselves. A provider cannot undo harm that has been done to their clients, but by practicing trauma-informed care they can easily reduce opportunities to harm a patient further.

Cultural humility, "incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon and Murray-García 1998:123). Cultural humility is distinct from cultural competency. "Unlike cultural competency, there is no specific end point to cultural humility as we are not being asked to demonstrate a 'quantifiable set of attitudes'" (Prasad et al. 2016:1). Culturally humility often overlaps with the tenets and practices of trauma-informed care.

Failure to implement best practices such as trauma-informed care and/or culturally humble care affects health outcomes. Trauma, unfortunately, is highly prevalent in the United States and that context matters. The CDC, for example, reports that one in four children have experienced a form of maltreatment (physical, sexual, emotional); one in four women have experienced domestic violence; one in five women and one in 71 men have experienced rape at some point in their lives (Tello 2018). LGBTQ+ people and persons living with HIV (PLWH) are significantly more likely to have experienced trauma (National LGBT Health Education Center 2017; Peterson 2018).[6] Violent and often severely traumatic experiences have long-lasting effects that need to be considered in medical situations, especially when treatment involves any kind of physical contact with the patient. Training in medical best practices, such as

[6] Compared to counterparts (i.e. cisgender folks, heterosexual/straight folks, people that are not living with HIV).

trauma-informed care, provides practitioners with the knowledge and skills necessary for thinking critically about what harm may look like for different populations in various situations and contexts. I will talk more about these concepts in later chapters.

All harm is not preventable; however, critical research and education on disproportionally affected populations can significantly aid in the reduction of poor and/or traumatic medical experiences, as well as in the resulting potential emergence of population level-health disparities and inequities.

These concepts are not new. We need not look far (back) to find an abundance of examples of how several previously approved protocols and/or approaches to medicine (and medical research) have done significant harm to racial minority individuals, people living with HIV, and/or clients belonging to both of those categories. In the infamous Tuskegee Syphilis study, Black men that didn't know they could have been cured were allowed to die so White scientists could study the progression of the disease in their bodies—and ultimately their corpses. The study began in 1932 and continued for a total of 40 years, which was 30 years beyond the development of the cure (penicillin). After a reporter broke the news in 1972 the atrocity became public and the study was shut down. The former director for the U.S. Public Health Service study, Dr. John R. Heller stated in a 1972 interview, "To me, it was a completely ethical, straightforward, scientific study that didn't harm anyone and for which scientific results were, I think, obtained and were useful to the scientific community" (Taylor 1972). This willful and *approved* manslaughter is often referenced today to explain the need for important ethical concepts and safeguards such as *beneficence* and *informed consent* in medical research.

A sociological analysis of this issue for my population is so critical. Our beliefs, how we identify, do things, construct knowledge, educate, provide medical treatment, etc.—are socially

and societally influenced. Also, these beliefs, identities, etc., can (and do) shift according to time and place. Culture and practice do not, however, change at the same speed, especially if/when certain long-standing ideologies (i.e., White supremacy, sexual dimorphism) are deeply embedded within the systems in which we operate.

Further, medical hegemony, or "the dominance of the biomedical model, the active suppression of alternatives as well as the corporatization of personal, clinical medicine into pharmaceutical and hospital centered treatment," reinforces and sustains dominant ideologies and related inequity (Weber 2016:1). Medical hegemony and the dominance of biomedicine have also led to a "widening [of] social arenas and behaviors into the jurisdiction of biomedical treatment," a process called *medicalization* (Weber 2016:1). While gender and sex have long held seemingly inseparable connections to and origins in biology and biomedicine, differences in human anatomy and human identity have, in most U.S./Western cultures, never been seen as just differences that exist, or as normal human variation. Rather, they've routinely been categorized as pathological and in need of remedy. John Money's infamous yet normalized approach to performing surgical interventions on intersex babies is an excellent example of medical hegemony and medicalization at work (Karkazis 2008). The clinical term and sex category, *intersex* broadly refers to individuals whose reproductive and/or sexual anatomy differ from conventional (sexually dimorphic) definitions of "male" and "female" (i.e. genitals, hormones, internal anatomy, or chromosomes) (interACT n.d.).

Money argued that quality of life concerns (i.e. having a penis that is "too small") and future stigma demanded (often immediate) medical action to ensure the babies "fit properly" into one—and only one—distinct, predefined category of "male" or "female." Depending on the differences documented at or soon after birth, as well as how the babies' external genitalia

literally measured up, doctors would prescribe (and urge) surgical intervention. Parents were then instructed to "raise their child as the sex and gender" they were ultimately assigned, post-op. Once the child hit puberty and/or began developing visible secondary sex characteristics (i.e. breasts, pubic hair, etc.), they would start taking hormones to ensure their developing bodies matched the sex and gender they had been assigned (Karkazis 2008; interACT n.d.). Thanks to decades of activism by and on behalf of intersex individuals, these practices have been facing increased public scrutiny in recent years, leading to bans in some states/countries. The practice, and those who support and recommend it as a viable medical intervention, rely on pseudoscientific, non-empirical assumptions about gender and sex to make serious (and personal) medical decisions for infants. Despite being unethical, and a violation of medical autonomy and human rights, the practice still occurs. (ISNA 2008; interACT n.d.).

As I will detail further in the chapters to come, LGBTQ+ individuals, including sexual and gender minorities (SGM), trans, nonbinary, and gender expansive (TGE) individuals, and/or gender diverse (GD) people, are among those with complex histories and strained relationships with the institution of medicine. Such a strain can have significant and detrimental effects on health and well-being, especially if/when a minority group/individual lacks privilege in other areas of their life and identity. Like all marginalized populations, despite cultural shifts toward alleged "diversity, equity, and inclusion" (DEI) efforts and increased understandings of inequity in general, contemporary approaches to medicine for oppressed groups need *significant* attention, not only in the academic/research world but in medical education and practice as well.

One way in which an inattention to SGM health is visible is by examining national datasets and the metrics intended to provide macro-level population information. The datasets provide a large amount of information to various stakeholders and decision-makers (i.e.,

Congress, the courts, local governments, federal programs such as WIC or Medicaid, the Centers for Disease Control (CDC), etc.). We can't measure what we don't have, and the majority of national datasets do not include sexual orientation and/or gender identity (SOGI) information. When this information is not collected, decision-makers choose not to represent the experiences of SGM populations in the national record. I will address this issue further in the next chapter.

In recent years, more attention has been drawn to LGBTQ+ health and some changes are starting to take effect. There is, however, still so much we don't know about gender and sexuality and how they intersect with and affect health, especially for groups within the non-homogenous LGBTQ+ acronym. Further, gender diversity doesn't always (or only) exist alongside sexual diversity; gender and sexuality are not synonymous. In-depth research acknowledging these nuances must take place. I aim to do so in this project.

For the most part, the fields and associated literature related to this work (i.e., Sociology, Public Health, Medicine, Bioethics, etc.) currently lack an understanding of the classed, raced, and gendered experiences of people with non-conventionally-feminine (NCF) birthing bodies. Simply put, if these fields do not understand the experiences and needs of a population, how can institutions and their employees serve them adequately? One of my former colleagues articulates this need for an intersectional lens in health very well: "When a person from an underserved population seeks care, they do not bring only the sick part of their self, nor do they only bring one facet of identity. People bring their whole selves when seeking care, and understanding critical differences in identity and experience equips people with the ability to break barriers to care and reduce health disparities" (Rose-Cohen 2019:4).

Further, the experiences of very few people of color within this population are represented in the existing literature on the racialization of pregnancy, gender, and sexuality

(Reed, Miller, and Timm 2011, Collins 2005, Crenshaw, 1991, and Roberts, 1997). Class, or socioeconomic status (SES), significantly impacts access to medical and social services and health outcomes. Class-based ideology also contributes to how successfully people conform to certain social norms/expectations of parenthood and/or "womanhood."

I provide an in-depth look at how non-conventionally-feminine (NCF) individuals who go through pregnancy and birth navigate these life-altering experiences and how they assess the medical services they receive. The next chapter (Chapter 2) contains an overview of existing literature related to my topic and population and the theoretical frameworks on which I lean in this work. In Chapter 3, I detail my methodological approach and the demographics of my sample. In Chapters 4-6, I present my findings, including recurring themes and notable discoveries. In Chapter 7, I discuss policy implications, address relevant audiences, and provide implications and recommendations for future research and practice.

2 LITERATURE REVIEW AND THEORETICAL FRAMEWORKS

In January of 2017, YouTube personalities Domonique (a.k.a. Domo) and Crissy, two lesbians of color, faced backlash and harassment online after posting a photo of themselves in an embrace centered around Domo's pregnant belly. Why were people mad about it? Domo sums it up in the following tweet: "People are really bullying me because I'm pregnant and I dress 'masculine'" [followed by many crying from laughter emojis] (@domoandcrissy 2017; Karlan 2017). Domo and Crissy responded to the criticism and bigotry repeatedly in subsequent social media posts and one of their YouTube videos. In one such response via Instagram, Domo stated in the caption of her post:

> I am a woman. I am a woman who has always wanted a child. I am a woman who likes to dress how she pleases and doesn't give two shits about your stereotypes. Who cares if I like to wear snapbacks[7] and joggers[8]? Who cares that I'm not the "normal" look of a pregnant woman… (@domo.crissy.15, 2017, ellipses in original).

Accompanying this text is a photo of Domo, pregnant and smiling; she is wearing a red snapback, a gold chain necklace, a red sweatshirt, jean joggers, red and white sneakers, and a plain white tee. She has pulled up her t-shirt, exposing her pregnant belly.

While society may not solely define today's woman by her choice to reproduce, the long and pervasive history of conflating "womanhood" and "motherhood" is intertwined with normative constructions of femininity—particularly White femininity. These strongly reinforced connections lead to a narrow depiction of what pregnancy (and those who go through it) should look like. What happens when those roles and identities misalign and/or begin to diverge from

[7] A snapback is "a type of baseball cap with a flat brim and an adjustable strap in the back that snaps together. They're a staple of international urban streetwear." Dictionary.com < https://www.dictionary.com/browse/snapback>

[8] Joggers "also called jogger pants…[are] casual, tapered pants of soft, absorbent fabric, typically with elastic at the waist and ankles." Dictionary.com <https://www.dictionary.com/browse/jogger?s=t>

conventional standards? What about the pregnancy and birth experiences of those who do not fit the prescribed mold, such as the butch/stud woman or the transgender man? What about the individuals who completely reject (or consider rejecting) the idea of giving birth, not because they don't want children, but because they feel it contradicts their gender identity or they fear violent backlash (Ryan, 2013)? What about the birth decisions and experiences of people of color?

Whiteness is heavily intertwined with mainstream notions of femininity and academic discussions of gender and gender politics. What do "non-traditional" or "non-conventional" femininities look like within and without whiteness? How do gendered language and meanings shift (or not) for the multiple and diverse racial groups categorized as "people of color" (POC)? The bodies and gendered cultures of meaning of Black, Indigenous, Latinx/Latiné, Asian, and other non-White races and ethnicities are not homogenous.

Consequently, what it means to be or look "non-traditionally" or "non-conventionally-feminine" may take on diverse forms. Internal and external notions of femininity and masculinity are also inextricably linked to race and ethnicity. What conflict(s) do intersections of race, class, and gender produce for this myriad of birthing bodies? While Domo and Crissy were both women of color, we don't know that their experience is *the* experience for all women, all lesbians, and/or all people of color.

Antiquated views of "a woman's place" coupled with ideology that rewards doing "womanhood" a certain way has relegated many a woman to the role of mother. The belief that a woman's sole purpose is to reproduce and mother still exists in many conservative households and institutions today, particularly White ones; however, activism and shifts in culture have

contributed to alleviating some of the heteronormative and patriarchal cultural pressures of reproduction.

Nonetheless, while employers may prefer (unmarried) childfree women over married women (Hurwitz 2016), in general, women who choose not to have children are still often seen by their peers and families as having made a radical (or impermanent) decision. Although the childless may typically experience less backlash than in previous decades, the "American Dream" narrative of growing up, going to school, getting a job, getting a spouse, buying a home, and having children is still strongly encouraged, and an aspiration for many. The idea that one should follow that path has been heavily ingrained in our culture.

In August of 2013, *Time* heeded the call for a PSA about women who do not want children by dedicating an entire issue to the topic. *The Childfree Life* issue included articles such as "Childfree Adults are Not 'Selfish,'" "I Just Don't Want a Child," and "The Declining Birthrate Doesn't Spell Disaster" (Sandler, 2013). Similarly, *HuffPostWomen* published the online article "23 Things You Should Never Say to A Childfree Woman," reminding the adamantly motherhood-or-bust folks that childfree women are tired of hearing: "You're being selfish," "You'll change your mind when you meet the right man," or "You're missing out on one of the best things in life" (Sandler 2013).

Expectations to reproduce demonstrate the intransigence of the gendered and sexed expectations of women. These reproductive norms also reinforce underlying expectations of heterosexuality, biological determinism, and adherence to the gender binary. Non-heterosexual and/or same-sex partnered individuals, for example, do not necessarily get the same kind of messages regarding their mothering or parenting. They may still have heard, "You'll change your mind when you meet the right (opposite sexed and heterosexual) person"—just not

regarding the topic of kids. Individuals or couples who don't fit the normative gendered/sexuality-based expectations of pregnancy likely won't feel those same pressures to reproduce. For some, this is liberating; but it may feel like a limitation for others—that pregnancy and birth might not be meant for them (Ryan 2013). Further, even with advances in reproductive technologies, the legal and financial hoops that same-sex couples have to go through to get pregnant/biologically reproduce can be severely limiting.

2.1 The Racialization of Reproduction

Cultural discourses about procreation differ based on race. For example, Black pregnancy and birth have a markedly different history and representation than White pregnancy in the United States; this history continues to affect the bodily autonomy, agency, and representation of Black women. (Roberts 1997; Johnson 2017). Historically, the notion that a woman's place is in the home has mainly applied to White women. Women of color have always worked in the paid labor market. Black women, in particular, have participated in the paid workforce at high rates since the late 1800's—for as long as they have been legally free from enslavement and forced labor (Banks 2019). While enslaved, Black women's bodies were commodified based on reproductive ability. The work of those who could bear children explicitly included the breeding of "more workers," which, according to the racist ideology and economic system of the time, was more profitable than those doing field or other domestic labor. Thomas Jefferson made it abundantly clear how slave owners used Black women's bodies to increase their profits when he wrote, "A child raised every two years is of more profit than the crop of best laboring man" (Jefferson to Yancey 1819).

Banks argues that, since times of slavery, White America's (U.S.) dominant, white supremacist view of Black women has been as workers; this consequently led them to be

devalued by U.S. society as mothers, particularly once the White man could no longer exploit their reproductive functions for profit (Banks 2019). As Dorothy Roberts states, "Not only are Black women exiled from the norm of true womanhood, but their maternity was blamed for Black people's problems" (1997:10). Black women workers have had (and continue to have) limited job options and were often caretakers of White women's children. Cultural ideology and controlling images portray(ed) Black women as praiseworthy for their care of White children yet simultaneously "careless and unable to take care of their *own* children" (Roberts 1997:4; Collins 2000; 2005). Similarly, psychological research on racial attitudes shows that research participants viewed pregnant Black women more negatively than White women; Black woman are also seen as more sexually risky (Rosenthal and Lobel 2016). In fact, Black women's bodies and their reproductive decisions arguably have never indeed been their own, at least not according to the state. White men and the U.S. government have been making reproductive decisions for Black women since they were first enslaved, from raping and commodifying their bodies to produce additional slave labor, to unethical and forced medical testing, abortions, and sterilizations (Davis 1983; Roberts 1997; Washington 2008).

While the *legality* of those particular acts of violence against Black women has since changed, arguably, Black women and mothers continue to be punished by the state in other ways (i.e., higher rates of pregnancy-related death, police murders of their children, etc.). Similarly, attacks on, and the murder of Black trans women are an epidemic in the U.S. In recent years, deadly violence against trans and gender-nonconforming people has risen significantly, and it is no coincidence that 21 of the 27 trans and gender non-conforming (TGNC) people killed in 2019 were Black trans women (Karimi 2021).

Black women have always fought back against their subjugation, whether internally as self-care or more overtly via social justice efforts. They have actively resisted their procreative (and other forms of) oppression in many ways. For example, during slavery, black women resisted forced reproduction by employing methods of birth control within their power (i.e. infanticide, self-induced abortions) (Cha-Jua 2020). Women of color (WOC) have often been the (invisible) leaders of major social movements. Another form of Black resistance is visible in the reproductive justice movement (i.e., SisterSong). Black women have worked tirelessly to reframe the racist, sexist, and classist meanings and connotations associated with Black reproduction and Black bodies in general (hooks 1981; 2016, Crenshaw 1989, Collins 1990). They have also fought to prevent similarly oppressive policies from becoming law. Such policies have been (and continue to be) put forth by lawmakers aiming to (continue) to legally restrict the bodily autonomy and reproductive choices of Black women (Roberts 1997; Johnson 2017).

Contrary to existing narratives that are purposefully stigmatizing, family and mothering are extremely important in Black culture (Reed et al. 2011). In their study of young Black lesbians, Reed, Miller, and Timm aimed to understand their pregnancy decisions better. The authors noted that previous examinations of young Black lesbians had only focused on their risk behaviors; they sought to go beyond that narrative (2011). The researchers were somewhat surprised to find that their respondents wanted children for reasons similar to heterosexual women—for example, a desire for unconditional love and seeing children as "the best gift" (Reed et al. 2011:575). Additionally, to many of their participants, intentional pregnancy was seen as a way of asserting and validating their sexual identity as lesbians; motherhood and being a lesbian could coexist. Pregnancy for them was not a means to appear more heterosexual (like the researchers had initially hypothesized), but rather a validation of their otherwise stigmatized

identities and their choice to create a same-sex family (Reed et al. 2011). Regardless, pregnancy in this community was not free from all forms of social control; it was not as acceptable for a stud to become pregnant as it was for a femme (Reed et al. 2011).

As the culture and representation of Black women has been affected by their forced arrival and labor in the U.S., the migration and immigration patterns (and associated politics, racism, and xenophobia) have affected the culture and representation of Latina/x/Hispanic women in the U.S. Despite Latinx/Latiné/Hispanic women seemingly "falling in line" with the normative gender and reproduction-related expectations of women in the U.S., they are hypersexualized and negatively portrayed as "hyper-fertile." Politicians have framed their fertility as a threat to White "American" families in the U.S. (Chavez 2004). The reproduction of Latina/x/Hispanic women (and other immigrant populations) has long been in the crosshairs of conservative politicians. Racist characterizations of the children of immigrant women as "anchor babies" have served to delegitimize their right to various forms of government assistance and U.S. citizenship (Lugo-Lugo and Bloodsworth-Lugo 2014).

Similar to Black culture, the family unit, or *familia*, is of major importance in Latino/a/x/Hispanic culture. Motherhood is highly valued and matriarchs are an important fixture within the family unit. Relationships with extended family are often close, extending the family bond beyond the common (White/U.S.) conceptualization of the nuclear family; grandparents may even live in the same homes as their children and children's children. In the past, this orientation towards family and family well-being was described by scholars as a potential impediment to economic success in the individualistic and competitive U.S. culture (Landale, Oropesa, and Bradatan 2006). More recent scholarship, according to Landale, Oropesa, and Bradatan (2006) emphasizes the opposite: that familism and high levels of social support can

actually reduce some of the adverse effects of poverty, but that this could decline with acculturation in the U.S.

Broadly and traditionally speaking, scholars have described Latino/a/x/Hispanic culture as holding gender-based ideologies that place men in breadwinner and women in caregiving roles, not unlike traditional roles of men and women in the U.S. Increased migration and immigration to the U.S. have affected these roles however. In both Mexico and the U.S., for example, migration and immigration patterns have led to more Mexican and Mexican-American women entering the paid work force (Knapp, Muller, and Quiros 2009). Research shows that younger Latinas in the U.S., "face the intersection of ethnicity and sex discrimination—and related barriers—at school" and that "gender stereotypes exacerbate [the] discrimination [they face] based on ethnicity" (NWLC & MALDEF 2009:19-20).

Cultural ideology and controlling images often stereotype Latina/x/Hispanic women as "submissive underachievers and caretakers" (NWLC & MALDEF 2009:2). Repeated exposure and internalization of such stereotypes (a product of living in a White supremacist society) can in turn affect how people, like teachers, interact with their students. For example, respondents to the previously cited NWLC & MALDEF's study on Latina's barriers to high school graduation shared that teachers' expectations of their Latina students were low. Further, teachers often made comments about how they presumed the girls would end up pregnant, regardless of how they were doing in school (NWLC & MALDEF 2009).

Until recent years, Latina/x/Hispanic folx held rates of teen pregnancy that were higher than any other racial/ethnic groups in the U.S (NWLC & MALDEF 2009:16). In 2009, they were almost twice as likely (compared to the national average) to get pregnant at least once before the age of 20 (53%) (NWLC & MALDEF). It is probable that school personnel see high

rates of teen pregnancy among Latinas as confirmation of these racist and sexist stereotypes and beliefs, rather than evidence of a larger, systemic failure of public health and government institutions.

Data and statistics can often be used by those in power (i.e. politicians, religious leaders, etc.) to spread and reinforce oppressive ideology, and it is often easier for people to accept the supplied information rather than think critically about the issue and context. For example, despite higher rates of Latinx/Hispanic teenage pregnancy, data suggest Latinx/Hispanic teens were *not* engaging in sexual intercourse *any more than* their White peers (Conklin 2012). The evidence-based reasons for high rates of Latinx/Hispanic teen pregnancy were/are multifaceted and largely attributed to social determinants and related inequities such as a lack of comprehensive and medically accurate sexual health education. White supremacist and xenophobic ideology have long placed blame on immigrant populations where (federal or state-sanctioned) issues of inequality or inequity are concerned. Racial/ethnic minority and/or immigrant populations are the scapegoats, and White politicians and voters support racist stereotypes and policies under the guise of "protecting the nation" (Lugo-Lugo and Bloodsworth-Lugo 2014).

Since the release of the NWLC & MALDEF report in 2009, national birth rate statistics document consistent declines in teen pregnancy for most races/ethnicities, including among Hispanic teens (Livingston and Thomas 2019; Hamilton et al 2020).[9] Perhaps most notably, Hispanic teens haven't held the highest teen pregnancy rate since 2016. The CDC indicates the causes for these significant declines in teen pregnancy aren't completely clear but suggests that greater abstinence and increased use of birth control are major factors (CDC 2021).

[9] In 2019 the teen birth rate in the U.S. dropped to 16.6 births per 1,000 girls/women ages 15-19, the lowest since collection of such data began in the 40's, and less than half since the most recent recorded spike in 2008 (41.5 per 1,000) (Livingston and Thomas 2019; Hamilton et al 2020).

Declines in birth rates have been recorded among Hispanic adults as well. From 2007 to 2017, the overall birthrate for Hispanic women fell by 31%[10] (Tavernise 2019). A *New York Times* article published in 2019 illustrates a growing trend to delay childbirth among young Hispanic women. The article profiles a young woman named Yoselin; she talks about how she often received the following message from her parents growing up: "'Don't be like us…[.] Don't get married early. Don't have children early. Don't be one of those teen moms. We made these sacrifices so that you can get educated and start a career'" (Tavernise 2019). According to demographers, this steep decline in birthrate "has been driven in part by generational differences between Hispanic immigrants and their American-born daughters and granddaughters" (Tavernise 2019). This trend among Hispanic women is similar to that of White women, who are also delaying childbirth to focus on their education and careers. Further, these cultural trends among Hispanic women may have played a part in why pregnancy rates for Hispanic teens have dropped below those of American Indian/Alaska Native teens in recent years.

The paragraphs above are an extremely brief look into gender and reproduction among Black and Latina/x/Hispanic women and are not intended to be in any way exhaustive. I've included the above simply as a snapshot of how radically different U.S. society views (and supports) pregnancy and mothering among two additional racial groups (Black and Latinx/Hispanic) compared to White women.

2.2 The Butch Lesbian and the Transgender Man

Previous existing research on non-normative pregnancies typically centered around two main themes: the butch lesbian and the transgender man. I argue this is because these two groups represent current exceptions to a "normative" and "feminine" pregnancy. The "butch lesbian" is

[10] Compared to non-Hispanic White (6% decrease) and Black (12% decrease) women

a culturally salient smattering of identities that frequently appears in academic literature at the mention of "female masculinity," particularly in theoretical works on gender. Although research on trans health, particularly trans men's, has increased quite a bit in the last several years, this is less the case for the women and/or people with uteruses who do not identify as trans men and fall into my target population. Their medical needs as a special population have been addressed very little thus far (particularly in pregnancy and birth).

Further, prior to 2016, most of the (non-sensationalist) literature on trans men's pregnancies was primarily focused on the biological possibility for trans male pregnancy, risk behaviors (i.e., sex work and unintended pregnancy), and/or medical or surgical needs related to transitioning (i.e., removal or reconstruction of organs). Only in more recent years have scholars started to examine in more depth trans male pregnancy (and pregnancy of other gender-variant people with uteruses) in terms of disparities and issues around the quality of the reproduction-related care they receive and/or have access to (Obedin-Maliver and Makadon 2016; Light et al. 2018; Fein et al. 2019; Moeseson et al. 2020). Papers on these topics are still most often published in specialized journals or publications (i.e., *Journal of Transgenderism*, *Journal of Lesbian Studies*, *LGBT Health*) which can pose issues regarding access to the scholarship.

Further, even with an increase in trans pregnancy-related research, like any nascent area of study, it only scratches the surface. Further, only part of my target population is addressed in such literature. A significant portion of my sample (i.e., non-trans butch women) are still being left out, and as a result, remain mostly unstudied and underserved. Current, albeit limited, critical analyses of "maternal" health illustrate a literal and figurative lack of care among medical practitioners for this population (i.e. women/people with conventional "female" anatomy).

"Women's"[11] health (and medical authority as it relates to women's health) has always been rife with pseudo-science and sexism. Women's uteruses, for example, were long blamed as the root cause of all their ailments (i.e. "hysteria"). As mentioned, women, particularly women of color, were unethically used by government/scientists as test subjects for medical products and procedures. While many of the most horrific practices of the past are arguably now illegal and/or seen as unethical, many of them live on within the culture of modern medicine, simply in more insidious and harder-to-prove ways. [Unless you live in Texas in 2021, where lawmakers' recent and obviously sexist legislation makes it permissible by law for civilians to bounty hunt individuals giving or receiving abortions (at/after only six weeks pregnant).]

The U.S. has the highest "maternal mortality" rate in the "developed" world; the U.S. is also the only developed country where these rates are (currently/still) trending upward (Martin and Montagne 2017). A "maternal death," defined for official reporting purposes by the World Health Organization (WHO), is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO 2012:9). The unborn and/or newborns, rather than the person delivering the baby, are often the focus of providers, which can lead to their missing important warning signs of related maternal distress, according to an investigation into maternal mortality conducted by NPR and ProPublica in 2017 (Martin and Montagne). During the investigation, agency representatives found the presence of hospital protocols "allowing for treatable complications to become lethal" and hospitals' under-preparedness (even among sites with

[11] Unless specified otherwise, my use of women (without quotes) is intended to be racially and trans inclusive. In circumstances where I use "women" (with quotes), I am calling attention to the routine use of *women* or *woman* by mainstream and medical parties to describe or communicate to/about AFAB people collectively, despite the fact that such use falsely implies all AFAB people are women.

newborn ICUs) to be major contributors to higher numbers of maternal death (Martin and Montagne 2017). They also highlighted concerns around lack of relevant training in the growing field of maternal-fetal medicine; apparently some doctors were able to successfully complete their required training and enter the field without ever spending time in a labor and delivery unit (Martin and Montagne 2017).

Akin to beliefs about racism in the post-Obama era, many people in the U.S. believe sexism is history, part of a bygone era. Such beliefs serve to further classist, White supremacist, and patriarchal policies and practices that prevent people from receiving equitable health services. These inequities are often compounded for folx possibly experiencing multiple forms of marginalization—someone like Rachel Epperson—a lesbian of color from Ohio. *The Columbus Dispatch* profiled Epperson on her connection to a recent study on lesbian health and the unique barriers and discrimination faced by women who are in romantic or sexual relationships with other women (Szilagy and King 2021). Epperson didn't go to the doctor for four years after a negative experience related to her sexual orientation. After disclosing her identity as a lesbian to a new provider, the doctor "excused herself to pull a nurse into the room. Later, the nurse laughed out loud when Epperson asked about the possibility of spreading HPV to her partner" (Szilagy and King 2021). Epperson describes having immediately been able to feel "the change" in the room after her disclosure—just before the provider excused herself. Alongside Epperson's story, the *Dispatch* article showcases recent research by a local scholar hoping to fill in some of the gaps in lesbian health scholarship. The research supports the argument that an experience like Epperson's is not an isolated incident. Among the study's sample were lesbians who identify reasons for not having a primary care provider (PCP) such as: "not being able to find a doctor, interest in alternative methods of health care, not considering primary care a priority and fear of

facing stigma or discrimination" as (Szilagy and King 2021). Specifically, among lesbians of color who participated, having access to providers who looked like them (i.e. POC) was "a key factor influencing their decision to seek health care" (Szilagy and King 2021).

Both previous research and my project point to existing inequities in health among marginalized groups in society, and more specifically, *as a result* of their marginalized identities/statuses. These concerns persist and potentially worsen for those experiencing multiple marginalization. In other words, there were/are serious existing concerns related to (cis) maternal health in the U.S. I argue that the likelihood a marginalized individual will have a negative health or medical experience that affects their subsequent engagement in (or attitude toward) "healthcare" increases if/when they experience additional or intersecting forms of marginalization. See **Figure 2.1** below for a visual example. Please keep in mind that the examples (the light blue rectangles within the larger, nested rectangles) are only intended to represent (and be interpreted as) groups that might share the same number of forms of marginalization, regardless of the fact that experiencing the forms may be qualitatively different (i.e. White (cis) women ≠ (cis) Black men).

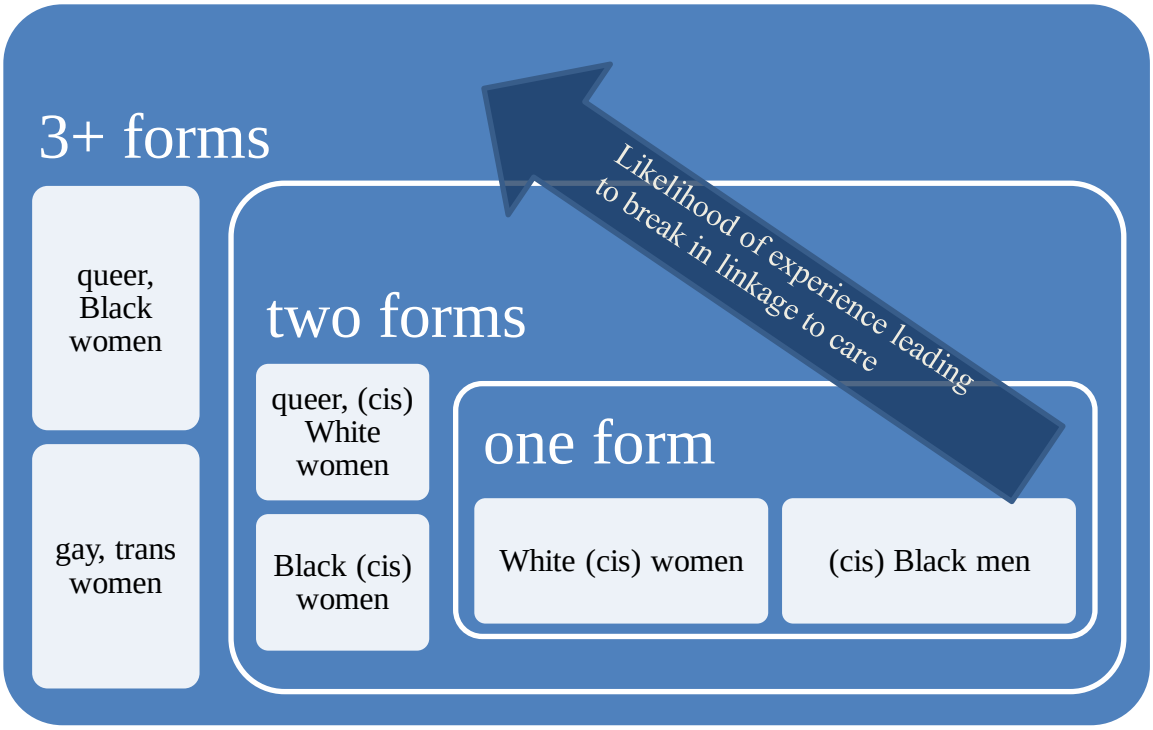


Figure 2.1 Hypothesized Relationship Between Medical Experience, Identity, and Subsequent Medical Service-seeking Behavior

2.2.1 The Butch Lesbian

Epstein and Ryan's projects specific to female masculinity and pregnancy within *lesbian* communities shed light on butch lesbian experiences and their varying conceptualizations of birth and motherhood (2002, 2013). Ryan studied the perceptions of pregnancy among "14 masculine-identified lesbians who are not parents and who have never been pregnant" (2013:122). Ryan found that how others might treat them during pregnancy due to their masculine appearance was crucial to their decisions to engage (or not engage) in pregnancy/birth in the future (2013). Ryan's participants acknowledged the socially constructed aspects of pregnancy and femininity, yet their feelings about and decisions related to pregnancy included "a distinctly essentialist understanding of pregnancy necessitating femininity" (2013:125). Ryan found that their participants decided to either reject or redefine pregnancy to maintain their

masculine identity (2013). Some participants who rejected pregnancy (and arguably femininity) desired their partner (whether current or future) to become pregnant instead. Others redefined pregnancy as something that masculine-identified people could also do. One such participant stated, '"I think that just like female bodies can be masculine, pregnant bodies can be masculine"' (Ryan 2013:130).

In "Butches With Babies," Epstein engages in an in-depth theoretical discussion of lesbian gender, sexuality, pregnancy, and motherhood. She draws on ten years of "thinking about, writing about and practicing lesbian parenting, as well as informal and formal talks and interviews with other lesbian parents" and the work of Butler, Martin, Halberstam, and other scholars, to shed light on butch identity and motherhood (2002:42). Epstein, referencing the work of Kennedy and Davis (1993), asserts that butch-identified women have always had babies and been mothers; they simply haven't always had the opportunity to hold those two identities simultaneously (2002). Epstein highlights a disconnect for butch lesbian parents in her work, indicating that many felt they had to strategically separate their lives as lesbians and parents. Although Epstein and Reed et al.'s works have 15+ years between when they were published, it is interesting how their data and analyses seem to contradict in terms of a separation and/or merging of their sexual and parental lives. Perhaps the passage of time had an impact; and/or perhaps there are racial differences affecting these interpretations and/or experiences. Many of Reed et al.'s Black lesbian respondents shared that pregnancy was a way for them to assert their lesbian sexual identity (2017). Epstein included a sentiment similar to that in Ryan's later work: that butch motherhood could happen via reconfiguring both butch identity and motherhood (2002). Epstein stated, "There can be no closure on any given identity, *nor should there be.* Butch mothers shift the meanings and the possibilities contained in motherhood, femininity, and

masculinity, femme and butch" (2002:56). This sentiment highlights the importance of my project and validates the pregnancy and birth experiences of NCF individuals. How have these meanings and possibilities shifted since the publication of Epstein's work in 2002? How do butch mothers and trans and non-binary people with uteruses continue to shift the meanings and possibilities contained in motherhood and femininity today?

2.2.2 The Pregnant Man

The "pregnant man" trope is not new, but it gained significant popularity and mainstream attention in 2008 with Thomas Beatie's public proclamation as the U.S.'s first "pregnant father" (Trebay 2008; Beatie 2008). Beatie, who is "legally male"[12] and identifies as transgender, has stated, "Wanting to have a biological child is neither male nor female desire, but a human desire" (2008).

Scott Moore, a pregnant trans-man highlighted by the media two years later, stated in an interview, "Thomas Beatie is not the first, and we're not the last… It's not that uncommon, it's just not talked about" (Drabinksi 2010). Moore said that the invisibility of his experience played a role in his decision to be public about his pregnancy; he wanted to help "make trans male pregnancy an unremarkable occurrence" (Drabinski 2010). Mara Kiesling from the National Center for Transgender Equality echoed this sentiment in 2008, "This is just a neat human-interest story about a particular couple using the reproductive capabilities they have. There's nothing remarkable [about Beatie's pregnancy]" (Trebay, 2008). In other words, trans pregnancy isn't, or shouldn't, be seen as sensationalist or abnormal and thus the focus of such commentary.

Thus, it appears that pregnancy on a masculine body really is only "remarkable" to those not involved and/or those with rigid, binary views of gender. Biological and essentialist views of

[12] "Legally male," (in quotes) refers to the words Beatie used to describe himself.

gender and reproduction remain dominant and contribute to the multi-faceted construction of a normative pregnancy. The seemingly inextricable connection between childbirth, womanhood, and female-ness lends to the "wow-factor" and sensationalism of the "pregnant man." Media coverage has the ability to reinforce such a connection. In an article about Beatie's exclusive interview with Oprah, Russell Goldman writes, "After years of struggling with his sexual identity and deciding to live as a man, he did the most womanly thing possible – he became pregnant" (2008). The profoundly problematic conflations of gender, sex, and sexuality in that sentence aside, Goldman fails to acknowledge the possibility that pregnancy could be anything other than womanly (2008). It is important to note that while media coverage can reinforce these rigid gendered connections and norms, media also have the power to reproduce counter-hegemonic perspectives, such as the concept that trans male pregnancy is, in fact, "unremarkable," at least in the way Moore and Kiesling intended (Trebay 2008).

In fact, popular culture, in the form of "emojis," is a step ahead. On September 14th, 2021, Unicode released their 14th version of The Unicode Standard, which included two new emojis: the "Pregnant Man" and the "Pregnant Person" (Soloman 2021). Unicode and the Unicode Consortium, created the Unicode Standard, "a character coding system designed to support the worldwide interchange, processing, and display of the written texts of the diverse languages and technical disciplines of the modern world" (Unicode 2021) This coding system helps address smart phone and computer communication issues at the intersection of linguistic diversity and programming; it "enables computers to support virtually every language in use in the world today, and for users and programmers to develop content in their own native language" (Unicode 2021). The Unicode Consortium also manages a well-known cultural phenomenon and subset of characters in the Unicode Standard: emojis. This recent release is an exciting step in

mass representation for non-conventionally-feminine (NCF) pregnancy and NCF people. Not only do these emoji additions make visible diverse pregnant and birthing bodies (to everyone with an updated smartphone), but it makes a powerful statement on inclusivity and gender diversity. Further, the process by which a new emoji is created is no small feat. According to Unicode, "Emoji submissions are open to the general public, but only a small percentage are accepted for encoding" (Unicode 2021). The proposal process is somewhat complex, requiring quite a bit of data, including for example, statistics addressing the expected frequency of use for the proposed emoji. In one section of their submission for the "Pregnant Man" and "Pregnant Person" emojis, the author highlighted important (and not new) facts about gender and pregnancy, such as: that one's sex does not dictate their "capacity to car[r]y children," and that not all people who have been pregnant or given birth identify as women (Daniel 2020). They also cite the British Medical Association (BMA), and how they advise use of the phrasing "pregnant people" instead of "pregnant woman" (Daniel 2020).

2.3 Gender and Pregnancy in Medicine

Various medical fields (i.e. reproductive medicine, plastics) have made substantial advancements in knowledge and surgical efficacy in recent decades. Scholars have produced (and continue to produce) significant, empirical evidence of diversity in gender and sex that goes beyond traditional binary classifications. Trans and gender non-conforming individuals (including those opting for parenthood) are increasingly visible in media, and as potential clients for services previously seen as exclusive to cishet partners (i.e. cryobanks, IVF). Despite all these factors, the normative constructions of pregnancy and their connection to femaleness remain salient. Patriarchally speaking, reproduction was/is a woman's purpose. The others who

do it are exceptions to the rule. Goldman is not alone in his view that pregnancy and femininity are inseparable; Beatie and Moore spoke of great difficulty finding doctors who were sensitive to their identities and related reproductive decisions and/or who were willing to take them as clients. The disconnect between pregnancy and anything other than "female," "woman", or "feminine," is not just a "bummer," so to speak, for these and other SGM people. This disconnect also contributes to health disparities and inequitable care and treatment for those presenting a different image of pregnancy. Beatie writes that he and his wife saw *nine* obstetricians before finding one willing to assist in his care (Goldman, 2008). Similarly, Moore reported that he and his husband literally called *every* doctor in New Mexico, none of whom took him seriously and/or were willing to take him on as a patient (Drabinski 2010). Unfortunately, such experiences are neither isolated nor limited to trans or LGBQ+ individuals who seek obstetric care (Seelman et al., 2018).

Mounting evidence indicates that it is not uncommon to encounter medical practitioners (primary or specialized) who lack a sensitivity to, and/or expertise in, the health care needs of LGBTQI+ individuals (Seelman et al. 2018; Grant et al. 2011; Obedin-Maliver et al. 2011). Kenagy and Bostwick found that 69% of transgender men participants reported that their identity "created a problem for them when going for a physical," meaning staff or providers were often not welcoming of trans identified patients (2005:63). Similarly, many trans individuals have reported needing to educate their doctors on their health needs (Seelman et al. 2018; Grant et al. 2011). Historically, medical personnel encouraged trans patients to see specialists (i.e., endocrinologists) for nearly all their care. Specialists are often more expensive, even with insurance, and in higher demand. Both of those factors are barriers to care that can affect access. While the need/culture of sending all trans folx to specialists is no longer considered medically

necessary for most trans health care, lack of training lends to providers either/both lacking the knowledge to care for trans clients and/or thinking they lack the credentials to care for trans clients. At a training on resilience and the provision of affirming care to LGBTQ+ populations, one of the guest speakers, a nurse practitioner, highlighted this issue and clarified that it is well within the purview of primary care providers (PCPs) like her to provide (affirming) health care to trans clients. She explained that this included the prescription and management of a patient's hormones, which are often involved in medically assisted transitions.[13]

In Moore's case, he and his husband ultimately had to move to another state to access the care they required. No one should have to pack up and move to another state to find a doctor. Regardless, it is not uncommon for LGBTQ+ folx, for example, to have to travel quite a distance to receive actual (affirming) medical *care* (Obedin-Maliver et al. 2011) Bill Hardy, the former[14] CEO of a federally-designated Community Health Center non-profit (and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the U.S.), Equitas Health, has acknowledged this issue when speaking about the future of its clinics. Equitas Health is currently primarily located in the Midwest and serves thousands of Ohioans and numerous clients traveling from Kentucky and West Virginia (Bilyj 2018; Equitas Health 2020). During his tenure as CEO, Hardy stated that his goal was to grow clinical operations to be big enough so that no LGBTQ+ person in Ohio would have to drive more than one hour to receive the affirming medical services they deserve.[15] Recall Rachel Epperson, the lesbian woman of color from Ohio whose medical encounter led to years without any visits to the doctor. About four years after

[13] I witnessed this as one of the planning and facilitating members of the educational event.

