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Pathways to Parenthood: Attitudes and Preferences of Eight Self-Identified Queer Women Living in Tampa Bay, FL

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Pathways to Parenthood: Attitudes and Preferences of Eight Self-Identified Queer

Women Living in Tampa Bay, FL

by

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ABSTRACT

This small-scale ethnographic study looks at the how queer women living in Florida imagine navigating family building decisions under the current climate of policies such as a lack of federal non-discrimination protections and the largely unregulated use of assisted reproductive technologies. Despite the federal legalization of same-sex marriage in the United States in 2015, state and county legislations continue to vary greatly on the extent of support they will provide for LGBTQ families. The goal of this research is to evaluate parenting desire, intentions, and preferences for queer women living in Tampa Bay since the passage of the Marriage Equality Act in 2015. Eight semi-structured interviews were conducted with self-identified queer women who have lived in the Tampa Bay area for at least a year since 2015. Queer family planning needs are not homogenous, and this research is not generalizable to the entire population of LGBTQ individuals in the U.S. because of local and legal nuances. However, this research may be relevant to inform state and national policies as other states and countries begin to offer the protections, rights, and avenues to strengthen LGBTQ relationships and promote healthy families.

1.1 Introduction

This study explores how self-identified queer[1] women living in the Tampa Bay area imagine navigating a pathway to parenthood in the current climate of legal policy. Despite the federal adoption of the Marriage Equality Act in 2015, studies on the current status of family health in the U.S. show significant disparities in family resources, services, and outcomes between heterosexual and LGBTQ families (Agénor, Austin, Kort, Austin, & Muzny, 2016; Wu et al., 2017; Hodson, Meads, & Bowley, 2017; Klein et al., 2018; Kreines, Farr, Chervenak, & Grünebaum, 2018). This study focuses on how queer women living in Tampa Bay would like to engage with assisted reproductive technologies (ARTs), different methods of conception, and alternative avenues to parenthood. The goal of this research is to explore what an inclusive family planning program might look like. As a small-scale ethnographic project, the data in this study comes from semi-structured interviews of eight self-identified queer women living in the Tampa Bay area. The interviews focus on individual attitudes and preferences as each participant imagines navigating a pathway to parenthood.

1.1.1 Study Objectives

The study objectives are to:

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[1] In the context of this study the term "queer" can be defined as any desire, identity, or relationship that is not solely based around standards of heterosexuality.

- Evaluate attitudes toward the various pathways to parenthood

- Explore how queer women in the Tampa Bay area define and construct kinship

- Explore perceptions of policy and available family building resources for queer families such as funding, information, and legal support

1.1.2 Expected Outcomes

The expected outcomes of this study are to:

- Contribute to further understanding of the desired use of family planning services in order to direct resources appropriately and effectively

- Provide knowledge of LGBTQ kinship building practices in the Tampa Bay area

1.1.3 Applied Outcomes

The expected applications of this study are to:

- Connect interviewees to resources and help guide individuals toward healthy futures for their families

- Provide policy recommendations that aim to promote healthy families for all LGBTQ individuals

1.2 Disparities in Family Services and Outcomes in the US

Despite recent political gains for LGBTQ rights in the United States, including the Marriage Equality Act in 2015, the support for LGBTQ families varies across state and county

legislation. Examples of political issues concerning LGBTQ individuals currently being discussed by legislators include non-discrimination protections and the use of assisted reproductive technologies. Due to the advancements of reproductive technologies and recent changes in federal and state policies, LGBTQ individuals and couples living in the US are able to become parents in the same ways that are available to heterosexual individuals and couples. However, LGBTQ individuals continue to face a variety of barriers as they navigate a pathway to parenthood, leading to disparities between heterosexual and queer families (Kissil & Davey, 2012; Jin & Dasgupta, 2016; Klein et al., 2018; Kreines et al., 2018). Queer family planning needs are not homogenous and differ across sexual orientations and gender identities (Nebeling, 2018; Ryan, 2013).

For example, the Center for Demographics and Population Health analyzed data from the National Survey of Family Growth (NSFG) from 2006 to 2010 and found that in a sample of 15,784 participants lesbian women were significantly less likely to become parents than bisexual or heterosexual women in the United States (Brewster, Tillman & Jokinen-Gordon 2014; Agénor et al., 2016). In a meta-analysis that included 13 studies on pregnancy outcomes for heterosexual, lesbian, and bisexual women in the US, Hodson (2017) found lesbian women had lower rates of pregnancy, fewer pregnancy attempts, and fewer previous pregnancies. This is despite data from the US Census and the National Survey of Family Growth that suggests the majority of lesbian women would like to have children (Schwartz & Baral 2015).

In multiple studies on sexual and reproductive health in the United States, researchers have found disproportionate parenting outcomes and opportunities for queer women pursuing parenthood are linked with intersections of race and class (Kissil & Davey, 2012; Lo, Chan & Chan, 2016, Agénor et al., 2016, Jin & Dasgupta, 2016). In a review of infertility rates and the

use of ARTs in the US, Kissil & Davey (2012) found women of color in the US were using

ARTs at lower rates than Non-Hispanic White women even though women of color were

experiencing high incidences of infertility. Although pregnancy and childbirth are considered

essential health benefits in all states under the 2010 Affordable Care Act, only 16 states in the

US have policies in place mandating insurance companies to cover the use of ARTs (Jin &

Dasgupta, 2016; Wu et al., 2017; "What Marketplace Health Insurance Plans Cover," n.d.; "State

Laws Related to Insurance Coverage for Infertility Treatment," 2019). Even in states where

coverage is mandated, Kissil & Davey (2012) found women of color use assisted reproductive

technologies less than Non-Hispanic White women. The authors assert that a reason for this

disparity is because women of color are less likely than Non-Hispanic White women to have

health insurance (Kissil & Davey, 2012). This study did not include a discussion on sexual

orientation; however, this study does suggest that queer women of color and women who do not

have health insurance may experience more structural barriers when pursuing parenthood

through ARTs.

Another example of the significant evidence of unequal parenting outcomes is evident in

a study exploring custody loss. In a study which included a survey of 339 Black women living in

Kentucky, Harp & Oser (2016) found Black women who were lesbian or bisexual faced a higher

rate of official custody loss than heterosexual Black women. According to The Children's

Bureau's Adoption and Foster Care Analysis and Reporting System (AFCARS) Report for 2017,

children of color are disproportionately placed in foster care more than White children in the US

(Children's Bureau, 2018). These findings suggest queer women of color experience higher

incidences of custody loss in the US than heterosexual or queer White women.

These are just some examples of how parenting outcomes and opportunities are disproportionate for some queer individuals. As institutions of power continue to treat certain social groups inequitably, the US will continue to privilege a classist, heterosexual, racialized stratification of reproduction (Mamo & Alston-Stepnitz, 2015; Agénor et al., 2016). Overall, the literature points to gaps in family building resources and policies that result in systemic consequences for LGBTQ individuals and their families. More research is needed to understand how states may more effectively direct resources for family planning programs and policies that will allow equal opportunities for all individuals to build healthy families.

1.3 Family Policy in Florida

Florida legislation has a long history of sanctioning blatantly discriminatory policies towards LGBTQ individuals, especially LGBTQ individuals seeking parenthood. Florida was one of the very last states to allow LGTBQ individuals to adopt. Florida legislators ended the state's ban specifically excluding LGBTQ individuals from adopting in 2010 but did not allow same-sex couples to jointly adopt without the execution of a second-parent adoption until after the federal legalization of the Marriage Equality Act in 2015 (Equality Florida, 2017; Phillips, 2015). The State of Florida is one of the majority states that do not require insurance companies to cover the use of assisted reproductive technologies (Jin & Dasgupta, 2016; Wu et al., 2017; "State Laws Related to Insurance Coverage for Infertility Treatment," 2019). For a state that did not opt to expand Medicaid coverage after the Affordable Care Act was passed in 2010, this means some individuals will not qualify for state health insurance until after they become pregnant (Kissil & Davey, 2012; Florida Department of Children and Families, 2014; Jin & Dasgupta, 2016; Wu et al., 2017; Esubalew, 2018). This lack of consideration for LGBTQ needs

actively discriminates against LGBTQ families, as well as some individuals with disabilities, by not providing relevant policies and resources to support the family planning efforts of individuals who require reproductive assistance to achieve pregnancy. This study aims to document systemic barriers that may inhibit queer women living in Tampa Bay, Florida from constructing kinship in a way that is meaningful and comfortable for each individual.