[14] Bill Hardy resigned as CEO of Equitas Health in October 2021 following employee unrest and related reporting from the *Columbus Dispatch*, all providing evidence of a culture of racism within the organization, including documented mistreatment of employees of color over a period of several years.

[15] I worked at Equitas Health from 2018-2020 as the Education Manager within the Equitas Health Institute. It was during my time in that role that I became aware of Hardy's goal.

that experience, Epperson's wife began working at Equitas Health. It was there that Epperson found the first doctor she "actually felt heard by" (Szilagy and King 2021).

Equitas Health, however, is an example of both what *to do* and what *not* to do, depending on the circumstances. There are many areas in which Equitas Health employees demonstrate/ have demonstrated excellence in the care and support of LGBTQ+ persons, some of which, for the purposes of this project, I will discuss in the next section. I would be remiss, however, to leave out that Equitas Health's leadership and many upper-management-level employees have been under recent and increased scrutiny for their treatment of their employees of color (LGBTQ+ and non-LGBTQ+). In early October 2021, Erica Thompson with the *Columbus Dispatch* published a major expose on the culture of racism that exists at Equitas Health, as well as how it has harmed current and former employees. Thompson's article shared that staff were calling for "an audit of Black employees conditions and an apology" (Thompson 2021). The article included a significant number of evidence-supported claims from employees that detail how unchecked power and implicit and explicit White supremacy within the institution and among leadership have manifested an unsafe workplace for Equitas Health's employees, particularly those who are Black (Thompson 2021). Fifteen former employees shared how they experienced or witnessed anti-Black racism and discrimination in hiring, promotion, and discipline, including one occasion where "an employee of color was placed in a closet as punishment by a white supervisor" (Thompson 2021). Employees explained that despite reports of these incidents, leadership have done nothing, and, in fact, one former staff member even reported hearing former CEO Hardy question the existence of microaggressions (Thompson 2021). While I can only touch on them briefly, the successes and failures of Equitas Health (and other organizations like them) are an excellent example of what happens when institutions,

leaders, policies, practices, etc. are *not* intersectional and/or do not *truly* aim or intend to be intersectional and equitable. I can say from my time there that most of Equitas Health's employees are/were drawn to the organization because of its mission: to provide equitable and inclusive care to LGBTQ+ people, PLWH, and any other folx seeking a welcoming healthcare home. While employees have in many ways been able to deliver on that mission for their individual clients, the employees often suffered as a result.

2.3.1 The Provision of "Medical Services" versus "Healthcare"

So keeping that in mind, what makes a medical service or medical institution affirming? How do medical providers reduce health disparities and create "welcoming healthcare home[s]" (2020)? The answer can shift and evolve similarly to culture and identity; however, there are feasible, practical steps that providers and medical institutions can take, particularly where sexual and gender minorities (SGM) are concerned.[16] Current research and experts who provide technical assistance in this arena specify that it is vital for a space to look and feel safe in addition to employing affirming providers. In addition to provider training, Equitas Health's education, community engagement, and research arm, the Equitas Health Institute (EHI), offers clients a service called a "Structural Competency Assessment" or "SCA." Metzl and Hansen (2014) define structural competency as:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or disease also present the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures medicalization or even about the very definitions of illness and health. (128)

[16] In-depth research on how these practices intersect with (and also affirm) other identities is needed.

The structural competency assessment revolves around one of the central tenets of this theoretical framework, the: "recognition that structures shape clinical interactions" (Metzl and Hansen 2014:128). The EHI's assessment process[17] involves a walkthrough and analysis of a physical space. The analysis provides insight into how that space does or does not cater to populations with disproportionate levels of health disparities or medical mistrust.

Conducting these assessments was one of my responsibilities as Education Manager within the Equitas Health Institute. Although our Institute was in many ways unique and forward thinking in offering and conducting these assessments, Equitas Health is not the only organization that utilizes these or similar principles to improve medical environments as a function of improving patient health outcomes. Fenway Health and the Fenway Institute/National LGBTQIA+ Health Education Center are known to provide technical assistance nationwide and the Human Rights Campaign's (HRC) Healthcare Equality Index (HEI) does include some metrics akin to cultural and structural competency (i.e., the trainings we [the Institute] offered qualified as fulfilling the HRC HEI education component). We were however one of, if not *the* only known entity to do so in such an individualized way, via an in-depth, in-person walkthrough, interview, analysis, and written report for each of our clients. This service was very well-received, in fact its popularity led to a level of demand greater than I and our staff could offer.

These reports (and the Institute's work) were all evidence-based and/or evidence-informed; however, they also had the unique benefit of having been conducted through the lens of a member of the LGBTQ+ community. This standpoint helped me establish an authentic feeling for the environment and understand whether I (and/or other LGBTQ+ individuals similar

[17] At least during my time there

or potentially dissimilar to me) would likely feel safe and/or affirmed during an actual visit. I would explain to the organization requesting our services that I needed to see/hear about anything that a client could/would encounter during a routine visit in order to provide the most accurate report on their structural competency. Such units of analysis included any/all client paperwork (i.e., intake forms) and/or electronic health or medical record (EHR[18]/EMR)[19] screenshots that could inform exactly *how* they collect information from the client and *what* specific information they ask their client to provide. For example, I would answer the following: Did they collect sexual orientation and gender identity (SOGI)[20] information? What did they *not* ask? How did they word their questions? What language did they use? Is it inclusive? I/EHI would then provide the organization with a full report detailing what they were doing well, what they could improve, and steps they could take to do so. This report would include detailed explanations as well as practical tips and strategies they could/should employ. See the below excerpt from one of these reports for an example.

> Update the figure/body illustration on the form used to document a victim/survivor's injuries so that it is more gender neutral …Further, some people think that all trans folks are visibly trans and/or that an individual can "tell" when someone is trans. Utilizing that method is […] strongly discouraged. Adding an opportunity to request SOGI information, whether on the intake form, or by using a supplemental form helps prevent staff from making assumptions as well (Freggens 2020:14-15).

As I mentioned, research shows that being trained in and providing welcoming and affirming medical environments—including staff, surroundings, procedures, etc.—are critical to improving health outcomes and to the reduction of health disparities experienced by marginalized groups (Crosby, Salazar, and Hill 2016, Seelman et al. 2018, Morris et al. 2019,

[18] EHR= Electronic Health Record:
[19] EMR= Electronic Medical Record
[20] SOGI= Sexual Orientation and Gender Identity; an abbreviation for two identities known to be crucial parts of a patient's medical record yet often left out/ not collected.

Gibson et al. 2020, Reisner et al. 2021). Some medical organizations have begun adopting and purposefully implementing the best practices of collecting SOGI information from their clients, a critical first step. Not only is the collection of this information necessary to assess, track, and improve known health disparities in LGBTQ+ populations, but the inclusion of these questions in a medical context helps doctors understand us (and treat us) better. It also highlights the importance of SOGI identity/identities and affirms their role in our health and wellness (The Fenway Institute 2018; The Fenway Institute and NORC 2019). Unfortunately, the collection of SOGI data, both within and outside the field of medicine, is still not yet commonplace or routine. For example, there are only a few national databases that collect SOGI information.

In 2010, the Office of Disease Prevention and Health Promotion (ODPHP) within the U.S. Department of Health and Human Services (HHS) initiated a 10-year agenda for "improving the Nation's health" called Healthy People 2020 (OASH Press Office 2010). The initiative takes a systematic approach to health improvement and is "grounded in the principle that setting national objectives and monitoring progress can motivate action" (OASH Press Office 2010). It places importance on ecological and determinants-based approaches to health promotion and disease prevention. The agenda was the product of "an extensive stakeholder feedback process that [was] unparalleled in government and health" (OASH Press Office 2010). The prior Healthy People 2010 process identified topic areas (and necessary data) missing from the analysis, including critical information related to LGBTQ+ health and LGBTQ+ health disparities. Among the comprehensive set of Healthy People 2020 Objectives was the topic area "Lesbian, Gay, Bisexual, and Transgender Health." Included there were objectives to increase the number of national datasets that collect SOGI information. (Some progress has been made, but there is still quite a way to go.) The Institute of Medicine published

a report in 2011 indicating that a lack of population-based data was "the greatest threat to describing the health status and needs of LGBT people" (Madhusoodanan 2015). This report spurred researchers at the University of California at San Francisco's (UCSF) School of Medicine to address the missing data problem.

In 2015, the first nationally representative, longitudinal, LGBTQ+ community health study, the Population Research in Identity and Disparities for Equality (PRIDE) study began (Madhusoodanan 2015). UCSF Research Fellows and founders of the study, Mitchell Lunn, MD and Juno Obedin-Maliver, MD, MPH, started this work "to engage the LGBTQ community, understand their health priorities, and frame research questions to address specific disease risks, outcomes, and resiliencies in this population" (Madhusoodanan 2015). Not only did the PRIDE study make LGBTQ+ population health more visible, but it also uniquely tackled the SOGI data collection issue. Researchers utilized existing standardized SOGI questions to compare their data and findings with the few national datasets that collected SOGI information. They also chose to collect SOGI information in ways they felt were less problematic, more inclusive, affirming, and effective. In hopes of promoting good data collection and reducing survey fatigue among participants, they also explained to survey takers exactly why there might be some repetition as far as the SOGI questions were concerned. In the future, these data could be used in efforts to formulate new, also validated, yet more inclusive, metrics of SOGI data collection. By asking for SOGI information using both the existing "validated" questions *and* arguably more inclusive versions, the researchers could then compare their data to those (few) national surveys that also include the validated SOGI questions, allowing for some longitudinal, national comparisons of LGBTQ+ health. The PRIDE Study's[21] approach takes an active role in *collecting* this

[21] Now housed at Stanford University

information and improving *how* we collect this information. (I will touch on these approaches more in a later section.) One of the PRIDE study's goals is to remedy the lack of evidence-based information on community health for this population; without this information, it is difficult to frame interventions to decrease disease risks, for example (Madhusoodanan 2015). Data do exist that document LGBTQ+/SGM/TGE health disparities to some extent; however, it is/has been extremely difficult to document the gravity and incidence of these disparities (and their effects on health) on a national level. Further, a lot of the progress made at the federal level in the last decade was later reversed by the Trump Administration.

HealthyPeople2020 objectives outlined specific goals to increase the number of nationally representative data sets containing SOGI information (HealthyPeople 2020). Under the Obama Administration, the number of databases collecting SOGI information increased. However, the Trump administration actively worked to undo the progress to improve LGBTQ+ health and LGBTQ+ data collection that was made under Obama. In 2016, the Census Bureau announced imminent plans to add SOGI questions to their American Community Survey (ACS), the largest survey in the U.S.

The addition was halted within a year of Trump taking office (Wang 2018). Further, several federal departments (i.e. Health and Human Services [HHS], Justice, Education, Housing and Urban Development [HUD] also changed how they "collect government information about "lesbian, gay, bisexual, and transgender Americans" (Sun and Eilperin 2017). Information on government websites advertising resources/services intended to help LGBT Americans were archived or taken down (Sun and Eilperin 2017). The Trump Administration also forbade federal officials from using (or including in federally funded research) several "controversial" terms. For example, in late 2017, CDC officials were given a list of seven words/phrases that they were

forbidden to use in official documents related to the 2018 FY budget; the forbidden terms were: "vulnerable," "entitlement," "diversity," "transgender," "fetus," "evidence-based," and "science-based" (Sun and Eilperin 2017). From 2017-2019, several national surveys removed SOGI questions and/or reversed their recent decisions to collect the data (Cahill and Pettus 2020).

Another critical and widely used national survey, the U.S. Census itself, also does not include specific SOGI questions. Yet, the information gleaned from the Census is used for everything from distributing medical research to reapportioning seats in the House of Representatives (Census Complete Count Committee Guide 2020). Not only will it be integral to reverse the data misdeeds of the Trump Administration, but there is also still a way to go before the majority, let alone all, national surveys collect SOGI data.

2.4 SOGI Data and Use of Assisted Reproductive Technology (ART)

The CDC defines assisted reproductive technology (ART) as inclusive of "all fertility treatments in which either eggs or embryos are handled" (Fertility Clinic Success Rate and Certification Act 1992; CDC 2020). These procedures typically involve surgical removal of eggs from ovaries, combining eggs and sperm in a lab, and subsequent insemination of the fertilized specimen into a/the uterus. Fertilized eggs may be returned to the body from whence they came, or they may be donated to others hoping to become pregnant. ART does not include handling or insemination of only sperm (CDC 2020). According to CDC ART Surveillance data, use of ART has nearly doubled in the past decade, and currently, approximately 1.9% of U.S.-born infants are conceived using ART. According to Pew Research Center data, U.S. births via ART are "up more than threefold since 1996" (Livingston 2018). These birth rates vary substantially from state to state, however. Some of the highest rates are found in the Northeastern U.S.; several of the lowest are in Southern states. The highest rate is in Massachusetts at 4.5%; the lowest rate is

in New Mexico at 0.5% (Livingston 2018). New Mexico's rate is attributed to a lack of fertility clinics and no mandated coverage, indicating that access to ART is a contributing factor (Livingston 2018).

In 1992, Congress passed the Fertility Clinic Success Rate and Certification Act. Since then, the CDC has surveilled the use of ART (including patient demographics and related medical history), ART procedures, and success rates throughout the U.S. through the National ART Surveillance System (NASS). NASS does not collect SOGI information as a part of their patient demographics.[22] As such, while we know that ART is not solely a method used by LGBTQ+ individuals and couples navigating infertility, the queer contribution to ART's increased use is not measurable via the national surveillance system. In an assessment of assisted reproductive technology, O'Brien shares usage has only increased and foreshadows that usage will continue to grow as more insurance companies begin subsidizing the costs (2018). O'Brien also asserts that "the increasing use of assisted reproduction, especially surrogacy, is influenced by the utilization and acceptance of the LGBTQ community (2018:48). Even more recent data support that claim as well.

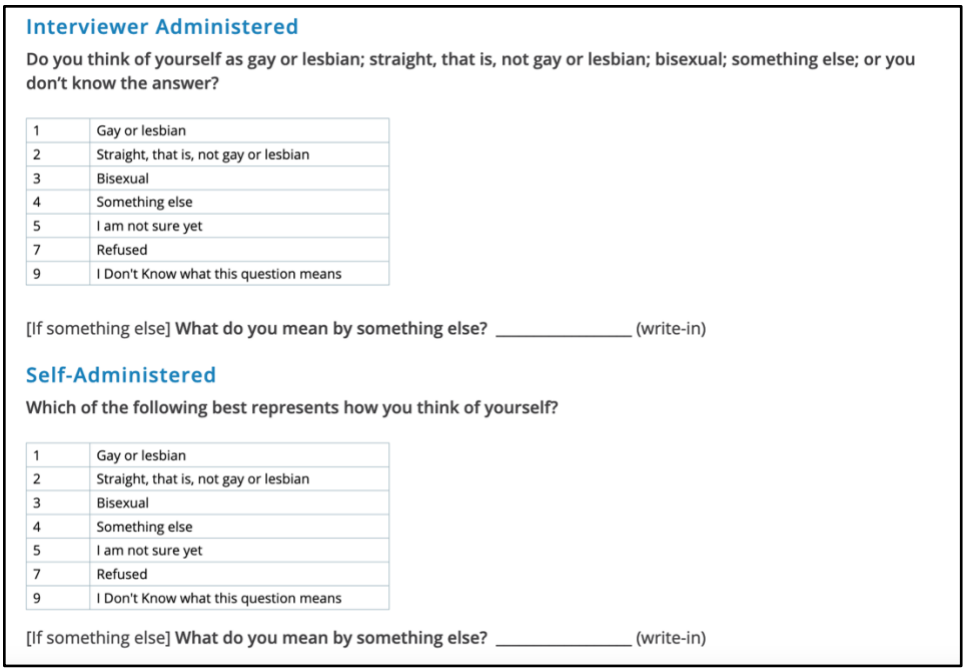
An organization called Family Equality conducted the "LGBTQ Family Building Survey," a comprehensive research study, which, according to CEO Rev. Stan J. Sloan, was designed "to help us better understand the landscape of family-building for lesbian, gay bisexual, transgender, and queer (LGBTQ) adults" (Family Equality 2019). The goal of the survey was to address significant gaps in knowledge around LGBTQ+ families in the U.S., particularly since the 2015 Supreme Court ruling legalizing same-sex marriage. The national study identifies the beginning of a significant shift in LGBTQ family building. They found that LGBTQ respondents

[22] NASS Help Desk, email exchange, July 6, 2021.

who are currently considering expanding their families are significantly less likely to do so via "traditional" intercourse (37%), which sharply contrasts with the previous generation of LGBTQ parents. Most of the previous generation (73%) built (or began to build) their families "in the context of a previous heterosexual relationship or as part of a different-sex relationship where one or both partners identified as bisexual" (Harris and Winn 2019). Not only does this suggest that culture change has occurred in terms of LGBTQ+ acceptance, but it also suggests that the use of ART and/or sperm banks have the potential to continue increasing substantially as "up to 3.8 million LGBTQ millennials are considering expanding their families in the coming years" (Harris and Winn 2019). While not all LGBTQ+ folx need ART to expand their families, the inclusion of SOGI data in national ART surveillance alone could lead to significant discoveries in LGBTQ+ health and reproduction that might otherwise remain unknown.

The problem of lack of visibility in the national record is twofold. As I alluded to previously, in addition to their limited inclusion, existing SOGI questions are not constructed as well as possible, particularly for current use. They fail to meet basic, yet imperative, rules of survey design.[23] The current "validated" metrics are quite limited in the identities they represent. See **Figures 2.2** and **2.3** for screenshots of these metrics (Williams Institute 2020). Additionally, in one of the sexual orientation response options, after "Straight," they clarify with the following text: "that is, not gay or lesbian." If these two are meant to be synonymous, the metric is no longer mutually exclusive; a participant could be both "not gay or lesbian" and "bisexual." With threats to both their validity and reliability present, the fight for SOGI data inclusion must also include major revisions to the metrics themselves.

[23] Mutual exclusivity, collectively exhaustive



Interviewer Administered

Do you think of yourself as gay or lesbian; straight, that is, not gay or lesbian; bisexual; something else; or you don't know the answer?

1	Gay or lesbian
2	Straight, that is, not gay or lesbian
3	Bisexual
4	Something else
5	I am not sure yet
7	Refused
9	I Don't Know what this question means

[If something else] **What do you mean by something else?** _____ (write-in)

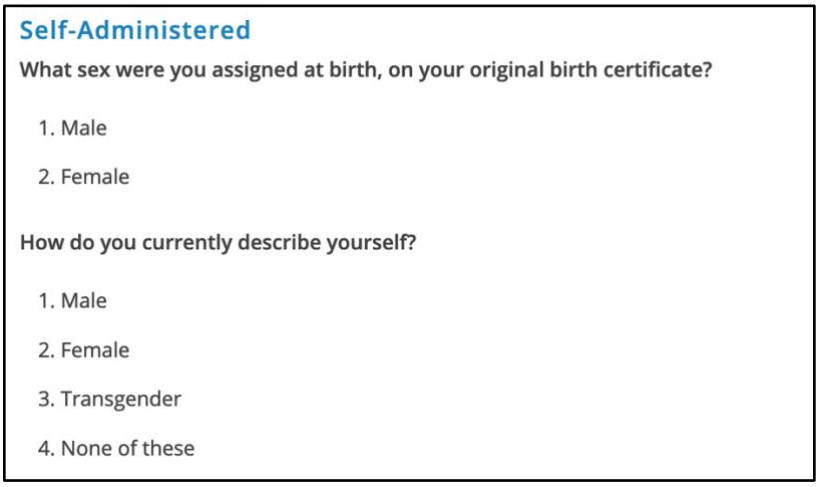
Self-Administered

Which of the following best represents how you think of yourself?

1	Gay or lesbian
2	Straight, that is, not gay or lesbian
3	Bisexual
4	Something else
5	I am not sure yet
7	Refused
9	I Don't Know what this question means

[If something else] **What do you mean by something else?** _____ (write-in)

Figure 2.2 Current "Validated" SO Metrics



Self-Administered

What sex were you assigned at birth, on your original birth certificate?

1. Male
2. Female

How do you currently describe yourself?

1. Male
2. Female
3. Transgender
4. None of these

Figure 2.3 Current "Validated" GI Metrics

The Williams Institute within the University of California at Los Angeles (UCLA) School of Law has often been referenced by LGBTQ+ and SGM health scholars and practitioners as a source of related data and best practices. In a statement it released in March 2020, it defends how the metrics are written. The publication seeks to address common questions

the Institute receives in response to its SOGI data collection recommendations. In response to the questions, "Why do questions used in general population surveys not include all the identity labels that sexual minorities actually use?" and "Why aren't aren't 'queer,' 'pansexual,' 'asexual' and other identities also listed?" Williams Institute Scholars assert that the inclusion of more expansive and representative response options would confuse cisgender heterosexual (cishet) respondents and lead to measurement error (Williams Institute 2020). According to the report, cishet respondents who misunderstand more representative terms such as queer, pansexual, and asexual would select them mistakenly, despite the existing inclusion of the following clarification after the "Straight" response option, "that is, not gay or lesbian." The scholars argue that potential inflation in measurement (due to this cishet confusion) would, "depending on the type of survey, mask any disparities in health and well-being when compared to heterosexual people" (Williams Institute 2020:3). It seems the position of the Williams Institute is to place greater importance on reducing potential cis-het confusion rather than accurately measuring SOGI information and sexual and gender minority populations. I see this position as merely an avoidance tactic as it is neither ethical nor empirically sound to poorly represent diversity because cis-straight people may get confused. Like the aforementioned clarification, "that is, not gay or lesbian," additional clarification or brief definitions could easily accompany other identity labels to remedy this issue. Another option would be to make SO a two-part question like GI; for example, there could be a follow-up question for those that do not select, "Straight, that is, not gay or lesbian."

When designing data collection metrics, it is important to do so in a way that both encourages participants to respond accurately while also minimizing the potential for error. However, if a metric will be used to measure a minority population on a national level, shouldn't

the accurate measurement of the minority population take priority? More representative SOGI metrics could easily be supplemented with clarification and definitional information to help respondents understand the terms, like the inclusion of "that is, not gay or lesbian."

In May 2017, the investigators of the PRIDE Study published a memo about a request for technical assistance in collecting data on sexual orientation and gender identity. As I mentioned previously, they (also) wrote that the then (and still now)-currently accepted ways of managing sexual orientation and gender identity were problematic and outdated. The PRIDE Study investigators revealed at the time that they were conducting field research to accompany their current research and help inform their metrics (PRIDE Study 2017). The Federal Committee on Statistical Methodology (FCSM) published "Updates on Terminology of Sexual Orientation and Gender Identity Survey Measures" in August 2020, after the previously referenced Williams Institute publication. The FCSM report acknowledges that the current categories lack representative response options and need to be revisited (Morgan et al. 2020).

The evaluation of the current metrics was completed by an NIH workgroup in 2009, over a decade ago; the metrics have not changed since (Salomaa and Matsick; PRIDE Study 2017). Design flaws and the fact that I would have done them differently aside, perhaps the current response options *seemed* exhaustive enough at the time they were developed; nonetheless revision is overdue. Mainstream culture, language, and identities related to gender and sexual identity have shifted and evolved dramatically in the past 12 years. It is my hope, however, that revisions are on the horizon, as a call was published in early 2021 asking for nominations for a workgroup to revisit these metrics (NIH 2021).

2.4.1 Medical Terminology and Communications: Small, Yet Powerful, Changes

In addition to the language used in data collection, language used in medical or other body-focused interactions also require special attention. Proponents of and experts in comprehensive *and* inclusive sexual health education encourage the use of "body-first language" (i.e., someone with a penis) as opposed to gendered language (i.e., saying "male" by default when referring to someone with a penis) in education and related programming (Vermont Agency of Education 2018:6). As a part of culturally humble and LGBTQ+ inclusive care, experts also recommend this practice of body-first language in medical contexts (Deutsch et al. 2013; Deutsch 2016; Greene et al. 2020). Some medical organizations have begun using a body organ inventory during intake, an approach that allows for the patient to identify which body parts they have, particularly those that are internal or not readily visible and perhaps considered more private, like sexual or reproductive organs (Deutsch et al. 2013; Deutsch 2016). See **Table 2.1** below for a list of organs to inventory from Deutsch et al. 2013.

Table 2.1 Example of Organ Inventory

Organs for Inventory	◎ / ●
Penis	◎
Testes	◎
Prostate	◎
Breasts	●
Vagina	●
Cervix	●
Uterus	●
Ovaries	●

This inventory of organs is significant for preventive health care purposes and the early detection of disease; many preventive cancer screenings are specific to gendered body parts. In their medical reference text, *Advanced Health Assessment & Clinical Diagnosis in Primary*

Care, the authors suggest the importance of not only the inventory of the patient's organs, but also, if/when relevant, the ability to include an inventory of organs the patient may have had removed via gender-affirming surgery for example (Dains, Baumann, and Scheibel 2018). Although research on SGM health is increasing, there is still a dearth of research on LGBTQ+ cancer prevention and care, and breast (or chest) cancer specifically. Just as providers instruct folx who have had cancer-related mastectomies to continue cancer screenings beyond remission, it is the recommendation that trans men (or others) who have had gender-affirming top surgery continue preventive screenings for breast/chest cancer. Getting a total mastectomy does not guarantee removal of all breast tissue; in fact, there is a high probability of remaining residual breast tissue (Griepsma et al. 2014).

Further, in terms of some breast cancers, surgeons may be aiming to surgically treat the patient while also conserving as much breast tissue as possible (Margenthaler, Gao, and Klimberg 2010). As such, those who have had a mastectomy have varying levels of remaining breast tissue that still needs to be monitored post-surgery and/or during remission. Additionally, there is little research on breast cancer in transgender clients. Overall, cancer research, especially longitudinal, on/among the LGBTQ+ community is still very limited. (Quinn et al 2015; National LGBT Cancer Network 2021). Lack of SOGI data in national data (national cancer registries and surveys of cancer incidence) limits significantly the possibilities for such research to occur (National LGBT Cancer Network 2021).

Primary care doctors are essential in helping their clients engage in necessary preventive screenings. Suppose they do not collect the necessary "gendered" information. In that case, they won't know that their patient—who may or may not have yet felt safe telling his doctor he's trans—should be getting preventive breast/chest cancer screenings instead of prostate cancer

screenings. See **Table 2.2** below for another visual example: a list of gender-affirming surgeries, whereby their inclusion in the patient's medical record can indicate the removal of specific organs and thus assist in determining various preventive health needs.

Table 2.2 Example of Gender Affirming Surgery Inventory

"Feminizing" Surgeries	◎ / ●	"Masculinizing" Surgeries	◎ / ●
Feminizing vaginoplasty	◎	Metaoidioplasty (clitoral release/enlargement, may include urethral lengthening)	◎
Breast augmentation	◎	Masculinizing chest surgery ("top surgery"); mastectomy and chest contouring	●
Orchiectomy	◎	Hysterectomy or oophorectomy	◎
Facial feminization procedures	◎	Vaginectomy	◎
Reduction thyrochondroplasty (tracheal cartilage shave)	◎	Masculinizing phalloplasty or scrotoplasty	◎
Vocal cord surgery	◎		
Lipo suction	◎		
Lipo filling	◎		

Allowing the client the option to identify their organs for a medical provider helps reduce opportunities for gendered assumptions that can inform the patient's medical record or care. For example, because of the schemas our brains create to aid with interpreting our social world efficiently, it is not uncommon for people/our brains to "automatically" (and almost instantly) do the following upon seeing a feminine person with the appearance of breasts: femininity and breasts means woman; woman means vagina; vagina means a, b, and c health concerns, therefore this patient needs x, y, and z screenings. These schemas, or categories of things we associate (i.e., breasts and woman are not always accurate; these schemas include our understanding and interpretations of gender and gender identity (Bem 1981). Extensive research on stereotypes,

implicit and explicit bias, sexism, racism, heterosexism, and classism, etc., also provide us with insight as to how these processes can (and do) affect decision making and interactions with others, especially when we are in a hurry and/or stressed. For example, a study of 450 cancer care providers from across the U.S. demonstrated what many LGBTQ+ folx and LGBTQ+ health scholars already knew; that a significant number of providers assume their patients are straight/heterosexual until they are provided information to the contrary (Schabath et al. 2018). Approximately 33% of the cancer providers surveyed presume their patient is heterosexual upon the first encounter—thus placing the burden and risk of (not) receiving inclusive care on the *client*; they have to either come out to their provider and hope for the best or stay in the closet as a result of real and/or perceived fears (Lamda Legal 2010; Schabath et al. 2018).

Additionally, the same study illustrated that even providers who identified themselves as well informed and equipped to provide equitable care to LGBT patients, lacked knowledge of fundamental yet critical health issues facing the community (Schabath et al. 2018). We simply don't know what we don't know. In my opinion, this also reflects an assumption that there is little to know to be able to provide equitable care to SGM populations, which simply isn't true. Unfortunately, in medicine, what providers don't know has the potential to bring harm to their clients. People in the U.S. increasingly identify as more than one race and/or as one or more LGBTQ+ identity. Should no attempts be made to alleviate these problems in medicine, the most commonly cited harms experienced by minority clients will worsen.

Further, when our brains take in data that challenge one or more of our existing schemas or beliefs, we tend to resist adoption or integration of the new information and instead label it an outlier; this is an example of a cognitive bias called the conservatism bias (Edwards 1968; Luo 2013). In a clinical context, just like we are asked to list other past surgeries (i.e., wisdom teeth

removal or knee surgery), an explicit inventory of gender-affirming surgeries gives the provider a fuller picture of our whole selves and reduces client burden and fear to disclose this potentially sensitive information. It also provides the opportunity for the medical provider to hear what words the client uses to refer to these parts of their body—hearing the client's own terms cues the medical provider on how best to communicate with them in return. Similarly, the aforementioned PRIDE Study utilizes survey technology that can replicate user-generated language throughout their surveys (Moeson et al. 2020). One of the many ways in which providers can meet their clients where they are is via using a shared language.

The organ inventory practice is also particularly important when considering the use, efficacy, and variation of electronic medical records (EMR) or electronic health records (EHR) systems, as they are routinely programmed to auto-populate specific preventive tests for a client based on information the provider inputs into the system (i.e., gender, sex, medical history, etc.). For example, in the case of a client who was assigned female at birth (AFAB) but identifies as male (whether or not they've gone through any form of medical or psychological transitioning), the provider (and thus the EMR) may not be aware of the possibility that the individual has a cervix and should therefore be getting regular pap smears. Perhaps the client told their provider they were a trans man and/or the provider already collected SOGI information from the client and thus either assumed they have a uterus or confirmed with the client they still had a uterus. Either way, if the EHR/EMR only auto-populates/allows gender or sex-specific tests to be displayed based on the client's sex (or assigned sex at birth), they still may be limited in terms of ordering the tests and/or inputting additional critical information in the system. Suppose there are no fields for them to input information about gynecological care. In that case, this could easily turn into missing or forgotten data, particularly if the provider inputs their trans male client into

the system as male to affirm their identity and/or prevent misgendering (by them or by other staff). Some providers/organizations will try to avoid this via inputting their client's assigned sex at birth in the system, taking care to address them by the name/gender/pronouns the client specifies. This can help mediate some of the auto-population issues within the EHR/EMR; however, anyone other than that provider may not know the client is trans. If other staff go by what is in the system, they are likely to accidentally misgender the client in whatever capacity they serve the client (i.e., scheduling, billing, etc.).

For a more specific example, Deustch et al. stress the importance of uncoupling hysterectomy, oophorectomy, vaginectomy, orchiectomy, and breast augmentation from any gender-coded templates within the system, regardless of the patient's gender or sex markers (2013). "Such practices would allow enhanced decision support for transgender-specific care, such as medication interactions, organ-sex-specific preventive health alerts, or accommodations for sex-specific laboratory normal value ranges" (Deutsch et al. 2013:702). Typical values for specific lab tests vary based on sex—a value for a presumed-AFAB individual may seem high if the person reading it does not know that the patient was actually assigned-male-at-birth (AMAB), for example (Deustch et al. 2013). Additionally, there must be fields within these systems wherein providers can indicate a patient's name, pronouns, and gender identity, mainly, for example, if that (preferred) name differs from their legal name. It would be helpful to include a place for special considerations/notes that can prompt a provider to use the correct name.

Electronic medical records are instrumental and have many advantages over paper health records. However, not all EHR/EMR systems provide medical organizations and providers with flexibility in their record-keeping; some EHR/EMR systems are less customizable than others, and many of them have gender/sex coded restrictions, which can make it much more difficult to

provide (and prompt the provision of) the best (equitable) client care. These issues are exacerbated for SGM folx when SOGI information is not even collected, contributing to poorer health outcomes and health disparities. Not being able to document such client information properly leads to an incomplete and inaccurate medical record—thus defeating some of the main reasons to use an EHR/EMR in the first place. For the most part, this is easily remedied. Some EHR/EMR companies/developers are working toward making their systems more flexible and/or customizable to account for these issues. Other health organizations/systems choose to develop their own such systems, allowing complete control of how questions are asked and the ability to make changes quickly and easily. Deutsch et al. and places like the Fenway Institute or the Equitas Health Institute provide best practices for medical personnel on how to capture a fuller and more accurate medical record for their SGM patients (2013). It is important to remember though, that all of these changes, easy or not, take time and effort on the part of the organization and the company managing the EHR/EMR (if external). The time and effort (and associated costs) will also vary depending on the size of the health system and any existing policies affecting such changes.

2.5 Gaps in the Research

In 2010, Lambda Legal released a report on the findings of its first-of-its-kind, national survey on discrimination against LGBT[24] people and people living with HIV, "When Health Care Isn't Caring." This report examined refusal of treatment and barriers to health among the aforementioned communities (N=4,916 individuals). The major findings illustrate that the majority of all respondents (LGBT individuals and people living with HIV) had experienced at

[24] Usage of 'LGBT' here is to reflect the language Lambda Legal used. Wherever I use an acronym other than 'LGBTQ+,' it is because I'm referencing the acronym (and associated populations) being used by the author or authors of that publication/resource.

least one of the following types of discrimination in health care: (1) "being refused needed care"; (2) "health care professionals refusing to touch them or using excessive precautions"; (3) "health care professionals using harsh or abusive language"; (4) "being blamed for their health status"; and (5) "health care professionals being physically rough or abusive" (Lambda Legal 2010:5; See the full report here). Another important finding was a high degree of belief or anticipation that they would experience discrimination—and that such a perception would directly impact their decision to seek care (Lambda Legal 2010). Of respondents who reported they'd been outright denied needed care, eight percent (8%) were LGB individuals, nearly 27% were trans and gender-nonconforming individuals, and 19% were living with HIV (Lambda Legal 2010). The finding also signifies that in almost every category, trans and gender-non-conforming individuals reported higher rates of discrimination and barriers.

Similarly, in nearly all categories, there was a higher proportion of respondents of color and/or individuals characterized as low-income who reported discriminatory and substandard care (Lambda Legal 2010). Although this report was released over a decade ago, experts assert that the problems it articulates remain. For example, the Center for American Progress (CAP) and the research group NORC at the University of Chicago designed a study to explore many of the issues facing "LGBTQ Americans" (Gruberg, Mahowald, and Halpin 2020). The major findings indicate one in three LGBTQ Americans and three in five trans Americans faced some kind of discrimination in the past year; statistics for trans Americans include those identifying as Nonbinary, genderqueer, agender, or gender-nonconforming, who reported the highest rates of discrimination (69%) (Gruberg, Mahowald, and Halpin 2020). They also found that three in ten LGBTQ Americans and more than half of trans Americans faced difficulties accessing medical care due to cost; one in three trans adults report an annual household income below $25,000

(Medina et al 2021; Gruberg, Mahowald, and Halpin 2020). Further, fifteen percent (15%) of LGBTQ Americans and almost three in ten trans[25] Americans report postponing or avoiding medical treatment due to discrimination (Gruberg, Mahowald, and Halpin 2020). It is not uncommon for trans (and other LGBTQ+ identified people) to share that they are often required to teach their doctor about their trans (or other SGM) identity in order to receive proper treatment and services; one recent analysis indicated one in three trans individuals had to teach their doctor about trans identity according to the aforementioned CAP data (Szilagy and King 2021; Gruberg, Mahowald, and Halpin 2020). Additionally, recent analyses illustrate that trans adults are significantly less likely than cis adults to get flu shots and have routine medical visits (Medina et al 2021).

Some point towards the lack of medical instruction on this population (LGBTQ+) and their medical needs as one of the primary causes for their negative medical experiences. Not long after the release of the Lambda Legal report, researchers collected the reported hours of LGBT-curricular content at 176 allopathic and osteopathic medical schools in Canada and the United States. Obedin-Maliver et al. found that of the 150 schools that responded, the median reported time dedicated to teaching LGBT-related content during the degree program was 5 hours, if at all (2011). The study reports that 44 out of the 176 schools (33.3%) reported 0 hours of LGBT content during clinical years; nine schools reported 0 hours during preclinical years and five reported 0 combined hours Obedin-Maliver et al. 2011). There was variation in what LGBT-related topics were covered at schools that did report hours of LGBT curricular content (Obedin-Maliver et al. 2011).

[25] It is possible this statistic is being skewed by a proportion of white trans men who do not refrain from going to the doctor. For example, Seelman et al. illustrates that trans men are typically not less likely (than cis men) to engage in preventive health behaviors (2017). I suspect this three in ten statistic would be higher for trans and/or non-binary folx who are not white and men.

Since 2010/11, some reforms have been made to address the (lack of) LGBTQ-health education at the undergraduate medical education (UME) level (the technical name for post-bacc schooling wherein medical students obtain an MD; the post-medical school residency period is considered their graduate medical education [GME] level); however, Pregnall et al. state that new literature supports the claim that "didactic education at the UME level is not enough to prepare future physicians to properly and compassionately care for LGBTQ patients" (2021:828). Consequently, while there are increasing efforts to highlight the unique challenges facing the LGBTQ+ community and the role medical education plays in mediating and preventing those challenges, there is at this time (of publication) no formal requirement on behalf of the Accreditation Council for Graduate Medical Education (ACGME) for medical programs to include residency requirements related to LGBTQ-health (Pregnall et al. 2021). Further, not all client-facing providers or staff even go to medical school. Nurses, physician assistants, lab technicians, and administrative staff are often even less likely to have received any LGBT-specific education at all, or during any initial medical training . They may however interact with such topics via later continuing education (CE's) opportunities required to maintain their licensure. That being said, what CE's are available and whether or not an individual's organization pays for them can also affect what training topics they've been exposed to. These professions may receive post-graduate training on LGBTQ+ health topics through their employers or continuing education (CE) requirements, but specialized education on treating this medically underserved population is not considered required knowledge by medical education institutions or licensing boards.

As mentioned previously—while there is increasing research on and attention to LGBTQ+ health, there are still many unknowns. The language and moniker so often used to

refer to sexual and gender minority people (LGBTQ+ and/or LGBTQ+ community) implies a certain level of connectedness between gender and sex and sexuality, as well as a unity among those who identify as lesbian, gay, bisexual, trans, queer, etc. It would be incorrect to say these things aren't connected, or that people in this community are not at all unified. Still, it is dangerous to presume that LGBTQ+ folx and/or sexual and gender diverse peoples are a homogenous group that are easily labeled and boxed (and thus similarly measured and understood). Studying an entire community of diverse sexualities and genders is not an easy task; nor do research findings carry equal weight for all identities within the acronym. Sexual and gender minorities are not a monolithic people; individual identity groups within the larger acronym have varied experiences (Szilagy and King 2021). Further, the LGBTQ+ community (and folx who identify as sexually or gender diverse but not with the LGBTQ+ community or acronym) are not free from the power differentials and systems of oppression that have been forged alongside and within our larger society and institutions.

Racism, sexism, classism, even homonegativity and transphobia—to name a few—also exist and create hierarchy and division within the LGBTQ+ community. In other words, research on the health behaviors of gay men/MSM[26] will only be so applicable when considering the health behaviors of lesbian women/WSW[27]. Gender and sexuality are neither binaries nor discrete categories of identity, so studying them as such will lead to error. Additionally, activists, ingroup members, and gender scholars from varying disciplines and backgrounds know and have demonstrated that constructions of gender are far more complex than a simple man-woman binary allows (Hubbell, 2016, Serano, 2013, Hope, 2012, Halberstam, 1998). Nevertheless, our language and institutions have been constructed around an 'either-or' binary of gender and sex.

[26] Men who have sex with men
[27] Women who have sex with women

There are a lot of problems surrounding mainstream understandings of sex, gender, and sexual orientation, and that they are binaries is but one of many misconceptions. It is commonly thought that gender and gendered expressions determine one's sexual orientation, i.e., if an individual assigned female at birth (AFAB) displays a more masculine (or butch) appearance, they must be a lesbian. Another common assumption is that a trans man is probably also gay. Even with an acknowledgement that stereotypes might begin from a half-truth, and that there are plenty of masculine women who do, in fact, identify as a lesbian, it is dangerous to presume knowledge of someone's sexual orientation based on a *perception* of *someone else's* gender identity or expression, and vice versa. For medical providers, making assumptions and/or making judgments based on assumptions is a function of substandard care and can harm clients.

Such behavior may even lead to a client breaking their linkage to much-needed medical care. There is no way for a client to know whether a medical provider's ignorance is just ignorance or, worse: a precursor to discrimination or violence. Such assumptions can also cause financial stress on LGBTQ+ clients, specifically those without insurance.