1.4 Organization of Thesis

The next section of this thesis looks at how parent-child kinship is constructed by examining the genetic, biocultural, and legal pathways that might bond them together. This will be followed by a section on strategies some queer families use to maximize their kinship connections. After going over some of the pathways and strategies queer parents may use to forge kinship connections to their children, this paper aims to reframe kinship within broader practices by looking at how policy can result in the stratification of reproductive and parenting opportunities for certain groups of people. Lastly, this paper takes a glimpse at how current policies and institutions shape kinship practices, rights, and access for queer individuals to begin families around the world. Each of these sections is meant to frame kinship through a range of practices and policies before focusing on how family policy in Florida may impact how kinship is formed for eight queer women living in Tampa Bay.

CHAPTER 2:

UNDERSTANDING KINSHIP PRACTICES

2.1 Introduction to Practice Theory

This study uses a practice theory framework to examine how queer women living in Tampa Bay imagine navigating a pathway to parenthood within the current medical and legal institutions, under the present economic and political conditions, and in regard to relevant state and national policies. Practice theory looks at how social actors operate within systems, such as institutions and social groups, and how individual and collective actions and practices reproduce or transform the current systems in place (Ortner, 1984; Roth, 2013; Howson, 2013). Practice theorists argue that systematic reproduction takes place through daily practices and routines (Ortner, 1984; Ortner, 2006). Habitus refers to an individual's inventory of learned and subconscious material and symbolic capital (Roth, 2013). According to practice theory, queer women living in Florida operate within specific fields and institutions in reference to their individual habitus and resources.

Historically, kinship has been defined as an economic exchange, a biological truth, and a legal matter (Levine, 2008). After more recent kinship studies looking at LGBTQ families, assisted reproductive technologies, and adoption practices, kinship is being redefined as an intentional relationship rather than an expected one, a process of establishing connections through similarities or "affinity ties", and a practice or performance of "doing acts of kinship" such as participating in caretaking activities (Weston, 1991; Jones, 2005; Mamo, 2005; Hayden,

2007; Levine, 2008; Dempsey, 2010; Nordqvist, 2012; Logan, 2013; Nordqvist, 2014; Browne, 2018). McKinnon (2015) argues kinship operates within global economic and political institutions. By looking at how queer women living in Florida navigate family planning within specific institutions, this study seeks to answer how individual practices may transform heterosexual systems of kinship.

Klein et al. (2017) performed a systematic review of literature to assess the quality of family planning services for LGBTQ individuals in the United States. The authors found LGBTQ individuals often put off seeking family planning support due to barriers such as fear of provider discrimination, previous negative provider experiences, and a lack of provider knowledge (Klein et al., 2017). A recent survey of online information by Kreines et al. (2018) found there is a lack of quality family planning information for LGBTQ people online according to the 2016 US Department of Health and Human Services Website Information Reliability Evaluation Instrument. Kreines et al. (2018) found LGBTQ family planning content has increased since the 2015 ruling of the Marriage Equality Act, but information for bisexual and transgender individuals remains inadequate. In a study analyzing 379 fertility clinic websites for clinics across the US, Wu et al. (2017) found the likelihood of quality LGBTQ content online was impacted by clinic size and geographic region. These studies suggest resources for LGBTQ family building are insufficient and may be especially limited in certain regions in the US.

The gap between actual use and desired use of family building resources by queer women in the US suggests the current systems and policies in place are ineffective at meeting LGBTQ family needs. This gap provides policymakers, state and local court workers, and healthcare professionals a chance to create relevant resources and programs for LGBTQ families. Looking at how queer women in the US define and construct kinship through the current institutions and

within their daily lives can lead to applicable solutions to develop the resources and programs necessary to meet queer family needs..

2.2 Pathways to Parenthood

What is kinship and how is it created? Human kinship is defined as a set of practices, influenced by biological, cultural, economic, and political factors, used to establish and sustain informal and formal social bonds (Weston, 1991; Morgan, 1996; Jones, 2005; Mamo, 2005; Finch, 2006; Levine, 2008; Nordqvist, 2012; Logan, 2013; Nordqvist, 2014; Browne, 2018). There is not one singular criterion to define human kinship because human kinship is multidimensional (Cahn, 2013; Mamo, 2015). Bonding can occur along a wide variety of pathways.

A parent-child bond involves biological, cultural, and legal practices of establishing "guardianship," often tied to a rhetoric of proving parentage. Understanding how LGBTQ families pursue, balance, and negotiate parenthood is one way to begin conceptualizing how to redefine limiting legal definitions of custody and autonomy (Levine, 2008; Mamo, 2015). In the U.S., self-identified queer women have multiple options to establish parenthood, although access is controlled by state-approved programs and policies, in addition to federal regulations. The next few sections look at possible pathways to parenthood for queer women.

2.2.1 Genetic Pathways

Self-identified queer women have multiple options to establish genetic parenthood. At-home insemination techniques allow queer women to engage in the process of conception without requiring medical assistance. For at-home insemination techniques requiring donor

sperm, unwashed sperm can be used to do Intracervical Insemination (ICI) or Intervaginal Insemination (IVI); however, the specimen must go through a sperm washing process in order to perform Intrauterine Insemination (IUI) at home (Tampa Bay Birth Network, 2019). IVI involves the placement of sperm into the vagina, ICI involves the placement of sperm into the cervix, and IUI is the placement of sperm directly into the uterus (Tampa Bay Birth Network, 2019). The sperm washing process is the process of creating a concentrated amount of semen and must take place at a specific facility (USF Health IVF and Reproductive Endocrinology, n.d.). Other options utilize medical assistance through assisted reproductive technologies. Those options include: In Vitro Fertilization (IVF), Reciprocal IVF (rIVF), and Surrogacy (Florida Fertility Institute, n.d.; Tampa Bay Birth Network, 2019). rIVF is also described as the reception of oocytes from partner or ROPA (Marina et al., 2010; Pennings, 2016). IVF involves the surgical removal of eggs from an ovary and then the fertilization of the egg in a laboratory dish (Florida Fertility Institute, n.d.). The fertilized egg is then implanted into the uterus (Florida Fertility Institute, n.d.). rIVF involves a routine IVF procedure, however, instead of implanting the fertilized egg in the uterus of the individual from whom the eggs were removed, the fertilized egg is implanted in the other partner's uterus (Path2Parenthood, 2019). For queer women, traditional surrogacy involves a non-partner third-party individual who would carry the pregnancy using their own fertilized egg (Path2Parenthood, 2019). The gestational surrogacy method would involve a routine IVF procedure; however, the fertilized egg would be implanted into a non-partner third party individual ("About Surrogacy", n.d.). Each pathway consists of multiple steps and may involve hormone treatments (USF Health IVF and Reproductive Endocrinology, n.d.; Florida Fertility Institute, n.d.). Some options may be more feasible than others and are determined by each individual or couple's resources and needs.

The same reproductive options are available for transpeople and individuals who identify as outside the binary to establish genetic ties to their children, although the individuals may need additional gender affirming care (Coleman et al., 2012; UCSF Transgender Care, 2016; Ingraham, 2017). Individuals who are transgender who decide to go through genital reassignment surgery may decide to freeze their eggs or sperm before permanently transitioning (Coleman et al., 2012; Deutsch, 2015). This can be a difficult decision because individuals beginning their transitions may not be in a position to face family planning decisions, may not be able to afford the cost of cryopreservation, may not be willing to stop their hormone treatments at that point in time in order to produce sex cells, or may not be comfortable participating in reproductive activities that are highly gendered (Jin & Dasgupta, 2016).

There are several ways genetic information is being exchanged in these encounters between partners, donors, surrogates, and children. For some transgender couples both partners are able to establish genetic ties to the child if one partner is able to share sperm cells and another partner is able to share egg cells, but for other LGBTQ couples only one partner is able to establish a genetic connection of kinship with their child. This means there will most likely be a third-party individual who may feel they have a claim to kinship because of their genetic connection (Wiley, 2017). Genetic ties are one way to fortify custody rights for LGBTQ parents; however, there are other biological routes that express parent-child kinship.