2.6 Theory

In this project, I draw on social constructionist understandings of the aforementioned identities and experiences, with specific attention to intersectionality and hegemony. I acknowledge the significant roles people and language play in our perceptions, interpretations, and understandings of our social world. I built this project on empirical evidence that gender identity and expression, as well as the gender-binary and the categories that typically "make up" gender and sex, are not natural, biological, genetic, or innate. People (and communications) attach meanings to the concepts of gender and sex that exceed physical and chromosomal differences, and these meanings are not static. They change and/or shift across time and place.

The internalization of these meanings and the presence (or absence) of power reinforce and sustain the inequity associated with them. Although understandings and definitions of gender have changed over time, at no point in U.S. history has what it means to be a woman changed so much that it has ever been interpreted as being more powerful than being a man. This distinction is important because how gender is defined, or certain roles associated with gender, aren't solely responsible for gender oppression—it is those definitions/roles in tandem with dominant patriarchal ideology and the power structures that enforce and maintain ideologies that allow gendered meanings to have oppressive consequences (Gutman 1996; Eskilsson 2003; Schippers 2007).

2.6.1 Intersectionality and Intersectional Theory

While the conceptualization is not new (scholars can trace it back as far as the 1800s in the work of Black feminists like Anna Julia Cooper and Sojourner Truth), the moniker "intersectionality" was coined by Kimberlé Crenshaw in her work "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" (Crenshaw 1989). Intersectionality and intersectional theory allow for the understanding that our identities are not mutually exclusive pieces of us that affect our lives separately and in different ways (Crenshaw 1989). Rather, our identities affect, inform, and shape each other *and* our experiences in the social world (Crenshaw 1989).

Unfortunately, a great deal of activism, scholarly work, and social policy have not been intersectional. As a result, "the perspectives of privileged women are often treated as decontextualized universals," and thus, integral perspectives of our social world are swept to the margins (Chadwick 2018:7). It has (and does) often fall to the ingroup members experiencing injustice to make visible these intersectional viewpoints. In addition to Crenshaw, the work

furthering such an understanding has primarily been produced by women of color (WoC) scholars, such as Patricia Hill Collins, Audre Lorde, Adia Harvey-Wingfield, Mary Romero, Evelyn Nakano Glenn, Della V. Mosely, and Pearis Bellamy, to name but a few.[28]

Patricia Hill Collins's "matrix of domination" is one example of how critically important Black feminist thought and intersectional modes of thinking are to this project. In *Black Feminist Thought* (1990), Collins introduces her conceptual framework for understanding these interlocking systems, "the matrix of domination." Collins here states that,

> Additive models of oppression are firmly rooted in the either/or dichotomous thinking of Eurocentric, masculinist thought. One must be either Black or white in such thought systems—persons of ambiguous racial and ethnic identity constantly battle with questions such as 'what are you, anyway?' This emphasis on quantification and categorization occurs in conjunction with the belief that either/or categories must be ranked. The search for certainty of this sort requires that one side of a dichotomy be privileged while its other is denigrated. Privilege becomes defined in relation to its other. Replacing additive models of oppression with interlocking ones creates possibilities for new paradigms. The significance of seeing race, class, and gender as interlocking systems of other oppressions, such as age, sexual orientation, religion, and ethnicity. Race, class, and gender represent the three systems of oppression that most heavily affect African-American women (222-223).

The matrix of domination highlights how privilege exists and operates within social systems and people's experiences. The myriad existing privileges defined by dominant and ruling culture altogether intermingle, push and pull, and intertwine into a gestalt reality where no one characteristic defines who we are in our social world at any given time. In other words, our identities coexist and cooperate. I am White *and* queer. I am White *and* queer *and* a woman.

[28] Patricia Hill Collins, PhD, Distinguished University Professor Emerita of Sociology; Audre Lorde, BA, MLS (1934-1992), self-described "Black, lesbian, mother, warrior, poet" with major contributions to literature, poetry and black & third-world feminist theory; Adia Harvey-Wingfield, PhD, Associate Dean for Faculty Development and Professor of Sociology at Washington University in St. Louis; Mary Romero, PhD, Professor of Justice Studies and Social Inquiry at Arizona State University and 2019 American Sociological Society President; Evelyn Nakano Glenn, PhD, Professor of the Graduate School in Asian American and Asian Diaspora Studies at the University of California at Berkeley; Della V. Mosely, PhD, Assistant Professor in Counseling Psychology at the University of Florida and co-creator of Academics for Black Survival and Wellness; Pearis Bellamy, Counseling Psychology PhD Student at University of Florida, and co-creator of Academics for Black Survival and Wellness.

Similarly, Collins's matrix illustrates that people can belong to both privileged and oppressed groups simultaneously. Collins posits that these privileges and oppressions operate throughout four different domains of power: *structural*, *disciplinary*, *hegemonic*, and *interpersonal*. The matrix allows us to understand how these domains of power shape human action, and the domains of power serve to maintain the status quo (Collins 1990). A non-hegemonically feminine or non-traditionally feminine pregnancy and birth is not, so to speak, "the status quo," and those who experience it are informed, shaped, and impacted by all these domains of power in some way or another. Through this research, I aim to understand better those experiences, including how they relate *and* how they differ amid varying privileges and oppressions.

There are known racial and ethnic disparities in birth outcomes in the U.S. (Chadwick 2018). The Centers for Disease Control (CDC) define *health disparities* as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (CDC 2018). In Collins's terms, functioning domains of power produce health disparities. One manifestation of this theoretical concept is visible in documented racial disparities in pregnancy and birth. For example, according to the CDC, pregnancy-related causes of death are highest among Black and American Indian/Alaska Native women; they are 2-3+ times higher than for White women (CDC 2019). All women experience gender oppression; however, White women have racial privilege while Black and Native women experience racial oppression. See **Table 2.3** below for data from a recent CDC report: "Pregnancy-related deaths by sociodemographic characteristics—Pregnancy Mortality Surveillance System, United States, 2011-2015" (2019).

Table 2.3 Pregnancy-Related Deaths in the U.S., by Race/Ethnicity

Characteristic	No. of pregnancy-related deaths	Pregnancy-related mortality ratio*
Total	3,410	17.2
Race/Ethnicity† (N = 3,400)		
White	1,385	13.0
Black	1,252	42.8
American Indian/Alaska Native	62	32.5
Asian/Pacific Islander	182	14.2
Hispanic	519	11.4

* Number of pregnancy-related deaths per 100,000 live births.
† Women identified as White, Black, American Indian/Alaska Natives, or Asian/Pacific Islanders were not Hispanic. Hispanic women could be of any race.

Further examination of those reported as having a pregnancy-related death illustrates marked differences in these rates across different regions of the U.S. as well. For example, some of the highest rates of maternal mortality in the country exist in the U.S. South (Leins 2019). Black women in Georgia have a mortality rate of 66.6 per 100,000 live births compared to 43.2 for White women (CDC 2019; Leins 2019). Black women in Louisiana fare even worse, with a rate of 72.6 per 100,000 live births compared to 27.3 for White women (CDC 2019; Leins 2019). Although not all Southern states have high maternal mortality rates, these two states do have particularly racialized histories that likely continue to color the health outcomes of PoC today. Disproportionately affected women tend to be of lower socioeconomic status as well, illustrating how raced, classed, and gendered forces all significantly affect health outcomes. These particular pregnancy-related deaths are preventable. They are not the product of a genetic or biological problem specific to non-White pregnant bodies but rather the result of racism and associated health inequity (CDC 2019). Health inequity is systematic, socially produced, and unjust (Braveman and Gruskin 2003). The presence of these race and class-based disparities in birth are two examples of why an intersectional lens is critical in general and in this project.

2.6.2 Reproduction at the Intersection of Race and LGBTQ+ Identity

Additionally, the above maternal mortality data do not even begin to offer an understanding of how these rates look for LGBTQ+ or women who have sex with women (WSW) populations, including LGBTQ+/WSW populations of color. Recent research (and the lack of research) point to the fact that there is little known about "maternal and infant health among sexual minority women (SMW), despite the large body of research documenting their multiple preconception risk factors" (Everett et al 2020). Everett, Kominiarek, Mollborn, Adkins, and Hughes (2020) utilized 2006-2015 National Survey of Family Growth (NSFG) data to investigate the inequities in pregnancy/birth outcomes for SMW. They investigated pregnancies and births of heterosexual-WSM (i.e. women who only report sex with men), heterosexual-WSW (i.e. women who report sex with women), bisexual women, and lesbian women. They found that compared to heterosexual-WSM, lesbian, bisexual, and heterosexual-WSW were more likely to report miscarriage, even when controlling for race/ethnicity, education, maternal age, public assistance, income-to-needs ratio, IUI, IVF, prenatal care, smoking, gravidity, and month of interview (Everett et al 2020).

They also found similar results in terms of pregnancies ending in stillbirth for lesbian and bisexual women. Lesbian and bisexual women more likely reported low birth weight infants compared to heterosexual-WSM (Everett et al 2020). Bisexual women reported significantly higher prevalence of c-sections (30.1%) than heterosexual-WSM (18.7%). Also notable, lesbian-identified women had much higher rates of having ever used intrauterine insemination (IUI) and while no differences were found in terms of the use of prenatal care, SMW's rates of smoking during pregnancy (11.9%-15.5%) were 2-3 times higher than heterosexual-WSM (5.5%).

These findings support previous findings that sexual minority women experience disproportionate and elevated adverse maternal and infant health outcomes. These results are particularly striking, considering most persisted even when Everett et al. controlled for socio-demographic characteristics (i.e. race, education, etc.) that often affect access to medical services (2020). While we currently don't know how SMW fit into rates of overall maternal mortality, there are clearly data that suggest that adverse outcomes occur along racial and sexual lines and that more research including both racial and SOGI metrics (and their relationship) is desperately needed.

Also important to consider here is the Williams Institute data showing that 42% of LGBTQ adults also identify as a person of color (POC). They may also use the acronym BAME, which stands for Black, Asian and minority ethnic, QTIPOC, which stands for Queer, Trans, Intersex, People of Colour, or QTIBOPOC, Queer Trans Intersex Black People and People of Color (Stonewall's BAME/POC Staff Network 2019).[29] The racial diversity among LGBTQ+ people (42% POC) is actually higher than that of the general U.S. adult population (40%). Twenty-one percent (21%) of LGBTQ POC identify as Latino/a, 12% identify as Black, two percent (2%) Asian, and one percent (1%) as American Indian/Alaska Native. Their data also suggest that there are higher proportions of LGBT POC raising children compared to White LGBT folx (Williams Institute 2017). See **Table 2.4** below for the proportions of these groups (25 and older) that are raising children.

Table 2.4 Percent of LGBT Folx Raising Children by Race/Ethnicity

Race/Ethnicity	**Percent (%) Raising Children**
Latino/a	39%
White	21%

[29] While the source for QTIPOC and QTIBOPOC is outside the U.S. (Scotland), I have also seen these abbreviations used in U.S. context.

Black	34%
Native Hawaiian or Other Pacific Islander	51%
Asian	25%
American Indian and Alaska Native	36%
More than one race	33%

2.6.3 Hegemony

Originally coined by Antonio Gramsci, hegemony indicates the presence and maintenance of domination by one social group over another. Supporters of this theoretical framework identify the dominant group as the ruling class, with the power to manipulate the culture of society to reinforce and perpetuate its ideologies and thus consolidate its reign (1971). According to Schippers (2007), "Hegemonic features of culture are those that serve the interests and ascendancy of ruling classes, legitimate their ascendancy and dominance, and encourage all to consent to and go along with social relations of ruling" (90). Drawing on this concept of hegemony, Connell defines *hegemonic masculinity* as a set of practices that promotes the dominant social position of men while also reinforcing the subordinate position of women, and some subordinated masculinities as brought forth by Chen and revised by Connell later (1999 and 2005). Connell argues that there are no hegemonic femininities because femininity is constructed "in the context of the overall subordination of women to men" (1987:187). She puts forward the concept of *emphasized femininity* instead, which is defined "around compliance with this subordination and is oriented to accommodating the interests and desires of men" (Connell 1987:184). Schippers builds upon Connell and other gender hegemony researchers and purposefully makes space for *hegemonic femininity*. She provides a missing piece of the puzzle: a "compelling and empirically useful conceptualization of hegemonic femininity and multiple, hierarchical femininities *as central to male dominant gender relations"* (2007:85). Furthermore, she argues:

> Hegemonic femininity consists of the characteristics defined as womanly that establish and legitimate a hierarchical and complementary relationship to hegemonic masculinity and that by doing so, guarantee the dominant position of men and the subordination of women. (2007:94.)

The concept of hegemonic femininity (HF) is of particular importance in this research because HF promotes and maintains the established connection between reproduction and "being womanly." This connection has long been a standard, or norm, within our society—the institutionalization of which provides a means to enact social control of people's gender expression and reproductive decisions. One of the many ways this control is maintained is via the ever-present perception that there are consequences to defying the status quo. Most simply put, for the dominant and subordinate positions of men and women to be "guaranteed" like Schippers theorizes, those who comply with dominant gender ideology are rewarded while those who do not are punished (2007:94). Could creating an expectation of low or unequal quality medical care be a means of controlling gendered noncompliance?

While we know that certain intersections between gender and sexuality exist (i.e., butch lesbian), gender and sexuality, and their meanings, are dynamic. For example, due to activism and shifts in culture and social attitudes making some aspects of holding an LGBTQ+ identity safer (in some places), evidence suggests more and more individuals identify with the LGBTQ+ acronym than ever before (Gates 2017; Lighthouse LGBT Inc 2020). The study and understanding of gender and sexuality continue to grow and expand over time, all of which are critically important to the groups and individuals they represent. Sometimes we find ourselves using a shared language, but not shared meanings, and vice versa. The language we use to describe our/others' identities can also sometimes (even unintentionally) limit us.

For example, while still an employee within the Equitas Health Institute, I was involved in a community health research project on lesbian health, titled "The Lesbian Health Study." Upon analyzing the survey created and implemented by my superior the previous year, we both realized how underrepresented Black women were in the results. We knew anecdotally that this did not mean that Black women in same-sex relationships had nothing to say about their health and health care experiences. Also, their experiences were integral to this work, as we aimed for our research, education, and community engagement efforts to be both representative and intersectional. We decided to conduct focus groups to supplement the survey data. During the planning process, we learned from trusted community members and gatekeepers that we would likely be more successful advertising our focus group as for "Black women who have sex with women" as opposed to "Black lesbians," due to some Black women's intentional distancing from the LGBTQ+ acronym and some of the terms within it. We took the advice given, and ultimately, the focus group was successful. Another Black woman who was a part of the community agreed to facilitate the discussion, which I believe also made it more appealing. An amazing group of Black women showed up to share their experiences. It was illuminating and an honor to hear their feedback and stories. From both a human and research perspective, I saw firsthand how using a shared language (and making significant efforts to build rapport and create a safe and affirming space) positively contributed to their engagement.

I also wanted to allow for the opportunity to hear from trans (binary or non-binary) and gender non-conforming (or genderqueer, gender fluid, etc.) individuals in this research, as being TGNC/TGE complicates beliefs in sexual dimorphism. Despite being a part of the LGBTQ+ acronym, trans identity does not dictate one's sexuality. Further, unlike Ryan, Epstein, and Reed, Miller & Timm, who all made significant contributions to this nascent area of inquiry, my goals

and focus for this research do not require that I limit my inquiries to only lesbians or WSW. I want to examine gender and pregnancy while purposefully allowing for the opportunity to both include and potentially go beyond the known correlations of (and language around) masculine gender construction and lesbian identity. Also, when dominant society defines and describes gender identity and expression in terms of masculinity and femininity, typically, individuals and institutions are not applying those meanings solely to anatomical, physical, or visible attributes (i.e., hair, clothes, gait). For many, parts of our gender identity and/or expression include more internal and/or less immediately visible aspects of our identity, personality traits, and career choices. This is evident among respondents in Epstein's (2002), and Ryan's (2013) works on lesbian/butch pregnancy. I did not want to assume which parts of one's identity/life are connected to, or an expression of, their gender and/or sexuality. However, I also wanted to consider instances in which certain identities cannot necessarily be examined separately from one another. For example, in a 2020 lecture on conducting intersectional research, Jioni Lewis articulated how it is ineffective (and not intersectional) to ask Black women about their racialized and gendered experiences separately (i.e., with questions like "How does your race affect your medical experiences?" and "How does your gender affect your medical experiences?"), because they're always working together (2020). Dr. Lewis clarified that an inquiry that incorporates them both (i.e., "How do your race and gender affect your medical experiences?") is more suitable (2020).

I also wanted to minimize egregious and harmful assumptions that can stem from essentialist views of gender. U.S. institutions—such as (bio)medicine — (and often the individuals who work within them) insist on reinforcing such assumptions. In contrast, I desired to create a space for examining gender and pregnancy that doesn't require (implicitly or

explicitly) that the birth-giver identify as a woman—and/or that allows the birth-giver to have created (and shared) their *own* constructions of femininity, masculinity, and/or other modes of describing their gender entirely.

Pregnancy and birth have become increasingly medicalized over the years (Simonds et al. 2017). Medical mistrust, bad experiences with doctors, and lack of representation in the profession all play a role in the level of engagement marginalized groups have with medical organizations. Further, even when they are engaged, lack of culturally humble providers, and thus lack of inclusive and affirming health care, can often negatively impact the health outcomes of these patients (Rosenthal and Lobel 2016; Seelman et al. 2017; Huber et al. 2018). The city, town, reservation, etc., in which we live also affects our health outcomes and engagement in care. For example, populations and geographic regions can be identified as *medically underserved*. To be medically underserved means that a certain group of people or a specific geographical area have certain levels of the following conditions: too few primary care providers (PCPs), high infant mortality rates, and high poverty rates, and/or a high elderly population (Health Resources & Services Administration 2020).

Further, it may be harder to find affirming healthcare providers outside larger metropolitan areas. Although it's possible it has changed in the near-decade since I left, for example, there were no known LGBTQ+ health organizations or clinics in the small, southern town where I grew up; the closest Planned Parenthood was nearly four hours away. In this research study, I aimed to better understand access to affirming providers for pregnant folx.

This research contributes to the existing literature on gender and pregnancy and how hegemonic prescriptions of gender continue to oppress, marginalize, and simply make difficult the lives of individuals and groups that defy or queer those prescribed norms. It also supports

existing evidence of how gender and pregnancy are racialized and how racialization shapes the experience of people of color within my target population. This work also contributes to the existing literature on health disparities, urban bioethics, and the provision of medical care to marginalized bodies, bodies that birth, and marginalized birthing bodies.

3 METHODS

In this research, I aim to understand and explore the experiences of individuals who do not embody or identify with, in Domo's words, "the 'normal' look of a pregnant woman" (@domo.crissy.15, 2017). More specifically, I explore how NCF individuals navigate pregnancy and/or birth and how their gender expression or identity shapes those (medical) experiences on both intrapersonal and interpersonal levels.

I collected in-depth, online questionnaire responses from 51 non-conventionally or non-hegemonically feminine, pregnant individuals or individuals who had previously given birth (See Target Population and Participant Eligibility for a more detailed explanation of this chosen population descriptor). The survey had four main sections. The first section, "Demographic and Background Information," (41 questions) collected various demographics (i.e., racial identity, income, age, etc.), including several inquiries specific to their gender identities and expressions. The second section focused on the participants' "Pregnancy and Birth Decisions and Experiences" (45 questions). The third section was primarily concerned with collecting data related to participant's "Medical Experiences" (42 questions). While most of this section focused on their pregnancy and birth-related medical experience(s), I also included a few inquiries about their attitudes/experiences toward medicine in general. The fourth and final section, "Final Thoughts" (11 questions), asked participants if they felt they could share their experiences adequately and included opportunities for the participant to provide feedback. In this section, I also asked participants if they might be interested in participating in a follow-up interview with me. See Appendix E for the full survey.

I designed my survey using the Qualtrics software platform, and I made it accessible to (eligible) respondents via a secure and unique survey link. I ultimately conducted paid, follow-up

interviews with eight (8) of my survey respondents. The lines of questioning in the interviews varied depending on my initial analyses of the interviewees' data; most often, I used the interviews to ask clarification questions and/or prompt the participant to provide additional context about their experiences. I also had the chance to confirm (or correct) some of my initial interpretations of their responses. I used a modified version of grounded theory methods (constructivist GTM; Bryant and Charmaz 2007; 2019, Charmaz 2006; 2017, Charmaz and Thornberg 2020) to analyze and report on the data. The Institutional Review Board at Georgia State University approved this research.

Qualitative methods are well-suited for exploratory research, and qualitative research paradigms greatly influenced my approach to data collection. However, I was also curious about creating and employing mixed methods techniques that could potentially utilize and showcase some of the pros of qualitative and quantitative methods that are usually juxtaposed as antithetical to each other. For example, my survey included a variety of question types, and I designed it to mirror an in-depth interview as much as possible. I asked some questions in a few different ways in both an attempt to glean identity information from a variety of angles and to prompt the respondent to potentially expand upon their answers. I also included small notes after some questions to clarify what I was asking of the participant, hoping not to influence but provide context for the questions. See **Figure 3.1** below for two examples (text in *italics*).

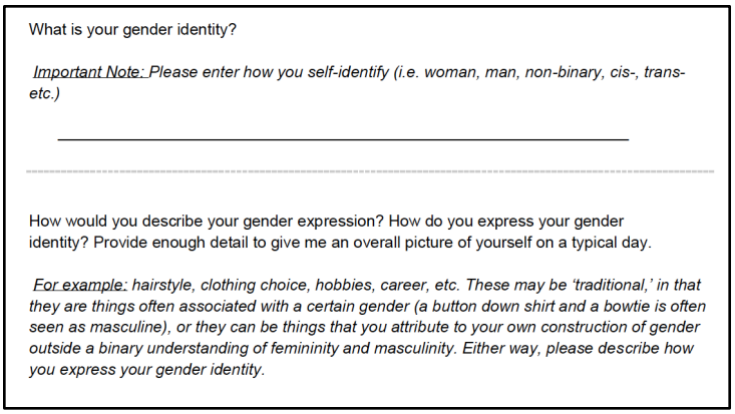


Figure 3.1 Examples of in-questionnaire participant guidance

I intentionally infused structural competency and cultural humility into my survey design. I posit that (1) restrictive and/or inaccurate gender, sex, and sexual orientation questions, whether the response options are binary or even a binary plus "Other, please specify": option at the end, for example, can be problematic for both research and research participants and (2) Data collection (including via survey) of the demographics mentioned above can be constructed and implemented in more reliable, valid, equitable, and inclusive manners that aren't necessarily too time constricting. To help mediate these issues, I drew upon best practices for collecting SOGI data (including their critiques) as an initial model; I included a larger sample of response options and opportunities for participants to self-identify, hopefully without feeling othered. I reframed the "Other" response option and moved it to the top of the list. See **Figure 3.2** on the next page to see an example of how I accomplished this goal.

We can't anticipate every possible reaction to our metrics, but we should be trauma-informed and mindful of how we communicate with research participants. Not only is this ethical because it can aid in the prevention of unintentional harm—particularly if scholars ask participants about potentially sensitive topics—but I believe it also can help the participant feel more comfortable. Participants may ultimately be more forthcoming in their responses as well.

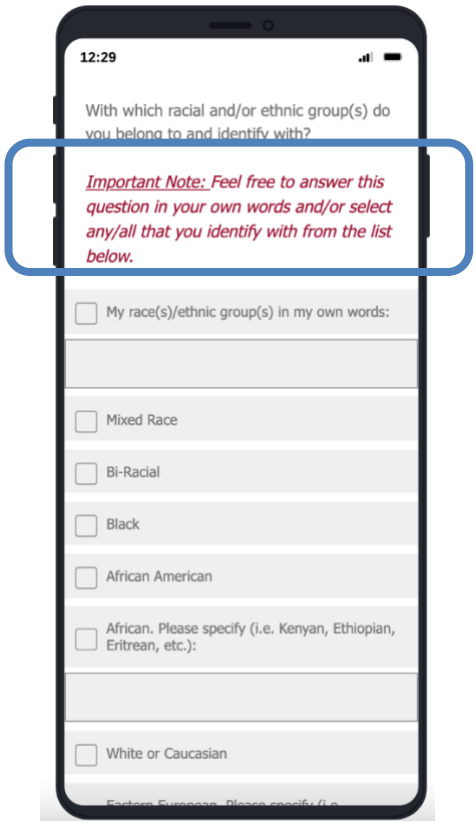


Figure 3.2 Reframing of other-style response option: "My identity in my own words"

My survey design not only allowed for rich, informative data but helped streamline some of the data collection without sacrificing the participants' voices and/or forcing them to choose from response options that may be too narrowly defined. I desired to be both topically and methodologically innovative with this project. Because gender and its variance are at the core of this study, in-depth and accurate operationalizing and measurement is already of great importance; this method I have created allows me an opportunity to test what I argue are potentially better modes of data collection for some of the variables mentioned above. I aimed to shed light on the measurement oversights associated with the standard and/or commonly used methods of sexual orientation and gender identity (SOGI) data collection and provide (and test) an example of how we can perhaps better measure these identities.

I implemented a four-part metric for gender to get a more robust picture of how the respondent interpreted and identified and so that I could understand what labels/identities/gendered language used meant to them. For example, say two respondents both identify as a lesbian. One may conflate their gender and sexual identity into that one term. To them, being a lesbian describes their gender *and* their sexual identity. The other may not attribute their sexual identity to their gender and/or how they express it at all. This context is essential. Similarly, I asked multiple questions regarding sex and sexuality/sexual orientation. See **Table 3.1** below for all SOGI and SOGI-related demographic questions.

Table 3.1 SOGI/SOGI-related demographic questions

Main Question	**Any additional, clarifying text**	**Question Type**
What is your gender identity?	Please enter how you self-identify (i.e., woman, man, non-binary, cis-, trans-, etc.)	Text entry
How would you describe your gender expression? How do you express your gender identity? Provide enough detail to give me an overall picture of yourself on a typical day.	For example: hairstyle, clothing choice, hobbies, career, etc. These may be 'traditional,' in that they are things often associated with a certain gender (a button-down shirt and a bowtie is often seen as masculine), or they can be things that you attribute to your own construction of gender outside a binary understanding of femininity and masculinity. Either way, please describe how you express your gender identity.	Text entry
How well do you feel the following words [masculine, androgynous; feminine; none of these describe me; other gendered descriptor not listed here. Please specify:] describe or identify you?	(Select any/all that apply to you at any given time)	Multiple choice, select any/all, text entry option for 'Other not listed'
Do you identify as trans or transgender, gender-non-conforming, genderqueer, gender-fluid, or non-binary?	(Select any/all that apply to you) Response options: 'Yes, ___' for each of the identities listed in the question; I don't know or I'm not sure; I identify with another term: ____; I do not	Multiple choice, select any/all, text entry option for 'Other not listed'

	identify with any of these; No, I identify as cisgender	
What is your sex?	Important Note: Please answer how you self-identify (i.e., male, female, intersex, etc.) Your answer does NOT have to match your legal sex or how you may have formally been categorized at birth.	Text entry
Does your current sex differ from your legal sex or your sex assigned at birth? *Yes; No: Prefer not to answer; Other, Please specify: ____*	Important Note: This question in no way intends to delegitimize your self-identified gender or sex categories. It is intended only to provide the research with context about your sex and gender identities, expressions, and experiences.	Multiple choice, text entry option for 'Other not listed'
Organ Inventory	See Appendix B	Multiple choice, select any/all
Gender Affirming Surgery Inventories	See Appendix B	Multiple choice, select any/all
With what sexual preferences, orientations, or identities do you identify?	Important Note: Please enter how you self-identify your sexual identity (i.e., heterosexual, straight, same-gender-loving, bisexual, queer, asexual, etc.)	Text entry
Do you consider yourself a member of the LGBTQ+ or LGBTQIAA+ community?	Response options: Strongly agree, Agree, Somewhat agree, neither agree nor disagree, Somewhat disagree, Disagree, Strongly disagree	Multiple choice

3.1 Target Population and participant Eligibility

One of the defining characteristics of my target population is that their gender identity and/or expression do not align with, or differ from, the dominant or expected gendered characteristics of a pregnant individual in the U.S. I have chosen my language carefully when describing my topic and the population I've recruited. Like gender norms, language is a product of the society in which we live, and there are few ways of describing gender that aren't either long and wordy or presumptive. Further, sometimes words used to describe a person or community intended to be all-encompassing and inclusive just aren't. Take the word "queer," for example. "Queer" is intentionally and inherently ambiguous and amorphous because it resists the

confines of schematic or categorical (particularly binary) organization. Queer has been/can be used pejoratively as well, particularly by outgroup members; thus, it is not uncommon for some middle-aged, and older generations of LGBT+ folx to find it offensive and refuse to adopt it into their current lexicon or as a personal identifier. However, other LGBTQ+ folx have decided to reclaim the word in an attempt to take power away from those trying to use it against them. Although not always, those identifying as queer tend to be younger (Cheves 2019 and Rocheleau 2019).

I describe below in detail who could be eligible for this study to illustrate the variety of gender identity possibilities rather than risk using potentially limiting language in recruitment (i.e., "pregnant women" or "queer pregnancies"). I also detail notable reactions to and interpretations of my chosen language in practice and how I managed those situations.

Eligible participants may or may not have identified with the label(s) "woman," "masculine woman," or "non-feminine woman," at all, but are, or have in the past, nonetheless, been capable of and chosen to engage in (or continue) pregnancy. Again, in shorter form, these were individuals who satisfy both of the following two requirements:

(1) Are currently pregnant and/or have given birth previously;

(2) do not (or did not at the time of their pregnancy/birth) typically ascribe to hegemonic or "traditional" constructions of "femininity" or "womanhood," or "motherhood."

3.2 Language in Practice

I chose to use "non-feminine" rather than "masculine" for two reasons. These descriptors are not dichotomous but rather are parts of a spectrum of gender expression. Secondly, I wish to refrain from describing aspects of gender and sex in ways that imply "feminine" and "masculine"

are discrete, opposite categories that, when done correctly, align with female and male identity, respectively (Halberstam, 1998).

After beginning outreach and data collection, a few instances did direct me to reconsider and/or adjust some of my language. First of all, I almost immediately abandoned using the wording "non-hegemonic" (i.e., in outreach). It's simply not a commonly used or understood word; in many ways, it's the epitome of academic language, which often serves to alienate non-academic individuals. The use of such language in practice is antithetical to my desire to be as accessible as possible in my scholarship. That being said, I often find myself in situations where the goal to be accessible, and the plan to be counter-hegemonic in my language (particularly when discussing gender, sex, and sexuality) are at odds. Because this is a dissertation (and thus inherently "academic"), I will use this as a platform to discuss these issues where relevant—and in this medium may resort to the use of some academic language where necessary, particularly if I feel there is no other way to convey the intended meaning). It is my hope, however, that these discussions will not remain solely in academic circles.

3.2.1 "Pregnant or formerly pregnant"

I had no way of knowing the circumstances (or the level of potential trauma) connected to my participant's state of being "formerly pregnant." I didn't want to potentially encourage folx who had gone through very painful miscarriages or terminations to relive that through a survey that likely only (at most) partially applied to them, depending on the nature of the prior pregnancy. Two of the individuals who fit the "formerly pregnant" criteria ultimately completed

the survey. I shifted from the use of "or previously pregnant" to "or have previously given birth" to help mediate this issue. [30]

3.2.2 "(Non-conventionally) feminine" VS. "(Non or not) conventionally feminine"

During my participant outreach efforts, twice[31] I received questions around my use of the phrase "non-conventionally feminine" arose. These inquiries requested clarification on the meaning and intent behind my language. These individuals were concerned I was referring (or that participants might think I was referring) to potential trans or nonbinary individuals as feminine and/or that trans or nonbinary individuals might think they were ineligible if they did not identify with the term "feminine." For example, one interpretation of this wording was that non-conventionally feminine meant that desired participants identified with femininity in some way, just not *conventionally*. As a result of that interpretation, my survey might appear less inclusive to trans/nonbinary folx who did *not* identify with "femininity."

One of these inquiries came from an LGBTQ+ health organization from which I was requesting study advertisement in its clinics. In a follow-up to my application, I explained that I intended it to mean non- (or not) conventionally feminine in the sense that however they identified their gender/gender expression, it *differed from* what one might consider "conventionally feminine." I intended the phrasing to include identification with "masculinity" or "androgyny," for example. It could have also included a connection to a personal definition of

[30] In my planning/proposal stages, I failed to realize that "pregnant or formerly pregnant" does not apply only to people who are currently pregnant *and/or* people who had previously given birth. It also includes individuals who may have gotten pregnant but had a miscarriage or chose to terminate the pregnancy. A few people who fit the "formerly pregnant" criteria helped me realize this problem within the screening questionnaire. I explained to these interested parties (who were otherwise eligible for my study) that this project did focus heavily on pregnancy and birth (and decisions to give birth, specifically) and that there would likely be large portions of the survey that did not apply to them as a result. I still provided them with a private link, but I explained that if they wanted to look through the survey (or only fill out what did apply to them), they were welcome to; however, I also strongly emphasized that they might want to reconsider their engagement, mainly if they experienced significant trauma or distress surrounding their former pregnancy.

[31] "Known" here reflects instances in which I had direct inquiries about this particular language.

femininity that diverged from mainstream constructions of femininity. In a way, I intended for the "non" to apply to both words, as I was not seeking individuals who were cisgender and "feminine" in a *traditional* or *conventional* sense. I provided similar explanations to both inquiries and also thanked them for their feedback. The health organization was satisfied with this response and subsequently approved my study to be advertised in their clinics for several weeks. I didn't receive a response regarding the other inquiry.

These experiences allowed me to see potential points of confusion or misinterpretation among those engaging with my outreach materials. I had not previously thought of these interpretations. My intent was for "non-conventionally feminine" and "not *conventionally feminine*" to be synonymous. I am curious as to whether the use of "not" instead of "non" would have prevented even this minor confusion. These experiences are also a reminder of the value of engaging the community you are studying at *every* stage of the research process.

The demographics of my sample show that my phrasing did not discourage all TGNC folx from participating in the study. It is possible this issue was mediated by where and how I posted my flyers online. I posted in as many TGNC-focused places that I could find and gain posting approval, including some specific to pregnant trans men. In an attempt to be clear about who I was looking for, I named various and known configurations of identities that would be eligible in each post. See Appendix A for my outreach materials.

3.2.3 "Pregnant women" or "Women who give birth" VS. "Pregnant individuals" or "People who give birth"

In response to the Reddit outreach I conducted in an online community for queer women of color[32], one Reddit user took issue with some of the wording that accompanied my flyer in my post. See Appendix C for an [anonymized, yet otherwise uncensored] screenshot of the interaction. The Reddit user took issue with my use of the wording "pregnant individuals." I used this wording in both (1) the title of the post and (2) a portion of text below my "flyer." See below:

> My name is Zoe (she/her/hers &/or they), and I am a queer graduate student currently working on my dissertation in sociology. My project focuses on gender, pregnancy, and health. More specifically, I aim to better understand (and celebrate) the diverse experiences of non-conventionally feminine individuals that engage in pregnancy and birth. I am striving to reach a racially diverse sample of non-conventionally feminine pregnant individuals for this study (queer_studies_grad 2020).

I received the following comment in response to my post:

> I understand your wish of inclusivity but using words like "pregnant individual" is not it. It contributes to female erasure. Please don't forget "pregnant women" when speaking about pregnancy. To say pregnant women, gender non confirming women and trans men is what inclusivity looks like. You're in a Women of colour Reddit after all so let's not erase the word "women" it's not an insult. Good luck with your research (Ok-Sympathy-5639 2020).

I formed my response with the hope and intention of exhibiting respect and understanding, particularly as a White woman who could be seen as invading their safe space. I also did not want to engage in any way that might be inappropriate for a scholar; however, I wanted to communicate at least that I heard them and their feedback. I chose not to remove the

[32] Reminder re. posting in subreddits: Per the rules of the subreddit, I was allowed to post there. Some subreddits do not allow any kind of recruitment, even for research purposes. I took every effort to follow all rules outlined by subreddit moderators. There were several subreddits from which I had to request permission prior to posting. Most subreddits requesting permission approved my post, however the r/pregnancy subreddit never got back to me and never approved my posting, despite the fact that they did not prohibit research opportunities.

wording "pregnant individuals." Still, I did adjust the last sentence of my post to include some of the commenter's proposed language[33]: "I am striving to reach a racially diverse sample of non-conventionally feminine pregnant individuals (*pregnant women, gender non-conforming women, trans men, to name a few*) for this study." A couple of additional comments ensued; a different Reddit user attributed the original commenter's opinion to trans exclusionary radical feminist (TERF) ideology and suggested I "ignore them."

Although the above instance is anecdotal, these comments do illustrate a genuine divide that exists and often breaks down solidarity in and among LGBTQ+, TGNC/TGE, and feminist circles. This divide is not exclusive to women of color, but I liken it to divides among White women and women of color. Just as some White women are not inclusive of women of color in their notions (and acts) of feminism, there are certainly cis-feminists who are trans-exclusionary. Similarly, however, not all White feminists exclude or aim to exclude women of color, and not all feminists concerned with the (linguistic) erasure of "women" are necessarily trans-exclusionary.

Unfortunately, it is often understandable for women of color or trans women of color, for example, to conclude that they are being left out of the conversation. They often are. This issue poses several questions and concerns about social justice efforts and how we can/should simultaneously, or at least equitably, center and represent the voices of oppressed groups *intersectionally*. Is it possible to speak broadly and intersectionally? If the presence of an identity is crucial to representation, which is vital to visibility and attention, can the absence of an identity ever be representative? Is representation despite the absence (explicit naming) of an

[33] The italicized text is what I added to the original post. With the exception of the, "to name a few," portion, I adopted the reddit-user's language in my edit.

identity only possible if we presume positive intent? Does presuming positive intent mask inequalities that should be challenged?

These questions are difficult to answer because hegemonic White supremacy, cis-normativity, heteronormativity, and patriarchal ideology and practice all have safeguards in place. Systems of power and oppression are sustained and reinforced by those in power and those they oppress. Scholars like Karl Marx and Audre Lorde have touched on this in their discussions of privilege, oppression, and liberation, albeit in somewhat different contexts (Marx [1867]1992; Lorde 1979, 1984). How can we overcome capitalism if the poor and working classes cannot agree on a common enemy (root cause) and unite against a capitalist economy? How can we dismantle systems of White supremacy or the cis-het-patriarchy if "the master's tools" are the only tools we've got (Lorde 1979)? I cannot answer all these questions thoroughly, and there is no simple or easily adopted practice we can employ to eliminate all of these issues. We can and should, however, continue to raise and communicate about these issues. We can and should continue to try to eliminate these issues. We can learn a great deal from those who have nonetheless resisted "the molds" just by existing within a world made for someone else, and when possible, by resisting the literal or figurative constraints placed upon us by our oppressors.

3.3 Data Collection

3.3.1 Recruitment and Sampling

I selected respondents via a mix of convenience sampling, snowball sampling, and voluntary response sampling. I shared the study links (eligibility link and online survey link)/how to access them (i.e., flyers) via my personal and professional contacts, including but not limited to university listservs, willing LGBTQ+ health centers and/or OBGYN offices,

community contacts, Facebook, Instagram, and Reddit. Reddit was where I had the most participant engagement.

I recruited participants from Reddit by posting in subreddits that I felt had the greatest potential of reaching eligible participants. I utilized several search terms to seek out relevant subgroup feeds (subreddits) such as: pregnancy, queer pregnancy, non-binary, trans, queer woman of color, lesbian, butch, lesbian pregnancy, butch pregnancy, queer families, non-conventional pregnancy, non-conventional families, and pregnant man/men. Pages that appeared as a result of some of the above searches helped me refine my searches for relevant subreddits further. For example, I ultimately found one subreddit called, "r/seahorsedads," which catered specifically to dad or man-identified individuals (i.e. or any folx not identifying as women) that were pregnant or had given birth. Several of my participants reached my study via that particular subreddit. I was also interested in reaching as many people as possible, so in some cases I sought to post in big identity category focused subreddits, like r/trans, r/lgbt, or r/nonbinary.

Whether or not I could share my study in a subreddit depended on their posted rules of engagement. Some subreddits do not allow any kind of recruitment, even for research purposes. I took every effort to follow all rules outlined by subreddit moderators. There were several subreddits from which I had to request permission prior to posting. Most subreddits requesting permission approved my post, however the r/pregnancy[34] subreddit I hoped to utilize due to their large membership (263k members) did not. Like See Appendix A for flyers.

3.3.2 Response Rates and Eligibility

I received 113 responses to my eligibility questionnaire (See Appendix D). Of those, 36 were immediately unable to proceed further due to having not provided me with an email

[34] This subreddit has since moved to a new page: r/babybumps.

address. I requested email addresses at this stage only so that I could send eligible participants a private survey link, as opposed to allowing anyone with access to the link the ability to fill out the survey. Of those, plus one individual who reached out to me about their eligibility via phone (N=78), 74 were deemed eligible to complete the survey. Of those eligible, 57 completed the survey. After my initial eligibility metrics described above, I determined whom to exclude due to residency based on three survey items. I asked respondents what state they lived in, which included an option to select, "I do not reside in the U.S."

I also asked if the U.S. was the respondent's country of origin. Lastly, I asked where else the respondent had lived, if anywhere. Per my IRB, I excluded respondents who selected "I do not reside in the U.S." *and* that the U.S. was *not* their country of origin. Further, I tentatively included any who did not currently live in the U.S. but were originally from the U.S., suggesting they had some exposure to gender socialization and/or medical care in the U.S. I clarified in the survey (under these questions) that if they weren't living in the U.S., but they were from the U.S./had lived for an extended period in the U.S. *and* had their pregnancy and/or birth (and associated medical care) in the U.S.—that they were eligible to participate. I also clarified that their eligibility would not be affected by one's citizenship or the circumstances surrounding their citizenship status. Of the 57 respondents who completed the survey, six (6) both lived outside the U.S. and had a country of origin other than the U.S. This narrowed down my final sample of respondents who completed my in-depth survey to 51.

Overall, I had a very low rate of ineligible responses. Although estimates certainly vary, according to Qualtrics, the average for survey response rates typically ranges from 20-30% (2021). If I include all respondents (to eligibility, N=113; and survey, N=57), my completion rate from step one (fill out eligibility questionnaire) to step two (fill out the survey) was 50%. My

completion rate, in terms of only those who completed the study (N=57) as a proportion of all those that advanced beyond the screening stage to receive a private survey link (N=74), my response rate increases to 77%. Lastly, for fully eligible (i.e., U.S.) survey-takers (N=51) as a proportion of those that received a private survey link (N=73), my completion rate was 69.9%.