2.2.2 Biocultural Pathways

Genetic inheritance is not the only process to establish biological ties from parent to child. Parent caretaking practices lay the foundation of physiological and emotional regulation in children (Hofer, 1994). Scientists have documented multiple biobehavioral feedback systems that

construct attachment at the biological level, especially in regard to parents and their offspring. By taking a biocultural approach to this issue, this paper recognizes the process of constructing social and biological attachment is different for each relationship according to varying developmental, genealogical, and environmental conditions (Kuzawa, 2005). Studies on parent-child biobehavioral feedback systems in early development offer vivid insights into how parenting practices become biology through physiological and behavioral regulation.

How does biological attachment occur from parent to child? Hofer's (1994) work with rat mothers and their babies captures one of the more vivid expressions of the multiple biobehavioral feedback processes occurring within the routine interactions of the mother-infant relationship. By separating a rat pup from the mother and recreating different material aspects of their relationship, Hofer (1994) was able to isolate some of the more immediate physiological responses and their related variable conditions originally provided by the mother. Some of the earlier arising physiological and behavioral responses due to the separation of the pup from their mother were indicated by a change in heart rate, body temperature, and behavioral activity level (Hofer, 1994). As Hofer (1994) began recreating sensory and behavioral aspects of the mother-pup relationship through olfactory, tactile, thermal, vestibular, auditory, and visual stimuli, even to the point of replacing the mother with a non-lactating foster mother, he found some of the pup's responses began to level back out. This demonstrates how the pup's biological responses are being mediated through routine caretaking practices involving physical and behavioral contact (Hofer, 1994). So what evidence is there for similar biological responses in human parent-infant relationships?

There are multiple pathways for parent-infant bonding to occur at the biological level. A closer look at early parent-infant caretaking practices shows that various biobehavioral feedback

systems are engaged through parent-infant interactions (Hofer, 1994; McKenna & Gettler, 2007; Gettler, McDade, Feranil, & Kuzawa, 2011; Miller, 2017). Numerous researchers have observed evidence of the impact of routine caretaking practices on both the parent's and child's behavioral, metabolic, endocrine, neurochemical, and autonomic systems (Hofer, 1994; McKenna, 1990; Gettler, et al., 2011; Kuzawa, 2009). Some of the ways parent-infant bonding may occur are through routine caretaking practices like sleeping, eating, and spending time together.

Studies on co-sleeping show how routine sleep practices can impact: an infant's sleep position, arousal patterns, sleep architecture, the number of maternal inspections, the thermal and CO_2 environment, the duration of infant crying, as well as infant heart rate and breathing (McKenna & Mosko, 1990; Mckenna, Mosko, Dungy, & McAninch, 1990; Mosko, McKenna, & Drummond, 1996; Mosko, Richard, & McKenna, 1997; McKenna & Gettler, 2007; McKenna, 2019); . These studies show mother-infant pairs who practice co-sleeping are able to synchronize their sleep states (Mosko et al., 1996; Mosko et al., 1997; McKenna, 2019). Synchronization suggests the biological bond established by caretaking practices may be traced from parent to child and vice versa.

Parents may also construct biological ties to their infants through infant feeding practices. Some of the noted biological impacts on an infant that are mediated through breastfeeding practices include hormone regulation, nutritional status, and immunological function (Miller, 2017). The immunological function of breastfeeding represents just one of the biobehavioral feedback systems established by breastfeeding. The term passive immunity is used to depict the directionality of the immunological relationship between mother and infant, suggesting the mother passes immunological information to the child. Miller (2017) argues biological evidence

of the immunological relationship between mother and infant mediated through breastfeeding practices points to a collaborative, not passive, relationship. More recently, researchers have started to look at the pathways an infant may pass information to the mother such as the microbiome, milk ducts, saliva, as well as skin-to-skin contact (Miller, 2017; McKenna, 2019). Human bonding occurs through collaborative routine interactions.

There is also biological evidence that shows new fathers exhibit changes in Testosterone levels, providing another example of the biological communication between infant and parent (Kuzawa et al., 2009; Gettler, 2010; Gettler et al., 2011). Researchers have found that fathers not only have a decrease in Testosterone overall during the first year after their child is born, but also demonstrate a significant decrease in Testosterone after just one hour of infant caretaking (Gettler et al., 2011).

Hofer (1994) argues parent-child bonding not only serves a biological purpose of physiological regulation, but also constructs the foundation for children to navigate emotional relationships and feelings. Understanding how emotional bonds are constructed leaves many important areas to be discovered, especially in relation to the pathways by which emotional bonds may form. These studies are not a comprehensive list of the many ways parenting practices may construct biological pathways to their child; however, they provide insightful examples of how parent-infant bonding occurs through collaborative biobehavioral feedback processes found in routine interactions.

Genetic expression is not required for a parent or child to exhibit effects of bonding at the biological level. Consequently, adoption and fostering can be considered a form of biological parenthood as well. The kinship bond may not be established through genes or a legal document, but the evidence of a parent-child relationship is biologically irrefutable. Parent-infant studies

show especially significant changes because infants are more susceptible to change while the child's foundational physiological responses are being established, however, bonds can be created throughout one's life (Kuzawa, 2005). As stated previously, the process of constructing social and biological attachment is different for each relationship according to varying developmental, genealogical, and environmental conditions (Kuzawa, 2005). Parenting practices also vary by regional and cultural beliefs and perspectives. Despite differences in parenting practices and routines, it is clear biocultural bonding occurs through child-rearing practices.

2.2.3 Legal Pathways

While recent changes in policies across the U.S. have given LGBTQ individuals the right to parental custody, queer parents continue to face barriers to obtaining and navigating parental custody. While LGTBQ individuals are able to apply for the same levels of custody that are available to straight individuals, queer families must take extra steps to fortify kinship and parental intention. This may involve seeking a second-parent adoption, a stepparent adoption, or negotiating pre- and post-birth contracts (Equality Florida, 2017; Tampa Bay Birth Network, 2019). LGBTQ couples facing the ambiguity of legal custody may not be able to participate in everyday life events like signing paperwork, taking a child to the doctor, or checking the child out of school (Raes et al., 2014).

The United States recognizes the following types of custody: legal custody, physical custody, voluntary kinship care, formal kinship care, foster care, emergency foster care, respite care, foster to adopt, and other types of adoption including open, closed, private, and public (Child Welfare Information Gateway, 2016; SAFY of America, 2019; Adoption Center, n.d.). A guardian may have legal custody but may not have physical custody (Child Welfare Information

Gateway, 2016). One example of this would be voluntary kinship care, for instance, if a parent is away for business and a grandparent is taking care of the child, the parent would still have legal custody, but the grandparent has physical custody (Child Welfare Information Gateway, 2016). Formal kinship care means the state assumes custody of the child and places them in the physical custody of a relative (Child Welfare Information Gateway, 2016). Foster care means the state assumes custody of the child and places them in the physical custody of a non-relative (Child Welfare Information Gateway, 2016). Emergency foster care is typically a short-term living situation which could last for a few hours to a few months (SAFY of America, 2019). Respite care is when one foster family provides short-term foster care for another a child living with a different foster family (SAFY of America, 2019). A foster to adopt scenario occurs when a family takes in a foster child with expectations to adopt the child (SAFY of America, 2019; Adoption Center, n.d). Open and closed adoptions refer to the level of information exchanged between the birth parents and adoptive parents, while public or private adoptions refer to the venue through which the child is selected (Adoption Center, n.d.). Queer women in the U.S. are able to claim parental rights through any one of those legal pathways but continue to face barriers seeking legal parenthood such as second-parent adoption (Dempsey, 2010; Raes et al., 2014; Pennings, 2016). Access to legal pathways to parenthood for people who are LGBTQ varies according to federal, regional, and local policies.

2.3 Strategies of Kinning

So far, this thesis has looked at genetic, biological, and legal pathways to parenthood including self, partner, or third-party insemination, IVI, ICI, IUI, IVF, ROPA, adoption, fostering and surrogacy. This paper has also attempted to extend the theoretical framework to

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include biocultural processes of attachment through caretaking practices such as co-sleeping, breastfeeding, and spending time together. This section looks at several strategies LGBTQ individuals and couples may use to navigate biosocial connections. Some of the common strategies to maximize and balance biogenetic and social parenthood affinities include matching, alternating, using or creating shared genetic siblinghood, and narratives (Mamo, 2005; Raes et al., 2014; Nelson & Hertz, 2017).

2.3.1 Matching

For individuals with the option to select a donor or to adopt, matching is a biocultural strategy both straight and queer individuals and couples are known to use in order to maximize social and biogenetic affinities. Typically, matching is in reference to using ARTs, however, it can also reference the adoption selection. Matching may refer to matching donor characteristics to the non-genetic partner or parents attempting to match their own characteristics to a child's whom they might adopt (Jones, 2005; Florida Department of Children and Families, 2018). Some of the common characteristics couples or individuals may attempt to match include physical likeness, interests, and disposition (Mamo, 2005; Ravelingien, 2015; Florida Department of Children and Families, 2018). This strategy serves to balance the number and quality of kinship connections between each party involved and actively draws lines of kinship from the parents to the child (Jones, 2005; Raes et al., 2014; Nelson & Hertz, 2017).

2.3.2 Alternating

Another strategy, mostly used by LGBTQ people to build biogenetic connections from parent to child is to alternate biological, genetic, and social connections in order to maximize

affinities between partners to their children (Raes et al., 2014; Nelson & Hertz, 2017). For example, if two partners are capable and consenting then they could alternate who will be the genetic donor, most likely over multiple pregnancies. For some queer women, they can choose who is the genetic donor and who is the gestational carrier and may use a combination of strategies to balance kinship affinities for both parents. In the case of rIVF or ROPA, both women are able to take an intimate part in the biological development of their children; one would share the collaborative biological environment of the placenta, and the other would share their chromosomes and genes (Pennings, 2016).

2.3.3 Shared Genetic Donor

Parents using donor materials or participating in pregnancy with a surrogate may attempt to construct biogenetic ties between siblings by binding the siblings together using the same donor or surrogate (Nordqvist, 2014; Jones, 2005;). Some parents may deploy this strategy while also alternating which parent donates their genetic material. By balancing social and genetic kinship, parents not only create pathways from the child to themselves, but they find ways to create other lines of kinship between children and from their children to others. This is an example of how parents are not only connecting the child to themselves but also to the social world around them.

2.3.4 Stories

Stories are a way to convey information between people about human relationships and the world around them. Researchers have documented many narrative devices used to support parent-child kinship construction (Hertz & Ferguson, 1997; Hicks, 2005; Mamo, 2005; Raes et

al., 2014; Nordqvist, 2014; Nebeling, 2018). Three narrative devices found in recent literature are the following: Origin story (adoption or assisted reproductive technology), genealogy, and photography.

The origin story. Parents often tell their child an origin story that represents different milestones along their journey to parenthood (Nordqvist, 2014). This story could be the first day the parents found out about the child, the day the child was born, the day adoption papers are signed, or even the first time they met the donor. Parents may use the origin narrative to center their own parental intention (Mamo, 2007; Levine, 2008; Nordqvist, 2012; Mamo & Alston-Stepnitz, 2015; Pennings, 2016). Researchers have found queer families are more likely to tell their children their origin story earlier than straight couples (Marina et al., 2010; Crawshaw & Montuschi, 2014). The origin story is an opportunity for parents to fortify biological and social bonds to their child.

Genealogical stories. Some parents may work to foster bonds between their children and friends, previous parents, donors, and/or donor siblings by sharing the child's genealogy (Hertz & Ferguson, 1997; Dempsey, 2010). The child's genealogical narrative might consist of one story, or multiple stories, coincide with their origin story, or be discussed entirely separate from the origin story. Discussing genealogy not only helps parents to foster bonds between their children and the wider world, it also provides LGBTQ parents an opportunity to actively draw lines of kinship and distinguish who is the parent and who is not (Hertz & Ferguson, 1997; Dempsey, 2010).

Visual stories. Technology has rapidly changed how people communicate and interact which has created more pathways to foster kinship connections. Photography is a narrative device a family may use to connect the child to the world around them such as a time or place

(Howell, 2001; Howell, 2003; Nordqvist, 2014). A visual narrative enables families to produce

material evidence of a story or memory that speaks to the connection between parents and child,

and possibly the child to whatever subject may be in the frame (Howell, 2001). Photography

provides material evidence to support the legitimacy of a family bond (Nordqvist, 2014).

2.4 Kinship Practices Summary

This section reviewed strategies some parents may use to fortify their parental kinship

status. Parents may use these strategies to maximize the number of affinities to their children

while also balancing relationships with their partners, donors, relatives, and friends. Parental

kinship in this sense is not only a way for parents to share or transfer their own identities to their

child but to also weave their child into a network of meaningful relationships (Hertz & Ferguson,

1997).). Many LGTBQI individuals do not have the option to have children or to claim legal

kinship over their own children, integrating strategies to maximize kinship connections into

inclusive family programs or initiatives is one way to strengthen family bonds and support

healthier communities.

CHAPTER 3

REPRODUCTIVE GOVERNANCE AND FAMILY POLICY

3.1 Stratified Reproduction and Reproductive Governance

Stratified reproduction is defined as "as the local and global circumstances whereby some categories of people are empowered to nurture and reproduce, while others are disempowered" (Smietana, Thompson, & Twine, 2018, p.6). Stratified reproductive outcomes are evidence of systemic inequalities produced within and by specific state, institutional, and cultural practices (Colen, 1995, Mamo & Alston-Stepnitz, 2015, Mason, 2015). Evidence across the globe shows disparate reproductive health outcomes and deterrents to parental rights occur along political lines of class, race, gender, sexuality, disability, migration status, and place in a global economy (Shelley-Sireci & Ciano-Boyce, 2002; Corbett, Frecker, Shapiro, & Yudin, 2013; Ikemoto, 2015; Twine, 2015; Schwartz & Baral, 2015; Agénor et al., 2016; Hodson, 2017; Lenhardt, 2017; Lo et al., 2017; Wiley, 2017; Leibetseder, 2018). Researchers have documented several ways LGTBQ individuals pursuing parenthood might find themselves situated within an inequitable system (Nebeling, 2018). Due to programs, initiatives, and policies that either fall short of meeting the needs of LGBTQ families, or more directly discriminate against people who are LGBTQ wishing to pursue parenthood, LGBTQ individuals around the world do not have equal opportunities to become parents (Nebeling, 2018). In addition, certain assisted reproductive technological and adoption practices LGBTQ individuals and partners participate in may uphold systemic inequalities (Nebeling, 2018; Leibetseder, 2018;). It is important to identify translocal policies

and practices resulting in stratified reproductive outcomes and opportunities, in order to come up with applied strategies and policies to mitigate a community's unique needs.

The following examples look at how queer women experience stratified reproduction in the U.S. Schwartz & Baral (2015) completed a scoping literature review to evaluate potential gaps in the literature on safe pregnancy outcomes. The researchers found women who fell in the following four categories were reportedly understudied when it comes to safer pregnancy outcomes including women living with HIV, women who use drugs, LGBTQ women, and female sex workers. The authors claim that the lack of studies on safe reproductive health outcomes for these groups of women is evidence that certain reproductive futures are undervalued.

In a study with 165 African American women in Alabama, Agénor et al. (2017) found African American lesbian women were significantly less likely than bisexual women to have ever been pregnant. This example shows how stratification is multi-dimensional and can occur within marginalized groups. The authors found a lack of studies on pregnancy outcomes for queer African American women. By not systematically evaluating reproductive outcomes and opportunities for all groups, policymakers and institutions continue to sanction systems of inequality.

Reproductive governance refers to legislation and policies surrounding reproductive rights that shape broader patterns of reproduction (Casper & Morgan, 2004; Morgan & Roberts, 2015). Stratified reproduction and reproductive governance provide an applied framework to understanding how LGBTQ parenting outcomes and opportunities are greatly shaped by policy. In a study examining sperm bank practices involving in-depth interviews with 31 individuals living in San Francisco, Mamo (2005) found current policies, regulations, and guidelines do not

responsibly take into account how people and their human biological materials become embedded in a market through a chain of biocommodification, nor adequately address the generational consequences of shaping reproductive outcomes and opportunities. Fosset (2007) argues the lack of federal or international oversight allows for local, regional, and cultural nuances to be considered in the construction of regulations or guidelines. However, strategic action aimed at alleviating disparities for parenting outcomes needs to be taken across broader platforms in order to deter biocolonial practices such as the practice of transnational surrogacy (Fossett, 2007; Nebeling 2018). Policy can be a means to either sustain or eradicate systemic inequities and stratified opportunities for LGBTQ individuals pursuing parenthood. The following section addresses examples of reproductive governance and the impact of family policy on kinship practices.