Once deemed eligible, participants had the opportunity to receive up to, but no more than, three (3) emails from me: the first being their private survey link, and the second two being reminder emails. In the first reminder email, I explained that they would not receive additional contact from me after those reminder emails or after completion of the survey, should they decide to participate. These reminder emails played a significant role in participation; I largely attribute to them the reason for my high response rate. Most potential participants completed the survey after receiving the reminders. I had to send new links to some participants.[35]

At the end of the survey, I asked participants if they would like the opportunity to speak with me further (via phone/zoom). I had the good fortune of having follow-up interviews with 8 of my respondents. I paid six of them $15 for participating; two refused payment. Before the follow-up interviews, I conducted initial coding of participant survey data in order to begin identifying potential areas of inquiry to address when we spoke. This process also allowed me to incorporate (on a smaller and modified level) an essential component of grounded theory methodology: the ability to probe respondents and make adjustments as new issues emerge.

3.4 Data Analysis

I employed rigorous GTM procedures (a la Charmaz & Bryant) to analyze my qualitative data (Charmaz 2006, 2014, 2015, 2019; Bryant & Charmaz 2007, 2019). My modified-grounded

[35] The private survey were not set to (by default) expire until 30 days after they were created, however once a participant opened the link, effectively starting the survey, the link only remained valid for 7 days. There were a few participants who after receiving a reminder email, needed a new link for that reason.

theory approach differs from Glaser and Strauss' traditional definitions of GTM in that I did conduct a preliminary literature review before collecting and analyzing my data. Further, I used some existing theory (in addition to my original analyses) to develop my variables, concepts, and indicators (1967, LaRossa 2005). I aimed to implement a particular contemporary iteration of grounded theory, or as Charmaz describes it herself, a "constructivist grounded theory" (2014; 2016). In this form of grounded theory, Charmaz draws on and diverges from GT predecessors via:

> (1) assuming a relativist epistemology, (2) acknowledging your and your research participants multiple standpoints, roles, and realities, (3) adopting a reflexive stance toward your background, values, actions, situations, relationships with research participants, and representations of them, and (4) situating your research in the historical, social, and situational conditions of its production (Charmaz 2016: 299).

Bryant and Charmaz's SAGE Handbook of the current developments in grounded theory (2019) includes coding guidance for constructivist GTM (as well as others, i.e., traditional Glaserian, Standpoint Analyses, etc.) and is one of several publications I have used as a guide throughout my data analysis process (Mills, Bonner, and Francis 2006; Charmaz 2006, 2014, 2017; Priya 2019; Charmaz and Thornberg 2020).

3.4.1 Analysis Process and Data Analysis Software Used

All survey data were exported as a .CSV file from Qualtrics and promptly deidentified. I imported my data set into R and/or SPSS, depending on the type of analyses or manipulations I was doing. I kept on my physical computer only one data file that served as a key to connect my de-identified data to my participants' identities. I kept that file, in addition to my computer, password protected (with different passwords). Further, I took care to always operate my laptop on a secure network. Next, I performed initial and open coding of the data as dictated by my method. I analyzed my data by hand and/or via the qualitative data analysis software Atlas.ti. I

conducted all of my quantitative statistics in SPSS and/or R. I started my initial coding by hand (i.e., iPad) and then imported my initial coding of the survey data into Atlas.ti, where I continued my initial coding and subsequently performed my more focused coding efforts. I did this multiple times as I continued to obtain participants.

After completing the transcription of my first follow-up interview, I decided to employ a transcription service for the remainder of my interview audio files for the sake of time. To ensure that I maintained the privacy of my participants and so as not to lose the benefits of self-transcription entirely, I utilized a secure auto transcriber (Rev.com) to produce my transcriptions. This service allowed me to quickly receive a draft transcript of my audio file (not seen/heard by other human eyes/ears) within minutes. I then listened (at average or higher speed) to these files in their entirety to ensure their accuracy. Rev did not receive any identifiable information via the audio files I uploaded for auto-transcription. When conducting (and recording) the interviews, I took care that whenever possible, I did not include names/other identifying information in the audio recordings of the follow-up interviews (i.e., I hit 'record' after they verified their name for me).

3.4.2 De-Identification and Pseudonyms

Per my IRB and the assurances made to my participants, all of my data were de-identified immediately after each export from the Qualtrics platform. Each response to my survey was then assigned a Participant ID number. As such, I didn't have the opportunity to form connections between their (first) names and their data, including those with whom I had follow-up interviews. When choosing pseudonyms for my participants, I tried to consider important ethical concerns outlined in Lahman et al. (2015). While I did not offer participants (verbally or in writing) the opportunity to choose their own pseudonym, I also did not receive any requests to do so.

3.4.3 Participant Demographics

See **Table 3.2** below for a more detailed view of the selected demographics of the sample. As they are central to this project and my analysis, I present notable demographics not included in the below table (i.e., gender, sex) in the next section.

Table 3.2 Selected Demographic Characteristics

Characteristic *Category represented in the sample*	**Frequency**	**Percent**
Age, N=51*		
18-24	3	5.9
25-34	22	43.1
35-44	24	47.1
45-54	2	3.9
Education		
High School Grad / GED	5	9.8
Some college	3	5.9
Graduated from a 2- or 4-year college	16	31.4
Some graduate school	2	3.9
Graduated with an advanced degree of any kind	25	49
Annual Income		
Less than $15,000	2	3.9
$15,000-$34,999	6	11.8
$35,000-$54,999	5	9.8
$55,000-$74,999	8	15.7
$75,000-$94,999	10	19.6
$95,000- $124,999	9	17.7
$125,000-$154,999	2	3.9
$155,000 or more	9	17.7
Areas of Residence		
Rural (under 10k residents)	1	2
Town or city (approx. 10k-50k residents)	9	17.6
Suburbs of a city (with over 50k residents)	8	15.7
Central city/Major metropolitan area (over 50k residents)	32	32
Missing/Blank	1	2
Health Insured		
Yes	46	90.2
No	1	2
Missing/Blank	4	7.8
Yes	43	84.3
No	2	3.9
Does not apply	2	3.9

Missing/Blank	4	7.8
Child Status, N=85[†]		
Currently pregnant	12	14.1
Have previously given birth	28	32.9
Currently have or care for a child or children	33	38.8
Partner (or surrogate) is currently pregnant	1	1.2
In the process of adopting	1	1.2
Do not currently have or care for any children	4	4.7
Other	2	2.4
Missing/Blank	4	4.7

[*]N=51 unless otherwise specified
[†] Select any/all question; Participant N=51
[‡] Separate selections in the survey, combined here for brevity

Almost all my respondents (46) fall within two age brackets, with a combined range of 25-44. Recent data indicates that, on average, U.S. women have their first child around age 26; the same source shows the average age for men (to become a parent) is 31 (Stahl 2020). Sources agree that current mean ages align with a previously established trend of individuals in the U.S. waiting longer to have children (Livingston 2018, Bui and Miller 2018, Stahl 2020).

Overall, the sample is moderately to highly educated, with 31.4% having indicated they had graduated from a two- or four-year college and 48% having graduated with an advanced degree of any kind (i.e., M.A., M.S., Ph.D., M.D., J.D., etc.). My participants live in 21 states/territories of the U.S., spanning nearly every region of the country. I also allowed participants to share where else they've lived and whether or not the U.S. was their country of origin. These additional geographical demographics are helpful for multiple reasons, including but not limited to: further ascertaining residency-based eligibility (i.e., again, if someone had the U.S. as their country of origin and spent the majority of their life there up until after they gave birth, they would fit my eligibility criteria as a U.S. resident); I can also use this information to potentially identify additional geographical influence or representation (i.e., participant lists X state as their state of residence, but they recently moved across the country from Y state, where

they spent the previous 20 years). There were seven additional[36] states in which participants identified as having lived 10 or more years before their current state/territory of residence. See **Figure 3.4** below for a visualization of the geographic representation of my sample.

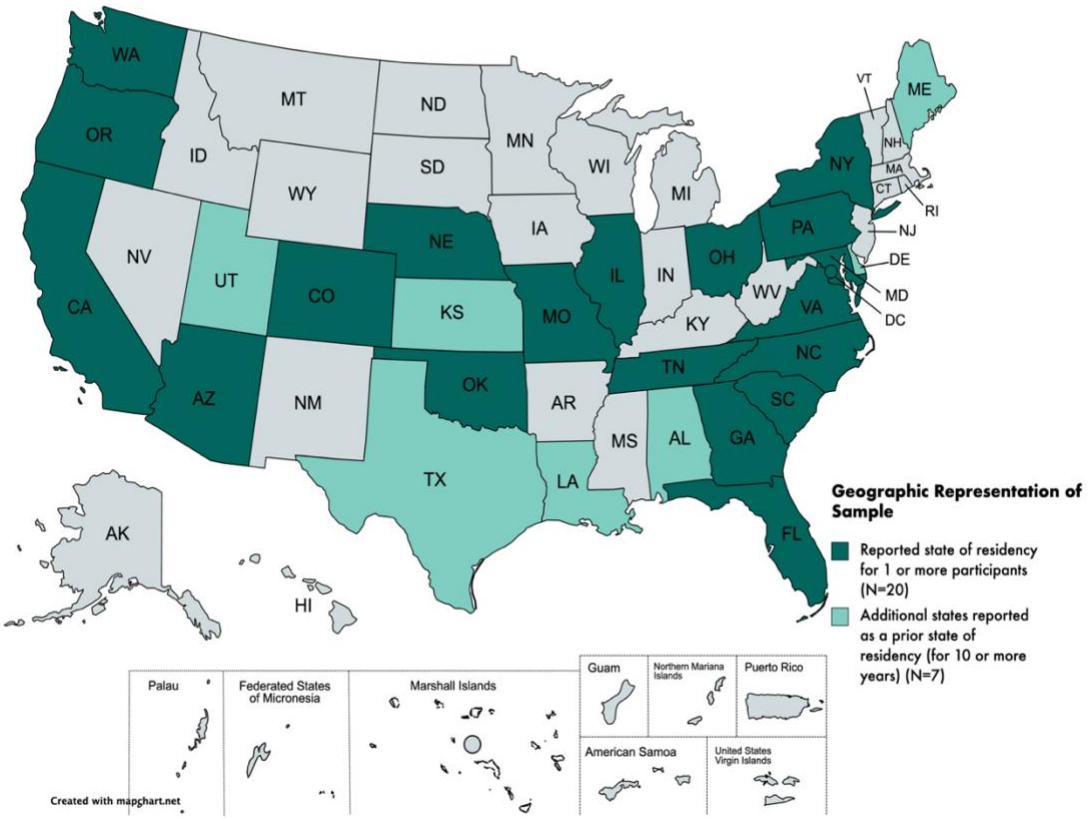


Figure 3.4 Geographic Representation of the Sample

The majority of respondents (31 of 50[37]) racially identified with "White or Caucasian." See **Table 3.3** below for the racial demographics of the sample. I chose to offer a robust number of racial and ethnic response options from which respondents could select (as well as the choice to select/any all that apply). As I began interpreting the data, I realized it would be tricky to

[36] Additional here means states that had not already been identified as a current state of residence by 1 or more participants. There were a few states in excess of the seven aforementioned where participants reported having spent 10 or more years.

[37] N=50 here because one respondent did not supply an answer to this question.

determine how best to represent the racial and ethnic makeup of my population. As oversimplified and limiting demographics can lead to misleading data and potentially ill-informed conclusions—placing *too* much emphasis on a participant's selection can sometimes have the same effect. For example, I had a few respondents who selected "White or Caucasian" and "Eastern European." These participants have been recorded on a separate line in my table illustrating racial and ethnic identity. I tried to remove the least amount of information necessary to maintain healthy levels of confidentiality in a small sample (N=50).

Table 3.3 Racial/Ethnic Identity Information of Sample (N=50)

Racial and/or Ethnic Identity(ies)			**N**	**%**
First Selection	*Second Selection and/or Answered Please Specify*	*"Please Specify" and/or Third Selection*	*Freq.*	*Percent*
Black			3	6%
✓[38]	Indigenous Peoples, AI, or AN[39]	✓	2	4%
Hispanic, Latinx, or Spanish origin	✓	✓[40]	1	2%
Mixed Race	White or Caucasian		1	2%
White or Caucasian			31	62%
White or Caucasian	European (incl: East, West, and EU)	✓	8	16%
White or Caucasian	Middle Eastern or Arab	✓	1	2%
White or Caucasian	Jewish	✓	2	4%
Missing/Left Blank			1	2%
Total			50	100%

[38] This check mark (✓) is intended to indicate these two participants share a selection of "Indigenous Peoples…," but do not share the other racial/ethnic category they selected. I redacted their other selections so as not to divide them further (for confidentiality purposes).

[39] AI = American Indian, AN = Alaska Native

[40] Someone counted in another section of this table also selected they identified with the "Hispanic, Latinx…" response option. I did not place them in a category of their own with all three of their response options due to confidentiality concerns. As a result, there is technically one exception to the mutual exclusivity of the categories in this table.

The majority of respondents (62.7%) were living in a central city or major metro area. The average household size of my population was 3.18, with an average number of children at 1.60. For those two averages, if a respondent was pregnant at the time of the survey, I added 1 to their total household number.

4 FINDINGS

The survey and interview data I collected offer a great deal of insight into the pregnancy and birth experiences of my sample of NCF individuals. The data provide an increased understanding of how they embody/ied pregnancy and birth and how they navigate(d) their medical systems and experiences. They also provide explicit, practical recommendations for how providers and medical institutions can improve their practices and thus how they can best serve these and similar sexual and gender minority (SGM) populations in the future. Because gender (and its measurement) is central to my research, I will first discuss the gender identity and expressions that make up my sample. Then, in the chapters that follow, I will outline and address the emergent themes I have discovered.

4.1 Gender and Sex

4.1.1 Gender Identity

In the "What is your gender identity?" question, within the text entries of participants, *nonbinary*, *woman*, and *trans*, were the individual words they included most frequently. Nearly half of the participants (N=23; 46%) included *nonbinary* in their gender identity response. Eight of those participants identified as exclusively *nonbinary* (or some other form of the term: non-binary, Non-binary, Nonbinary, etc.). The gender identities of the other 15 participants included *nonbinary* **and** one or more other words/descriptors/labels (i.e., nonbinary/agender, nonbinary trans, etc.). Fifteen participants included *woman* in their gender identity response (about half of which [8] used *woman* on its own). Other words used to describe the gender identities of my participants included *genderfluid*, *genderqueer*, *transmasculine*, *cis,* and *agender*, to name a few. See **Figure 4.1** for a frequency-based word cloud and **Table 4.1** below for frequencies of the gender identity terms used by my sample.

Figure 4.1 Word Cloud of Participant-Provided Gender Identity Terms

There are 39 discrete (case-sensitive) responses to "What is your gender identity?" in my sample. If I disregard spelling/capitalization differences between participants (i.e., if Nonbinary = non-binary or Woman = woman), I can narrow that figure down to 29. I could narrow them down significantly further depending on how one translates each respondent's use of commas, slashes, etc., in their response. Several participants typed in multiple descriptors/identities, some of which they delineated via commas (i.e., *nonbinary, genderqueer*) or slashes (i.e., *nonbinary/butch*); some separated identity words with conjunctions such as "and/&" or "or" (i.e., *nonbinary or agender*). Lastly, of those using multiple/a combination of words to describe their gender identity, some did so via a string of words that they did not separate with any punctuation (i.e., *nonbinary trans man*). User-entered text cannot always be directly translated into neat categories. Arguably, people tend to understand that; however, what can we glean from *how* participants characterized their gender identity when asked to do so via text? Should someone

who answered *nonbinary* and someone who answered *nonbinary/agender* be in the same category? For the latter, does that text response equate to selecting *nonbinary* **and** *agender* from a list where you can select any/all that apply? Does *nonbinary* on its own not fully describe their gender identity? Or were they just including any/all terms with which they're comfortable? In the future, the answers to these questions could be decided in advance and included in the instructions. These considerations provide essential context for interpreting **Table 4.1**, where I represent the gender identities of my sample.

Table 4.1 Words Used by Participants to Describe Gender Identity

Gender ID word(s)	**Total Freq.**	**Freq.** Gender ID *= as listed*	**Freq.** Gender ID = *word(s) from 1st Column + add'nl words or descriptors*		
(not case-or-space-sensitive) These are not all mutually exclusive; some of the words in this list may coexist/be reflected in another column	# Participant Gender ID responses including word(s) from 1st/leftmost column	Reported Gender ID *consists only of word(s) from 1st column*	Gender ID = *word(s) from 1st Column + [**comma, 'and'**] + one or more other word(s)*	Gender ID = *word(s) from 1st Column + [**slash / 'or'**] + one or more other word(s)*	Gender ID = *string of word(s) or sentence; separated only by spaces; no / and or ,*
Nonbinary	24	9	3	6	6
Trans man	9	4	1	1	3
Woman	15	8	1	3	3
Genderqueer	6	3	2	1	
Genderfluid	2	1	1		
Agender	5	1		4	
Female	2	1		1	
Boi	1	1			
Transmasculine	5		2		3
Cis	3		1		2
Neutrois	1				1
Two-spirit	1		1		
Masculine	1			1	
Butch	2			2	
Tomboy	1			1	
Funny sort of woman	1			1	
Reluctant woman?	1				1

The below image, **Figure 4.2**, is a cumulative representation[41] of my participants' responses to my question specific to TGNC Identities, "Do you identify as trans or transgender, gender-non-conforming, genderqueer, gender-fluid, or non-binary? (Select any/all that apply to you)." I included this question (in addition to asking for my participants to share their gender identities in their own words) to understand how existing gender terminology does or does not "fit" within my participants' discourse around their gender identities. I will discuss the related implications and potential practical applications further in later sections.

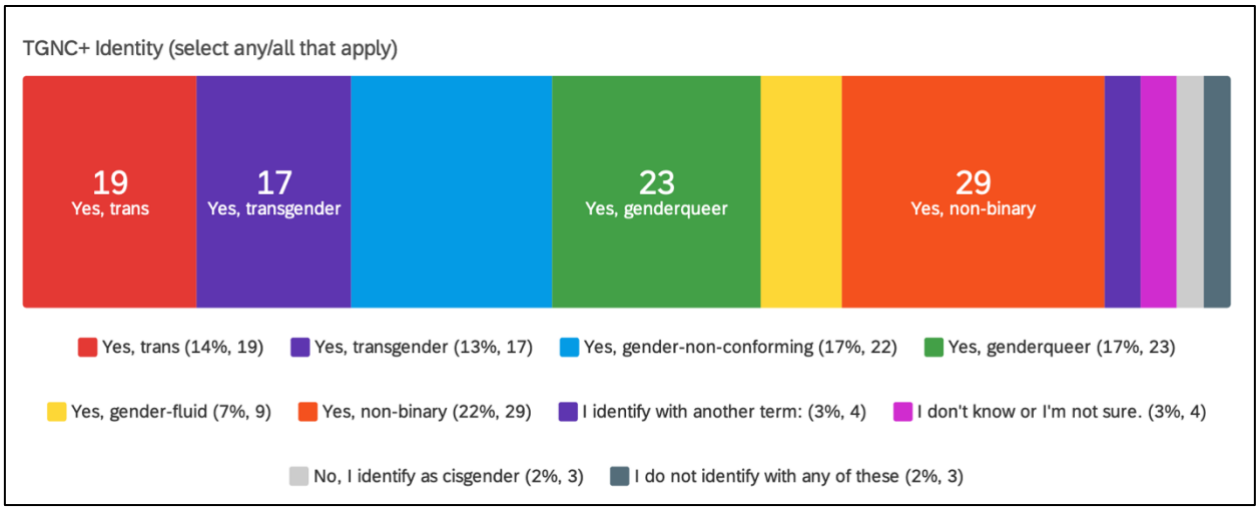


Figure 4.2 Participants' Responses re. TGNC Identity

4.1.2 Gender Expression

I also asked survey-takers to describe, in their own words, their gender expression or how they outwardly express their gender. These responses varied in length and in detail. Many of my respondents included in this description their hairstyle/length and what kinds of clothing they would typically wear. Commonly worn clothing included jeans, t-shirts, and button-down shirts. Many described their style as masculine, gender-neutral, and/or androgynous. Several portrayed

[41] These values are not mutually exclusive. They represent any/all participants that selected each category. For example, a participant may have selected both "Yes, trans" and "Yes, non-binary."

their expression by sharing they often wore men's clothes or "clothes that fit traditionally masculine bodies" (*Sam, any w/respect*). Some participants described their gender expression as more fluid, including both femme items as well as more androgynous or masculine styles. Several participants discussed the absence of makeup, or at least very little makeup, and not wearing jewelry (or not wearing any other than their wedding ring) in their responses. A couple of participants described how they wore more typically masculine clothes but felt their curvy bodies made them look less masculine.

Ten participants said they didn't explicitly think about gender but about "what felt right." Often though, "what felt right" for those participants were items on the less feminine and more masculine ends of the spectrum. Similarly, five participants shared that in their minds, they prioritized utility and comfort over gender in their clothing choices (i.e., having pockets, freedom of movement, etc.). There was definitely some overlap though—between comfort and utility focused participants and those focusing on "what felt right." For example, when describing their gender expression, one of my participants shared, "Very occasionally a dress, which I feel out of place in but have been trying to build comfort with because it's easy – no coordination of outfit needed to be seen as professional" (*Casey, she/they/any with respect*). In this situation Casey is stuck betwixt a desire for ease and efficiency (particularly in professional wear) and what "feels right" in terms of who they are and how they express their gender. In this scenario, Casey's solution is to try and increase their comfort with (and tolerance of) wearing dresses. Unfortunately, there is little alternative. Utility is rarely a priority in women's clothing designs; for example, multiple participants allude to the everyday struggle of women's clothes often lacking pockets (or at least pockets big enough to hold more than a key or a few coins). Further, *comfort* could take on two different meanings for participants; sometimes it was used to describe

explicit physical comfort (i.e. "comfortable shoes"); other times it was used to represent a more mental or emotional (and less tangible) form of comfort (i.e. "in spaces where I'm comfortable"). These clear preferences for comfort and what "feels right" are also present in later/additional responses, particularly when participants talked about what they wore/would wear during their pregnancy/ies.

Similarly, multiple respondents talked about how they were typically "read" by others in their gender expression responses. A couple of others included that they bind their chests; some mentioned that while they didn't bind, they made efforts to downplay the presence of their breasts/chests. Some of my participants distinguished between sports bras and non-sports bras, or "regular" bras. Some of my participants indicated they had previously had gender affirming top surgery.

4.1.3 Gendered Descriptors

As a supplement to the other responses about their gender, I also provided participants with a list of words commonly used to describe gender. I asked them to select any/all that they use/would use to describe themselves. They also had the option to write in any descriptors they used that I had not listed. They could choose from the following: "androgynous," 'feminine," "masculine," "none of these describe me," and 'other gendered descriptor not listed here (please specify: ____)." While my target audience was "non-conventionally-feminine" individuals, that does not necessarily rule out the possibility for potential participants to use this descriptor. Conceptualizing gender as fluid or on a spectrum, rather than a discrete binary, does not necessarily place masculinity and femininity at odds with or mutually exclusive of each other. An individual can identify as feminine at any given time and still be *non-conventionally* feminine. The vast majority of individuals who selected "feminine" (N=12, 13%) also picked

"Masculine" and/or "Androgynous." Further, five of the respondents that selected "feminine" also selected, "Other gendered descriptor not listed here…," thus contributing half of the additional gendered descriptors submitted by participants.

Participants submitted the following additional words/phrases they used to describe themselves (N=9, 9.8%): "I'm a little bit of everything," "masculine of center," "butch," "masculine-lite," "queer," "tomboy," "femme," "masc femme," "femby," "femboy," "enboi," "sporty – athletic," and "neutral." Of all possible selections/submissions, those most commonly selected were "androgynous" (N=33, 37%) and "masculine" (N=26, 29%), respectively. In tandem with how respondents identified their genders and described their gender expressions, these results provide additional evidence for how a binary understanding (and implementation) of gender is insufficient.

4.1.4 Sex

As mentioned previously, I also asked my participants to give the sex category with which they self-identify. In other words, I was not explicitly looking for their "legal sex" here (unless their legal sex and self-id sex happened to be the same). Just over half of my sample (N=27, 53%) identified their sex as exclusively and explicitly *Female*, *female*, or *AFAB*, which stands for Assigned Female at Birth. Seven (N=7, 14%) of my participants identified their sex as *male*, *Male*, or *man*. Including one participant who responded, *I identify as a non-binary person with a female reproductive system*, there were several individuals (N=7, 14%) who identified their sex with language representing one or more categories not limited to a male/female binary—such as: *X*, *Non-binary*, and/or *Intersex*. An individual identifying their sex as *X* had stated that their sex was what was listed on their driver's license—which was X. This individual lives in one of the few states that recently began allowing a non-binary/third sex category option

to appear on state identification/ driver's licenses. In their case, their non-(male/female)-binary sex category is not solely one of self-identity, but is also affirmed by the state within which they live. Affirmation of non-binary gender on behalf of the state is uncommon in the U.S.

One individual stated, *Unknown*, another, *I don't know*, and a third took it a little further, offering up, *I don't know, and that's okay*. (Yes, it is!) Lastly, except for one participant stating, *I prefer not to identify as a particular sex*, the remaining five (5) participants provided varied responses about where/how they felt they'd place themselves on a sex category spectrum of maleness and femaleness. For example, one of my participants shared:

> Female 85% but about 15% of the time I relate to my bodily experiences and sex organs as biologically male

Another described their sex as:

> Somewhere between male and female. I do not consider myself intersex as my biological androgyny is related to medical transition and not my original biology.

These five participants responses clearly differ from a standard binary response of "male" or "female." Sometimes a distinction between anatomy and identity is important in medicine, (i.e. preventive screenings), however how these individuals view and/or relate to their body and "sex" is important, regardless of whether or not it fits nicely into one of two one-word categories. While differing qualitatively and quantitatively from a M/F binary mode of categorization, I believe their responses, at least in part, are perhaps lengthier and more descriptive in this context than they might be in others.

4.1.5 Sexuality and LGBTQ+ Identity

As illustrated by **Figure 4.3** below, almost all of my participants (47 out of 51) agreed (to some degree) that they identified as members of the LGBTQ+ community. As the acronym includes gender and sexual identities, it is not a mutually exclusive measure of sexuality. By

comparing the below data with the data from the open-ended gender identity and sexual identity questions, I can further unpack their group membership. Of the 11 participants who identified as a "woman," "female," or "cis woman" (i.e., seemingly not trans*), none identified as "straight" or "heterosexual." Similarly, of the small group that identified as "heterosexual," none identified as "cis," "cisgender," or other terms commonly associated with those who do *not* claim identities under the trans umbrella. Therefore, all of my participants hold at least one sexual or gender minority identity, and the majority hold at least two (gender *and* sexuality).

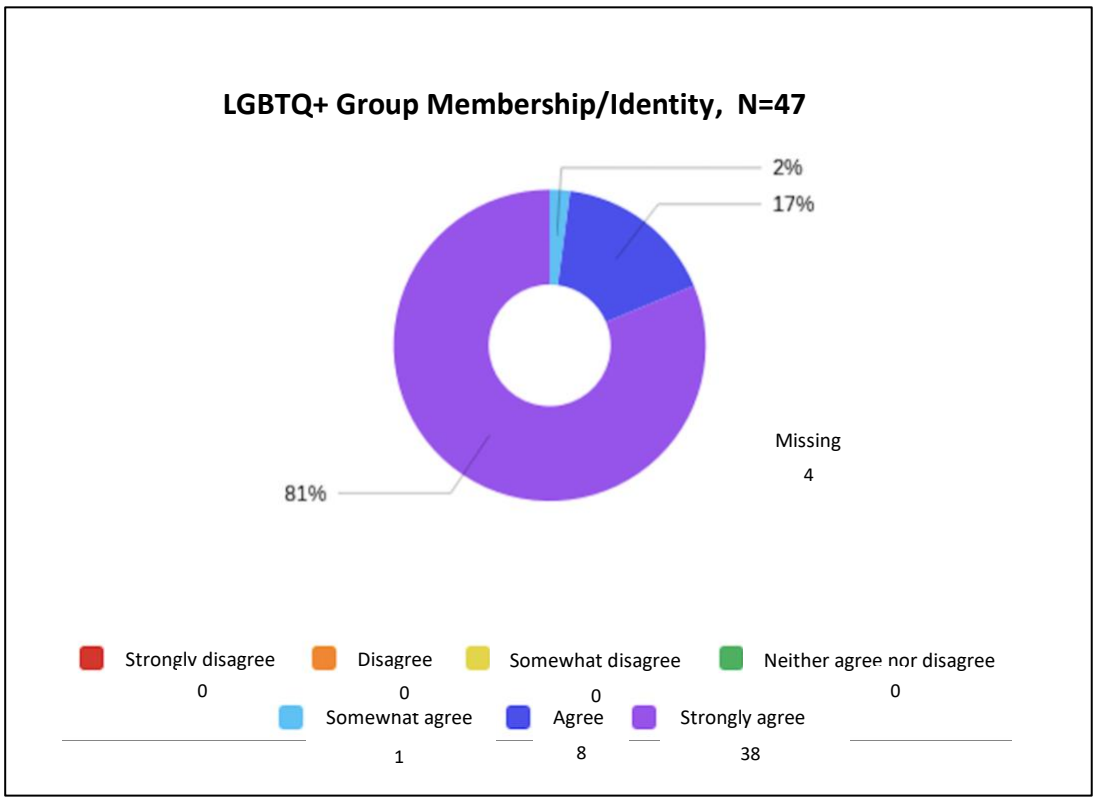


Figure 4.3 "Do you identify with the LGBTQ+ or LGBTQIAA+ communities/acronym?

4.1.6 Gender, Sex, and Pregnancy

While I asked respondents about their feelings and decisions related to pregnancy, I intended to focus primarily on previously pregnant individuals who ultimately gave birth and/or those who were currently pregnant. As I mentioned in an earlier section, I did offer the

opportunity to fill out my survey to several participants who were previously but no longer pregnant due to my initial use of the language, "or previously pregnant" instead of "or have previously given birth." Although most chose not to, there were two who did. I otherwise focused on the pregnancy and birth experiences of individuals who had previously given birth or were actively pregnant and intended to give birth (instead of folx who had only thought about what they would do in these situations).

While I do not have enough data to run any regressions or other predictive statistical analyses, I was able to see some interesting results from some crosstabulations. While I do not have enough data to assess the significance of the crosstabs or associated correlations correctly, they could perhaps be indicating an area of further study. Because I aimed for any NCF respondents (i.e., cis, trans, etc.) I was able to see some areas of difference among those who had or wanted gender-affirming surgery (N=21) and those who had not, nor planned to (N=23). It seemed as if those who had undergone gender-affirming surgery and/or claimed they wanted to, were slightly more likely to agree that pregnancy did not fit their gender than those who had no plans/desire to undergo gender-affirming surgery. Those who had no plans to undergo gender-affirming surgery were more evenly divided in their agreement/disagreement about pregnancy not "fitting" their gender. See **Figure 4.4** below for a visual representation of this finding.

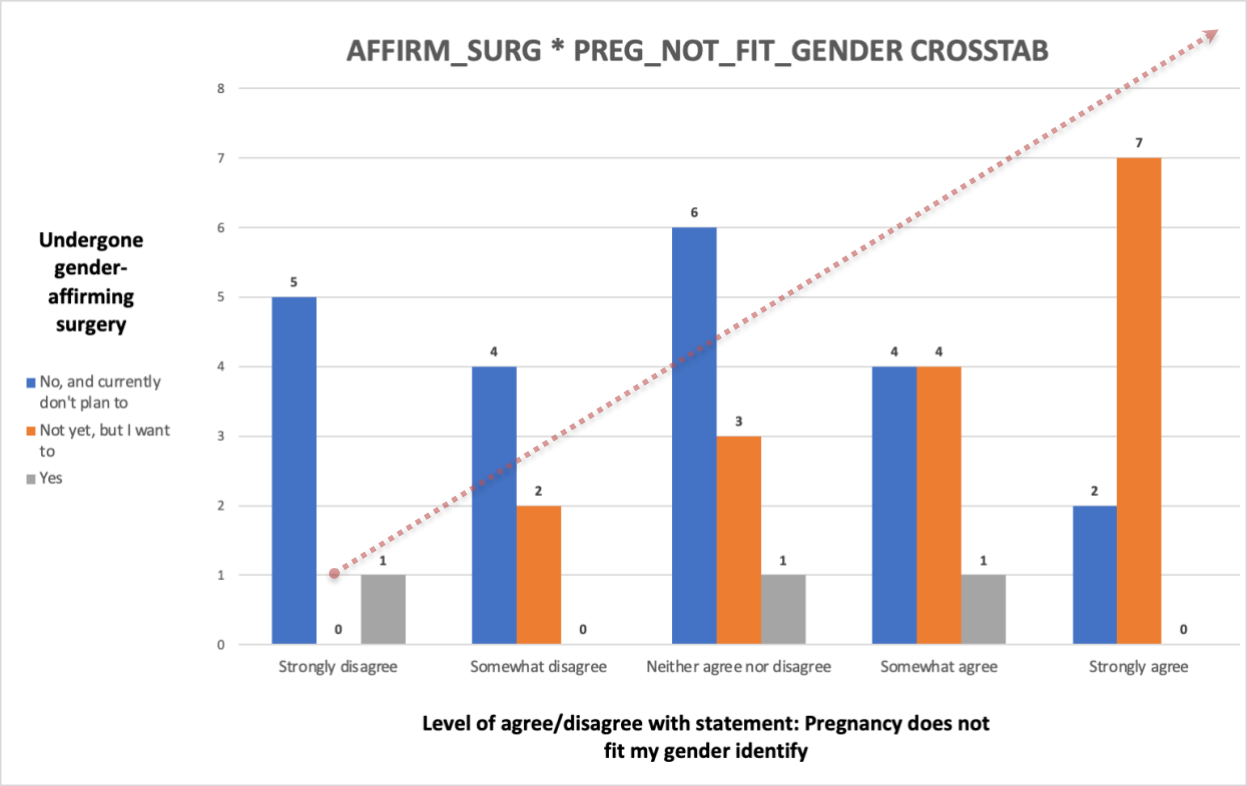


Figure 4.4 Crosstab: Gender-Affirming Surgery by Pregnancy Not Fitting Gender

This particular subset of data isn't large enough to do more than speculate, but future research could and should explore this potential connection further. That being said, I suggest the possibility of an important distinction between groups of NCF individuals that go through pregnancy/birth. This distribution could be illustrating both the spectrum of diversity that exists in gender and sex as well as the ways in which individuals manage the relationship between those two aspects of themselves/their bodies (and gender hegemony). These data, which I expand upon below, could also potentially support and expand upon what limited research does exist specifically on transgender men experiencing pregnancy, per a recent (2020) narrative literature review by Besse, Lampe, and Mann.

For some it appears that femininity, femaleness, or womanliness is more strongly connected to specific parts of the gendered physical body (i.e., sexual and reproductive organs),

and the anatomical ability of pregnancy and birth are reminders of how their bodies are perhaps not gendered (or sexed) in a way that fulfills their self-identity (i.e., "feels right" or physically represents their true self). This seems a possible interpretation for those who want gender affirming surgery in the future. For example, several participants indicated in their survey responses that surgery was something they were only delaying until they were done having their child or children.

Among those who did not want or plan to have gender affirming surgery in the future, some felt pregnancy fit their gender to some extent, while others did not. I will first discuss those whose NCF gender expression *didn't include* a feeling that being pregnant didn't fit their gender. These individuals didn't feel their bodies were contradictory to being pregnant or being a woman, for example; rather, the ways in which they felt about their gender and/or how they expressed their gender simply did not align with conventionally feminine interpretations of looking or dressing "like a woman." For example, one of my participants, Leah (she/hers), said "being pregnant really helped separate for me my feelings about sex and gender even though I still identify as female." Leah identifies as a cisgender (female) woman. She uses the gendered descriptor "masculine-lite," and describes her gender expression as "dapper." She wears her hair short and her typical dress includes items like "men's" button downs, dress slacks, vest, and dress shoes. She is comfortable in her female body, including the ways in which it changed during her pregnancy, and has no plans/desire to obtain gender-affirming surgery. Leah's pregnancy experience helped her understand how gender and sex differed for her and how (her gender and sex) fit within her pregnancy in a noncontradictory way; her being female, a woman, and a mom isn't dependent on wearing "women's" clothing or expressing her gender in feminine ways. Other NCF individuals who did not want gender affirming surgery and disagreed about

pregnancy not fitting their gender didn't necessarily all identify as women but didn't seem to have the same strength of association between the physicality of reproduction (and sexual or reproductive organs) and femininity that those desiring surgery seemed more likely to have. While pregnancy and reproduction may currently require anatomy that is conventionally referred to as "female," the gendered associations of femininity and womanliness need not apply. If individuals who aren't feminine and/or women can and do engage in reproduction and pregnancy, then arguably reproduction and pregnancy aren't (or aren't *only*) strictly feminine or inherently womanly. Engaging in pregnancy and birth doesn't make someone a woman, and it doesn't have to make someone feminine. Taking that a step further, pregnancy can, in fact, be non-binary, or as some of Ryan's participants voiced, reframed as masculine, and as fitting within a masculine gender identity (2013).

While how an individual can choose to view (or reframe) something can help them be resilient in the face of adversity, it doesn't necessarily change how they are viewed and treated by others who live and operate within a hegemonic framework of gender. Further, it is important to acknowledge that it is arguably not femininity that is the problem, but rather the meanings and inequitable treatment associated with being feminine, female, and/or womanly. Problematizing femininity does not dismantle or deactivate hegemonic masculinity's power and control. Whether meanings are shifted so that pregnancy is no longer seen as "inherently feminine," or femininity is removed as a barrier to the successful performance or embodiment of masculinity, institutions and staff must nonetheless (re)consider how best to provide medical services to non-binary bodies and identities.

4.2 "I worked hard to get pregnant!"

The level of planning required to become pregnant varied/s among my participants; depending on the reproductive capabilities of those involved, unintended or unplanned pregnancy (as a result of consensual sex) was possible for some of my respondents. Similarly, and contrary to popular belief, there are significant public health data that suggest LGBTQ+ youth, for example, have a disproportionate rate of teen pregnancy in the U.S. (URGE 2021, Planned Parenthood 2021; 2015). LGBTQ+ inclusive scholars and practitioners attribute this to a lack of comprehensive *and inclusive* sexual health education in the U.S., as well as an assumption that LGBTQ+ youth do not need this information because "same-sex couples can't accidentally get pregnant" (Planned Parenthood 2015). Like the wealth of evidence that says abstinence-only sex education is not an effective prevention tool (Santelli et al 2006; Advocates for Youth 2007; Kantor et al 2008; ACLU 2008; Stanger-Hall and Hall 2011; Santelli et al 2017; Planned Parenthood 2021), a lack of knowledge about sex, as well as policies preventing or limiting sex education efforts, are all factors that contribute to higher rates of unintended pregnancy and the spread of sexually transmitted infections (STIs), even among LGBTQ+ youth. I mention this because it is interesting how the belief that "same-sex couples can't accidentally get pregnant" can, in one context, contribute to adverse public health outcomes for LGBTQ+ youth. Yet, in a surgical context, an unwillingness to use such evidence can simultaneously undermine a client's credibility and limit their autonomy.

Considering the significant rates of sexual violence in the U.S. and that SGM populations can be disproportionately affected (CDC 2010, NSVRC and PCAR 2012, Dastagir 2018), I also wanted to be mindful of the possibility that while someone may have chosen to continue a pregnancy, it didn't necessarily mean they autonomously decided to become pregnant or that the

sex resulting in pregnancy was consensual. While I was not actively recruiting individuals whose pregnancies resulted from sexual violence, I wanted my survey to reflect the possibility and approach the subject respectfully. What a survivor decides after experiencing sexual violence (including when it results in pregnancy) is a very personal decision. Who they share that experience with is also personal. While I did include a question about whether or not respondents chose to become pregnant, I provided participants with a trigger warning (TW) and a brief explanation as to why the warning appeared. At that point, they could consent to see (and if they wanted, answer) two additional questions about the circumstances of their pregnancy; or they could choose to skip the questions and continue with the rest of the survey.

Almost all (44 out of 51) of my participants made an explicit choice to get pregnant before actually becoming/being pregnant. Three participants selected "No," that they did not choose to get pregnant, however one of the three clarified that while they did not explicitly choose it, the sex that led up to it was consensual. The other two are victims/survivors of interpersonal violence that included rape and resulted in pregnancy; both of these participants ultimately chose to terminate their pregnancies.[42] The remaining four participations either skipped the question or left it blank.

While many cis-hetero (passing)[43] individuals also *decide* to "get pregnant" prior to *actively trying*, I would argue it is around that point when their reproductive journey diverges

[42] These are two (aforementioned) participants who participated early on in the course of the study, when I was still using the "previously pregnant" language; I subsequently switched to the language "have previously given birth" in my outreach efforts. I am extremely grateful to these two folx for their willingness to share their experiences with me. Their responses were extremely illuminating and in many ways in line with the experiences of my other participants. I do, however, hope to conduct future research that focuses more specifically on pregnancy experiences like theirs.

[43] I use this phrasing because while a partnership may seemingly consist of a cis-man and a cis-woman, it doesn't necessarily mean they both identify as straight or heterosexual. One or more partners could identify as bisexual, pansexual, or another orientation, but are simply partnered (or appear to be partnered) with an oppositely sexed individual. It is not uncommon for bisexual individuals' identities, for example, to be rendered invisible due to the appearance of being in a "straight" relationship.

from that of most non- (cis-hetero [passing]) individuals. For many of my participants, this was because they and their partner(s) could not become pregnant without first obtaining sperm and/or various assisted reproductive methods. Some needed just the former, some required the latter, and others needed both.

My survey did not include questions that directly inquired about *how* my participants became pregnant; however, many of my respondents offered up this information as a part of their responses to other questions. At least 21 of my participants used assisted reproductive technology (i.e., IUI, IVF). Several others used a sperm donor, or, as one of my participants stated, they already "had the equipment to have [their] own baby" (*Elijah, he*). I feel it is important to touch on these differences because they create an opportunity for substantial inequity in terms of access.

Despite a longstanding myth that LGBTQ+ individuals are affluent, they are more likely to be poor than wealthy (Morash 2018). Compared to 17% of non-LGBT people living alone, 21% of LGBT people have annual incomes under $12,000. It is even worse for single LGBT adults with children, who are three (3) times more likely than single straight parents to have near poverty-level incomes (Heintz 2016; Center for American Progress [CAP] and Movement Advancement Project [MAP] 2014). It's also worse for Black and Latina women compared to White women in same-sex couples: Black women are three (3) times more likely, and Latina women are twice as likely, to be poor than White women in same-sex couples (Yochim 2020; CAP and MAP 2015).

Assisted Reproductive Technology (ART) is expensive, with in vitro fertilization (IVF) often being the costliest; it can cost tens of thousands of dollars, with or without leading to a successful birth. Families often have to pay for it out of pocket (O'Brien 2018). Many couples

try to exhaust less expensive (but still costly) options such as intrauterine insemination (IUI) before resorting to IVF. These services are often not covered by public or private insurance. According to one of my participants, insurance coverage still only did so much:

> Assisted reproduction, even with insurance based out of [redacted] state (mandated to cover infertility), was expensive (co-pays and sperm, etc.). My wife's employment provided the insurance as well as the paychecks that paid for the babymaking… (*Everett, they/any w/respect*)

Everett needed and used their partner's take-home pay (*in addition* to their partner's employer-provided health insurance) to pay for their process of getting pregnant. Arguably, most couples do not have significant portions of their salaries to devote solely to family building, especially if it is an income (or even the only income) on which they rely. Several of my participants remarked on the expense of these services and various hurdles they faced:

> It was a challenge finding a[n] OB/GYN after I was released from the fertility clinic. One wanted $1.7K upfront before seeing me. The OB/GYN I settled on worked with me on payment during my insurance gap. (*Kay, she*)

> We were in grad school when we had our child and were living on modest stipends, but at least we had health insurance through our teaching assistantships. We have wanted to have a second child, but until this year, we lacked the money to do so. We are drowning in debt. (*Elijah, he*)

> My decision to begin trying to conceive coincided with the start of my first professional job with benefits. It was the first time I felt financially stable enough to support a child. If I hadn't had that opportunity, I might have just decided family wasn't an option for me. Starting a family meant quitting that first dream job to become a stay at home parent, which was a painful decision to make, but the cost of childcare allowed me no other option. (*Ellis, he/they*)

> Class played a significant role in the process of getting pregnant. We used a fertility clinic, and paid for donor sperm, and none of it was covered by insurance. We borrowed/were gifted a significant sum of money from my parents, and also refinanced our house in order to afford the treatment. We would not have been able to engage in pregnancy without our relatively privileged status. (*Bailey, she*)

Similarly, participants, when applicable, often acknowledged their class privilege as it related to ART access and other pregnancy/birth-related costs:

> I am extremely privileged as my partner works at the hospital I gave birth in. Our insurance paid for the entirety of the birth and we only had to come out of pocket for very miniscule amounts (*Alex, he/they*).

> We are extremely fortunate to have insurance that covers, though with a lifetime limit, infertility. Purchasing sperm was expensive and the out of pocket costs really add up. That being said, our economic situation was extremely fortunate because we didn't have to resort to IVF which adds up so fast (*Eva, she*).

> Class definitely played a role in our access to fertility treatments. We are firmly middle class with good insurance. The clinic kind of glossed over the financials discussion with us. Which is unusual considering IVF is the most expensive fertility option (*Kay, she*).

Although there is quite a bit of variation in insurance coverage, almost all of my participants had some form of insurance at the time of the survey (N=46 [out of 47 who answered the question about insurance], 98%) *and* at the time of their pregnancy/birth (N=45 [out of 47], 92%). The most common type of insurance held by my participants was through "preferred provider organizations (PPOs)" (N=14). The following most common form of insurance was a three-way tie between "Health maintenance organizations (HMOs)," "I'm on my partner's insurance," or another type of insurance not listed, such as Medicaid or through the VA (N=6 for each).

Based on the Federal Poverty Guidelines (2021) and the relevant information provided by my participants, I concluded that seven (7) of my participants were at or near the federal poverty level (FPL), and one (1) was below 185% of the FPL. This value (185%) is one of a few values (i.e., 125%, 150%, 185%) used to assess eligibility for assistance by some government agencies; the number of my participants falling below rose to six (6). While the FPL guidelines are arguably unrealistic in terms of how many families in the U.S. are suffering financially, most of

the rest of my participants reported incomes well above the FPL guidelines for their household sizes.

While some of my participants' identities (i.e. race, class, education level) offered them certain access and/or privileges, it is important to note that those identities did not typically provide enough additional leverage to completely avoid inequitable, prejudicial, and/or discriminatory medical interactions. It is also important to keep in mind that while my participants all ultimately got pregnant (a planned and explicit goal for almost all of them), there are still significant non-financial barriers for transgender folx needing ART. Prejudice and discrimination in reproduction-related services and/or child placement is by no means eradicated for same-sex folx, however some of the cultural and policy-related barriers of previous decades have been alleviated, making it at least somewhat more accessible and acceptable for them to build families these days. It is not yet quite as accessible for transgender folx needing ART-related services. Many ART programs are still reticent to assist trans clients (ASRM 2021). Additionally, not all trans clients are adequately counseled on fertility preservation options prior to their engagement in medically assisted transition procedures. Families and providers have expressed discomfort around this issue, particularly in situations where the individual who is undergoing medical transition is under the age of 18 (ASRM 2021). This concern has been raised in other areas of medicine as well, such as in the treatment of pediatric cancer. Likely due to taboos around the exposure of minors to sexuality and reproduction-related topics, there is debate about whether (and how) discussions on fertility preservation should occur where minors are concerned. The Ethics Committee of the American Society for Reproductive Medicine (ASRM) has recently officially acknowledged the existence of these and other associated issues (2021). In addition to several important recommendations in the favor of ART use by trans individuals:

> The Committee concludes that transgender identity/status by itself should not bar a person from accessing fertility preservation and assisted reproductive services. Unless other factors disqualify transgender persons from fertility services and based on empirical evidence rather than stereotypes or bias, reproductive services should be offered to all interested transgender or nonbinary individuals. Professional autonomy, although a significant value in deciding whom to treat, is limited in this case by a greater ethical obligation, and in some jurisdictions, a legal duty, to regard all persons equally, regardless of their gender identity. (2021:877).

It will be especially important for scholars, providers, and related organizations to (continue to) assess and evaluate transgender and nonbinary utilization of reproductive related services and fertility preservation in the coming decade. The experiences of applicable clients (as well as lessons learned) will be critical to ongoing efforts of health equity promotion for TGNC, SGM, and LGBTQ+ communities.

5 RECURRING THEMES

(1) Experiences and concerns regarding the severe lack of gender-affirming "maternity" clothing, (2) the feelings (personal) and perceptions (of others) around having and presenting a non-normatively gendered pregnant body, and (3) unnecessarily gendered or heteronormative assumptions connected to pregnancy/birth were three overarching themes that consistently appeared in my data. Overlap with existing concerns about women's/"maternal" health was also present. Some participants also provided their own interpretations of why their pregnancy/birth experience was as it was, mainly if they had a positive medical experience. Most respondents who described the medical aspects of their pregnancy/birth positively did so while also situating their experience within larger contexts of power and privilege. Many participants acknowledged how their privileged identities aided them in their pregnancy and birth experiences. Also related to one or more of these themes is how folx feel/felt about being pregnant and/or giving birth, specifically. While several participants shared, explicitly, that they wanted to experience pregnancy and/or birth, there were also several who spoke about their pregnancy and/or birth experience as purely a means to an end. For example:

> I wanted to give birth. [and] I always figured I'd carry. (Leah, *she/her*)

> I have deeply wanted to be a parent for many years. […] it was what we had generally discussed so that I would have the opportunity to experience pregnancy. (Mia, *she or they*)

> My partner and I wanted to have kids and she did not want to get pregnant. I very much wanted to get pregnant the first time. (Cori, *she, he, or they*)

Leah, Mia, and Cori all shared a desire to experience pregnancy/birth that for them did not conflict with their bodies or gender identities. Both Leah and her partner (and Mia and their partner) had been interested in experiencing pregnancy. Mia's partner had given birth first, 5 years earlier. The couple had previously discussed having another child so they could both

experience pregnancy, and Mia was pregnant at the time of the survey. There were several instances where both a respondent and their partner were interested in carrying a pregnancy, and one couple even chose to be pregnant at the same time. There were, however, also relationships where only the respondent wanted, was willing, or was able to give birth. Unlike Leah, Mia, and their respective partners, Cori did want to experience pregnancy, but their partner did not. Cori ultimately gave birth to both of their children as a result.

In contrast to those who voiced an explicit desire to experience pregnancy, there were also participants who saw pregnancy as their only viable path to biological parenthood. They didn't have the desire to experience pregnancy and birth but chose to go through with it because they wanted the end result. For example:

> I accept this as a necessary prequel to having a biological child but I am not particularly looking forward to the rest of the pregnancy. (Elizabeth, *any/all with respect*)

> I always wanted a family. I didn't look forward to going through pregnancy and birth. The idea made me very uncomfortable and felt alien, but I didn't have another realistic option. (Jeremy, *he/him or they/them*)

For Elizabeth and Jeremy, pregnancy and birth were not states of being they thought of fondly or were looking forward to experiencing; pregnancy was an obstacle they knew they would have to encounter (and overcome) to obtain a desired result: parenthood. Regardless of relationship/partnership status, some participants didn't bring up the topic of a partner's ability or desire to get pregnant/give birth.

All of these perspectives (similar and dissimilar) serve to dismantle the shared beliefs or presumptions that pregnancy/birth is inherently feminine and/or that it is only (or should only be) performed by "traditionally" or "conventionally," "feminine" or "female" bodies. These respondents also illustrate myriad examples of ways SGM individuals negotiate and define their own pathways to parenthood.

My research findings echo Schippers's (2007) call to empirically identify additional features of hegemonic masculinity and femininity and broaden our understanding of these features in various settings and among other populations. This call also overlaps with Budgeon's (2014) call for "developing understandings of change and continuity in the current gender order" (331). While Schippers (2007) does not address trans or nonbinary gender in her model, she briefly acknowledges it in a footnote stating that further exploration into trans identity and hegemony is needed. She shares that ongoing identification of features of gender hegemonies is required but is also just the beginning of what is still needed in this area of inquiry. Schippers posits the following are also crucial to understand:

> The *consequences* of embodying these ideals and putting them into social practice in terms of distribution of power, resources, and value are the true measures of gender inequality…[and] We would have to see which features of femininity and masculinity are put into practice, deployed as rationale for practice, and institutionalized to establish and naturalize hierarchical and complementary social relationships between women and men and those who do not fit either category (100).

I suggest that through studying the experiences of a gender-diverse population, my findings do begin to address how dominance is ensured over those who, in Schippers words, "are neither men nor women" (2007:100). Naturalized and hierarchical meanings long attributed to gender and sex difference have certainly impacted how our society approaches pregnancy and birth, women's health, and SGM health in general. The biomedical model and medical hegemony also intersect here and serve to provide supplementary reinforcement of gender hegemony and the current gender order.

One of the ways a reinforcement of gender hegemony manifests is via a *compulsory mommification of pregnancy*. This mommification can best be described as a homogenization of identities expected of pregnant and birthing bodies: being *pregnant* presumes that you are *also* a *feminine woman* that is or will *also* be a *mom*/mother/momma etc. More simply put:

pregnant=feminine woman that's a mom, or pregnant=mom or future mom. The *compulsory* aspect of this concept can function internally or externally. For example, consider Zeke, who problematizes an external feeling of pressure associated with this *mommification*. One of their fears was "being pushed into a 'woman/mom' role by everyone around [them]" (*Zeke, they/ze, zie/hir)*. Unfortunately, Zeke's worries were confirmed; they went on to share that they *were*, in fact, pushed into that "woman/mom" role. Another participant, Chloe (*she/they*) illustrates experiencing the *mommification* as well, albeit a little differently. They share below how external pressures arguably led to an internal manifestation of the *mommification*:

> It was assumed throughout the pregnancy and childbirth process that I was a cis woman, no questions were ever asked about my gender or if I would prefer alternate pronouns, etc. I felt the need to present more femininely because that seemed to be what was expected of me. This was especially true in choosing clothing, as most of the maternity wear I saw was highly feminine and it was difficult to find any neutral or androgynous clothing options.

Chloe felt pressures to at least temporarily adopt the feminine, womanly role expected of them as a part of their experience reproducing. This was felt (and reinforced) by both their medical providers and the stores lacking clothing options for a pregnant body fitting their gender identity and expression. In **Figure 5.1** below I illustrate some of my participants feelings about and/or experiences with this *compulsory mommification of pregnancy*—which is also, in some way, shape, or form, a contributing factor present in all three of my emergent themes.

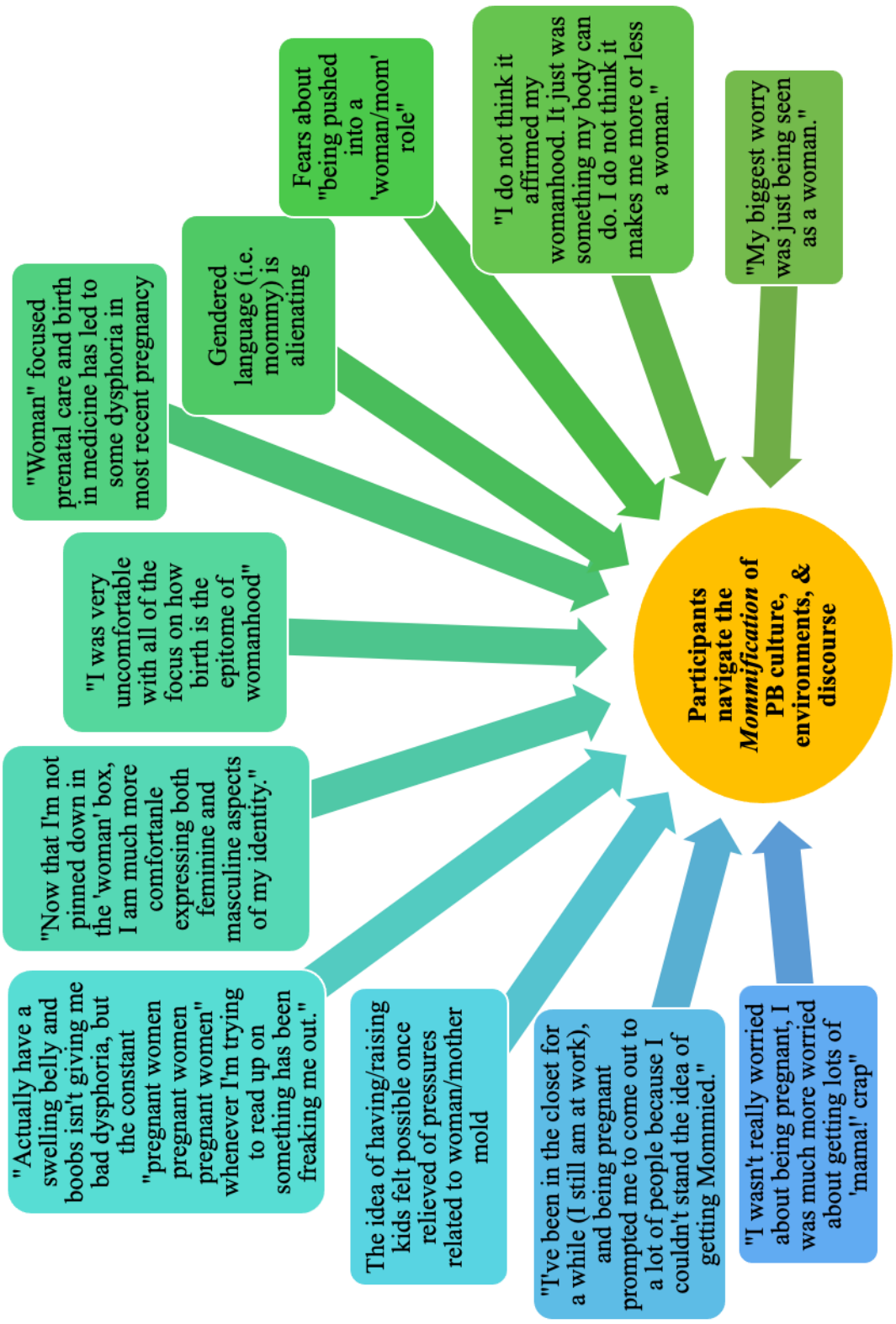


Figure 5.1 Navigating the Mommification of Pregnancy/Birth

Participants repeatedly problematized how pregnancy/birth culture were extremely (and often gratuitously) "mommy focused." Several respondents feared, dreaded, or at some point felt alienated or restricted by this focus. One of my participants, Harper (*he/him*), who is trans, was not out about his trans identity to his colleagues prior to his pregnancy. He shared that he ended up coming out because he "couldn't stand the idea of being Mommied" by his colleagues during his pregnancy. Harper's experience is also an example of how the physical embodiment of pregnancy isn't necessarily dysphoric for some, but rather the culture and rhetoric associated with pregnancy and birth. It wasn't being a pregnant man that worried Harper; it was that being pregnant meant he had to experience society's *mommification of pregnancy* and "unavoidably being seen as female" by the people with whom he had to interact. He went on to confirm that, "so far he was right to expect both of those things, ugh."

Another participant, Ari, shared, "I dissociate every time someone 'mamas' me." They also said that "Mentally/emotionally" their pregnancy experience, "was a negative spiral." Ari wanted nothing more than to hide and not be seen throughout the entirety of their (visible) pregnancy. In the survey, (relevant) participants were prompted to describe how their LGBTQ+ community belonging/support changed while they were pregnant/after giving birth. At the time Ari became a parent, none of Ari's queer friends had kids; apparently only one of their friends has in the time since. Unfortunately, their friend's shift into parenthood, however, has not provided an opportunity for meaningful connection. Ari shared that "Her [friend's] wife thinks of [Ari] as a mama." Ari stated they "never corrected her and just avoid them." While shared experience and/or community membership can often bring people together, sometimes it divides instead. As I mentioned previously, some participants remarked on how they experienced (LGBTQ+) community rejection because of their decisions to become parents. Ari's "rejection"

is more abstract, and also influenced by Ari's decision to avoid the friend-couple (likely as a means of self-protection), but it is nonetheless a function of gender hegemony. Because Ari (who identifies as non-binary, two-spirit, trans) did/does not comply with the hegemonic prescriptions of femininity and motherhood expected of birthing bodies, Ari is ultimately left to choose between alienation or interactions that may lead to further dissociation. While their friend's wife may not have intended Ari any harm, the friend's participation in the "mommy" culture is nonetheless a contributing factor in Ari's alienation and distress.

The *mommification* culture is undoubtedly a feature of hegemonic femininity which, according to Schippers (2007), is "put into practice, deployed as rationale for practice, and institutionalized to establish and naturalized hierarchical and complementary social relationships between women and men and those who do not fit either category" (100). Consider Ari's experience below:

> Some nurses at the clinic were fine and helpful. Some really gendered me over and over, as if reinforcing someone's femininity is a good thing that builds them up. […] My wife went to midwifes; they were way worse than my doctor on the reinforcing femininity front (Ari).

The hyper-prevalent mommy focus in most baby/reproduction-related environments, including health services, as Ari articulates, clearly also serves to establish and naturalize hierarchical and complementary social relationships between *those who do not fit either category*. As a result, such individuals lack a space where they can safely and affirmingly obtain services they need. The *mommification* also leads to hyper-gendered branding which successfully communicates that those not identifying as or with the terms "woman," or "mom" don't belong. Three other participants shared their experiences being in "women's" spaces while "not women":

> I've had dysphoria but it's all stemmed from how "woman" focused prenatal care and birth is in medical settings. (*Seneca, she/ze, zie/other, ze/zir*)

> I'm four months pregnant now and the "mama" stuff has started. Constant marketing emails addressed to "mommy to be" etc. Fucking sucks. This stuff is also all over anything I read about pregnancy, which is really alienating. […] Actually having a swelling belly and boobs isn't giving me bad dysphoria, but the constant "pregnant women pregnant women pregnant women" whenever I'm trying to read up on something has been freaking me out. (*Harper, he*)

> When I lived in [state], I drove up to a [city] Planned Parenthood for birth control. At the time my ID said "male." I was pulled aside in a room and told "We can't help you here." (I think they thought I was a trans woman trying to get estrogen…?) I tried to explain that I was just trying to get cheap birth control because I was underemployed and had no insurance. I was told again they could not help me. I asked what would happen if I could show them my passport, which listed my sex as female. I was told it wouldn't matter. I pushed hard enough that they eventually said I could come back later and speak with the director. I was 1 ½ hours from home, but I drove around [city] till they called back and said she could see me. She had me write a really graphic description of my genitalia and reproductive organs and what hormones/surgeries I had or hadn't had. Once I signed off on this statement, they gave me two packs of birth control, and I never went back there again. It has been hard finding accepting, respectful doctors. (*Elijah, he*)

Horrific experiences like Elijah's happen for two main reasons: (1) medical staff often fail to listen and acknowledge that clients often know (or at least have an idea of) what they need; and (2) "women's health" is often "feminine, cis-women's health." Even with the staff's ignorance and lack of competency in LGBTQ+ health, the majority of the disaster above could have been avoided had they simply *listened to Elijah*. Those who resist this *mommification* and/or those who are harmed by it, are upsetting the hierarchical and complementary order that gender hegemony stands to maintain (Schippers 2007:100). NCF individuals engaging in pregnancy/birth, and/or "those who do not fit either category," are in direct noncompliance with the tenets of hegemonic gender and hegemonic masculinity, particularly if their pregnancy/birth, and ultimately their parenting, do not serve to reinforce hegemonic gender ideals. The *mommification* also reinforces and maintains heteronormativity, for example:

> When the baby was in the N-ICU, they had this app that would send you pictures with little messages from the baby (you could only visit for an hour a day b/c of covid). The

> first night, the "baby" said "I love you mommy and daddy!" and we had to correct them at the next visit. (*Bailey, she*)

Gender hegemony dictates the appropriate "mom" is partnered with a man, the "dad." Despite increasing diversity in who becomes a parent in the last decade (including some mainstream representation), "mommy" and "daddy" are still what hospitals are expecting from their clients who give birth/become parents. If they weren't, the experience Bailey described wouldn't have happened. Not only does such language fail to acknowledge queer families, it also delegitimizes single parents and/or co-parents. It sends the message that if this, "mommy and daddy" message doesn't apply to you, something isn't right.

In the pages to come I offer additional examples of, and further analysis on, how my participants resist and embody counter-hegemonic narratives. I aim to contextualize my participant's experiences through Collins's (1990) paradigm, the "matrix of domination." While the majority of my participants hold some gender and/or sexual minority identity, both of which affect their levels of privilege and oppression, these are not the only identities shaping their experiences. Again, there are several instances in which my participants identify their experiences through lenses of both privilege and oppression, how they intersect, and how those intersections affect the opportunities afforded to them.

Despite experiencing myriad messages that pregnancy and birth are "not for them," my participants nonetheless go/went through the process of pregnancy and childbirth as a means to expand their family. For some, this process was far from enjoyable. It created distress and even caused dissociation. For others, both the bodily experience of pregnancy/birth and the end goal of becoming a parent were desirable and enjoyable. Overall, I argue that the actions and experiences of my participants were largely affected (in varying levels and combinations) by the following: (1) Levels of "Compliance" and "Noncompliance" with the gender binary and

expected presentations of femininity; and the associated repercussions and/or concessions they had to make; (2) Navigation of medical hegemony and medicalization (including compliance and noncompliance); how they were received/treated by their medical providers and related staff; (3) Their support systems (or lack thereof) and their specific triggers/stressors/dysphoria-inducing events; and (4) The level of freedom (autonomy/agency) they had in terms of their choice of pregnancy/birth-related medical provider(s) (and if applicable, whether or not that provider(s) was/were on call during their labor), their finances (class/SES), and any other privileges/oppressions (i.e. race). In the remaining chapters I will address these factors, as well as how they intersect with the recurring themes I have identified.

5.1 "Maternity" wear

I intentionally aimed to explore the pregnancy/birth-related medical experiences of a particular population in this project; as such, I expected to place special attention on the medical industry (and potential gaps in training and care). Despite my own difficulties with clothing and general awareness of this issue for many SGM people, I nonetheless did not expect to see such significant gaps in connection to this population and the fashion industry. While the experiences of my participants clearly convey that pregnancy and birth are not limited to the conventionally feminine, or even just to women for that matter, this project provides substantial evidence that clothing manufacturers do not (yet) acknowledge the existence and needs, let alone identities, of NCF pregnant individuals (or their potential purchasing power). The majority of my participants expressed difficulty dressing their pregnant bodies in ways that were comfortable and aligned with their gender identity. Considering how many respondents described their gender expressions via certain types of clothing, it makes sense that similar clothing would be desired during pregnancy. While some experienced dysphoria related to their anatomy and/or the bodily

changes they experienced during pregnancy, others' distress was not associated with their physical body, but was primarily caused by their inability to dress their bodies in ways that "felt right" to them.

5.1.1 "Have a pretty Pregnancy"

These findings prompted me to (briefly) dig a little further into the origins and history of "maternity" wear, a nearly $3 billion industry today (Technavio 2021). The first maternity-specific fashion line was introduced in the early 1900s by Lane Bryant. Before that, clothes for pregnancy seem to range in style from potentially dangerous pregnancy-specific corsets to dresses fitted in the back and loose in the front. Wearers of the latter had the option of belting the dress at the waist (or not); as such, it could supposedly accommodate a variety of body shapes/sizes *and* their growing midsections. Maternity wear fashions have continued to vary since their conception, mainly depending on the culture and beliefs of the time. High visibility and emphasis on the pregnant belly in fashion is a modern concept. For decades (before and after Lane Bryant broke into the market), maternity lines were seemingly focused on keeping pregnancy *hidden* via boxy, baggy styles of dress (Fisk 2018; Plante 2018). Today, however, it would not be unusual to find maternity ensembles that are intended to be (safely) tight-fitting to explicitly accentuate a pregnant person's "baby bump" (Plante 2018). While popular or mainstream maternity wear styles have fluctuated quite a bit in the past couple hundred years, the fact that these clothes were/are made *feminine* and *for women* has always been the case. Herein lies the clothing problem of the non-conventionally-feminine pregnant individual.

5.1.2 Go Broke with Bespoke

Much to many a queer AFAB person's dismay, androgynous or gender-neutral clothing is difficult to come by, particularly for those with curvier or more voluptuous features. This

problem is not limited to only pregnant bodies, but rather a concern of many within SGM and TGE populations. Many people in this situation find themselves browsing men's clothing sections—which can often work, but even success there depends on (1) what you are looking for and (2) your body shape and size. The curvier or more pronounced your "feminine" features, the harder it is to make men's clothes work. I offer a brief anecdote as an example. I spent hours trying to find a suit for a wedding I attended in 2018. I had previously always worn dresses in formal-wear situations, but that was increasingly feeling less "right" for me. I didn't want a woman's suit because they are often cut in "feminine" ways (i.e., open chest), or they lack features I want (i.e., pockets, buttons that go up to the neck/collar, etc.).

Unfortunately, I didn't have any luck with men's suits either (I'm short and curvy). I finally gave up after several hours of searching (in-stores and online) when I realized my only option involved shelling out *several hundred dollars* for a bespoke suit. During my search, I found a few specialty clothiers (less than a handful) that cater to women/individuals who want masculine or androgynous clothing made to fit their bodies. Still, the prices (even for non-bespoke items) were astronomical. However, I've since noticed (before COVID) that several of these retailers are no longer in business. I imagine this is because there are not enough folx in this target audience capable of buying pricey handmade clothing. The disappointing fact remains: there is simply no mainstream (affordable) clothing retailer explicitly making and selling androgynous clothing for women (or bodies that aren't traditionally gendered). So how did my participants manage getting dressed during their pregnancies? How did this lack of comfortable and affirming clothing affect them?

5.1.3 "Finding maternity clothes was a nightmare!"

Several years ago, in the early stages of formulating this dissertation topic in my mind, I came across a graphic memoir called "Pregnant Butch" by A.K. Summers. The story chronicles her (actual) pregnancy experience, wherein she spent "nine months in drag" (2014). Summers mentioned concerns around her visibility as a pregnant butch woman. She talked about how she approached this issue by simply buying bigger and bigger versions of her (typically men's) clothes. It wasn't ideal, and they were comically large pretty much everywhere but her midsection, but she made do. To her surprise, though, she found that, often, others read her as a fat man, not a (butch) pregnant woman. This differed from her expectation, but the invisibility comforted her. Reading about Summers's experience prompted me to include two questions about clothing during pregnancy in my questionnaire.

When asked if they could find comfortable clothes that aligned with their typical pre-pregnancy gender expression, only nine participants answered in the affirmative (out of 40 who responded to the question). However, three of those nine who said yes also included qualifying statements in their response. For example, one of those participants responded: "Yes. Although so much of it was ugly or just in a size much larger" (*Alex, he/they*) Another shared, "Yes I was [able to find clothing] because I did not limit myself to pregnancy wear. That type of clothing is made for feminine women" (*Merritt, she/they*).

Most participants commented on how *feminine* maternity wear was/is. The level of discontent present in the comments varied, but the majority of my participants were averse to maternity wear. For some, this hyper-feminine clothing (or at least the inability to wear what they were used to wearing) was dysphoric and caused them significant distress. In fact, one of my participants talked about how her issues finding comfortable and professional clothing to

wear during her pregnancy (i.e. clothing in alignment with her gender identity/expression) helped her distinguish her feelings between her own sex and gender. She realized that her changing body was not dysphoric to her; however, not being able to dress in a way that "felt right" to her caused her significant distress (*Leah, she*).

Others indicated they weren't comfortable in maternity wear or that they needed to adjust their style temporarily but did not describe the discomfort as extreme enough to cause them dysphoria; they often did the best they could with what they could find. Several participants mention finding one pair of pants or a couple of shirts that were the least offensive (least feminine) options, and resorting to wearing them over and over again for the duration of their pregnancy. Participants indicated there were far too few options that were neutral enough for them to appropriate for their use. One participant shared, "Even if you get the most androgynous stuff you can, there's just no getting around the fact that they're styled for women" (*Harper, he*). Similarly, another participant shared that even the "one plain black shirt [they were able to find] that wasn't super feminine" *still* had unwanted feminine features such as lace detailing and a scoop neck (*Chloe, she/they*). Participants who found anything in the maternity section described these clothes as the most "plain and casual" or "neutral-colored" (black, gray) items they could find. Most of my respondents had to find workarounds for various issues. One of my respondents, who referred to finding maternity clothes as "a nightmare," shared that her support system referred to her pregnancy clothing style as her "'rocker preggers' look" (*Kay, she*). Kay went on to share that she was able to wear her usual boots (i.e., Doc Martens) or flats until the last month of her pregnancy and that Old Navy was a "godsend for maternity leggings," which prevented her from having to alter her jeans (*Kay, she*). Several other folx took a route similar to the one Summers described from their pregnancy (i.e., opting to go up in men's sizes rather than

going femme). Harper *(he)*, for example, went on to say, "I'm going to try clothes for fatter guys next."

One participant responded in all caps, "NO," to my question about whether or not they were able to find anything comfortable/in alignment to wear (*Elijah, he*) case. Elijah went on to share how he had to employ multiple strategies mentioned above throughout his pregnancy, including oversized t-shirts, maternity "boyfriend jeans," maternity flannel shirts, and wearing maternity tanks underneath unbuttoned men's dress shirts.

Although the vast majority of participants had some kind of issues with clothing while they were pregnant, it is important to note that these issues did appear to be weighted differently for some. Again, while Elijah answered, "NO," to whether or not he could find comfortable clothing that matched their pre-pregnancy gender expression, he goes on to describe how they made do mixing and matching some larger sizes, men's clothing, and maternity wear. While his making do included utilization of some maternity wear, it is clear by his answer it was a problematic experience for him, and that these "workarounds" weren't really *solutions* per se. Conversely, other participants who employed tactics similar to Elijah answered affirmatively to the same question, indicating they *did* frame these "workarounds" as solutions. I argue this was likely for at least one of two reasons: participants had varying thresholds of comfortability/distress when it came to dressing outside their personal norms of gender expression; and/or participants had varying interpretations of what constituted comfortable and within close enough range to their pre-pregnancy gender expressions. Both of these factors could be influencing each other as well.

For example, some participants seemed more willing or able than others to even consider searching for and/or making do with anything from the maternity section. When I say "willing,"

I *do not* mean to imply those who had severe clothing difficulties and/or related dysphoria were simply being stubborn, but again, that participants' compromise(s) in this arena of their pregnancy (and how they felt about them) varied. Some could manage with an item or two from the maternity section, especially those comforted by the fact that it was temporary. Others could not. Some needed to focus solely on the fact that their *even being pregnant* was temporary—an uncomfortable means to a very much desired end—in order to cope with the resulting distress and dysphoria. I got the impression that for those individuals, *being pregnant* was the *gender-related concession* they had made; they wouldn't or couldn't compound that distress with another concession, such as having to wear maternity clothes. My participants made various *gender-related concessions*, or negotiations, throughout their pregnancies and births. Like with maternity wear, these concessions vary in type, scope, weight (i.e., how much distress they caused).

To elucidate further these varying weights, in **Figure 5.2** are the following five cases related to maternity wear and other clothing during their pregnancies. I also provide additional context on Mitchell and Leah's pregnancy-related concerns.

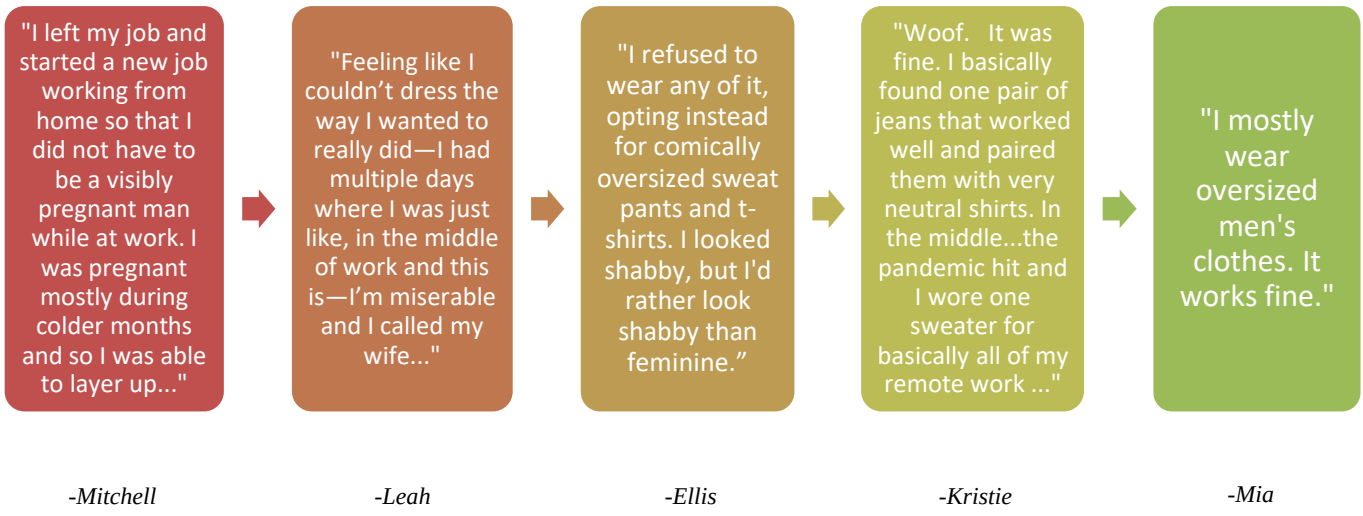


Figure 5.2 Dressing While Pregnant Caused Varying Concern for Participants

5.1.4 Mitchell (he)

Hiding his status as a pregnant man was a major priority for Mitchell. I argue this was one of the ways he coped with the gender-related distress of being pregnant, which ultimately helped him to get through this challenging experience. Mitchell made explicit efforts, or changes in order to ensure that his pregnancy went unnoticed by others; it was important to him that he be "in control of his public self."[44] As such, he left his in-person job for one that allowed him to work from home. Additionally, the colder season (i.e. layers, bundling up) allowed him to avoid "most people noticing [he] was pregnant."

In our follow-up interview, Mitchell shared with me that he knew he "didn't want to be a parent if [he] had to be a mother." He went on to say, "I am male" and "fatherhood speaks to me." He described his discomfort with the idea of being pregnant; it didn't fit his gender expression and he wanted to be gendered correctly. He also shared three main components that ultimately led him to his decision to become pregnant. Mitchell described how several conversations with his husband played a role; his husband had always desired to have kids (biologically) but as a gay man, he'd originally concluded that wouldn't be a possibility for him. Mitchell shared how this mindset shifted for his husband. Having then ultimately partnered with Mitchell, a trans man, his partner thought, "Can I now?" These conversations and assurances of support were impactful and helped Mitchell begin opening up to the idea. Mitchell went on to describe a major turning point for him, which came via social media. He found an online group, where folx shared photos and talked about their experiences with pregnancy as trans men. Being able to see that other trans men had done it—were doing it—and getting

[44] Follow-up interview, 2020.

through it, made Mitchell feel like he could do it too. Mitchell also shared that his becoming more comfortable with his body since having top surgery also contributed to his decision.

Mitchell's *gender-related-concession* of quitting his job, however, is a nuanced one. He shared that part of his leaving was connected to the fact that he wasn't out (as a trans man) at work. As a result, being pregnant *and* maintaining his position there would require him essentially to come out twice to his colleagues of three years: first, as being trans, and second, as being a pregnant (or soon to be pregnant) trans man. While Mitchell didn't go into detail about the social climate at his previous job, it is clear he didn't want to go through that, and it is extremely important to note the critical social *and* legal implications at work in Mitchell's situation.

It is not uncommon for trans folx to not be out at work. Prior to June 2020, it was perfectly legal for employers to fire their trans employees simply for being trans (National Center for Transgender Equality [NCTE] 2021). While some states, cities, and individual employing agencies had already passed laws or added policies protecting transgender workers, there were no protections at the federal level. Thanks to the landmark Supreme Court ruling (Bostock v. Clayton County) last summer, federal law now prohibits anti-transgender discrimination in employment (NCTE 2021).

The possible legal and financial ramifications may or may not have played a role in Mitchell's decision, but they are nonetheless important to consider. Several participants referenced a need for them to have financial stability prior to getting pregnant. Worrying about the shelf life of one's employment (and potential discrimination) is neither just nor ethical and can cause undue stress for individuals like Mitchell. No one should have to quit their job to (safely) have children.

5.1.5 Leah (she)

Leah's experience somewhat contrasts with Mitchell's in that she was not concerned with the physical changes her body would go through, nor with being seen as a pregnant person. Rather, these were aspects of her pregnancy and birth that she embraced. Leah shared that she had always wanted children and that unless she had ended up with a partner who felt strongly about adopting instead, she knew she wanted to experience pregnancy and birth. Leah specified that her desire for a kid didn't change because of her gender expression. Leah identifies as a woman and describes her gender expression as "dapper." Her common aesthetic includes slacks, a button down, a tie, a vest, and nice (dress) shoes.

Leah realized early on, even before they began the "getting pregnant" process, that clothing would be an issue for her. Leah's wife was supportive about the clothing issue and made it clear that such a concern was an entirely acceptable reasons to not want to be pregnant. Leah, however, rebutted with, "But also we can invest in tailoring," and that clothing concerns "never really made me not want to get pregnant it more just was a like, oh I'm gonna flag this now so that it's not an utter shock [later] and I'm already thinking about it."

Overall, Leah's petite frame and pre-pregnancy gender expression limited her clothing options significantly. It was difficult for her to dress in the way she wanted and was used to, which ultimately caused her to experience dysphoria and distress. As her normal clothes became unwearable and she started going up in pants size, she said she didn't feel "dapper" at all anymore, but rather, she felt "shlubby," and she was miserable. For example, in our follow-up interview, Leah said:

> Feeling like I couldn't dress the way I wanted to really did—I had multiple days where I was just like, in the middle of work and this is—I'm miserable[.] And I called my wife and she's like OK we are gonna meet at the Macy's downtown after work and we are gonna find you things that we can then tailor to make work.

Ultimately Leah worked with the slacks (likely thanks to some tailoring) but was unable to wear her normal vests and button downs, having to opt for polo shirts instead. In Leah's case, when she wasn't able to dress how she wanted it made her feel less like herself, which in turn affected her mood. She explained that when she was able to dress even a little closer to her normal style, she was happier and less distressed.

5.1.6 Our Bodies, Our Different-Looking Selves

It is also important to consider the reality that there is significant diversity in body shape and size even before bringing pregnancy into the mix. Aside from there typically being some expansion in the midsection, pregnant bodies and how one's body adapts to pregnancy varies a lot. With or without the presence of dysphoria, it is within reason that one's degree of clothing concerns could vary along similar lines. As such, this variation could also influence participants' responses in terms of how problematic clothing was for them. For example, one participant who was pregnant at the time of the survey shared,

> One other thing to note is that so far, at 4 months pregnant, I'm still wearing my full tank style chest binder. It's not as effective, but it hasn't been nearly as painful as I expected either. And the spandex over my belly is actually a nice support for the bump (*Harper, he*).

Another participant shared that they actually *lost* weight during their pregnancy. As a result, she was able to wear her normal (gender-affirming) clothes throughout and after the pregnancy (*Bailey, she*). Nonetheless, while clothing was not an issue for her, she described experiencing body shaming via comments from others about her weight (and weight loss); some even provided unsolicited "concern for her baby" due to her size. It seemed that such comments were not so much as legitimate concern for Bailey, but rather Bailey's fitness for motherhood. It would be understandable to have some concerns about a loved one's weight loss during

pregnancy, as it could indicate a larger or more serious health concern; however Bailey made it clear that she and her doctors were in control of the situation. Nonetheless, continued comments indicated to Bailey that others clearly felt *they* knew what was best for her body. Bailey was seen as potentially putting her baby in danger and so—before her baby is even born—her ability as a mother is questioned.

Some participants remarked on how pregnancy-related weight gain seemed acceptable, as opposed to any other reason or time (for a "woman") to gain weight. Jojo (*she/any with respect*) explained that pregnancy felt like the one time in their life where it was acceptable for them to "take up space." Another participant, although they felt maternity wear was "feminine and invalidating," also added that it was "interesting to notice that women's clothes don't shame pregnant women for being big like regular women[']s clothes do" (Ari). These responses were the closest any of my participants got to saying anything overtly positive about their experiences with maternity wear.