3.2 Kinship Policies Around the Globe

The family planning needs of LGBTQ individuals and couples are not homogenous and should reflect cultural, regional, and other intersectional differences in perspectives and family building practices. Recently, policies have begun to take shape around the world in regard to LGBTQ relationships and the construction of kinship surrounding matters of marriage, adoption, the use of reproductive assistance technologies, and surrogacy. While some of the policies expand inclusion, other laws specifically ban LGBTQ individuals and couples from pursuing guardianship all together (Nebeling, 2018). In some areas of the world, the state of LGBTQ relationships remains criminalized (Nebeling, 2018; Nyanzi, 2013). Global studies on kinship structures, ARTs, adoption, and surrogacy give insight into how culture, policy, and power might change how individuals utilize different family building resources.

In Cuba, social policy, cultural practices, and limited access shape the available avenues to parenthood for LGBTQ individuals and couples. Browne (2018) interviewed 17 self-identified lesbian and bisexual Cuban women to examine their perception of state support for their families in reference to social policy. Same-sex partnerships are not recognized by the state, but due to social support programs including childcare, healthcare, and education many types of kinship structures such as non-nuclear, blended, and matrifocal households are able to flourish. Browne (2018) found the use of assisted reproduction technology is accepted but widely unavailable to LGBTQ individuals living in Cuba because of a shortage of resources. The shortage of available resources creates long waiting lists where heterosexual couples are given priority. Due to resource constraints, adoption is also limited for LGBTQ individuals and couples (Browne 2018). Even though LGBTQ families are supported by state mediated social programs, establishing equal rights for LGBTQ remains an important issue for the participants so they can begin to build their families within the parameters of their own comfort and desires.

China is known for their strong measures and policies used to regulate reproductive practices. Lo et al. (2016) surveyed 438 Chinese lesbian women living in Hong Kong to elicit their perceived importance of childbearing and attitudes toward assisted reproductive technologies. The authors also used the surveys to measure levels of anxiety. Currently, same-sex unions are not legally recognized in China and assisted reproductive technologies are only available for heterosexual married couples who are experiencing infertility issues (Lo, et al., 2016). Lo et al. (2016) found the majority of the participants wanted to legalize the use of ARTs for same-sex couples, although only half of the women wanted children of their own, and less than half said they would use assisted reproductive technology if they were given the choice. The authors found anxiety was positively correlated with the women's responses to the perceived

importance of childbearing to their partner or parents. Lo et al. (2016) suggest the women's anxiety could be related to the cultural emphasis on collectivism and heritage. The authors believe the participants' lack of desire to become parents could be related to the stigmatization of same-sex couples, policies against it, as well as the inaccessibility to legitimate avenues of conception or parenthood.

Studies in Egypt and Israel show how religion and policy shape the usage of reproductive assistance technologies. Inhorn (1994) found that according to religious beliefs of some Coptic Christians and Sunni Muslims, IVF is looked at as if it is not of the body and therefore any child conceived through this type of assisted reproductive technology would not be considered the couple's biological offspring (Mckinnon, 2015). This is important for LGBTQ family planning because for some cultures and religions reproductive technologies may not be considered a valid option to establish kinship. Kahn (2000) provides an example of how religious beliefs are tied to social policy in Israel in regard to assisted reproductive technology. Kahn (2000) points out the reason why Israel provides complete coverage of the use of assisted reproductive technology is because of their procreative cultural and religious beliefs. In both examples, the interaction between religious beliefs and social policy may impact the availability of reproductive services, the utilization of family building resources, and the meaning and rationalization of kinship practices.

The development of an international adoption market in South Korea provides an example of how social policy, race, and transnational military occupation came to shape global and national parenting opportunities. After the Korean War in the 1950s, American military men abandoned many Korean women with children (Wiley, 2017). Until 1989, it was South Korean policy for children born to unwed women to be taken from their mothers, and due to the lack of

social support programs, many women had no other choice (Wiley, 2017). Wiley (2017) found the state encouraged mothers to give up their children by using narratives of nationalism and morality. One technique used to advertise for the adoption of the children was their proximity to whiteness (Wiley, 2017). Many of the infants and children were shipped to the U.S. by cargo airplanes (Wiley, 2017). Due to devastatingly exploitative practices in the international adoption market, the Hague Convention on Intercountry Adoption was ratified in 1995, which required many countries to develop policies meant to deter international adoption and encourage domestic adoption practices (Wiley, 2017). The rise of the adoption market in South Korea is just one example of how policy, race, and power came to shape parenting outcomes and opportunities internationally.

Transnational surrogacy is an example of how class, race and regional policy construct power relations for LGBTQ individuals and surrogates. Nebeling (2018) found in his interviews with seven gay couples in Denmark that transnational surrogacy laws are rapidly changing. The couples initially sought out surrogates in India because the surrogate mother would not be listed on the birth certificate (Nebeling, 2018). However, in January 2013, legislators in India began passing policies to regulate the transnational surrogacy industry, including the need for a medical visa which requires couples to be heterosexual (Nebeling, 2018). The policies were meant to protect their citizens from exploitation, yet they simultaneously deny access for LGBTQ individuals (Nebeling, 2018). LGBTQ couples started to seek surrogates in Thailand, but after a couple from Australia abandoned a baby born with Down Syndrome in 2014, policy makers in Thailand completely banned transnational surrogacy and now require all applicants for domestic surrogacy be heterosexual (Zimmerman, 2016; Nebeling, 2018). This sparked a new industry for transnational surrogacy in Mexico, where legislation was quickly passed to ban all transnational

surrogacy in 2015 (Nebeling, 2018). Nebeling (2018) points out power relations in transnational surrogacy are very nuanced where even though the couples are using their economic and racial privileges to be eligible for reproductive technologies, LGBTQ individuals and families continue to experience discrimination through policy aimed at protecting citizens from transnational exploitation (Twine, 2011; McKinnon, 2015; Mamo & Alston-Stepnitz, 2015; Zimmerman, 2016; Leibetseder, 2018).

Each example shows how kinship may be imagined through and altered by institutions of power, policy, and culture. Regional differences in culture transform the meanings of kinship and impact policies that may legitimize, or delegitimize, options for LGBTQ family building efforts. In some cases, social policy may restrict access, which could lead to demand in another region, and in other cases, social programs may allow a variety of kinship structures to flourish but may not necessarily provide access to family building resources tailored for LGBTQ individuals and partners. Each example above takes place outside of the US and looks at how regional policies shape the realities of family planning. Most studies taking place in the US focus on identifying disparities stemming from the current family planning system in place. This study seeks to identify policies that may shape the landscape of available parenting options for LGBTQ families in Florida. However, the primary goal of this research is to examine how queer women wish to engage with family resources to build their families. This research will help to define the gap between actual use and desired use of family resources. As a small-scale ethnographic study, the research can more intimately examine the underlying themes guiding parenting intentions and preferences which could lead to a more in-depth understanding of how queer women living in the US may conceptualize kinship within the current policies, institutions, and systems in place.

CHAPTER 4:

METHODS

4.1 Setting

Florida is a coastal state located in the Southeastern corner of the United States. Florida's geography is very diverse including expansive coastlines, the Everglades, mangroves, limestone aquifers, large natural springs, cypress tree swamplands, and agricultural plains. Florida became the 27th state to join the United States in 1845 and now represents the 3rd largest state in the US in terms of population (Florida Department of State, 2019; U.S. Census Bureau, 2018). Currently, there are an estimated 21 million people living in Florida (U.S. Census Bureau, 2018). In 2019, Republicans control the majority in the Florida Senate and the Florida House of Representatives.

Tampa Bay is located in the eastern central part of Florida and was built along the Hillsborough River that eventually leads into the Gulf of Mexico. Tampa was largely settled by Native American groups as well as Cuban, Spanish, Italian, and Eastern European immigrants (Mormino, 1998). The City of Tampa was established in 1855 (City of Tampa, FL 2019). Today, Tampa Bay has an estimated population of 3 million people and extends through multiple counties including Hillsborough County, Pinellas County, Pasco County, and Manatee County (U.S. Census Bureau, 2018). Some of the largest cities in the Tampa Bay area include Tampa, St. Petersburg, Clearwater, Brandon, Plant City, Bradenton, and Wesley Chapel.

The extensive area of Tampa Bay allows a diversity of industries to thrive including

marine-based industries, agriculture, aviation, defense, tourism, telecommunications, and manufacturing ("Employment and Industries in the Tampa, Florida Area," n.d.; Bureau of Labor Statistics, 2019). There is a military base, multiple public and private universities, community colleges, vocational and technical schools, as well as three professional sports teams including the Tampa Bay Buccaneers (NFL), Tampa Bay Lightning (NHL), and the Tampa Bay Rays (MLB). Some of the economy is based on transient and seasonal population shifts including incoming and outgoing students during the Fall and Spring, incoming and outgoing military personnel, increased tourism throughout the Winter, Spring, and Summer months, seasonal work for agricultural communities, and multiple professional baseball teams use sports complexes located in the area as preseason training facilities in the Spring.

These seasonal shifts also contribute to transient demographics marked by migrant and refugee populations. According to categorizations by the 2010 United States Census, the population of Hillsborough County, the largest county in the Tampa Bay area, is made up of a majority of non-Hispanic White people, with a 25% Hispanic or Latino population, 16% Black or African American population, and less than 10% of the population represent people from other races or ethnicities (United States Census Bureau, 2010). Florida has the largest refugee population in the U.S., and Hillsborough and Pinellas Counties are two of the main areas that refugees are resettled. The refugees may be from Haiti, Cuba, the Democratic Republic of Congo, Syria, Iraq, Afghanistan, Myanmar, Ukraine, Colombia or Eritrea (Grogan, 2017). Desegregation was slowly carried out through the 1960s and 1970s, however, highway construction projects, discriminatory housing practices, and the 2008 recession have contributed to persisting disjointed neighborhoods (Prince, 2016). Racial and ethnic based neighborhoods are also common as a strategy for migrant communities to create communities within metropolitan

areas in order to have culturally relevant grocery stores, ethnomedical facilities, and other familiar commodities; however, neighborhood preference does not explain the persisting segregation between White and Black neighborhoods (Massey, 1994; Massey, 2004).

PRIDE, an annual event acknowledging the anniversary of the Stonewall Riots and celebrating LGBTQ lives, is held in both Tampa and St. Petersburg. Tampa has a few areas of nightlife dedicated to LGBTQ individuals in Ybor City, also referred to as "Gaybor"; while St. Petersburg has an area called the Grand Central district where businesses advertise as LGBTQ friendly. There is a neighborhood located south of St. Petersburg called Gulfport which has many LGBTQ residents. There are multiple LGBTQ community organizations and resources in the area that focus on LGBTQ sexual health, mental health, and homelessness; however, there are only a few businesses that refer to family building and reproduction. Metro Wellness is a non-profit organization established in Tampa in 1993 and has been dedicated to serving the LGBT community since its inception. Metro Wellness offers "comprehensive HIV services and medical care, social activities, classes, support groups, counseling, health and fitness programs, youth programs, substance abuse programs, older adult programs, behavioral health services and free HIV testing", however there is no mention for services to help create LGBTQ families (Metro Inclusive Health, n.d.)

There are twelve fertility clinics located in the Tampa Bay area including the Fertility Clinic of Tampa, Reproductive Medicine Group, University of South Florida IVF, Center for Reproductive Medicine, Florida Fertility Institute, and Shady Grove Fertility. The Fertility Clinic of Tampa is the only fertility center that does not perform assisted reproductive technology procedures and instead focuses on acupuncture, muscle testing, and nutrition (Fertility Clinic of Tampa, 2016). The Reproductive Medicine Group has four locations in the Tampa Bay area and

three of the clinics have opened within the last three years. The Reproductive Medicine Group website has been recently updated to include LGBTQ family services (Reproductive Medicine Group, n.d.). USF IVF has two locations in Tampa. The USF IVF website mentions family-building for single and LGBTQ parents but does not offer any additional information (USF Health, n.d.). The Center for Reproductive Medicine website does not mention LGBTQ family services (Center for Reproductive Medicine, 2014). There are two Florida Fertility Institute locations in Tampa Bay. The Florida Fertility Institute website advertises to LGBTQ individuals (Florida Fertility Institute, n.d.). Shady Grove Fertility, which opened two new locations in the Tampa Bay area in 2019, also advertises for LGBTQ family services (Shady Grove Fertility, n.d.).

Five out of the six fertility clinic websites address financing options except the Center for Reproductive Medicine website. The cost of services at the Fertility Clinic of Tampa ranges from $4150 to $4800. The USF IVF website re-directs the online viewer to another website that offers discount programs and loans for fertility treatments. All of the other websites including Shady Grove Fertility, the Florida Fertility Institute, and the Reproductive Medicine Group list certain insurance plans they accept while also offering discount programs, refund programs, and loans. The discount and refund programs have certain exclusions and eligibility requirements such as multi-cycle contracts or volunteer egg donation, and the discount or refund can only be applied to certain services. The same three fertility centers only offer financial assistance for individuals who do not have health insurance; however, the cost for treatment can range from $5,000 to over $40,000 which does not include maternity care.

Equality Florida, an organization focused on LGBTQ civil rights in Florida, offers a free Legal Handbook for LGBTQ families, and provides a FAQ section on their website regarding

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current family law and policies, however, the website does not list any family building resource suggestions (Equality Florida, 2017). Planned Parenthood of Southwest and Central Florida advertises for LGBTQ health services but does not offer any direct family building services. The Ybor Youth Clinic is another resource in the area that provides services for LGBTQI individuals who are experiencing homelessness and for individuals who have HIV who range in age from 13 to 24 years old. The clinic offers free sexual health services, but, again, no direct services to build a family. The University of South Florida published a Guide to LGBTQ Resources in 2014 but there are no resources that refer to family building, reproduction, or adoption ("Guide to LGBTQ Resources," 2014). The Florida Department of Health does not offer any relevant prenatal initiatives, services, or resources for LGBTQ individuals (Florida Department of Health, 2017). There are no cost-friendly, or state-sponsored, family building resources that directly help LGBTQ individuals and couples to conceive.

4.2 Positionality

In order to provide further context to this research, I think it is important to acknowledge my positionality and how I came to focus on this thesis topic. I am a queer White woman who was raised mostly in the southern United States. Being a part of a military family and prior to moving to Tampa, the longest I had lived in any one city is four years. In 2012, I moved to Tampa and for the past seven years I have participated in the LGBTQ community in the Tampa Bay area. I have volunteered for LGBTQ community events, joined rallies and protests to bring awareness to LGBTQ and other social justice issues, and I have been actively researching LGBTQ health issues in the area for the past 5 years.

As a university student and through employment in the area, I have made friendships with LGBTQ folks along the way. In 2018, I became a mother. As a pregnant woman living under the federal poverty level, I began the process of applying for Florida Medicaid. This is when I started to become curious about the policies and procedures LGBTQ individuals must face to start a family, especially for individuals living near the federal poverty line. I knew this was a topic of interest within my community groups, and using my privilege as a student researcher, I began to explore the topic further. As I followed my own journey to parenthood, I began to take note of the effort for certain tasks required of LGBTQ individuals seeking parenthood. Due to pregnancy, lack of childcare, and other life demands I was unable to interview as many participants as were willing.

4.3 Recruitment

Recruitment for this study took place through snowball respondent-driven sampling methods (Trotter II, et al., 2015). Four couples living in the Tampa Bay area participated in the study. Each participant was interviewed individually leading to eight semi-structured interviews. This is not a representative sample and because of the heterogenic characteristics of the target population it is not practical to use a randomized sample (Guest, 2015). Participants were asked to refer individuals from their own networks to the study. To be eligible for the study the participant had to be over 18, be a self-identified queer woman in a relationship, and have lived in the Tampa Bay area for at least a year since the Marriage Equality Act passed in 2015. The participants were interviewed between November 2018 and May 2019. No research data was collected through email or social media.

4.4 Methods

Data was collected through individual interviews that ranged from 30 minutes to an hour and a half. Semi-structured interviews allow qualitative comparisons leading to a deeper analysis of individual perceptions (Levy & Hollan, 2015). The interviews were conducted verbally and face-to-face at a location of the participant's choosing which allowed an open forum for each participant to imagine navigating a pathway to parenthood. Individual interviews were conducted in order to understand individual preferences and to avoid placing any unnecessary pressure on the couple in the possible case the couple had not yet discussed a certain topic covered in the interview. Semi-structured, person-centered interviewing provides greater opportunities to elicit further detail than written responses or multiple-choice questions might. The interviews were conducted, recorded, and transcribed by the principal investigator. The semi-structured interviews included the following sections: Demographic Information, Beliefs Concerning Pathways to Parenthood, a forced-choice pile sort and preference ranking activity regarding the different pathways to parenthood, Detailed Preferences, Family Policy, and Resource Information and Result Dissemination.