Clothing choices were sometimes dictated by more physical concerns or needs. For example, one participant talked about how the early and severe nausea they experienced affected their clothing choices; they didn't want to wear anything that put any pressure on their stomach because it made them feel worse. Another participant shared,

> Since I was pregnant with twins, ultimately I gained a lot of weight and my belly was much larger than most pregnant bellies, which made wearing clothing difficult. We didn't really have the money to buy many maternity clothes, especially since we knew this would be our only pregnancy, so we purchased one pair of black maternity pants that I wore to work every day, a stretchy maternity band to cover any exposed stomach, and two work-appropriate maternity blouses (*Harlow, any w/respect)*.

Harlow's experience with clothing is an example of not just how the size of their pregnant body affected their ability to find gender-affirming clothing, but their ability to find and wear *any*

clothing, at all. Additionally, Harlow's response highlights how class status and income are important to consider here as well. Multiple participants problematized the cost of maternity wear (and pregnancy). Whether or not participants purchased and/or utilized any of the expensive maternity items, access remains a concern, in terms of cost and style.

Another participant, however, (*Zeke, they/ze/zie*) described part of their clothing experience as positive, but this was in large part because of their community support at the time. In response to whether they were able to find comfortable and affirming clothes to wear during their pregnancy, Zeke shared: "Mostly. My group of long-time friends has a bin of masculine pregnancy clothes that has now gone through 7 different pregnancies (6 different pregnant people). That bin felt like an expression of love from queer community." The affirmation here is twofold. Not only was Zeke able to access masculine pregnancy clothes, but they also received affirmation of their pregnancy—and support—from their long-time queer friends. Zeke's experience of queer support and solidarity is also important to highlight because such community support varied substantially among my participants. The responses among participant's (pre-pregnancy) queer friends/community are divided. I will discuss this further in a later section.

5.1.7 "Maternity" Wear and Hegemonic Femininity

Although local and regional cultures, climates, and politics certainly vary, and some communities are more accepting than others, particularly in recent decades, with defiance of hegemonic norms often comes some form of consequence or barrier. For a lot of my participants, these issues manifested in multiple ways throughout their experience.

In their revision of Connell's (1995; 2000) model of gender hegemony and hegemonic masculinity, Schippers (2007) established that *hegemonic femininity* consists of the characteristics defined as womanly that establish and legitimate a hierarchical and

complementary relationship to hegemonic masculinity and that, by doing so, guarantee the dominant position of men and the subordination of women" (94). Schippers (2007) provides an alternate model that builds on Connell's and provides needed context and evidence for how femininity *is* also hegemonic, and how it, in its "naturalized, complementary, and hierarchical relationship" with masculinity creates a standard rationale, or "legitimating discourse," for the *modes* and *methods* in which men sustain their domination over women (93). The naturalization and legitimization of a hierarchical relationship between masculinity and femininity allow for robust and widespread implementation of policies, practices, and structures that guarantee inequality (Schippers 2007). These also fuel other hegemonies (i.e. medical, racial, etc.). By conceptualizing hegemonic masculinity and hegemonic femininity together, (as opposed to separately like Connell (1987) articulates), Schippers (2007) argues that we can identify other configurations of femininities and masculinities and how they rank in terms of their difference from the ideal, that is, those supporting male domination. Schippers (2007) goes on to state,

> If hegemonic gender relations depend on the symbolic construction of desire for the feminine object, physical strength, and authority as the characteristics that differentiate men from women *and* define and legitimate their superiority and social dominance over women, then these characteristics must remain unavailable to women. To guarantee men's exclusive access to these characteristics, other configurations of feminine characteristics must be defined as deviant and stigmatized. This is needed to define the ideal for femininity, but also to ensure swift and severe social sanction for women who take on or enact hegemonic masculinity (94-95).

The unavailability of "maternity" clothing that aligned with my participants' gender identities and expressions illustrates two functions of gender hegemony at work, which in turn, is also reinforcing the *mommification of pregnancy*. (1) The (hyper)feminine labeling (i.e., *maternity* wear) and clothing made specifically for pregnant bodies *encourage* and *reinforce* hegemonic masculinities and femininities, as well as the "idealized relationship" between femininity and masculinity (Schippers 2007:94). Maternity wear offerings illustrate how a

gender-compliant pregnant individual should look during their process of reproduction; similarly, their strict confines within femininity simultaneously communicate what non-compliance looks like (i.e., anything else). (2) The "non-feminine" pregnant individuals are (indirectly) sanctioned for not engaging in a feminine and gender-compliant pregnancy. One of my participants shared that it felt "emotionally like people like me had been left out of this category" (*Cori, she/they*). These sanctions and their effects vary on the individual level (i.e., frustration, stress, dysphoria) but successfully communicate that maternity wear wasn't made for people *like them*. If maternity wear is gender-compliant, and maternity wear does not provide ample options for gender diverse pregnant and birthing bodies, does that not imply that pregnancy and birth are not meant for the non-feminine and/or gender diverse?

As mentioned previously, many of my participants talked about clothing when describing their gender expressions; several also talked about how they were typically "read" by others. It is here where gender *expression* (possibly a little less than gender *identity*) straddles the line of what "feels right" to someone versus how they will be/are perceived by others. Whether we are explicit or intentional in how we express our genders or not, we are nonetheless sending messages to others via our appearance. The majority of my participants were unable to comfortably *and* affirmingly dress their pregnant bodies. For some, that affirmation depends not just on "what feels right" but also on how they will be subsequently "read" and gendered by others.

Again, some were able to make do with men's clothing in larger sizes, however it wasn't a universal solution. Men's clothing seemed to work significantly less well for those who were short, curvy, and/or had large breasts or a large chest. Being petite, curvy, and/or big busted are generally considered "feminine" features—and thus aren't really considered in the design and

manufacturing of men's clothes. I argue that the more prominent their "conventionally feminine" physical features, the more difficult it would be for them to find their pregnancy wear in the men's department. I believe that can account for why going up in size in the men's section was not a viable solution for all of my participants who (pre-pregnancy) typically or often wore men's clothes but didn't respond affirmingly about finding clothes that worked for them. To some extent I believe size and weight were also factors at play; I think it is possible that it was *relatively* easier for thinner or more slender participants to find clothing they were comfortable with during their pregnancy.

I argue that the influence of one's body shape and size extends to more than just clothing. My data suggest that perceived "success" in terms of one's visual identity, or how one is "read" and/or "accepted" can also be impacted by one's weight/size/shape. Consider the following statements from three different participants:

> I dislike the way that nonbinary often centers an image of thin white masc afab folks, but it's also the most accurate. (*Mia, she/they*)
>
> My body type is the "typical hourglass" shape, so even if I'm dressed in masculine clothing I'm perceived as a woman from outsiders. (*Kaiden, they*)
>
> I wish I could look more masculine but my body is very curvy and I am short. I am also fat. (*Zeke, they/ze/zie*)

In Mia's case, we see an explicit vocalization of a cultural norm they've identified in some SGM, particularly non-binary (AFAB), communities, that is, Whiteness, masculinity, and thinness are ideal. Arguably, this is evidence of (hegemonic) dominant ideology persisting within subgroups of a non-dominant group, the presence of which reifies an old, familiar, standard, simply with a little re-branding as "except not cis-gender." Further, it speaks to the strength, deeply entrenched, and far-reaching characteristics of gender hegemony; a group, community, or institution is not

protected from the ideology and its effects simply because they hold or represent at least one non-dominant (subordinate) identity.

Kaiden (*they*) and Zeke (*they/ze/zie*) indirectly approach parts of this ideal in their statements. They share there are specific features of their bodies that make them feel *less masculine* and/or more often *read as a woman*. For example, Kaiden describes their body as "the typical hourglass shape," and how that shape trumps coexisting (and in this case, contrasting) expressions of gender (i.e. masculine clothing on a "feminine" body) and signals to others to read: "woman." Zeke expressed a similar sentiment; they explicitly identify their curviness, shortness, and fatness, as barriers to what they wish their body was: "more masculine."

Mia, Kaiden, and Zeke's statements could be interpreted as evidence of hegemonic masculinity being reproduced within an arguably gender-noncompliant subgroup, or as Connell might describe them, *subordinate masculinities* (2005). However, while Schippers agrees that there are certainly varying levels of power and privilege, for example, among racial minority men versus White men, she argues that classifying their masculinities as *subordinate* does not fit the bill (Connell 2005; Schippers 2007). Schippers argues this is because a subordinate masculinity could not exist within a hegemonic framework of gender that identifies masculinity as dominant; and with dominance being the ultimate ideal and goal, hegemonic masculinity would never and could never, be *both* subordinate *and* the ideal. That would be contradictory, for under a hegemonic framework of gender and gender categorization, if something was subordinate, it would *not* fit the criteria of being labeled *masculine*. It would be something else. Schippers's argument lays the groundwork for the function and properties of hegemonic femininity, including additional reconceptualization and renaming of previously theorized non-dominant-femininities.

My participants provide personal (and cultural) insight and understanding regarding physical manifestations of the feminine, not feminine, masculine, and/or not masculine. I argue how these classifications seem to directly affect their feelings about their body, and similarly their (in)ability to properly mirror their desired expression, is further evidence of hegemonic masculinity at work within this subgroup of gender diverse individuals. Consider another example from Blake, who focuses on the effects of his masculine physical features: "Physically, I generally pass as male as I have a deep voice, have facial hair, am not curvy, and am relatively tall" (*Blake, he/they*). In this instance, by identifying his *lack of curviness* as one of multiple physical components that contribute to his passing (as male), Blake's assertion that *not curvy=masculine* indirectly *supports* Kaiden and Zeke's constructions of *curvy=feminine*. Again, Mia, Kaiden, Zeke, and Blake provide insight into the ways in which those interpretations may work for them or against them in terms of their ideal expressions of gender.

Discourse related to how one is "read" or how they "pass" was common among my participants. While sharing how they felt others perceived them seemed to be a common and effective descriptive tool used by many participants, whether they had wanted, intended, or felt it was a *success* to "pass" or be "read" in the way they described was not always clear. For *some* (but not all) trans-identified folks, it was explicit, (i.e. one trans-man specified it was his desire to be read as a man versus another participant sharing they're often read as male by others, but not really sharing how they felt about it or if it had been their intention). It seemed like it was more common for my participants to be seeking or aiming for a gender *descriptor* in their expression (i.e. masculine or androgynous) versus a specific gender identity (i.e. man), thus deconstructing the mainstream binary-based presumption that these are one and the same. Again, a large proportion of my sample identified, in some combination or form, as trans and/or nonbinary. So,

while certainly keeping in mind there are myriad individual interpretations of SGM terminology and identities, and not all trans folks feel at home outside a binary interpretation of gender, the aforementioned deconstruction does not surprise me.

For some however, how they are or may be read is less an influence on their expression; again, some simply focus on what "feels right" to them. They may be acutely aware or conscious of how they are perceived by others—and how those perceptions may affect their interactions—but the perceptions seem less a factor in their level of associated (gender identity) fulfillment. For others, however, there seems to be a stronger connection between their individual identity fulfillment *and* how they are perceived by others. The gender identities and expressions of my participants play a role in how they were/are perceived in and by the world. In referencing Connell's model of hegemonic masculinity, Schippers stated that performing masculinity, "affects the way individuals experience their bodies, their sense of self, and how they project that self to others" (Schippers 2007:87). Arguably, any gender performance (i.e. not performing masculinity) would also affect one's sense of self and projection of that self to others. Internal manifestation and/or how the projected selves are received, however, would vary depending on the environment, one's identities, and levels of compliance or non-compliance.

I posit that beliefs, consideration, and concern about how others will read, or gender, them, is not only (additional) evidence of general hegemonic masculinity at work, but also a specific example of an attempt to naturalize a complementary and hierarchical relationship, and thus create a standard rational for gender, among those who *do not identify as cis-gender*.

By setting certain standards for masculinity and femininity, society also creates the possibility for achieving or not achieving masculinity and/or femininity. Further, because of the purpose of gender hegemony and hegemonic masculinity (male dominance) and some of the

ways they function (social control, sanctioning noncompliance), "achievements" or "successes" in *doing gender* are less determined by the individuals themselves, and more so by other individuals (and/or institutions). My data support the following: how we are perceived and gendered by others, as well as what is categorically feminine or masculine (and not feminine or not masculine), would hold substantially less power if not for gender hegemony. Hegemonic masculinity creates opportunity for the potential negative impacts (including those to health) associated with gender noncompliance. My project differs from existing theoretical knowledge in that it provides an opportunity to consider the ways in which gender hegemony may also operate among those who, in Schippers words "are neither man nor woman" —or in other words—those who are typically non-cis and/or non-het (i.e., SGM, TGE, TGNC, GD, and/or LGBTQIA+ folx) (2007:100).

I also acknowledge the presence of individual differences and how other variables (i.e. SES, geographic location, politics) certainly allow for difference among cis-gay men and TGNC folks. As I've mentioned previously, the LGBTQ+ acronym reflects a combination of many different gender and sexual identities. Similarly, there is great diversity in what it means for someone to *be* trans, non-binary, and gender non-conforming, etc., including, but not limited to: what it means to *look* TGNC and/or *pass* as (Cis or) TGNC; what it means to *feel* TGNC, what it means to be *binary* trans, *non-binary* trans, or maybe not trans, but not Cis; what roles *masculinity* and *femininity* do or don't play into one's TGNC identity, and also, how all of these aforementioned things are *expressed*, and subsequently, *interpreted* and *classified* by others. In the next chapter, I analyze further my participant's social location at the intersection of compliance and resistance, and how they and their identities were negotiated, considered,

rendered (in)visible and/or seen as "novel" throughout their pregnancy and birth-related medical experiences.

5.1.8 "Homonormativity"

I mentioned previously that community support varied substantially among my participants. Recall Zeke and their group of long-time friends who shared a bin of masculine pregnancy clothes, which they described as "an expression of love from [their] queer community." While several participants mentioned the importance of such forms of positive (queer/LGBTQ+) community support during their pregnancy/birth journeys, others shared experiences or feelings of community *rejection*. These participants described some of their friendships/community members (i.e. queer/LGBTQ+) as having exclusionary attitudes toward their family-building plans. In some cases, participants felt that queer and childless members of their community framed parenthood as supporting and reinforcing heteronormative ideology and anti-queerness. This response is not new; it resembles and reinforces a previously identified phenomenon called "homonormativity" (Bolen 2016). Homonormativity represents the adoption of a politics of "sameness," wherein "gayness" is acceptable so long as it essentially mimics (and reinforces) heteronormativity.

While some scholars (and some fellow queer community members) might see pregnancy and birth as embodiments of hegemonic femininity (or homonormativity) that only serve to ensure male domination and heterosexism, I do not support that position. Instead, I argue that the social locations of my participants and their decisions to get pregnant or stay pregnant are excellent examples of *resistance*—and what can happen to those existing at the intersection of the hegemonic and the counter-hegemonic.

Further, as a scholar who is also childfree and queer, I argue it unjust to place such a burden on a fellow community member. Even if someone is of the mind that reproduction is a baseline function of male domination and thus gender hegemony—does that really mean that all queer aspiring parents have to sacrifice their desire for kids in order for everyone to achieve gender and sexual liberation? How is such a sacrifice liberatory? It doesn't make sense. For starters, one can't equate a systemic-level issue with individual agency. Blaming the oppressed group for exercising its agency only serves to reinforce the domination, not liberate.

I worry some of my friendships will be forever changed by my friends' desires (and my and my wife's lack of desires) to be parents—but that doesn't mean they shouldn't become parents. It also doesn't mean I have to want to be around (their) children. Lastly, it also doesn't change the norms, values, and beliefs in the U.S. which often favor the nuclear family and/or having children. They're not mutually exclusive. While not the focus of this study, I believe it is important for feminist, critical, and/or queer scholars to better understand this within-community variability regarding children and family building. I urge scholars to research the topic further, including how such a variability may affect social justice efforts within/on behalf of an oppressed community.

6 AT THE INTERSECTION OF COMPLIANCE AND RESISTANCE: "I EXPECT DOCTORS TO REGARD ME WITH DISDAIN AND JUDGMENT"[45]

Often, a provider's first perception of a client is a visual one. As mentioned in Chapter 2 (2.3.2), we often use visual data to inform our behaviors. Overreliance on cues that are gendered (and classed, raced, etc.) are problematic at best. Nonetheless, it happens, and how my participants were perceived by their providers often affected their medical services. Our experiences inform our expectations and behaviors, especially those experiences that are highly impactful and/or frequently occurring. Alongside thinking about and negotiating how others perceive us, I argue that it is a defense tactic for minority groups to routinely expect the worst in certain social interactions. According to recent research (Flentje et al 2021), safe community environments strongly correlated with the health outcomes of SGM people and concluded that "increasing safety and buffering the effects of unsafe communities are important for SGM health" (1). Less minority stress burden and less structural stigma were related to better physical health among SGM people (Flentje et al 2021).

Medicalization, focus on profit, and the bureaucratization of medicine have all contributed to reinforcing medical hegemony and the "streamlining" of many medical interactions. When there is limited time for a provider and client to spend time together, it makes sense for providers to look to and rely on techniques that help condense and simplify the flow of information to which they are privy. These features of medicine and medical hegemony, among many, are made visible by my participants and their pregnancy/birth experiences.

What did/does it feel like for my participants to encounter and navigate a highly feminine space while non-feminine? One of the most common suggestions I received from my participants

[45] *Mia, she/they*

is a simple one: many felt their providers could have improved their experience if they had just asked for their clients' genders and pronouns. Doing so would have immediately prevented the need for providers and other staff to rely on any form of gender or sex related assumptions.

In my survey I asked respondents about the frequency with which their providers collected 16 pieces of basic demographic information, whether on forms, through their EMR, or verbally: i.e. marital status, HIV status, gender, legal name, preferred name, etc. See Appendix E for the full survey). My participants' self-reports indicated that *gender* and *pronouns* were infrequently collected by providers. Only nine of my participants reported being asked for their genders and/or pronouns. *Gender* and *pronouns* were tied for 12th (out of 15[46]) in frequency of being collected (from lowest to highest) by their providers. Further, fewer than half (N=20) of participants reported even being asked for *sex*. Only 16 participants reported providers having collected their *sexual orientation*. These data indicate at least the following two things: (1) SOGI data were not collected by the majority of my participants providers; and (2) gender and sex related assumptions are routinely occurring in reproduction-related medical interactions.

These findings are not surprising given that biomedicine operates under inaccurate and outdated beliefs that gender and sex are binaries, and that only one of those two discrete sexes is capable of birth. Nonetheless, when such assumptions are made, it can quickly lead to substandard levels of care. Consider, for example, the experience of Leah and her partner.

6.1 "I'm not 20 weeks pregnant."

Leah and her wife originally planned for each of them to give birth, although not at the same time; they decided Leah would go first because she was a little older. For reasons unrelated to this work, they later realized they would likely only have the one that Leah carried; I mention

[46] The original total of 16 turned into 15 because of tied frequency metrics.

this because Leah and her partner had distinct gender expressions. Leah shared that most people, including doctors, regularly assumed that Leah's partner (the "much more femme" of the two) was pregnant. Some members of her partner's family even thought it was a mistake when Leah's wife shared the news, responding first with, "You mean you're pregnant?" Leah said there were a lot of "Oh…"-type responses in the beginning. They quickly realized that they had to be more explicit when sharing the news with others if they wanted to prevent these assumptions. For example, they would say "Leah is pregnant," versus, "We are having a baby." Leah explained that if they weren't explicit in that way, people almost always assumed that it was Leah's more feminine partner who was pregnant.

In one instance, one of the nurses even tried to take Leah's wife back for *Leah's* pregnancy-related blood draw. In our follow-up interview, I asked Leah how she and her wife navigated situations like that. Leah shared that they corrected folx, and depending on the situation, (such as medical) they "corrected and were very pissy about it." Behaving that way is understandable. Such a mistake is not only offensive, but a provider fails at their duty to confirm the identity of the client they are about to treat. Rather than asking a couple who should go to the waiting area and who should go with them to have their blood drawn, (or calling out the client's last name) the provider *guessed* who the client was based on what they looked like. Leah's wife immediately told the provider, "I'm not 20 weeks pregnant!" and Leah was quickly identified as the actual client. But the mistake had been made.

While physical harm would most often be avoided because a client or a client's partner can correct the mistake, how might a language/communication barrier and/or seeing a doctor in a foreign country complicate this situation? What would have happened if Leah had been at the appointment alone? Or, what if the provider in question isn't a pregnancy-specific provider (i.e.

OBGYN, midwife) at all, and the staff member has actually just violated HIPAA regulations by sharing personal medical information without the actual client's consent? *These assumptions were made because of Leah's appearance as a masculine or androgynous woman*. To some the above interaction may seem innocent and harmless, especially because no one was physically harmed, but I argue that it reminds us of a deeply concerning reality: providers make decisions about clients – and ensuing treatments -- based on their individual, unchecked assumptions.

6.2 Fears

Participants' medical experiences prior to their pregnancy/birth(s) influenced their expectations, decisions, and fears going into pregnancy and birth. Many of my participant's shared similar fears. Some were general fears commonly associated with pregnancy and reproduction. Others were specifically related to a gender, sexual, and/or other marginalized identity that they held.

Participants frequently voiced fears around the possibility of having a c-section. Some participants specifically feared they would feel/be coerced into having a c-section too quickly and/or unnecessarily. Others feared the possibility of having one for any reason at all. While not everyone who voiced c-section related fears (and had also given birth by the time of the survey) was able to avoid having a c-section, several of those who did ultimately have c-sections seemed to articulate that it wasn't as bad as they expected it to be and/or that they felt that their providers had at least tried their best to facilitate the possibility of a safe and natural birth. Fears related to a traumatic or unhealthy outcome for themselves or their babies, including death or miscarriage, were also common. A few participants specifically voiced fears related to a loss of control or a lack of respect for their autonomy on the part of medical staff. Concerns around violations of bodily autonomy included their wishes being ignored by providers, being operated on without

informed consent, and being seen as "less than human" or "as their exploited body" (*Ari*). For example, one participant, Terry (*she, any w/respect*), chose to switch providers at the end of their second trimester. Terry's increasing concerns about the way in which their provider treated them ultimately led them to feel that they couldn't trust the provider.

Some of my participants' identity-related fears included: being seen as a woman; not having their gender identity respected; expecting that providers' assumptions about the woman/mother identity would override their own nuanced identity; worrying that strangers would "project…their 'mommy' BS" on them; and not having legal protections. They were concerned about minor social stigma related to gender/sexuality and expressed significant apprehension that the experience would be dysphoric. One participant feared that, once medical providers or random people found out they were trans, that they would be rejected or even attacked. Some participants also voiced identity-related fears that were specific to how their child would fare as a result. For example:

> A lot of my fears came from the outside. I was afraid that society would think our child would be missing out on not having traditional parents. I was afraid that people would judge us for being a queer family (*Jamie, she*).
>
> I don't want my child exposed to the amount of bullying and ridicule that they may receive being born to a non-gender conforming individual (*Raine, she, he, they, any w/respect*).
>
> I worried that my children would inherit my disability and that they would have a difficult life as a result. Similarly, I worried that if I had female children, or LGBTQ+ children, that they would experience some of the challenges that I have (*Harlow, she, he, they, any, no pronouns*).

The fears voiced by Jamie, Raine, and Harlow share a focus on the potential for their marginalized identities and lived-experiences to extend to, and thus negatively affect, their future children. These fears are understandable considering the ways in which SGM identities and individuals—as well as individuals who manage chronic illness or disability, for example—are

routinely othered and sanctioned for existing. Arguably, Jamie, Raine, and Harlow were concerned that the norms by which they were judged would in turn be used to judge their children. This brings me to another important point: the fears voiced by all my participants are rational. While I don't know or necessarily have reason to believe individuals who go through pregnancy and birth (who are not NCF) typically also present with some irrational fears, I think my participants' fears (and the potential likelihood for at least some of them to occur) nonetheless illustrates the existence of some major problems in the culture of reproduction and medical service in the U.S. At the very least, no birthing individual should have to experience legitimate fear their provider will cause them physical or emotional harm at some point—or of the possibility that their low-risk pregnancy/birth could (or even *likely* could) result in their death. My participant's fears about their pregnancy/birth medical experiences should be unsettling to the medical community.

6.3 General Medical Attitudes/Experiences

To aid in the later interpretation of my data, I included three survey questions for my participants to provide feedback about their medical experiences in general (i.e. not their PB medical experiences). A little more than 2/3 of respondents (26 out of 41) rated their experiences with medical professionals as slightly, moderately, or extremely positive. Slightly fewer than 1/3 (12 out of 41) rated their experiences with medical professionals as slightly or moderately negative in general. A small proportion (the remaining 3 who responded) rated their experience with medical professionals as neither positive nor negative. I also asked them to rate their general level of trust in medicine, medical authority, and/or medical professionals. The responses were similarly dispersed: approximately 2/3 trust and 1/3 distrust. To my surprise, on those two metrics, there were more generally positive/trusting ratings than negative/distrusting ratings. My

participants' qualitative responses, however, (which I will discuss further in this chapter), help provide context for many of these ratings.

My third "baseline" question asked participants to choose from a list of emotions in response to how they typically feel when they have to go the doctor (i.e. comfortable, concerned, self-conscious, unaffected, etc. See Appendix E for full survey). The list of emotions contained emotions typically interpreted as positive, negative, and/or neutral. Respondents most frequently selected negative feelings. The three most common selections were *anxious or nervous* (N=33), *self-conscious* (30), and *uncomfortable* (22). This data could hypothetically illustrate that this population is for example, more likely to feel anxious about going to the doctor, however it is impossible to know without further research. It is not unreasonable for anyone (i.e. cis or trans) to be uneasy about visiting the doctor, although it is certainly possible the *level of anxiety* or the *reasons for that anxiety* could be markedly different for a trans person, for example.

From some of my participants, I was able to gain insight into factors that played a role in shaping their participants' attitudes toward medicine through their responses to other survey questions. These pre-existing attitudes toward medicine may have also played a role in their quest to quality care. Others pre-existing attitudes changed as a result of their pregnancy/birth experiences. For example, the following two participants went into their reproduction-related medical encounters with confidence in medicine and/or the expectation that they would receive good care:

> I think that myself and my partner being white, along with being professional-class and highly educated and myself from a family that taught me-I am entitled to high-quality medical care gave me a sense of confidence that I'd receive good medical care, and I therefore did not worry about it. It gave me a sense of entitlement to find a queer OB/GYN and midwife and expect to be treated well by all the providers I engaged. (*Cori, she/hey/they*)

> In general, I feel very comfortable with medical professionals, in large part because my father is one, and all the doctors I saw growing up treated me with respect. However, once I got pregnant this started to change. (*Leah, she*)

While Cori's experiences with pregnancy/birth providers weren't perfect, they rated their general experiences with providers as *extremely positive;* they went into their pregnancy/birth experience confident with regard to their future medical treatment; and they describe their pregnancy/birth-related medical experience as *moderately positive*. They said, "I got good care and no one was weird." Leah also entered the experience with an existing feeling of comfortability and positivity toward medical providers. Her interactions, however, with medical professionals that she sought out to treat her for post-birth related concerns (i.e. post-partum depression and anxiety) were "actively unhelpful." For example, they refused to acknowledge her concerns around extreme weight loss that she knew wasn't related to her depression. While she acknowledged that she did have a couple of good specialist providers during that time, she shared that her significant negative interactions led her to "now view the regular medical professionals with distrust." Cori and Leah also both mentioned privileges and/or economic or social capital as influencing their attitudes/experiences, which I will address further later in this chapter.

6.4 Pregnancy and Birth (PB) Specific Medical Services

I asked participants to rate and/or describe several components of their PB "care," including whether or not their provider did any specific behaviors (i.e. share pronouns, speak in understandable terms, misgender or deadname, etc.). See **Table 6.1** below. Most of my participants responded that their medical provider(s) treated them with respect (N=30, *Somewhat* or *Strongly Agree*). Most of my participants' PB medical providers spoke to their clients in terms they understood. Additionally, most providers informed their clients of their breast/chest feeding options. Most of my participants providers did *not*, however, share their pronouns (verbally or

via a pin or ID badge), nor did they ask for their clients' pronouns (directly or via paperwork). My respondents reported that most of their providers also did *not* provide PB info that catered to any of their identities. Many participants (N=26) indicated their providers left out information regarding PB that would have been relevant to their identity or identities (21 respondents selected *Maybe/Sometimes* and five respondents answered *Yes*). Thirteen of my respondents shared that their providers did, or *Maybe/Sometimes* did, misgender them; a smaller proportion were called by the wrong name or deadnamed (*Yes*: one, *Maybe/Sometimes*: three). While my participant's responses indicate that misgendering and deadnaming were in the minority of occurrences, for some, it could also be the most traumatic. That being said, my participants identities, while not *conventionally feminine*, did vary, and it is possible some were more likely than others to be misgendered from the start (i.e. lack of data collected by provider, client appearance, how far long they were in their pregnancy, etc.).

Table 6.1 Presence/Absence of Certain Medical Provider Behaviors

Did your medical provider(s) do any of the following?	**Yes**	**Maybe/ Smtms**	**No**	**NR/ Missing**	**Total**
Tell you their pronouns?	1	3	33	6	43
Wear a pin/badge displaying pronouns?	0	4	32	7	43
Ask for your pronouns?	6	4	28	6	44
Speak to you in terms you could understand?	30	7	1	5	43
Inform you about your breast/chest feeding options?	25	9	3	6	43
Provide you w/PB related info that catered to one or more of your identities (i.e. race, gender, sexuality, etc.)?	5	8	24	7	44
Leave out information regarding your PB that would have been relevant to you or one of your identities?	5	21	11	6	43
Misgender you?	6	7	23	7	43
Call you by the wrong name, or deadname, you?	1	3	31	9	44

I also asked my respondents directly whether they felt they were treated differently by their medical provider(s) because of their race, gender expression or identity, sexual orientation, class status, religion, or spirituality, and/or marital status. See **Table 6.2** below. Except for *Sexual orientation (SO)* and *Gender identity or expression (GI)*, most participants did not feel as if they were treated differently by their provider(s).

Table 6.2 "I feel like I was treated differently by my medical provider(s) because of my:"

I feel like I was treated differently by my medical provider(s) because of my:	***Clearly* [+ or *Mostly*] describes my experience**	***Moderately* describes …**	***Slightly* describes …**	***Does not* describe ...**	**No Response/ Missing**	**Total**
Race	1	3	1	30	8	35
Gender identity or expression	7	3	10	14	9	34
Sexual orientation	6	7	8	14	8	35
Class status	3	6	4	21	10	34
Religion or spirituality	3	0	1	29	10	33
Marital status	1	2	5	26	9	34

My participants were, however, much more likely to have felt like they were treated differently because of their sexual orientation and/or gender identity or expression. More than half of respondents (21 out of 35) reported some level of differential treatment (*Slightly describes my experience – Clearly describes my experience*) based on their sexual orientation. Similarly (20 out of 34) reported some level of differential treatment related to their gender identity or expression. Approximately one third (13 out of 34) reported experiencing/feeling some level of differential treatment because of their class status. Least frequently reported by participants was having felt like they were being treated differently because of their marital

status (N=8), race (N=5), and/or religion or spirituality (N=4). For race, however, I feel it is important to note that most respondents in this study reported their racial identity as *White* and albeit not impossible, as the norm, it is less likely for them to have been treated differently based on their race. I did not collect religious/spiritual affiliation from my participants and therefore do not know if religious affiliation was common/proportionate among my participants.

Many of my participants' qualitative responses about their pregnancy/birth-related medical experiences support feelings of having been treated differently because of their SOGI identities. The metrics (closed-ended) related to my participant's medical experiences that I've described thus far, in conjunction with the associated open-ended questions, provided me a robust picture of my participant's experiences "doing pregnancy without doing womanly."

The following six, open-ended questions specific to respondents' pregnancy/birth related medical care provided the most robust data, and typically, synthesis of most respondent's responses to these questions provided a well-rounded representation of their experience with seemingly minimal, obvious gaps.

1. Tell me about your experience giving birth.
2. Describe your experiences with the medical professionals and establishments you visited or interacted with re. pregnancy/birth.
3. Please expand upon the previous ratings of your medical provider(s). What made you rate them that way? Were they all the same providers? Different providers? Did you choose them or were they chosen for you?
4. How did those actions (or lack thereof) make you feel?
5. In what ways could your medical provider(s) have approached your care differently?
6. Is there anything else you would like to share about the medical aspects of your pregnancy and/or birth?

Participants' responses to open-ended questions were often detailed and nuanced, and in addition to sharing a narrative of their experience, also provided multiple frames of reference and context to aid in the interpretation of them (and other) responses. I do not believe it was the first time for many of them to have shared their stories, or at least parts of them, in depth, whether in research or another capacity. Two of the participants with whom I had brief follow-up conversations did mention or allude to having participated in other similar or semi-related research. This likely also aided in their ability to create and share with me a clear narrative.

While many of my participants' medical narratives included details that described both positive *and* negative aspects of their experiences, many of their qualitative responses seemed to ultimately end up leaning more one way than the other (i.e. their experience overall seemed more positive than negative). While their qualitative responses largely coincide with their closed-ended ratings, as a whole, it appeared as if my sample's gestalt view (and subsequent, summative, closed-ended rating) of their *pregnancy/birth as a medical experience* seemed to skew slightly more positive compared to how I would have expected based on their open-ended responses. This could be happening for a variety of reasons, including, but not limited to, some of my own minor errors of interpretation (i.e. situations where emotion was less clear in the text) or potentially the validity of the [*pregnancy/birth as a medical experience (overall)*] variable. This measure may not have been adequately captured via the likert scale I used. I suspect, however, that this skew is occurring because an assessment of their pregnancy/birth as a medical experience is likely also influenced by other factors inherent to pregnancy that just aren't the main focus of this project (i.e. objective pain and discomfort associated with pregnancy and childbirth). In the sections that follow, I provide a more detailed view and interpretation of the

negative and positive experiences of my participants, as well as how they reflect on and rationalize those feelings and experiences.

6.4.1 The Negative

Many of my participants reported the presence of negative medical interactions or experiences during their pregnancy/birth. Participants' negative or negative-leaning interactions and experiences were typically associated with at least one of the following categories (1) unnecessary or unexpected physical pain or explicit violence/assault; (2) instances wherein misgendering or other non-affirming interaction related to sex, gender or sexual identity occurred (i.e. assumptions/mistakes made); or (3) instances wherein a provider crossed ethical and/or professional boundaries during an interaction with the client (participant) that were not related to sex, gender, or sexual identity (but perhaps another identity). Some participants reported experiencing multiple types of these interactions.

Some participants reported experiencing physical violence, aggression, or assault at the hands of a medical provider.[47] In response to the prompt, "Tell me about your birth experience," Jojo (*she*) provided a succinct characterization of her violent birth experience:

> Traumatic. I was assaulted by one of the doctors during my three day long induction. Then had to have an emergency c-section. Two infections followed." (JoJo, *she*)

JoJo provided additional context in a later response, sharing that she was treated and ultimately gave birth in a big practice that was attached to a hospital. She described how she saw myriad different providers throughout her pregnancy, and that the attending she would ultimately have

[47] I would like to take a moment to thank my participant's again for their bravery in sharing their experiences with me, as well as their willingness to, as a result, relive some of those moments as they filled out the survey. Thank you for your time, exemplification of resilience, and of course, for helping me complete this project.

during her birth "could be any of them." In contrast to her experience with the doctor, JoJo said her nurses were "amazing during my pregnancy and childbirth experience."

Another participant, Shelby, also had a physically painful interaction with a provider that was seemingly unfamiliar to her (like JoJo). On the second day of Shelby's induction, the on-call OB performed an extremely painful pelvic exam on her. She described his treatment of her as "absolutely awful." She went on to share:

> He was the only male OB I had during my entire pregnancy, and I'll never know whether he was unprofessional, rude, and brutal to me because he was in a bad mood or because my partner was with me and we were obviously a same-sex couple. I filed a complaint against him which was corroborated by the nurses' notes. I have been advised that as a result he was on a watchlist with the chief of staff. I cried for months just thinking of him and what he did to me. (Shelby, *she*)

In addition to the physical aggression, what struck me about Shelby's situation was her conceptualization of the possible reasons for why the provider had treated her that way. I do not believe that Shelby felt her provider being "in a bad mood" was a legitimate reason for her treating her the way he did; however, it led me to consider whether the provider *himself* might see it a legitimate reason for his behavior. While not the case for all participants who experienced violence, three violent experiences faced by my participants were at the hands of male providers who were also strangers. Is it possible that some providers opportunistically utilize these intimate settings because it is there that they are uniquely-situated to exercise (violent) control over their vulnerable clients? Existing research identifies and documents the occurrence of obstetric violence (OV) against birthing bodies throughout the world (Tillman 2021). Consider Pat's experience below:

> The one prenatal visit I went to was with an elderly male doctor who gave me absolutely no warning before shoving tools into my vagina. He was also about to not wear gloves until his assistant reminded him to put them on." (Pat, *she ,they, any w/respect*)

What might have happened had the provider's assistant not been in the room? While I do not know the gender or sex of the provider's assistant, it is important to note that not all states require men providers to have another (woman) provider in the room with them as they examine women clients. Regardless, Pat's experience is horrific.

While nothing can erase a violent experience, justice, in whatever form it may take, can often help individuals cope with trauma. Shelby mentions that she did file a complaint and she ultimately found out the provider was on a watchlist. I don't know what, if any, repercussions Shelby's doctor (or any of the other aforementioned providers) will or did ultimately face. Such situations raise important questions for medical administrators and those who have been harmed. Our legal system is not currently designed in such a way that typically benefits those who have been harmed, but rather, it benefits the institutions (and elites causing the harm). Most states, for example, have caps on reparations for medical malpractice that may not even cover the medical services the individual received, let alone acknowledge or begin to address the physical or emotional damage done.

Seneca and Brennan's experiences below, highlight another important function and effect of (gender) hegemony:

> First time I was underprepared and young, and stressed. I got an epidural and it stalled labor and I needed a vacuum assist and had a third-degree tear. I felt like such a failure afterwards and hated not being able to walk for a day. Second time was truly traumatic as I experienced assault and major aggression at the hands of my midwife. It was 24 hours, they used every intervention they could but it was unmedicated. Pushing and after birth was SO much better than with my first. (*Seneca, she/ze, zie/other, ze/zir*)

> "There was a lot of assembly line feel to it. Any time I had a question or concern that slowed that assembly line, I felt stupid and ashamed. I had a lot of pelvic pain that was shrugged at (SPD) except by a problematic chiropractor who tried to convince me not to vaccinate my kid, and my postpartum recovery was framed as typical when it was NOT, at least for me. (*Brennan, they*)

In the situations they described, Seneca should not have felt like a failure and Brennan should not have felt stupid or ashamed. But when their experiences are measured (by themselves and/or providers) against a hegemonic measuring stick, it is understandable that they would experience backlash, whether self-imposed or via medical staff. These (gendered) expectations are so normalized and naturalized that those who fail to comply with expected (gender) norms can, and likely will still, be measured against those norms. Further, the individual's noncompliance with those norms (or the individual's marginalized identity) can lead to medical providers seeing a client in a negative light, discounting client concerns, and/or even as rationalization for perpetrating violence against a client. The client's noncompliance (transgression) can serve as an opportunity for providers to rationally shift blame/responsibility for client outcomes from themselves to their client.

Several of my participants reported incidents in which non-physical boundaries were crossed as well. While these boundaries were non-physical, they are nonetheless reminders of the unequal balance of power between providers and clients. In medical contexts, SGM folx (and/or other marginalized populations) often negotiate (in real time) whether or not their medical need outweighs whatever (potential) threat they may be expecting, perceiving, or receiving. Everyone's threshold for these boundary crossings/negative experiences varies, like I mentioned in an earlier chapter re. the lack of gender-affirming "maternity" clothing. The threshold can also shift depending on how badly the individual needs medical services, or how vulnerable a position a client is already in. Arguably, an individual who is actively in labor is at peak vulnerability compared to someone, for example, who has a cough. It can nonetheless feel like there are certain things an individual simply has to put up with in order to obtain what they need, and many of my participants communicated how they had little to no expectations of affirming

or quality treatment going into medical appointments. As such, and because of heteronormativity, cisnormativity, and a common default expectation that everyone believes in God, for example, sometimes behaviors that are obviously inappropriate or unprofessional to some are seen as normal and appropriate to others.

> One doctor (a locum for my OBGYN) was clearly befuddled and off balance as soon as he learned I was trans, and had to excuse himself to consult with more knowledgeable colleagues. My OBGYN was lovely, but regularly forgot my gender and slipped up while talking to/about me. During delivery, the doctors and nurses were confused about how to refer to/about me and spent much of my labor asking me questions. Which was all very friendly and in the interest of education, but still kind of inappropriate: a patient in labor should be put in the position of being an educator. (Ellis, *he/they*)

> The OB/GYN told me he'd stay with me to the end. (He did not.) […long and difficult labor ensued, ultimately leading to a c-section.] The photos of his misshapen head make me nauseated. But at least the doctors convinced me that I made the right choice in the c-section. And then the pink nursing gown. And the lactation coach and misgendering. And the pediatrician and misgendering. And the nurses and misgendering. In addition to us being queer, we were also viewed with suspicion because we had clearly tried to have a homebirth and failed. On the plus side, I was so tired and relieved that it was over that I didn't care much about the misgendering." (Elijah, *he*)

These interactions address what is expected of my participants in these settings and/or what they can expect if they do not comply. More specifically, they send the following message: "I am a symbol and agent of medical (and gender, religious, or other) hegemony and I will be dictating how you are treated. If you don't like how you are treated, that's on you." Marginalized populations are often involved in efforts to counter that marginalization. They're also often called upon to help educate those who are not facing that form of marginalization. While the standpoint of the marginalized is critical to understanding and proper education and change, Ellis's experience is a perfect example of not to go about familiarizing oneself with a different standpoint. Further, the presence of certain behavior, and absence of other behavior, such as what

happened to Jayden (*he, it/its, fae/faer*) and as reflected by Chloe (*she*) below, both serve to inform and reinforce a hegemonic culture.

> I have only seen one [provider] so far, but she was very Christian and asked to pray with me, which I found uncomfortable. (*Jayden, he, it/its, fae/faer*)
>
> I can't recall any gender-neutral language being used at the hospital. (*Chloe, she*)

That being said, the presence of certain behavior (i.e. asking and using correct pronouns) and lack of (and condemnation of) other behavior (i.e. asking a client to pray with them) can also, however, serve counter-hegemonic purposes. My participants make it very clear in their narratives that it is a lack of hegemonic attitudes and behaviors and the presence of counter-hegemonic attitudes and behaviors that make for a positive experience for them.

6.4.2 The Positive

Pregnancy/birth-related medical experiences that participants identified as positive or positive-leaning typically involved some combination of one or more of the following characteristics (1) limited to no egregious misgendering or other sex, gender, or sexuality-related missteps; if such missteps did occur, they were typically acknowledged and corrected swiftly and respectfully; (2) behaviors that were conducive to demonstrating a respect for client bodily autonomy (and knowledge) and/or implementation of practices associated with a trauma-informed care approach; (3) transparent communication, including maintaining a consistent flow of information between a client and the providers, and listening (and responding effectively) to a client and their wishes and concerns. Additionally, these positive experiences typically involved the presence of little to no significant negative interactions (i.e. including those outlined in the previous section and/or any counter to the above, positive, behaviors).

Feeling heard, supported, and that their bodies were respected were the most common characteristics of a positive birth experience.

> I don't think my birth could have gone any better. I felt supported and heard and my support system got me through it. (Jamie, *she*)

> The medical team was excellent. Answered my questions. Talked me through everything they were doing. And told my mom to stand down when she tried to override my medical decisions. (Kay, *she*)

> Actually, giving birth was super empowering. I had great caregivers who respected my autonomy. I had the birth experience that I wanted-unmedicated vaginal delivery. I felt on top of the world! It's the most I've ever felt positive about my body. (Terry, *she, any w/respect*)

> I felt intense and competent and supported (Emery, *he/they*).

> My medical team was pretty great. They answered all my questions, talked me through every procedure, and kept things upbeat since they knew I struggled to have a baby. (21)

Feeling in control was also extremely important and memorable to my participants.

> My birth experience was so positive, I decided I'd do it all over again. […] I always felt that I was in control and being listened to. I tried a variety of positions and aids through a combination of midwifery techniques with the benefit of being in a hospital if I or babe needed emergency care." [And] "My OB team had had trans patients before so they were all very affirming and respectful of my gender identity. I only went to their practice and the hospital I gave birth in and both facilities were very supportive (use of inclusive language, asking pronouns for myself and baby). (Alex, *he/they*)

Last but not least, affirmation and inclusion of SGM identities during their care was also critical to a positive experience. Lack of this affirmation and inclusion could have potentially mattered less if the aforementioned factors were present. For example, if a client was treated with respect and autonomy and made to feel safe, a gender-related mistake could potentially have less of a negative effect. If the client did not have some of those baseline comforts, gender-related mistakes could exacerbate and worsen a negative experience. The best experiences though, were those with all of these characteristics:

> I had a surprisingly very positive birthing process. I had some labor at home but then went to the hospital as my contractions became very close together. I had an epidural, which was very successful and still allowed me to have awareness over my body for pushing later. My midwife was amazing -- along with both nurses that were present throughout labor. (Eva, *she*)
>
> My obgyn was incredibly affirming, always gendered me correctly, and caught herself any time she used gendered language to speak about pregnancy in general. Nurses were often less actively affirming, but had no trouble being a baseline level of affirming once they were corrected after misgendering me. (*Mitchell*, *he*)
>
> My experience at the hospital was great, and it was clear that the vast majority of the medical professionals there had been trained on how to give affirming care to transgender patients. (Mitchell, *he*)
>
> [W]e did our own online research and found an OBGYN office that was openly supportive of LGBTQ+/disabled patients and where the primary doctors were a woman and a gay man. My OBGYN really listened, asked good questions, and offered accommodations throughout that made the experience bearable. I've dropped my previous PA and now only see my OBGYN for healthcare. (Harlow, *she, he, they, any, no pronouns*)

It is definitely inspiring to read about the ways in which my participants were treated appropriately and affirmingly. Still, I feel it is important to acknowledge the effort expended on behalf of my participants' providers was by no means extravagant nor beyond their scope. Clients should, at baseline, be receiving treatment that *at least* does not include any of the negative experiences mentioned above, for example. Ideally, providers would also routinely include the fairly basic characteristics described by participants as having contributed to their having a positive pregnancy/birth experience.

The practices, attitudes, and behaviors that are necessary to the provision of positive, inclusive, and affirming health services are often not particularly complex or burdensome; at most, their implementation may require a provider to undergo some supplementary training and practice (i.e. if a provider has not previously been trained and become familiar applying the tenets of trauma-informed care, for example). Engaging in supplementary training/education is a

low-risk, high-reward approach that could ensure the reduction of client harm and the promotion of client satisfaction and fidelity.

6.4.3 Participants' Rationalizations of their Experience

Some level of rationalization for why things occur is expected when you ask people to share their experiences. People typically want to present their best self to others. Still, it did seem as though many of my participants had spent time reflecting on their experience and what factors were likely to have contributed to the good and/or bad outcomes they described. When participants explained *why* they felt they had a positive experience, they seemed to imply, that they knew it wasn't the norm (either for them, or for others alike or different), they hadn't expected it to happen in that way, and/ the positive experience seemed to require some kind of explanation. For example, consider the following statements made by several of my participants:

> I didn't really have any negative experiences. Likely giving birth in a major metropolitan area at a large hospital impacted this. (*Bailey, she*)

> I mostly seek out LGBT-affirming doctors, so most of my healthcare is great. 54 It's totally hit or miss between providers. One's I've chosen or been referred to by providers I already trust, have been fabulous. Ones I've just been assigned to (like that nurse at the IVF clinic [with whom they had a bad experience]) have…not been fabulous. (*Harper, he*)

> My OB was good practically, although definitely a doctor (didn't assume I knew myself, kind of a pill). I elected to have my aunt at the birth because she's a midwife. It made such a difference. We also had a queer nurse while I was in labor, who was so helpful. (*Sam, any w/ respect*)

> I [believe] my answers might be more positive but that is simply because I research every single doctor and practice before making an appointment. It is rare that I see a doctor without having done any research first, that wouldn't normally be an emergency or urgent care situation. (*Eva, she*)

Several of my participants were able to find providers who were affirming and/or seemingly trauma-informed, characteristics I argue played an instrumental role in why many participants report positive pregnancy and birth experiences overall. Most of those participants

paid for that privilege in other ways (or with other privileges). Many, if not all of my participants who described their pregnancy/birth as positive—had those experiences because they had the capacity to engage in proactive efforts geared toward improving their health interactions and outcomes. Those proactive efforts resulted in a privileged experience. This experience occurred while still maintaining their status as holding (and thus experiencing) one or more oppressed identities.

Individuals reporting positive experiences were more likely to have had available to them at least one or more factor serving as a catalyst to make it possible that they would be able to achieve quality healthcare. These participants were able to use some form of social and/or financial capital to negotiate a higher probability that they would have a positive medical experience (i.e. pregnancy/birth outcome). This conceptualization differs from general notions of privilege (and thus access) because it actively incorporates (and applies) the notion that our intersecting identities are pushing and pulling, simultaneously affecting our lived experiences. Additionally, in this scenario, the social and/or financial capital that an individual negotiates isn’t necessarily connected to one of their identities—it could be something as simple as living in a metro area and/or happening to have a trusted friend or colleague with medical connections. Some of these forms of "capital” are/were more involved or costly than others. For example, some of the proactive efforts involved spending significant time searching for (or even interviewing) providers, which is arguably more involved than just happening to live in an area with a larger LGBTQ+ population or having a family member that is a medical provider.

7 CONCLUSION AND LIMITATIONS

There have been several instances during this project where I have personally related to my participants experiences, including the time I began writing this section. I had just sent an exasperated message to one of my medical providers, after several prior attempts to be heard in-person, pleading that they address a complication I was experiencing related to a recent surgery. Not unlike many of my participants, it is so rare for me to feel that the concerns I present relate to my queer, tattooed, "womanly," and (currently overweight) body are taken seriously, that when they are, it comes as a genuine surprise. I do my base my decisions on scientific evidence; I know that prevention and primary care, when possible, are key to promoting good health; I do my best to be proactive in my (and my community's) health and wellbeing; but it is still difficult for me to trust in *providers and practitioners* when so many of my interactions with them, and the *institutions* within which they operate, are negative. I want to be healthy, but I also want to avoid potentially negative experiences where my identities can be a hazard to my care and wellbeing. Sometimes the decision to do the latter (i.e. avoid) is just because of general anxiety (like many have about the doctor); other times, it's a trade off in order to protect my emotional health.

While cultural understandings of gender have begun shifting from a binary focus to a more fluid, spectrum-based focus, for the most part, discrete sex and gender categorization (and related approaches to "care") are still guiding forces within medical environments. Paine (2018: 3) articulates why it is so important for that to change: "Medicine is a key social institution through which social categories are constructed, produced, and reified—as well as (potentially) challenged and redefined." A shift in how (bio)medicine defines and approaches gender and sex would be a major step toward safer and more inclusive medical services. Such a shift would also

require institutions of medical education to (re)educate their current, former, and future pupils on those definitions and how to apply them in practice.

Aside from the legal and "justice" systems in the U.S., there are arguably few other institutions that carry the kind of unchecked power and authority that medicine does. It's as if medicine holds the key to health, and through restrictive social categorization, it determines who is and is *not* worthy of health. Medical hegemony establishes and promotes a model of inequality between provider and client. A client isn't deemed worthy of the knowledge and authority their providers hold; a client's own bodily-awareness is secondhand information, ad-hoc.

From feeling unheard and invisible to being mis-identified or physically violated, the individuals who participated in my study frequently described encounters defined by medical constructs of binary biological sex and conventional interpretations of femininity. There were distinct characteristics associated with participants whose pregnancy/birth experience was positive (overall). Participants with the access and wherewithal to research and select specific providers who had been identified as affirming typically had better experiences.

So, in some ways, the answer to my original question (what happens when someone does not embody or identify with "the 'normal' look of a pregnant woman?") is quite simple: they're often treated differently—meaning—inequitably. Additionally, negative experiences often directly affected participants' attitudes toward and engagement in future medical services. Preventing and/or appropriately handling the missteps I've described would exponentially improve the experiences of SGM folx, mediate disproportionate stress and fear associated with medicine, and over time, reduce medical mistrust. Such actions will, over time, help contribute to an overall reduction in health disparities experienced by SGM and LGBTQ+ populations.

My research suggests that many of the burdens associated with having a minority identity have not been eradicated because the U.S. has become "more liberal." The burdens of gender/sex hegemony have simply shifted or taken on a new form. The exorbitant financial resources necessary to just *try* to get pregnant, for individuals to have to maintain very low expectations going into medical experiences, and/or SGM folx devoting significant time researching doctors, hospitals, and midwifery services as harm reduction. Why does it have to be such hard work to be treated with affirmation and understanding? The truth is it doesn't have to be. I argue that medical providers and institutions simply aren't taking on their share of the burden.

This final chapter will serve to further address relevant and interested audiences, provide implications for policy and practice—including research-based solutions to many of the problems I've discussed— and touch on proposed changes for any potential replications of this study, including limitations and prospective directions for future research.

7.1 Implications for (Sociological) Scholarship, Policy and Practice

If I go back to the basics—the concepts I first learned in my Introduction to Sociology course—the concepts I teach to my Intro students—we (scholars and members of society) know that nothing occurs in a vacuum. We can acknowledge the existence of social norms, and we can follow them or break them, but we can't ever really be entirely outside the ideologies and structures that inform them. The closest we can get is via theory and speculation, but we are still subject to social influence, even if only in subtle ways. Nonetheless, there are still degrees within which we exist, embody, reinforce (and resist) various dominant ideologies. Norms, expectations, and social scripts vary in strength; some are far harder or have more significant consequences should we break them. And yet, people do break (and continue to break, purposefully) even the strongest of norms with the strongest of sanctions. This norm-breaking

indicates that our social world and how we move through it is not, and never will be, as simple as some of our "canonical" fathers theorized. As a sociologist, it is an exceedingly rare occurrence for me to refer to anything as *human nature*; however, I think perhaps, one explanation (of many) for why some of us continue to resist social control over our identities is that the desire for genuine autonomy, agency, and liberation is often stronger than even the most omnipresent and seemingly omnipotent ideologies. As such, over time and place, it has (and could continue to) become the "nature" of some humans to regularly defy certain doctrines should those ideologies be oppressive.

While "who we are" or "what we do" may be counter-hegemonic, who we are is nonetheless *also* a product of existing dominant ideology *to some extent*—at least so long as our current hegemonic structures remain. In this project I am, however, starting from a place that presumes my participants autonomously, and with agency, decided to give birth. Starting from that point, I argue that while we can use our agency to make autonomous decisions even within hegemonic and oppressive structures and institutions, the self we construct and express still exists within and navigates those oppressive structures and institutions. I liken this, in some ways, (with a respectful acknowledgement that I do not equate the lived experiences of racial and gender difference) to DuBois's (1903) concepts of the "veil" and "double-consciousness." DuBois's (1903) development of these concepts helped articulate the unique positioning and experience of African-Americans/Black-Americans in the U.S., specifically, how they navigate and understand a (White) world, how White (U.S.) Americans navigate the same (White) world and the stratification, or veil, between them. He gets at how Black folx negotiate their self-identities as they move through a White world and how they are perceived by White (U.S.) America. DuBois argues this provides Black folx with a *double-consciousness*, or a deeper—and

personal—understanding of the inner workings and stratifications of race and Whiteness in the U.S. This double consciousness is a unique perspective that is integral to understanding (and ameliorating) the problems (i.e., broadly, racism, racial inequity) created when racial stratification, or "the Color Line," is imbued with power and dominance according to White, colonialist ideologues.

Most of my participants articulate (in their own words) that they are not hegemonically (or conventionally) feminine and/or distance themselves from hegemonic femininity in their descriptions of their gender expressions or experiences. While gender hegemony-related ideology and associated concerns (i.e., sanctions, policies, backlash, etc.) did not prevent those in my sample from engaging in pregnancy and birth—acts that some might argue, "aren't for them,"—it did/does influence how others perceive them and how they *believe* others will perceive them. It is worth noting, however, that gender-related ideology and associated concerns did and does prevent some folx from engaging in pregnancy and birth. This is evident in Ryan's earlier research on masculine lesbians (2013) as well as some of my own participants (i.e. they would never do it again, and/or if surrogacy had been a financially viable option they never would have considered getting pregnant/giving birth). Perception and experience are key to understanding the gender and sex related issues permeating medicine, and each of my participants (and all NCF individuals that give birth) possesses their own double-consciousness (or even triple-consciousness) that makes them some of the voices that medical institutions need to *hear* from and *listen* to most. Their experiences are key to understanding the unique issues facing sexual and gender minority populations, as well as preexisting issues related to "women's" health and the medicalization of everyday life.

7.1.1 The Provision of Medical and Midwifery Services

While medicine embraces binary models of gender and sex, there are arguably no legitimate reasons for why such invalid and unreliable models need remain. The institution and field of medicine is routinely making and adapting to technological and medical research advancements. Operating under a binary standard of gender and sex (and sexuality) is like operating with outdated medical equipment: it may kind of work, but it doesn't work well, and clients suffer as a result. It would financially and ethically behoove medical (and related) institutions, contracted businesses, staff, clients, and their families, to (1) accurately and affirmingly measure and record SOGI demographics of all clients; (2) explicitly acknowledge (and educate personnel on) the health disparities and needs of SGM persons, in general and in reproductive medicine specifically; and (3) take steps toward ensuring the provision of equitable and affirming medical and/or midwifery treatment and services to all SGM persons is a priority, via institutional adoption and implementation of the best practices I outline in the next few sections.

My data and findings from this empirical study can quickly and easily be put to use. I plan to create a "best practices" format for use by providers and other relevant staff/personnel in medical, health, and/or appropriate social service settings. These affirming, equity promoting, and trauma-informed practices are meant to assist in engagement with this population and during the provision of their medical services, particularly pregnancy and birth related medical or midwifery services.

7.1.1.1 Medical Administrators (Accounting, Legal, Marketing), Medical Center or Hospital Chairpersons, Trustees, Stakeholders, etc. (i.e. Decision makers and enforcers)

Medical policies and procedures are oft not designed with the well-being of the client in mind, but rather lawsuit prevention and the bottom-line. For example, in my own experience, twice before surgeries, medical staff pushed me to have a pregnancy test because it was "routine"; I was able to successfully resist the testing one of the times, but it took a great deal of energy and I encountered strong resistance even though there was no possible way I could be pregnant. This example, while slightly less relevant in situations where providers are already caring for individuals known to be pregnant, is nonetheless important to SGM health in general. Sometimes routine policies and procedures thought to be useful—like pre-operative pregnancy screenings—can actually be harmful to certain groups.

Forced or coerced and unnecessary pregnancy testing is common, despite neither empirical research nor the American Society of Anesthesiologists deem the practice necessary. These authorities also do not suggest pre-operative pregnancy testing be required by medical organizations (Palmer, Van Norman, and Jackson 2009; Homi and Ahmed 2012; American Society of Anesthesiologists 2016). Research indicates the rates in which a pre-op pregnancy test positively identifies an unknown pregnancy—that *also* would affect the individual's decision to proceed with surgery—are negligible (less than 0.1%). The practice advisory of the ASA Task Force on Pre-anesthesia Evaluation "recommends *offering* an informed patient the opportunity to choose whether or not she wants to have a pregnancy test" (Jackson 2009:24). Requiring the practice is an unnecessary barrier to surgical care, especially in situations where a client has already answered "No" to both "Do you think you might be pregnant?" and "Is there a chance you could be pregnant?" (Strote and Chen 2006; Kerai 2019). Under the guise of "patient care"

(or really, care for a hypothetical fetus), the practice really only serves to protect the legal and financial interests of medical institutions and providers (Kerai 2019). Rather than protect clients, the testing serves to undermine a client's right to bodily autonomy and may instead lead SGM clients to feel unaffirmed and unsafe in the/a medical environment. For what it is worth, forced/coerced pre-operative testing isn't just a threat to the relationship between a provider and an LGBTQ+ client. It could also sour a relationship between a provider and a cis and/or het woman experiencing infertility.

Irrespective of the outcome of a pre-operative pregnancy test, requiring the process, particularly in the absence of reason, can make clients feel as if their voices are irrelevant in what happens to them. Feeling powerless in a medical environment is scary and deeply unsettling. The last thing I want to feel before being placed into a drug-induced unconsciousness is that my medical provider may not be concerned with my personal medical preferences or directives. Organizations can protect their legal interests without infringing on the rights of their clients through a combination of informed consent and documentation wherein the client can waive pre-operative testing. It is important that clients retain their autonomy in medical interactions and that client autonomy is prioritized over fear of future legal action. SGM individuals (as well as non-SGM women and/or persons of color) experience these or related kinds of interactions frequently. When interactions such as these (and other negative interactions addressed in previous sections) occur, they increase stress levels. The negative effects of stress on the body are well documented (Lick, Durso, and Johnson 2013, Frost, Lehavot, and Meyer 2015, APA 2018, NIMH 2018, Marks 2019, Caraballo 2019, Cleveland Clinic 2021, Yaribeygi et al. 2021, Mayo Clinic 2021, and MHF 2021). What does it say about our medical system that engaging in it may only make you sicker (or feel worse) in the long run? As little as one bad medical

interaction (or the expectation of a bad experience) can keep someone from obtaining needed (sometimes even life-saving) medical treatment.

Stakeholders such as board members, leaders, and administrators in medicine must continuously look to empirical research to inform their policies, procedures, and practices. Additionally, application and implementation effectiveness must not be compromised by (short-term) profit-related concerns. Further, it is imperative that more diverse populations be represented and heard in formal research. Academic and government research institutions also have their own limitations where reaching critical populations are concerned. Ongoing collection, compilation, interpretation, and utilization of knowledge from community members is a critical supplement.

Practically speaking, the level and manner in which the above recommendations can be successful are directly related to intent and goals of the organization seeking input. The best way to promote equity is to actively cease, condemn, and implement steps to prevent attitudes and behaviors that promote inequity.

7.1.2 SOGI Measurement (Medical Informatics, EMR/EHR Developers: Client/Patient Facing Staff; Government; Researchers/Scientists)

In addition to better understanding the experiences of NCF individuals who engage in pregnancy and birth, I am also able to illustrate further why the collection of SOGI data is critical to the improvement of LGBTQ+/SGM/TGE health. As mentioned in the previous section, the collection of additional data such as gender identity and pronouns are simple steps organizations can take to improve staff/client relationships and thus the experiences of their SGM clients. Lack of this information (and/or failing to deem such information relevant to serving clients) opens up organizations and providers to countless opportunities for missteps, the effects of which can have

serious, long-term consequences for client health and well-being. The following may be useful to organizations completely new to the issues I've presented in this dissertation and/or organizations that have begun to collect (or are taking steps to begin collecting) SOGI or SOGI-related data. This information is also relevant to researchers. Whether or not researchers wish to specifically target SGM audiences, SOGI data is important demographic information that can help bring visibility to groups and experiences that may otherwise go unnoticed. Research on oppressed groups is often focused on risk and/or only negative experiences. While knowledge gained from such research no doubt serves a purpose and is critically important for scientists to understand, science and research can also be a catalyst for the exploration and celebration of so much more than how we struggle. Similarly, I believe that ongoing innovation and experimentation into how we can reliably and validly measure identities—in increasingly non-binary ways—stands to take us into a new horizon of scientific discovery.

7.1.2.1 "Other:" considerations

In addition to increasing and expanding response option choices for metrics such as gender identity and sexual orientation, it may also be useful to have an *other* option in place. Having non-discrete response options like "Other not listed here" or "Other, please specify" are not inherently wrong or unethical response options when collecting data. In some circumstances, adding an "Other" category may be an organization's most viable option for starting to go beyond the binary in their data collection. However, it is important to know that when an "Other" response option is used as a catchall, it can connote a feeling of othering or lack of respect on behalf of the individual filling out the questionnaire. Ideally, we are able to see ourselves represented when we fill out a form related to and/or before receiving a service. Putting this idea into practice can be more difficult with some identities than others, but it is not impossible, nor is

it unquantifiable. Certain more non-discrete categories simply need more planning and testing, similar to how one might employ various statistical measures to operationalize more abstract concepts for measurements, such as emotions or a state of mind. Inclusion of an "Other, not listed" option can serve a purpose beyond simple categorization. It can also be useful for an organization or researcher to routinely assess the use of an "Other, please specify:" response option. Such specifications provided by respondents or clients will not only inform your research or services but provide an opportunity to assess whether or not your existing response options may need to be reviewed and/or be updated.

7.2 Limitations, Lessons Learned, and Future Research

There are many things that I have learned throughout this research project. If I were to conduct this research a second time, there are a few minor changes that I would make to my survey. For starters, I would change the way that I collected participant income. In a future iteration I would either use response options with smaller income ranges and/or solely a fill in the blank method. The latter may result in more missing data due to stigma around sharing income information, but the numerical values would be more useful statistically speaking. I think it would be worthwhile to be able to collect financial data from this (or a similar) sample so that one could statistically illustrate the economic impact of reproduction on SGM/LGBTQ+ families compared to cis-het families that do not require any kind of assistive reproductive technology or donor eggs/sperm etc.

As in the PRIDE Study researchers did, I would also include the current "validated" SOGI questions for comparison alongside my four-part gender metrics—that was a missed opportunity on my part. I would also consider including a question or two about the representativeness of those metrics and ask for feedback. Most of my participants had gender and

sexual identities not reflected in the "validated" SOGI metrics, and I think it would have been useful to not only get an idea of their decision-making process in a situation in which they are prompted to provide identity information in a restrictive and non-representative manner, as well as their opinions on the matter. Cognitive interviews aimed at understanding intricacies in decision making, identity management, and the communication of non-binary identities would be incredibly meaningful and go far to improve SOGI data collection and how we can affirmingly represent and measure greater nuance with respect to the diversity in SGM identity. Not everyone feels the same way when a form or survey doesn't list their identity. This experience is more painful or traumatic for some compared to others. Regardless, this potential participant-supplied information would be useful to researchers and survey designers who desire to implement inclusive and affirming survey methods in their work.

Several of my participants provided valuable feedback with respect to my survey. Where relevant, I was able to use some of these suggestions in follow-up interviews with select participants. Collecting information about the gender expression of partners, a question or questions related to folx at the intersection of reproduction and disability, and a way for applicable participants to differentiate their experiences across multiple pregnancies are all important suggestions I received. I hope to be able to implement this feedback in future research on this topic.

I grappled quite a bit with not having been able to pay all my participants. I received guidance and assurance on this from my committee, but the issue has nonetheless continued to sit poorly with me. I was able to allot a very small sum ($150) of my own money to those (up to 10, for $15 each) who conducted a brief follow-up interview with me, but I know I would have been able to attract a more racially or economically diverse sample, for example, had I been able to

offer survey respondents compensation as well (regardless of the length of the survey). I know this based on my existing knowledge and experiences, but also because I received that very feedback from someone on Reddit after posting my recruitment flyer in a Women of Colour subreddit.

I firmly believe any/all oppressed groups should be compensated financially for their time. I firmly believe it matters not whether the research is for a good cause, potentially helpful for that particular group, or to "help out a graduate student." Why should a woman of color on reddit help some white stranger complete their dissertation? How many times have women of color used their voices only to be erased by a white woman whose racial privilege gave them more visibility and credibility? Why should they help me get a leg up in the world? "Helping out a graduate student" may not even be a familiar concept for a lot of folx; tons of people don't even know what a dissertation is, and that is OK. Further, how diverse and inclusive can research be if we only hear from fellow academics or highly educated populations with exposure to graduate school lingo and procedures? I do not mean to imply that the voices and experiences of minorities and/or oppressed groups that have staked their claim in academia and/or have attained high levels of education are not relevant; they simply aren't representative of the minorities and/or oppressed groups that do not have those credentials. I'm simply not comfortable with my potential future success (as a result of completing my doctorate) having been a product of unpaid labor. I think more people should be concerned by that. We must organize and determine a course of action for how to change academia's expectation of unpaid labor.

There is the legitimate concern that money can be coercive; however, I think that is really only a concern in situations where there is significant risk involved in participation. Everyone should be paid for their time. We should never ignore concerns about coerciveness, but we must,

at the very least, address the fact that compensation should be non-negotiable, especially when working with populations that routinely experience inequity/inequality. The (eligible) people who participated in research to "help out a graduate student" are invaluable, and I'm extremely grateful to those who did just that for this study. But it is important to note that such folx typically can do so due to greater economic privilege. I firmly believe the ethics and expectations around compensation in human subjects research requires further examination. We need to revisit how to reach and engage with more diverse populations *ethically, respectfully, humbly,* and *equitably*. I learned a great deal from my amazing participants, but I know there are likely experiences missing from this narrative. I think I might have been able to hear from substantially more people had I been able to offer compensation for participation.

I believe research participation should be treated like paid work, not volunteerism. Volunteerism is inherently exploitive for everyone, except the economically privileged. The amount paid should be comparable to the amount of physical or emotional labor involved in the study, like the pay scales of actual jobs. Ideally, the compensation should at least pay a livable hourly rate, preferably a rate matching at least whatever a given participant makes at the time of the research (or more if not a livable wage). For example, if someone is making less than $15 an hour at their full-time job, do you think they're going to want to do more work for less than what they're already struggling to make ends meet with? It's nonsense to think they would, or that they *should*. There are so many surveys I would love to participate in. I'm a scientist—I certainly want to help other scientists, especially those working to shed light on issues facing my communities. But I'm usually too busy or too tired to do so at the end of the day. I deserve to be paid for my time. I firmly believe that there needs to be an in-depth, interdisciplinary review of the ethics surrounding this issue on behalf of the Institutional Review Board. I argue that due to

inequities that still exist, as it stands, a scientist cannot truly or fully implement in their research practices the principles of beneficence, respect for persons, and justice without providing compensation to their participants.

I also believe that funds for national advertising would greatly increase participation in a study like mine. When I worked at Equitas Health, we put a small amount of funds into a few Facebook ads about our campaign to increase mammograms among relevant LGBTQ+ folx, and it was one of the organization's most successful campaigns. This was likely, at least in part, because we had been able to do a photo shoot with real, local LGBTQ+ people at a welcoming and inclusive mammogram provider's office, thus making the campaign highly representative. I believe having similar resources for this project would have greatly increased visibility and participation.

7.3 The End…For Now.

While a lot of the problems associated with medical care in this country can be traced back to medical hegemony and profit-seeking decisions, sometimes you do have to speak the language of the power elite to make important changes. Having said that, this research provides an overview of the issue associated with NCF pregnancy and birth *and* clear courses of action that providers and medical institutions can take to improve their services to SGM people. By applying these principles to medical and midwifery (or other related health) services, providers and institutions will not only promote equity, inclusion, and the opportunity for all to achieve good health, but medical institutions *will* make money while they do it. Doing the right thing can be profitable. Conservative, homonegative, and transphobic values are no longer the majority in this country, and business practices built on such values lack both innovation and the forward thinking necessary to adapt to an ever evolving and increasingly non-binary society.

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APPENDICES

7.4 Appendix A: Outreach Materials

Appendix A.1

Figure 0.1 Flyer Used for Outreach (Left: Initial, Right: Adjusted)

Appendix A.2

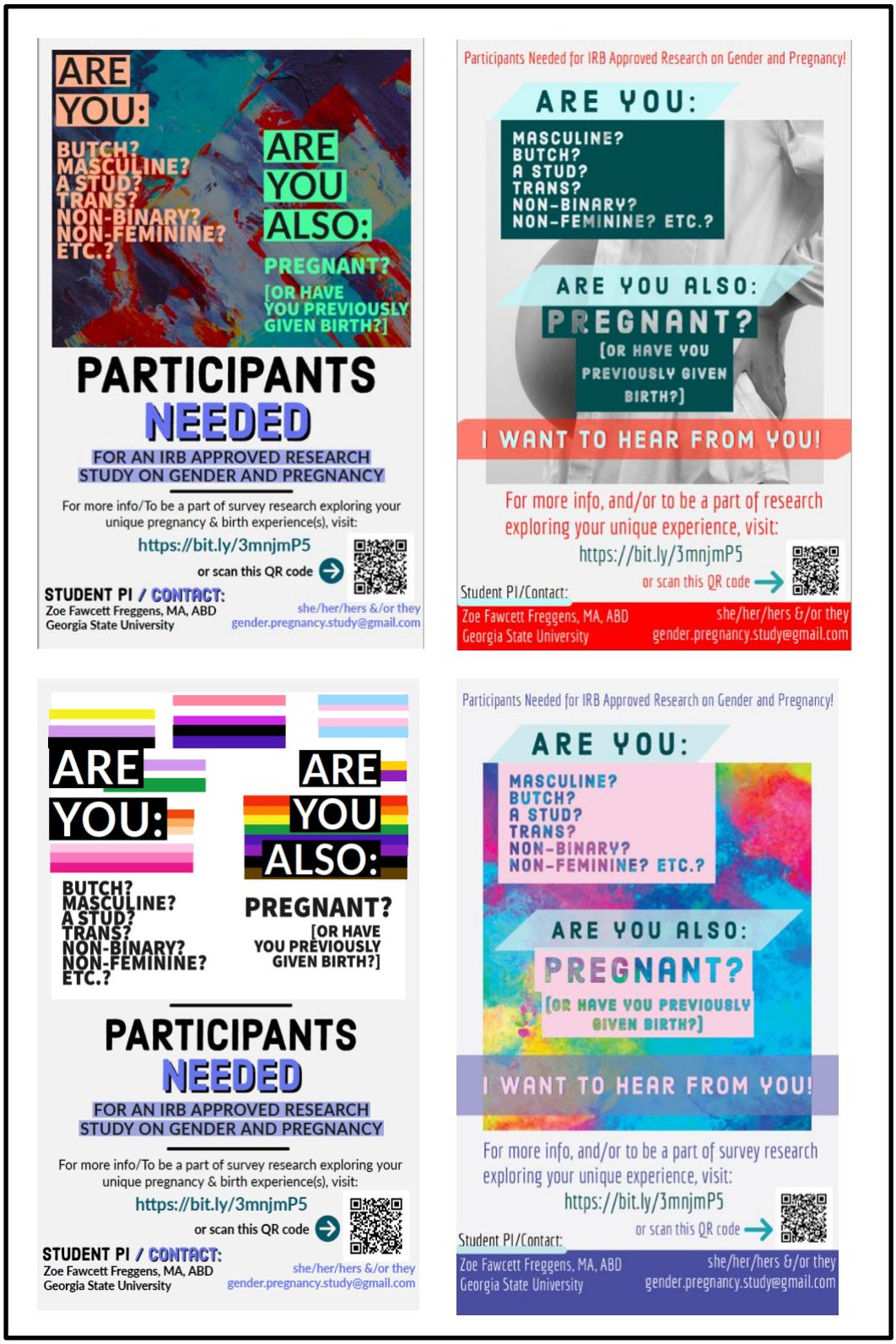


Figure 0.2 Additional Outreach Flyers

7.5 Appendix B: Organ and Gender Affirming Surgery Inventory Questions

Sexual and/or Reproductive Organ Inventory

Pretend the below graphic is intended to represent *your* body. Please select the body parts or organs that you have at this time.

Important Note: For the purposes of this study, if you've had gender or sex-affirming top surgery to remove your breast tissue, please select 'chest' (unless you prefer to and continue to refer to the area as your breast(s)).

Why am I asking this?: Research indicates the asking of this question is part of a method that promotes the provision of welcoming and inclusive medical care. As this study relates to that topic, and specifically pregnancy, I wanted to include the question as well. Again, all participation is voluntary and you may skip this question, or stop, at any time.

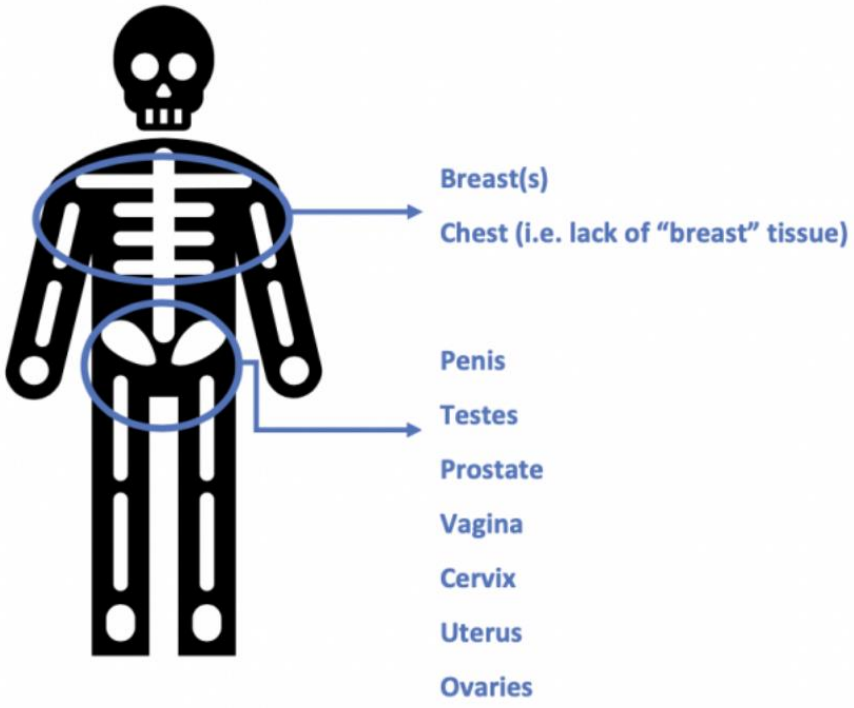


Figure 0.3 Sexual and/or Reproductive Organ Inventory

Have you undergone any type(s) of gender or sex-affirming surgery?

- ◯ Yes
- ◯ Not yet, but I want to.
- ◯ No, and currently don't plan to.

Gender-Affirming Surgery Inventory

Pretend the below graphic is intended to represent *your* body. Please select the names of any gender or sex affirming surgeries that you have had.

Important Note: Please do not include surgeries that you may have had for reasons other than to affirm your gender or sex (i.e. a cancer related mastectomy).

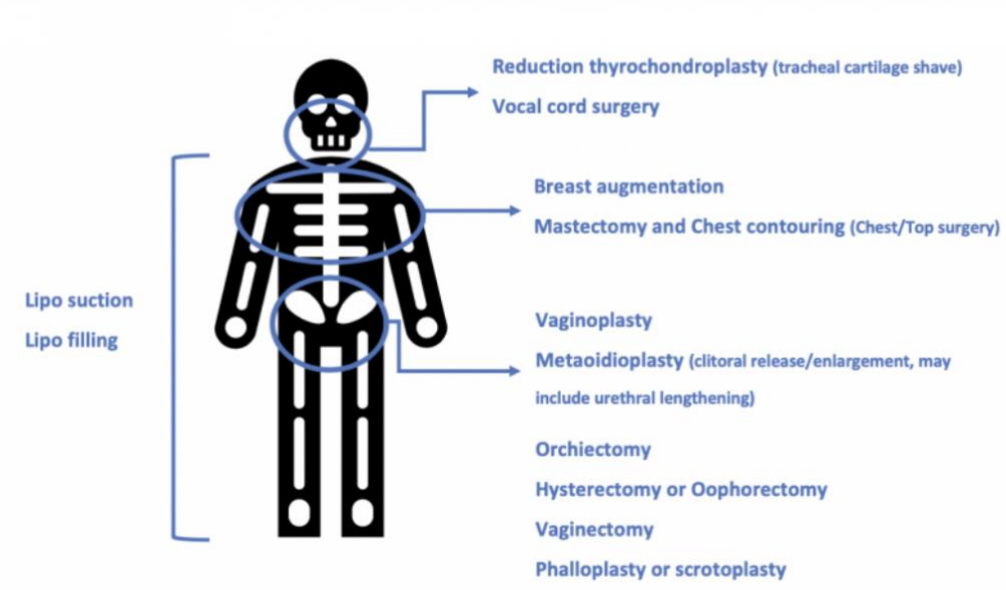


Figure 0.4 Gender Affirming Surgery Inventory Questions

7.6 Appendix C: Referenced Reddit Interaction

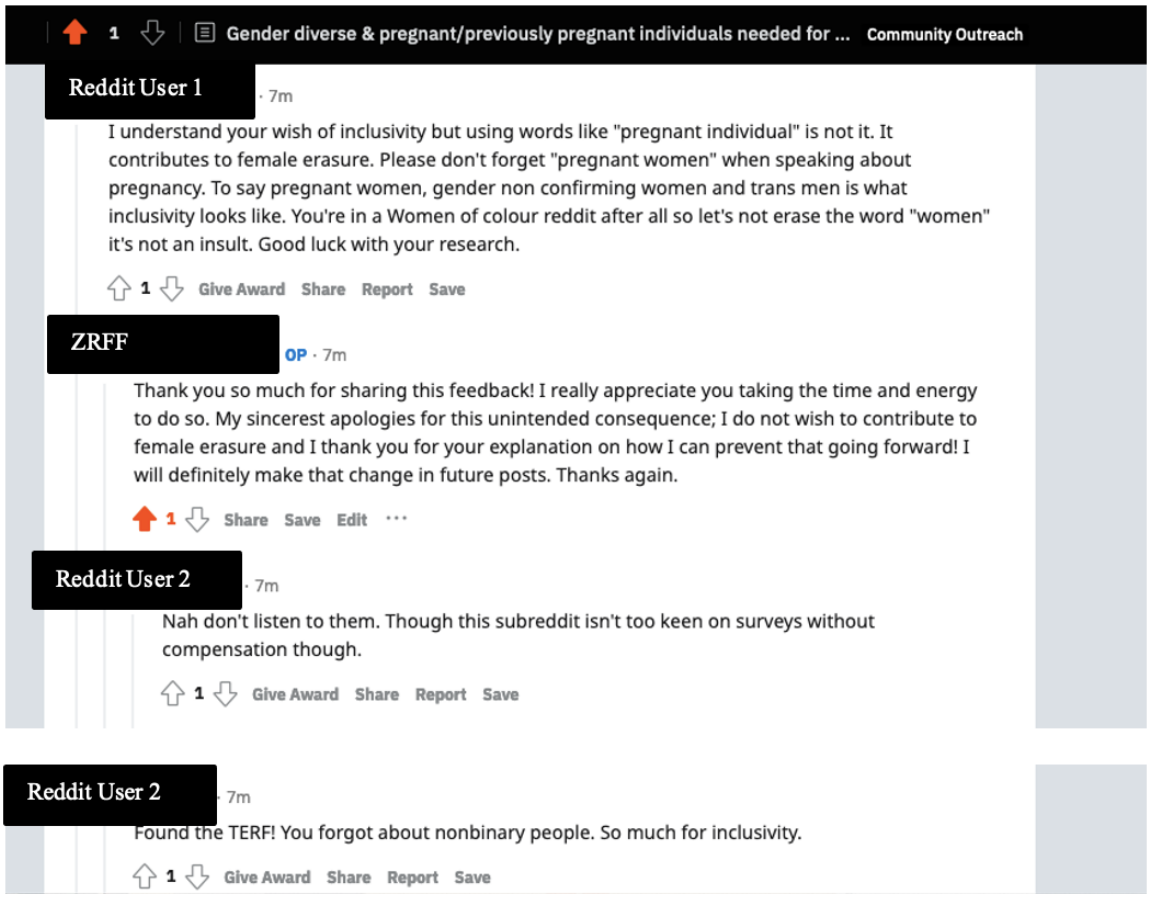


Figure 0.5 Screenshot of Interaction with Reddit Users

7.7 Appendix D: Eligibility Questionnaire

Are you *currently* pregnant?

- Yes
- No
- I don't know

Have you *been pregnant* and/or *given birth* previously?
(Please select the best answer from those below, regardless of the circumstances of the pregnancy and/or birth.)

- Yes. I have been pregnant and given birth.
- I have been pregnant, however I have not given birth.
- No. I have never been pregnant nor given birth.

Are you considering becoming pregnant in the future?

- Yes
- Maybe
- No
- I don't know

Display This Question:
If Are you currently pregnant? = No
And Have you been pregnant and/or given birth previously? (Please select the best answer from those b... = No. I have never been pregnant nor given birth.
Or Have you been pregnant and/or given birth previously? (Please select the best answer from those b... = I have been pregnant, however I have not given birth.
And Are you considering becoming pregnant in the future? = No

Is your decision not to become pregnant/give birth at all related to your gender identity or expression?