1) *Individual and Demographic Information*: Participant information including (a) age, (b) ethnicity, (c) education level, (d) gender identity, (e) sexual orientation, (f) relationship status, (g) duration of residency in Tampa, and (h) whether or not the participant has health insurance.

2) *Pathways to Parenthood*: This section included open-ended questions asking participants to discuss the pathways to parenthood they are familiar with.

3) *Order of preferences:* A forced-choice pile sort and ranking activity by cards was administered to discuss participant preferences more thoroughly. The participants were asked to

sort cards with the following options into pathways they would consider and pathways they would not consider: Adoption, Fostering, Self or Partner Insemination, Direct Insemination by Donor, In Vitro Fertilization (IVF), Intrauterine Insemination (IUI), Reception of Oocytes from the Partner (ROPA), Traditional Surrogacy, and Gestational Surrogacy. The participants were asked to sort the remaining cards by order of preference. The participant's order of preferences provided further data on the participant's justifications, reasoning, and development of certain preferences, based on their own expectations, resources, and parameters. The order the participant ranked each pathway was discussed at length.

4) *Detailed Preferences:* This section ask participants about their individual preferences concerning family planning intentions regarding the self, partner, third parties, and the child. Questions in this section were based on responses from the previous exercise; for example, if the participant was not willing to consider adoption as a pathway to parenthood then the prompt asking for details about the adoption process was excluded. The semi-structured questions connected to themes gathered from recent literature on kinship and included questions of preferences concerning gestational carriers, breastfeeding, donors, and the processes involved with selecting kin. Open-ended prompts were utilized for response clarification, expansion of any emerging themes, and to elicit further detail of the nuances of the individual decision-making process.

5) *Family Policy*: Open-ended questions gave the participants the opportunity to share their opinion on family policies they are aware of in Florida and the United States. This section sought to act as a free-response space to give the participant a chance to discuss any policies they are aware of or have concerns about. Participants were also given the chance to give their own

suggestions for inclusive family building programs and policies. The responses may allow for direct conversation between policy makers and the participants.

6) *Resources and Research Dissemination:* Applied questions were used to involve the participants in the academic process so that they might actively participate in the co-construction of knowledge and to have a chance to voice how to appropriately apply the results directly back to the community. The questions in this section were intended to provide an opportunity for each participant to have control of their own data and results. This aligns with the Society for Applied Anthropology ethics regarding the dissemination of information and allows for the flow of resources back to the participants and possibly into the wider community.

4.5 Data Analysis

The interviews were transcribed and then analyzed through thematic analysis. Microsoft Excel was used for data entry. The thematic analysis focused on identifying participant preferences, the strategies participants may use to maximize kinship affinities, and any policies that might impact the participants' journey to parenthood. This method of analysis aligns with the tenets of Practice Theory- that people perform behaviors and practices based on their beliefs and resources, or habitus, and individual agency may be constrained by structural or personal factors (Ortner, 1984). Thematic analysis was used to identify themes each participant found important throughout the family building process and to provide broad reflections into the reproduction and transformation of the current kinship systems.

The open-ended questions surrounding preferences and current family planning policies in Florida were analyzed by comparing participant responses. The interview responses are not regarded as significant or as reflective of trends of the general population but may add to the

literature of what queer individuals find important along their journey to parenthood. This analysis will be useful to compare how queer women living in Florida desire to use family building resources and how policies may prevent or assist individual access.

4.6 Ethical Considerations

This research has been approved by the University of South Florida IRB. No funding was used to complete this project; therefore, this study is free from any conflict of interest involved with funding requirements or research agendas from outside institutions. This study recognizes knowledge is co-construed and is only able to happen with the participants' willingness to share their knowledge. Any contact information collected has been kept separate from data. No research data was sent through email or social media. This study is considered minimal risk. There were no express benefits to individual participants for this study. Participants did not receive payment or other compensation for taking part in this study. It did not cost the participants anything to take part in the study. All participants took part in an informed consent process.

CHAPTER 5:

RESULTS

5.1 Participant Characteristics

Four couples participated in the interviews for this study. Bridget and Erin are the first couple I interviewed. They are married and are both White. Bridget identifies as a non-binary femme who is queer. Erin identifies as an assigned female at birth with a non-binary gender identity and is pansexual. The couple have previously researched multiple pathways but have put their plans on hold until Erin finishes school. I interviewed Alex and Lauren next. Alex and Lauren have been together for over a year and are both White. Alex identifies as a lesbian woman, while Lauren identifies as a bisexual female. Lauren and Alex are not actively pursuing parenthood at the moment. The third couple is Jess and Val who have been together for over a year. Jess is White and of Jewish heritage, and Val preferred not to identify her race but identified her ethnicity as Hispanic. Jess says her gender identity is loosely female and she identifies as a lesbian. Val identifies as a gay female. Val and Jess would like to pursue parenthood and have discussed their preferred pathways but are waiting until they have more resources to begin actively seeking parenthood. The last couple I interviewed are Heather and Steph. Heather and Steph are married and are both White. Heather identifies as a queer woman and Steph identifies as a bisexual female. Heather and Steph are actively pursuing parenthood. They first chose to use a known donor but then decided to choose a donor through a sperm bank. All eight participants have at least some college experience. All participants had health insurance

at the time of their interview either through the marketplace or employee benefits. At the time of the interviews, the participants ranged in age from 22 to 30. All names are made up in order to protect the participant's anonymity.

5.2 Interview Analysis

The interviews focused on individual attitudes and preferences towards various pathways to parenthood. The pile sort and ranking activity provided an opportunity for each participant to contemplate the values and boundaries that are important to them along their journey to parenthood. The participants were asked whether they would consider the following methods: self or partner insemination, direct insemination, intrauterine insemination, in vitro fertilization, reception of oocytes by the partner, traditional surrogacy, and gestational surrogacy. The participants were then asked to rank the pathways that they would consider pursuing in order of preference. The emerging themes across the interviews included the negotiation of kinship connections, health concerns, and concerns about policy. At the end of the interviews participants were given the opportunity to discuss any policies they are aware of that might impact their decision to build a family and each participant provided their own recommendations for future programs and policies concerning LGBTQ individuals navigating the various pathways to parenthood.

5.2.1 Known Pathways

All eight participants had a basic awareness of the different pathways to parenthood that were included in this study, even if all the pathways were not initially stated. One participant broadly defined the pathways into two categories: adoption and using a sperm donor. Three

participants stated additional methods not included in this study: the use of stem cells, using two women's chromosomes, and intra-cervical insemination which can be performed at home and could be considered a self or partner insemination technique.

5.2.2 Adoption vs. Conception

All eight participants said they would consider adoption, but it varied whether the participant would consider adopting primarily or as a last option. Five of the participants preferred adoption as their first option, while three of the participants would consider adoption as a final option. Some of the reasons why the participants prefer adoption over a route to pregnancy include: one participant prefers not to go through a medical procedure, one participant does not want to pass on a genetic disorder, two participants mentioned a family history of difficult pregnancies, and three of the participants brought up social justice and environmentalism as their motivation behind their preference to adopt. For example, one participant said,

> One of the reasons we don't want to have kids biologically is just because like you can't do it together just from having sex, so we kind of thought that it would make more sense for us to adopt because there are a lot of kids who don't have homes and with climate change and all sorts of things that are going on, we just kind of thought, since we can reproduce by having sex anyways, we might as well adopt.

Another participant stated in reference to their preference for adoption,

I just believe that this planet is overpopulated and there are too many children without

homes. I've never been too keen on bringing a child into the world because of all the

problems this world has. The downside to having my own child is eventually the world is

going to be too crowded.

Some of the reasons why pregnancy was preferred over adoption: six out of the eight

participants felt that having a child that looks like them would be an advantage to choosing a

biogenetic pathway, two participants wanted to experience pregnancy, and one participant said

they would prefer to have a chance to raise their child from the very beginning.

5.2.3 Adoption and Fostering

Four participants collapsed adoption and fostering into a single category during the

ranking activity, and three of those four participants specifically stated they would be more

comfortable with a foster-to-adopt situation. Three of the eight participants stated they would

consider adoption but did not feel comfortable with a foster only situation because they felt it

would be emotionally challenging for various reasons. When discussing the possible difficulties

of fostering one participant stated,

I don't know how I would feel putting so much love and care into somebody and then

them not be in my care anymore. I don't have a good mental space to be able to handle

things like that. People that I love or things that I love being gone, stuff like that, or

having the possibility of being put into the situation where they wouldn't be in as good of

an environment, and then I would feel completely guilty. I think I would feel better with

adoption because I wouldn't be having a child possibly leave my care.