- Yes
- No
- I don't know

Do you consider yourself belonging to or identifying with any of the following categories or descriptions? (Choose any and all that apply to you.)

- ☐ Masculine woman
- ☐ Butch or Butch woman
- ☐ Non-feminine woman
- ☐ Stud
- ☐ Tomboy or Tomboi
- ☐ STEM
- ☐ Gender non-conforming
- ☐ Non-binary or enby
- ☐ Gender queer
- ☐ Trans-masculine
- ☐ FTM
- ☐ Transgender man
- ☐ Any other gender classification that differs from "traditional" constructions of femininity or "womanhood." Please describe:_____
- ☐ No, or none of the above.

Display This Question:
If Do you consider yourself belonging to or identifying with any of the following categories or desc... = No, or none of the above.

In your own words, briefly describe your gender identity and gender expression.
_____
_____

Did you also identify with your answer choice(s) from the previous question at the time of your pregnancy?

- Yes
- Somewhat
- No
- Does not apply to me.

Display This Question:
If Did you also identify with your answer choice(s) from the previous question at the time of your p... = No

Please describe your gender identity and gender expression at the time of your pregnancy.
_____
_____

How did you find out about this study?

- Reddit, please specify subreddit _____
- Facebook
- Twitter
- Research Match
- Friend
- Family member
- Co-worker
- Other, please specify _____

What is your email address?
Important Note: *If you do not supply an email address, I will not be able to contact you to participate in the study. Your email will not be shared or used for any other purpose beyond the study.*

7.8 Appendix E: Full Survey

Gender and Pregnancy Study

Start of Block: Informed Consent

Q1.1 You are invited to participate in a research study. The goal of the study is to collect information about the pregnancy and birth experiences of non-feminine, or non-conventionally feminine, individuals.

…

At the end of this survey you will see a summary of your responses This will include the informed consent. Please save or print a copy for your records. You can also contact the student PI, Zoe Fawcett Freggens, for a copy of your informed consent.

By consenting to participate, you assert that you are at least 18 years of age or older.

Q1.2 Would you like to participate in this study?

- ○ Yes. I consent. (1)
- ○ I need more information before I consent. (2)
- ○ No. I do not consent. (3)

Skip To: Q1.4 If Would you like to participate in this study? = 1
Skip To: Q1.3 If Would you like to participate in this study? = 2
Skip To: End of Survey If Would you like to participate in this study? = 3

Display This Question:
If Would you like to participate in this study? = 2

Q1.3 For more information about this study, please contact Zoe Fawcett Freggens at gender.pregnancy.study@gmail.com or (252) 489-9000.

Display This Question:
If Would you like to participate in this study? = 1

Q1.4 Thank you for your willingness to participate in this study!
What is your email address?
Important Note: For security purposes, to ensure you are the intended recipient. Your email will not be shared with anyone outside of the study.

_____

Page Break

End of Block: Informed Consent

Start of Block: Demographic and Background Information

Q2.1 This next section will ask you for important demographic information, including a few questions related to your medical history.

Important Note: Your answers to the questions in this section are confidential. Everything will be de-identified (separated from your name and/or other identifiable information). This demographic information, like any other identifiable information, will be kept private and protected to the fullest extent of the law.

Page Break

Q2.2 What is your first name and/or what do you like to be called?

Important Note: You do not need to provide your last name.

Why am I asking this?: Collection of your name ensures that any potential pseudonym that could be assigned to your responses is dissimilar enough from your actual name.

_____

Q2.3 What is your age?

- Under 18 (0)
- 18 - 24 (1)
- 25 - 34 (2)
- 35 - 44 (3)
- 45 - 54 (4)
- 55 - 64 (5)
- 65 - 74 (6)
- 75 - 84 (7)
- 85 or older (8)

Q2.4 What is your highest level of education?

- Grade 8 or below (1)
- Some high school (2)
- Graduated from high school or GED (3)
- Some college (4)
- Graduated from a two or four year college (5)
- Some graduate school (6)
- Graduated with an advanced degree of any kind (for example, M.A., M.S., Ph.D., M.D., J.D., etc.) (7)

Page Break

Q2.5 Including yourself, how many people reside in your household?
Important Note: Please only include yourself and those you care for financially or share financial responsibility with (i.e. do not include housemates that you do not support or share income with in some way).

▼ 1 (1) ... 12 or more. (12)

Q2.6 Please select an income range that is closest to your current estimated annual income.
Important Notes: If you reside in a multiple income household, please choose the category that closest reflects your total shared household income.
If you are comfortable sharing a more precise annual income (rather than a range) please do so in the text box at the end of the answer choices.

- ○ Less than $15,000 (1)
- ○ $15,000-$24,999 (2)
- ○ $25,000-$34,999 (3)
- ○ $35,000-$44,999 (4)
- ○ $45,000-54,999 (5)
- ○ $55,000-$64,999 (6)
- ○ $65,000-$74,999 (7)
- ○ $75,000-$84,999 (8)
- ○ $85,000-$94,999 (9)
- ○ $95,000-$104,999 (10)
- ○ $105,000-$114,999 (11)
- ○ $115,000-$124,999 (12)
- ○ $125,000-$134,999 (13)
- ○ $135,000-$144,999 (14)
- ○ $145,000-$154,999 (15)
- ○ $155,000 or more (16)
- ○ ***Precise Amount:** (88) _____

Page Break

Q2.7 In which state (or territory) do you currently reside?

▼ Alabama (1) ... I do not reside in the United States (53)

Q2.8 Which of the following best describes the area in which you currently live?

- ○ Rural (under approximately 10,000 residents) (1)
- ○ Town or city (with approximately 10,000 to 50,000 residents) (2)
- ○ Central city or Major metropolitan area (with over 50,000 residents) (3)
- ○ Suburbs of a city (with over 50,000 residents) (4)

Q2.9 Is the United States your country of origin?

- ○ Yes (1)
- ○ No (0)
- ○ I don't know (2)

Q2.10 Have you ever lived outside the United States?
Important Note: Do not include vacation or temporary travel.

- ○ Yes (1)
- ○ No (0)
- ○ I don't know (2)

Display This Question:
If Have you ever lived outside the United States? Important Note: Do not include vacation or tempo... = 0

Q2.11 Where else have you lived, for how long, and at what age(s)?

_____
_____
_____
_____
_____

Page Break

Q2.12 With which racial and/or ethnic group(s) do you belong to and identify with?
<u>Important Note:</u> Feel free to answer this question in your own words and/or select any/all that you identify with from the list below.

- ☐ My race(s)/ethnic group(s) in my own words: (89) _____
- ☐ Mixed Race (1)
- ☐ Bi-Racial (2)
- ☐ Black (3)
- ☐ African American (4)
- ☐ African. Please specify (i.e. Kenyan, Ethiopan, Eritrean, etc.): (5) _____
- ☐ White or Caucasian (6)
- ☐ Eastern European. Please specify (i.e. Russian, Croatian, Serbian, etc.) (7)_____
- ☐ Western European. Please specify (i.e. French, Danish, Irish, etc.) (8)
- ☐ Middle Eastern or Arab. Please specify (i.e. Iranian, Turkish, Saudi, etc.) (9) _____
- ☐ Chinese (10)
- ☐ Filipino (11)
- ☐ Asian Indian (12)
- ☐ Vietnamese (13)
- ☐ Korean (14)
- ☐ Japanese (15)
- ☐ Other Asian identity not listed here (i.e. Hmong, Bengali, etc.). Please specify: (16)____
- ☐ Indigenous Peoples, American Indian, or Alaska Native. Please specify: (17))____
- ☐ Native Hawaiian (18)
- ☐ Samoan (19)
- ☐ Chamorro (20)
- ☐ Other Pacific Islander not listed here (i.e. Tongan, Fijian, etc.). Please specify: (21) ____
- ☐ Hispanic, Latinx, or Spanish origin. Please specify (i.e. Mexican, Cuban, Dominican, etc.): (22) _____
- ☐ Some other race(s)/ethnic group(s) not listed here: (88) _____

Page Break

Q2.13 What is your gender identity?
Important Note: Please enter how you self-identify (i.e. woman, man, non-binary, cis-, trans- etc.)

_____

Q2.14 How would you describe your gender expression? How do you express your gender identity? Provide enough detail to give me an overall picture of yourself on a typical day.
For example: hairstyle, clothing choice, hobbies, career, etc. These may be 'traditional,' in that they are things often associated with a certain gender (a button down shirt and a bowtie is often seen as masculine), or they can be things that you attribute to your own construction of gender outside a binary understanding of femininity and masculinity. Either way, please describe how you express your gender identity.

_____
_____
_____

Q2.15 How well do feel the following words describe or identify you?
(Select any/all that apply to you at any given time.)

- ☐ Masculine (1)
- ☐ Androgynous (2)
- ☐ Feminine (3)
- ☐ None of these describe me. (4)
- ☐ Other gendered descriptor not listed here. Please specify: (88)

_____

Q2.16 Do you identify as trans or transgender, gender-non-conforming, genderqueer, gender-fluid, or non-binary?
(Select any/all that apply to you)

- ☐ Yes, trans (1)
- ☐ Yes, transgender (2)
- ☐ Yes, gender-non-conforming (3)
- ☐ Yes, genderqueer (4)
- ☐ Yes, gender-fluid (5)
- ☐ Yes, non-binary (6)
- ☐ I don't know or I'm not sure. (7)
- ☐ I identify with another term: (88) _____
- ☐ I do not identify with any of these (8)
- ☐ No, I identify as cisgender (9)

Q2.17 What pronouns do you use?
(Select any/all that apply to you)

- ☐ she/her/hers (1)
- ☐ he/him/his (2)
- ☐ they/them/their (3)
- ☐ xe/xem/xyr (4)
- ☐ ze or zie/hir/hirs (5)
- ☐ No pronouns (6)
- ☐ Any or all, with respect (7)
- ☐ Other not listed here. Please specify: (88)

_____

Q2.18 What is your sex?
Important Note: Please answer how you self-identify (i.e. male, female, intersex, etc.)
Your answer does NOT have to match your legal sex or how you may have formally been categorized at birth.

_____

Q2.19 Does your current sex differ from your legal sex or your sex assigned at birth?
Important Note: This question in no way intends to delegitimize your self-identified gender or sex categories. It is intended only to provide the researcher with context about your sex and gender identities, expressions, and experiences.

- ○ Yes (1)
- ○ No (0)
- ○ Prefer not to answer (3)
- ○ Other. Please specify: (88) _____

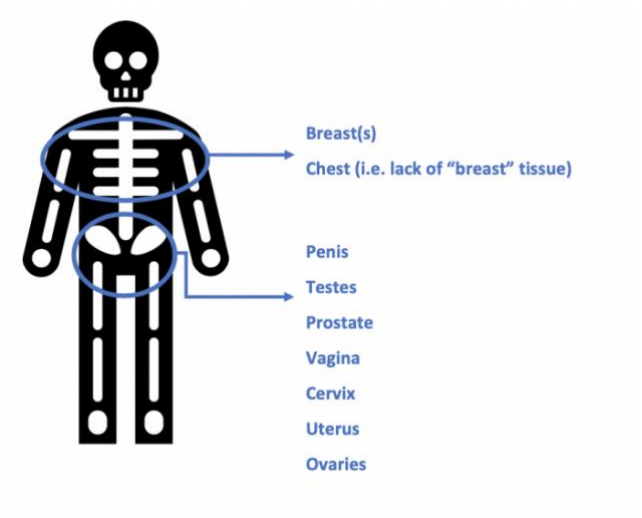
Page Break

Q2.20 Sexual and/or Reproductive Organ Inventory

Pretend the below graphic is intended to represent *your* body. Please select the body parts or organs that you have at this time.

Important Note: For the purposes of this study, if you've had gender or sex-affirming top surgery to remove your breast tissue, please select 'chest' (unless you prefer to and continue to refer to the area as your breast(s)).

Why am I asking this?: Research indicates the asking of this question is part of a method that promotes the provision of welcoming and inclusive medical care. As this study relates to that topic, and specifically pregnancy, I wanted to include the question as well. Again, all participation is voluntary and you may skip this question, or stop, at any time.

	Off (1)	On (2)
Breast(s) (7)		
Chest (8)		
Uterus (9)		
Vagina (10)		
Cervix (11)		
Penis (12)		
Testes (13)		
Prostate (14)		
Ovaries (15)		

Q2.21 Have you undergone any type(s) of gender or sex-affirming surgery?

- Yes (2)
- Not yet, but I want to. (1)
- No, and currently don't plan to. (0)

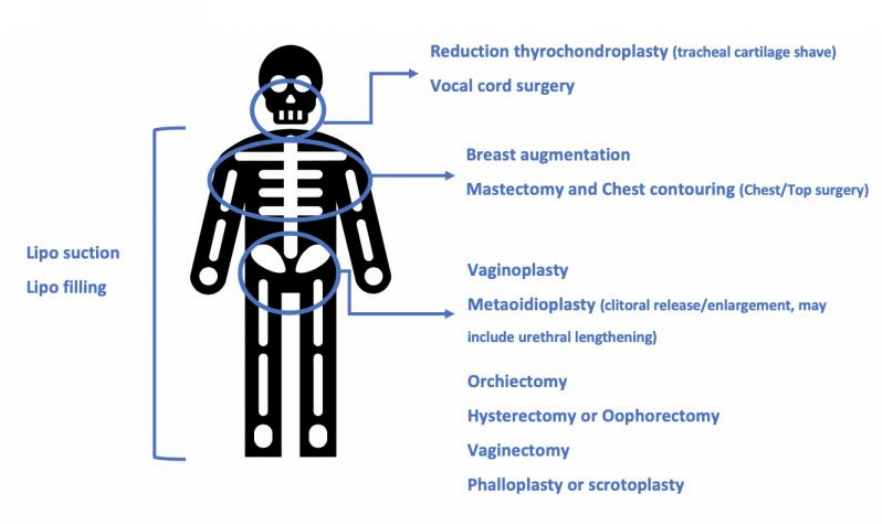
Skip To: Q2.22 If Have you undergone any type(s) of gender or sex-affirming surgery? = 2
Skip To: Q2.23 If Have you undergone any type(s) of gender or sex-affirming surgery? = 1
Skip To: Q2.24 If Have you undergone any type(s) of gender or sex-affirming surgery? = 0

Q2.22 Gender-Affirming Surgery Inventory

Pretend the below graphic is intended to represent *your* body. Please select the names of any gender or sex affirming surgeries that you have had.

Important Note: Please do not include surgeries that you may have had for reasons other than to affirm your gender or sex (i.e. a cancer related mastectomy).

	Off (1)	On (2)
Reduction thyrochondroplasty (7)		
Vocal cord surgery (8)		
Breast augmentation (9)		
Chest/Top surgery (10)		
Vaginoplasty (11)		
Metaoidioplasty (12)		
Orchiectomy (13)		
Hysterectomy or Oophorectomy (14)		
Vaginectomy (15)		
Phalloplasty or scrotoplasty (16)		
Lipo suction (17)		
Lipo filling (18)		

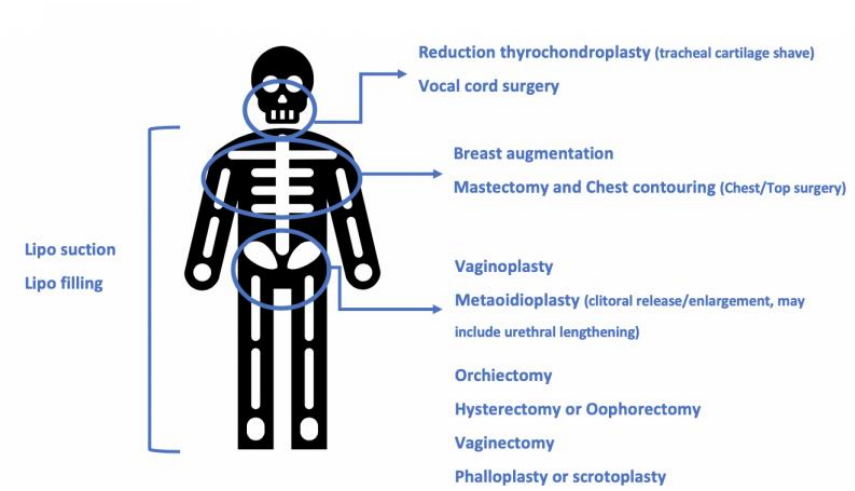


Q2.23 Gender-Affirming Surgery Inventory

Now pretend the below graphic is intended to represent your *ideal* body. Please select the names of any gender or sex affirming surgeries that you *would like to have.*

Important Note: Please do not include surgeries that you may need/want to have that are not related gender or sex affirmation.

	Off (1)	On (2)
Reduction thyrochondroplasty (7)		
Vocal cord surgery (8)		
Breast augmentation (9)		
Chest/Top surgery (10)		
Vaginoplasty (11)		
Metaoidioplasty (12)		
Orchiectomy (13)		
Hysterectomy or Oophorectomy (14)		
Vaginectomy (15)		
Phalloplasty or scrotoplasty (16)		
Lipo suction (17)		
Lipo filling (18)		



Q2.24 How did you feel about answering the organ and surgery inventory questions?

Important Note: If you chose to skip them, just put "N/A."

_____

_____

_____

Q2.25 Have any medical providers ever asked you these (or similar) questions?

- Yes (20)
- Maybe (21)
- No (22)

Q2.26 Rate your level of agreement/disagreement with the following statements:

	Strongly agree (5)	Somewhat agree (4)	Neither agree nor disagree (3)	Somewhat disagree (2)	Strongly disagree (1)
⊗Medical providers should conduct an organ and/or surgery inventory with all new patients. (8)	○	○	○	○	○
⊗Medical providers should conduct an organ and/or surgery inventory with all gender minority patients. (9)	○	○	○	○	○
⊗Medical providers should NOT be collecting this information from any patients. (10)	○	○	○	○	○
⊗Medical providers should only collect this from applicable patients. (11)	○	○	○	○	○
⊗I don't see the point of medical providers asking these inventory questions. (12)	○	○	○	○	○
⊗Related other not listed here, Please specify: (13)	○	○	○	○	○

Q2.27 With what sexual preferences, orientations, or identities do you identify?
Important Note: Please enter how you self-identify your sexual identity (i.e. heterosexual, straight, same gender loving, bisexual, queer, asexual, etc.)

_____

Q2.28 Do you consider yourself a member of the LGBTQ+ or LGBTQIAA+ community?

- ○ Strongly agree (7)
- ○ Agree (6)
- ○ Somewhat agree (5)
- ○ Neither agree nor disagree (4)
- ○ Somewhat disagree (3)
- ○ Disagree (2)
- ○ Strongly disagree (1)

Q2.29 Are you currently in any kind of romantic and/or sexual relationship or partnership?

- ○ Yes, romantic (1)
- ○ Yes, romantic and sexual (2)
- ○ Yes, sexual (3)
- ○ No/not currently (4)
- ○ It's complicated (5)

Q2.30 Which of the following best describes you and your relationships?

- ○ Completely or exclusively monogamous (not at all open) (1)
- ○ Generally monogamous (2)
- ○ Generally polygamous (3)
- ○ Completely or exclusively polygamous, or completely open (4)
- ○ Other, please specify in your own words: (88)

_____

Q2.31 What is your current marital and/or partnership status?

- ☐ I am married and living with my spouse/partner(s). (1)
- ☐ I am married but not currently living with my spouse/partner(s). (2)
- ☐ I have a partner or partners but we do not live together. (3)
- ☐ I'm not married and I live with a partner or partners. (4)
- ☐ I'm not married nor do I live with a partner or partners. (5)
- ☐ I'm not married and I do not have a parter or partners at this time. (6)
- ☐ None of the above. Please specify: (88)

_____

Q2.32 Do you currently have health insurance?

- Yes (1)
- No (0)
- I don't know (2)

Q2.33 Did you/will you have health insurance during your pregnancy and/or at the time of your child's birth?

- Yes (1)
- No (0)
- Does not apply to me (62)

Q2.34 What type of insurancedo you have?

- Health maintenance organizations (HMOs) (1)
- Preferred provider organizations (PPOs) (2)
- Exclusive provider organizations (EPOs) (3)
- Point-of-service (POS) plans (4)
- Catastrophic plan (5)
- High-deductible health plans (HDHPs) and/or Health Savings Accounts (HSAs) (6)
- I have no idea. I just know I have insurance. (7)
- All I know is I get it from my employer. (8)
- I'm on my partner's insurance. (9)
- Other not listed here. Please specify: (88)

_____

Page Break

End of Block: Demographic and Background Information

Start of Block: Pregnancy and Birth Decisions and Experiences

Q3.1 In this next section you will begin answering questions about your pregnancy/birth decisions and experiences. Where relevant, please include as much detail as you are comfortable sharing.

Page Break

Q3.2 Do you currently have or care for any children?
(Select any/all that apply to you at this time)

- ☐ Yes, I currently have or care for a child or children. (1)
- ☐ I have previously given birth to one or more children. (7)
- ☐ I'm currently pregnant. (2)
- ☐ My partner/spouse (or a surrogate) is currently pregnant. (3)
- ☐ Yes, my partner/spouse has children that I consider mine and/or care for. (4)
- ☐ I am in the process of adopting a child or children. (5)
- ☐ No, I do not currently have or care for any children. (6)
- ☐ Other not listed here. Please specify: (88)

_____

Display This Question:
If Do you currently have or care for any children? (Select any/all that apply to you at this time) = 1
And Do you currently have or care for any children? (Select any/all that apply to you at this time) = 7
Or Do you currently have or care for any children? (Select any/all that apply to you at this time) = 4

Q3.3 How many children do you have?
Important Note: Include any children you consider your own, regardless of whether or not you share genetic material. Do NOT include unborn children, i.e. if you are currently pregnant.

_____

Q3.4 Do you currently share parental responsibilities with anyone?

- ○ Yes (3)
- ○ Sometimes (on a regular basis) (2)
- ○ Sometimes (incosistently) (1)
- ○ No (0)
- ○ Does not, or does not yet, apply to me. (62)

Q3.5 Have you gone through a physical birth (including c-section) with ***any*** child or children in your care?

- ○ Yes, I physically gave birth to a child or children in my care. (5)
- ○ No. I did not. (4)
- ○ No, but my partner or spouse did. (3)
- ○ Not yet, but I will be in the near future. (2)
- ○ No, but I will at some point in the future. (1)
- ○ Other not listed here. Please specify: (88)

_____

Display This Question:
If Have you gone through a physical birth (including c-section) with any child or children in your c... = 5

Q3.6 How old were you (or will you be) at the time of your ***first*** birth?

_____

Display This Question:
If Have you gone through a physical birth (including c-section) with any child or children in your c... = 5

Q3.7 ***If you've given birth more than once:*** how old were you at the time of each of your births? Please list the ages in the field below i.e.: 21, 35, 37, etc.

_____

Q3.8 *True or False:* I have given birth as a surrogate for someone else.

- ○ True (1)
- ○ False (0)

Page Break

Display This Question:
If Have you gone through a physical birth (including c-section) with any child or children in your c... = 5

Q3.9 Did you give birth in a hospital?

- Yes (1)
- No (0)

Display This Question:
If Did you give birth in a hospital? = 0

Q3.10 Where did you give birth?

_____
_____
_____

Q3.11 ***For those that have NOT YET given birth:*** Whom would you like to have with you when you give birth?

For those that HAVE given birth: Whom was with you while you gave birth?

Was there anyone whom you wish had been there that wasn't? Anyone that was there whom you wish hadn't been?

Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____
_____

Q3.12 Do you identify (or plan to identify) with any of the following?:
(Select any/all that apply to you)

- ☐ Mother (1)
- ☐ Mom (2)
- ☐ Mama (3)
- ☐ Mommy (4)
- ☐ Father (5)
- ☐ Dad (6)
- ☐ Papa (7)
- ☐ Daddy (8)
- ☐ Parent (9)
- ☐ None of the above. (10)
- ☐ I don't know. (11)
- ☐ I haven't given it much thought. (12)
- ☐ Other not listed here. Please specify: (88)

_____

Display This Question:
If Do you identify (or plan to identify) with any of the following?: (Select any/all that apply to you) = 10

Q3.13 What do you (or will you) call your role as a caregiver to your child/children?
_____

Q3.14 If different from your previous answer(s), what does/do your child/children call you?
_____

Page Break

Q3.15 *Trigger Warning (TW): consent, rape, sexual assault.*
The next question could potentially cause you some discomfort. I do not intend to cause you any harm. This question is in place to determine whether or not it was your choice to become pregnant and/or whether or not the acts that led to your pregnancy were consensual.

Like any of the questions in this survey, your answers are voluntary, however because of the

sensitive and potentially triggering nature of the next question, you may first choose whether or not you would like the question to be displayed.

- ○ I would like to skip this question. (1)
- ○ I would like you to display this question. (2)

Skip To: Q3.18 If Trigger Warning (TW): consent, rape, sexual assault. The next question could potentially cause y... = 1
Skip To: Q3.16 If Trigger Warning (TW): consent, rape, sexual assault. The next question could potentially cause y... = 2

Page Break

Display This Question:
If Trigger Warning (TW): consent, rape, sexual assault. The next question could potentially cause y... = 2

Q3.16 Did you choose to become pregnant?

- ○ Yes (1)
- ○ No (0)

Display This Question:
If Trigger Warning (TW): consent, rape, sexual assault. The next question could potentially cause y... = 2

Q3.17 If you would like to expand upon your answer to the previous question, please do so below.

_____
_____
_____

Display This Question:
If Trigger Warning (TW): consent, rape, sexual assault. The next question could potentially cause y... = 2

Q3.18 Thank you for considering these potentially sensitive questions. Please continue the survey on the next page.

Page Break

Q3.19 In your own words, tell me about your decision to engage in (or continue your) pregnancy/birth.

_____
_____
_____

Q3.20 In your own words, describe how you feel your ***race*** played a role in shaping your decision to engage in pregnancy/birth.
Important Note: When answering this question, please do not feel as if you need to try to separate your race from your other identities to answer this question. Please speak about them however they may (or may not) intersect. As such, feel free to skip either of the next two questions if you've already addressed them in this or another field.

_____
_____
_____

Q3.21 In your own words, describe how you feel your ***gender*** **(i.e identity, expression, etc.)** played a role in shaping your decision to engage in pregnancy/birth.
Important Note: When answering this question, please do not feel as if you need to try to separate your gender from your other identities to answer this question. Please speak about them however they may (or may not) intersect. As such, feel free to skip any (of these three) questions if you've already addressed them in this or another field.

_____
_____
_____

Q3.22 In your own words, describe how you feel your ***class*** played a role in shaping your decision to engage in pregnancy/birth.
Important Note: When answering this question, please do not feel as if you need to try to separate your class from your other identities (including the two previous ones) to answer this question. Please speak about them however they may (or may not) intersect. Again, feel free to skip any (of these three) questions if you've already addressed them in a previous field.

_____
_____
_____

Q3.23 Prior to getting pregnant and/or giving birth, which of the following most closely fit with your thoughts about having children?

- ○ "Will I have kids?" (1)
- ○ "When will I have kids?" (2)

Q3.24 Please rate your level of agreement or disagreement with the following statements:

	Strongly agree (5)	Somewhat agree (4)	Neither agree nor disagree (3)	Somewhat disagree (2)	Strongly disagree (1)
⊗I've wanted to have kids for as long as I can remember. (11)	○	○	○	○	○
⊗I didn't used to want kids but I changed my mind over time. (12)	○	○	○	○	○
⊗I've gone back and forth over the years regarding whether I want(ed) kids. (13)	○	○	○	○	○
⊗My partner wanted kids. (14)	○	○	○	○	○
⊗My partner and I both wanted kids. (15)	○	○	○	○	○
⊗I don't, or didn't really, want kids. (18)	○	○	○	○	○
⊗I would be OK whether I had/have kids or not. (19)	○	○	○	○	○
⊗I've NOT wanted kids for as long as I can remember. (16)	○	○	○	○	○
⊗I want(ed) kids, but I don't/didn't want to birth them myself. (17)	○	○	○	○	○
⊗Being pregnant/giving birth fits within my gender identiy and expression. (20)	○	○	○	○	○
⊗Being pregnant/giving birth does NOT fit within my gender identity and expression. (21)	○	○	○	○	○

Page Break

Q3.25 What were your fears going into, during, and/or after the pregnancy and/or the birth?

_____
_____
_____

Q3.26 Tell me about your experience being pregnant.

_____
_____
_____

Q3.27 Whom did you tell you were pregnant and at what point did you tell those individuals?
Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____
_____

Q3.28 How did you decide whom to tell and/or whom not to tell?
Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____
_____

Page Break

Q3.29 What positive feedback or interactions with others (friends, family, co-workers, strangers) did you have while you were pregnant? Please describe.

_____
_____

Q3.30 During or after your pregnancy, did you experience any of the following interactions with folks you did not know well and/or strangers?
(Select any/all that apply)

- ☐ Being asked when you were due (2)
- ☐ Looks or comments about your weight and/or size (1)
- ☐ Touching you without your consent (i.e. touching your belly) (3)
- ☐ Any issues regarding public breast/chest feeding (4)
- ☐ Any other questions about your body/pregnancy that you felt were invasive. Please specify: (88) _____
- ☐ Other interaction not listed here. Please specify: (89) _____

Q3.31 Did you encounter any problems or conflicts while you were pregnant? (i.e. physical, social, financial, etc.)
Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____
_____

Q3.32 What negative feedback or interactions with others (friends, family, co-workers, strangers) did you experience while you were pregnant? Did you experience any prejudicial or discriminatory comments or actions? Please describe.
Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____
_____

Q3.33 Please describe your reactions/responses to the above backlash and/or negative encounters?

_____
_____
_____

Q3.34 If it differs from how you reacted or responded in those encounters, how do you wish you (could) have responded? Why did you choose to react the way you did?

_____
_____
_____

Page Break

Q3.35 Describe your experience(s) with clothing (including shoes and any relevant accessories) while you were pregnant (or post-birth).

_____
_____
_____

Q3.36 Were you able to find comfortable clothes that aligned with your typical pre-pregnancy gender expression?

_____
_____
_____

Q3.37 Did you ever feel unsafe in public or at work while you were pregnant?

_____
_____
_____

Q3.38 Did you have a support system while you were pregnant/when you gave birth? If so, who/what was it? If not, where else did you seek/find support?
Important Note: Please do not include any names or other identifying information about yourself or others.

_____
_____

Q3.39 Did you seek out any support in the form of online communities or blogs?

- A great deal (4)
- A lot (3)
- A moderate amount (2)
- A little (1)
- None at all (0)

Q3.40 Did your sense of (LGBTQ+) community belonging/support differ while you were pregnant? After giving birth?

- A great deal (4)
- A lot (3)
- A moderate amount (2)
- A little (1)
- None at all (0)
- I do not believe this question applies to me. (62)

Display This Question:
If Did your sense of (LGBTQ+) community belonging/support differ while you were pregnant? After givi... = 4
Or Did your sense of (LGBTQ+) community belonging/support differ while you were pregnant? After givi... = 3
Or Did your sense of (LGBTQ+) community belonging/support differ while you were pregnant? After givi... = 2
Or Did your sense of (LGBTQ+) community belonging/support differ while you were pregnant? After givi... = 1

Q3.41 How did your (LGBTQ+) community belonging/support differ? Please describe.

_____
_____

Q3.42 Tell me about your experience giving birth.
(Skip or type N/A if this does not yet apply to you.)

_____
_____

Q3.43 This question is for individuals whom are post child birth:
Have your support systems or group belonging changed since you've had your child? How or how not?

_____
_____

Page Break

End of Block: Pregnancy and Birth Decisions and Experiences

Start of Block: Medical Experiences

Q4.1 This section will ask about your general views on and experiences with medical professionals, as well as those specific to your pregnancy and/or birth.

Page Break

Q4.2 In general, how would you rate your experiences with doctors and other medical professionals?

- Extremely positive (7)
- Moderately positive (6)
- Slightly positive (5)
- Neither positive nor negative (4)
- Slightly negative (3)
- Moderately negative (2)
- Extremely negative (1)

Q4.3 Please rate your general level of trust in medicine, medical authority, and/or medical professionals.

- Complete trust. (7)
- Moderately trust. (6)
- Somewhat trust (5)
- Neither trust nor distrust. (4)
- Somewhat distrust. (3)
- Moderately distrust. (2)
- Complete distrust. (1)

Q4.4 Have you ever delayed going to the doctor despite a need for medical care?

- ○ Definitely yes (1)
- ○ Probably yes (3)
- ○ Might or might not (4)
- ○ Probably not (5)
- ○ Definitely not (6)

Display This Question:
If Have you ever delayed going to the doctor despite a need for medical care? = 1
And Have you ever delayed going to the doctor despite a need for medical care? = 3
And Have you ever delayed going to the doctor despite a need for medical care? = 4

Q4.5 Why?

_____
_____

Q4.6 Which, if any, of the following emotions do you generally feel when going to the doctor? Select all that apply.

- ☐ Anxious or nervous (1)
- ☐ Fearful or scared (2)
- ☐ Ambivalent (3)
- ☐ Threatened (4)
- ☐ Concerned (5)
- ☐ Sad (6)
- ☐ Angry (7)
- ☐ Ashamed (8)
- ☐ Embarrassed (9)
- ☐ Frustrated (10)
- ☐ Grief (11)
- ☐ Overwhelmed (12)
- ☐ Self-conscious (13)
- ☐ Uncomfortable (14)
- ☐ Unaffected or not bothered (15)
- ☐ Comfortable or at ease (16)
- ☐ Carefree (17)
- ☐ Hopeful (18)
- ☐ Happy (19)

Q4.7 Describe why you selected those emotions.

_____
_____
_____

Page Break

Q4.8 What kind of medical professionals did you see during and related to your pregnancy and/or birth?
(Select any/all that apply)

- ☐ a physician or medical doctor (MD, DO), that was not my primary care doctor (1)
- ☐ obstetrician/gynecologist (OBGYN) (2)
- ☐ nurse practitioner (NP), was not my primary care doctor (3)
- ☐ physician's assistant (PA), was not my primary care doctor (4)
- ☐ a nurse-midwife (5)
- ☐ a direct-entry (home birth) midwife (6)
- ☐ a doula (7)
- ☐ my primary care provider (PCP). If possible, please specify their title/profession (i.e. MD, NP, PA, etc.) (8) _____
- ☐ Other not listed here. Please specify: (88) _____

Q4.9 Tell me about your experiences with the medical professionals (nurses, doctors, midwives, etc.) and establishments that you visited or interacted with as a result of your pregnancy/birth. Include as much detail as you are comfortable sharing.

_____
_____

Q4.10 Tell me about your experiences with the administrative staff associated with your provider(s) or provider's offices during your pregnancy/birth (front desk/check-in staff, billing, insurance, etc.).

_____
_____

Q4.11 Which of the following best describes your feelings about your pregnancy/birth as a medical experience?

- ○ Extremely positive (7)
- ○ Moderately positive (6)
- ○ Slightly positive (5)
- ○ Neither positive nor negative (4)
- ○ Slightly negative (3)
- ○ Moderately negative (2)
- ○ Extremely negative (1)

Q4.12 Please rate the following statements concerning your pregnancy/birth experiences:

	Clearly describes my feelings/experience. (1)	Mostly describes... (2)	Moderately describes… (3)	Slightly describes…. (4)	Does not describe…at all. (5)
⊗I feel like I was treated differently by my medical provider(s) because of my ***race***. (7)	○	○	○	○	○
⊗...because of my ***gender expression or identity***. (8)	○	○	○	○	○
⊗...because of my ***sexual orientation***. (9)	○	○	○	○	○
⊗...because of my ***class status***. (10)	○	○	○	○	○
⊗...because of my ***religion or spirituality.*** (11)	○	○	○	○	○
⊗...because of my ***marital status.*** (12)	○	○	○	○	○

Q4.13 Did you ever feel unsafe in the presence of your medical provider while you were pregnant? Or giving birth?

_____

_____

Q4.14 Throughout your pregnancy/birth experience, select which, if any, of the below pieces of information were collected by ***any*** of your medical providers or intake/administrative staff at a medical office. (It could have happened in various ways i.e. verbally, via paperwork, via electronic medical records).

- ☐ Sexual Orientation (1)
- ☐ Preferred Name (2)
- ☐ Legal Name (3)
- ☐ Sex Assigned at Birth (4)
- ☐ Sex (5)
- ☐ Legal Sex (6)
- ☐ Gender (7)
- ☐ Gender Identity (8)
- ☐ Gender Expression (9)
- ☐ Pronouns (10)
- ☐ Relationship status (11)
- ☐ Marital status (12)
- ☐ Sex and/or Gender of partner (if applicable) (13)
- ☐ HIV Status (14)
- ☐ If you've had any prior pregnancies (whether terminated or carried to term/born) (15)
- ☐ Space/a place for you to write in/include missing identities or additional pertinent information (i.e. Bisexual wasn't an available option to choose, but you were able to write it in next to Other:_____) (88)

Q4.15 Did your medical provider(s) do any of the following?

	Yes (2)	Maybe/ Sometimes (1)	No (0)
⊗Tell you their pronouns (she/he/they/etc.) (1)	○	○	○
⊗Wear a pin or ID badge displaying their pronouns. (2)	○	○	○
⊗Ask for your pronouns (directly or via paperwork) (3)	○	○	○
⊗Speak to you in terms that you could understand? (4)	○	○	○
⊗Inform you about your breast or chest feeding options? (7)	○	○	○
⊗Provide you with pregnancy or childbirth related information that catered to one or more of your identities (i.e. race, gender, sexuality, etc.)? (6)	○	○	○
⊗Leave out information regarding your pregnancy or childbirth that would have been relevant to you or one of your identities? (8)	○	○	○
⊗Misgender you? (9)	○	○	○
⊗Call you by the wrong name, or deadname, you? (10)	○	○	○

Q4.16 How did those actions (or lack thereof) make you feel?

_____

_____

_____

Q4.17 Please rate your level of comfortability on the following items:
Important note: The provider(s) in this question refer to provider(s) you had for your pregnancy/birth care.

	Extremely comfortable (5)	Somewhat comfortable (4)	Neither comfortable nor uncomfortable (3)	Somewhat uncomfortable (2)	Extremely uncomfortable (1)
Are/were you comfortable **being out** to your provider(s)? (8)	○	○	○	○	○
Are/were you comfortable discussing your **sexual identity** with your medical provider(s)? (9)	○	○	○	○	○
Are/were you comfortable discussing your **gender identity** with your medical provider(s)? (10)	○	○	○	○	○
Are/were you comfortable correcting your provider(s) should they make a mistake? (i.e. they incorrectly assume that you are married or the gender of your partner) (11)	○	○	○	○	○
Other, Please Specify: (Optional) (12)	○	○	○	○	○

Q4.18 Please select the responses that you feel most apply to you and your experience(s):

	Strongly agree (5)	Somewhat agree (4)	Neither agree nor disagree (3)	Somewhat disagree (2)	Strongly disagree (1)
In general, do you feel as if your medical provider(s) treated you with respect? (12)	☐	☐	☐	☐	☐
Do you feel as if your medical provider(s) should take into account your sexual and/or gender identities when providing care and/or treatment? (8)	☐	☐	☐	☐	☐
Do you feel as if your medical provider(s) respectfully took into account your **gender identity** during your course of care? (9)	☐	☐	☐	☐	☐
Do you feel as if your medical provider(s) respectfully took into account your **sexual orientation** during your course of care? (10)	☐	☐	☐	☐	☐
Other, Please Specify: (Optional) (13)	☐	☐	☐	☐	☐

Q4.19 What about your experiences with other medical staff (i.e. reception, billing department, janitors, etc.)?

- ○ They always treated me with respect. (1)
- ○ I was treated with respect most of the time. (2)
- ○ I was treated with respect about half the time. (3)
- ○ I was treated with respect sometimes. (4)
- ○ I was never treated with respect when interacting with other medical staff. (5)
- ○ I didn't have any notable experiences/interactions with such staff. (6)

Q4.20 Please expand upon the previous ratings of your medical provider(s). What made you rate them that way? Were they all the same providers? Different providers? Did you chose them or were they chosen for you?

_____
_____

Q4.21 In what ways could your medical provider(s) approached your care differently?

_____
_____

Q4.22 Is there anything else you would like to share about the medical aspects of your pregnancy and/or birth?

_____
_____
_____

End of Block: Medical Experiences

Start of Block: Final Thoughts

Q5.1 Are there any questions you think I should have asked in this survey, or anything else you want to share?

_____
_____

Q5.2 What questions do you have for me?
Important Note: If you would like a response, be sure that you have also provided me with your preferred method of contact.

_____
_____

Page Break

Q5.3 Do you feel as if you've been able to adequately share your pregnancy/birth story through this survey?

- Definitely yes (5)
- Probably yes (4)
- Might or might not (3)
- Probably not (2)
- Definitely not (1)

Display This Question:
If Do you feel as if you've been able to adequately share your pregnancy/birth story through this su... = 3
And Do you feel as if you've been able to adequately share your pregnancy/birth story through this su... = 2
And Do you feel as if you've been able to adequately share your pregnancy/birth story through this su... = 1

Q5.4 What do you feel hindered you from adequately sharing your pregnancy/birth story via this survey?

_____
_____

Q5.5 Do you feel as if you've been able to adequately share your gender and/or sexual identities via the questions in this survey?

- Definitely yes (5)
- Probably yes (4)
- Might or might not (3)
- Probably not (2)
- Definitely not (1)

Page Break

Q5.6 Would you be interested in a follow-up phone call or videoconference to better discuss your experience?

- ○ Definitely yes (5)
- ○ Probably yes (4)
- ○ Might or might not (3)
- ○ Probably not (2)
- ○ Definitely not (1)

Display This Question:

If Would you be interested in a follow-up phone call or videoconference to better discuss your exper... = 5
Or Would you be interested in a follow-up phone call or videoconference to better discuss your exper... = 4
Or Would you be interested in a follow-up phone call or videoconference to better discuss your exper... = 3

Q5.7 If you would like me to reach out to you to potentially schedule such a phone call or videoconference, let me know the best way to contact you in the space below.
Otherwise, feel free to contact me at any time via email: gender.pregnancy.study@gmail.com or call/text: (252) 489-9000. If calling, should I be unable to answer, please leave a voicemail.

_____
_____

End of Block: Final Thoughts