Only one participant solely wanted to either Adopt or Foster and preferred not to pursue

other pathways; however, during the ranking activity the participant did discuss other pathways.

5.2.4 Self or Partner Insemination vs ARTs

All eight participants would consider at-home insemination techniques. For five of the

eight participants, self or partner insemination came before the use of assisted reproductive

technology. The five participants who would consider self or partner insemination before using

ARTs mentioned they would prefer taking the route of least medical intervention. One

participant discussed how they feel about IVF in particular,

> Umm, I don't like, I just don't like the invasive, them removing things from me to then
>
> put them back. It just seems like, one- painful, and two- very uh impersonal. Just kind of
>
> invasion of privacy and stuff like that just makes me feel weird.

One individual who prefers to use assisted reproductive technology before trying at home

self or partner insemination stated it was because they believe pregnancy would be more likely

achieved under a medical professional. This same individual mentioned it would take an

emotional toll on her to go through multiple attempts of pursuing pregnancy. Another participant

would only consider adopting or self or partner insemination and preferred not to use assisted

reproductive technology. One couple mentioned they prefer to do at-home insemination because

they feel it has the highest success rate, lowest medical intervention, keeps costs down, and allows them to keep the conception process an intimate experience between partners.

5.2.5 ARTs and ROPA

Four out of the five participants who would consider ROPA ranked the different assisted reproductive technologies in the same order first preferring to pursue IUI, then IVF, and then ROPA. One participant ranked ROPA before any other assisted reproductive technology, while their partner would consider ROPA but not any other assisted reproductive technology. This same couple both mentioned they would like for both partners to get to participate in the reproductive process.

5.2.6 Pathways Less Likely to be Considered

Some of the pathways that were less likely to be considered were the two types of surrogacy and direct insemination. Three of the participants stated they would possibly consider surrogacy if one or both of the partners were physically unable to go through pregnancy and they found themselves unable to adopt.

5.2.7 Pregnancy

After the ranking exercise, the participants were asked more details about their preferences concerning pregnancy, adoption, and selecting a donor. Each individual answered the question, "Who would you prefer to be pregnant?", with the same answer as their partner, even though two couples mentioned they have not yet discussed this topic with their partner. Only one couple said they would both like to experience pregnancy. Out of the three participants

who preferred for their partners to be the one to carry, two were the only participants to identify as lesbian, and the third participant is the only person who did not identify as a woman, female, or femme. Two of these same three participants also stated they preferred not to be pregnant because of a family history of difficult pregnancies and the third participant did not want to pass on a genetic disorder. Despite preferring not to take part in the gestational aspect of reproduction, all three of the participants were interested in ROPA and did not mind taking part in the assisted reproductive labor.

5.2.8 Breastfeeding

Six out of the seven participants who would consider becoming a parent to an infant said they would be interested in using breastmilk when they were asked. One couple stated they would be interested in finding donor breastmilk if they found both partners were unable to breastfeed, while two participants said they prefer not to use donor milk because they may not know the contents of the breastmilk. One of the participants who would prefer not to be pregnant said they would try to breastfeed if their partner was unable and if they were able to induce lactation. The couple who would both like to experience pregnancy expressed interest in co-nursing either by inducing lactation through the Newman-Goldfarb method or in the scenario one partner goes through childbirth they hope to follow tandem breastfeeding practices. The Newman-Goldfarb method involves inducing lactation so that an individual may breastfeed without going through a pregnancy (Canadian Breastfeeding Foundation, 2002).

5.2.9 Adoption Factors

The factors the participants brought up when considering adoption included age, race,

mental and physical health, sexual orientation, and custody status. While only one of the participants stated the child's age did not matter, the other seven participants said they prefer to adopt a child within a certain age range. One of the participants said she would prefer adopting an infant, while another participant specifically said she does not want to adopt an infant. Two other participants said they would be interested in adopting older kids. One couple both mentioned they would prefer to adopt a child younger than 6, however, they would like to have a child through a biogenetic pathway first before considering adoption. The couple said the reason why they would prefer to adopt a younger child is because they both felt they would be unable to meet a preteen or teenager's needs. This same couple stated race would not be a factor of preference for adoption, even though it was an important issue for them when considering ARTs.

Mental and physical health was a major concern for all eight participants. Five of the participants raised concerns about their own mental health limiting their ability to provide the children with what they need. One participant stated she would not be able to provide the resources for a child with a severe mental or physical disability because of the responsibilities of her career path and home life which involves nurturing a multi-species community. The participant stated,

> I don't think I would be strong enough to handle like any kind of real serious mental or physical handicap. Because all of the stuff that I do, it would depend on the severity and stuff but anything like that would inhibit basically my ability to still do what I do with the birds and outdoors and nature and all that kinds of stuff. I view this adoption/fostering thing as like an additive deal to all that. Rather than one that would limit my ability to

carry on in my life and like develop professionally and like personal growth and all of that stuff kind of by extension of the career path.

This participant also stated later in the interview, "I know a lot of people who have fur children and it doesn't make them any less of a family regardless of like their relationship". Another participant specified they would prefer to not have a child with a personality disorder because of how it might impact their own mental health and prevent them from providing their child with the right environment. One couple mentioned they were alerted by a community organization about the need to adopt LGBTQ kids in the area and they both feel this could be a factor they would look for when pursuing adoption.

Five of the participants asked questions about the differences in how open, closed, public, and private adoptions operate. Seven out of the eight participants prefer for the adoption to be an open adoption. The one participant who would prefer a closed adoption still wanted to know the parents' medical history. Three participants brought up issues over the differences in how state and private adoptions operate. One participant felt confused with how religion might come up in the adoption process, especially voicing a concern that religiously affiliated groups are able to directly discriminate against LGBTQ adopters. Five of the eight participants also brought up concerns about the second-parent adoption process as an important LGBTQ issue.

5.2.10 Donor Factors

Selecting a donor. The participants were interested in a number of topics when it came to donor preferences including anonymity and choosing from a sperm bank. Participants thought mental health, genetic health, family history, personality characteristics, physical looks, race, and

emotional and general intelligence were all important factors in the process of selecting a donor. Mental and genetic health were most commonly listed as the most important factor to be considered. One couple said race is the first factor they decided on as they began the process of selecting a donor. One of the partners said the couple asked themselves, "What would be the meaning behind choosing a donor with a race different than both of ours? Because we're both White, it would be irresponsible for us to do so". Five of the participants brought up the donor's emotional intelligence as an important factor in donor selection. The participants felt it was important to them that the donor has empathy for them as parents, empathy toward any possible future offspring, and is generally a kind person. One participant said they would prefer the donor to be "someone who is donating for good reasons and is just an all-around good person, that's kind of a fun story, I guess, in your head or for your kid". One participant mentioned intelligence as one of their top three important factors, while one couple stated academic achievement was their least important consideration.

Donor anonymity. Most participants would like some degree of knowing who the donor is. The preferred amount of donor contact ranged from only needing some general health information about the individual, to feeling more comfortable having a well-known friend or sibling be the donor. One couple felt it is almost impossible to keep any adoption truly closed because of the use of popularized DNA kits and genealogy websites and their unintended consequences of revealing cases of adoption. Five of the participants wanted the donor to be a stable and present influence in the child's life. One participant contemplated donor involvement by imagining the story she might tell her child about the donor's role in the child's life.

Selecting a sperm bank. One couple went into depth about how they not only chose a donor but also the process of selecting a sperm bank. The couple's initial plan was to use a

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known donor, but after this no longer worked for them, they began searching for donors through sperm banks. This took them on a nation-wide sperm bank facilities search. The couple ended up selecting the sperm bank they used because of one main policy-- the cap on how many families may use one individual's donated genetic material. The sperm bank they selected only allows 10 families to use the donor's genetic material. The next lowest limit was 25 families. The partners would like to set their children up as genetic siblings so it is their hope this will be able to happen before the limit is reached. One of the partners mentioned that there is no way to enforce the bank's policy to report any live births, but they both feel it would be in their best interest to report any births they might have.

5.3 Policy Concerns

When asked to define family, one participant commented, "It doesn't have to be biological or legal, but I think the legal aspect really matters because so much can be taken away from us as LGBTQ citizens in this country and we don't really know what's coming down the pipe. So, I feel that is what's important to me to be able to, like, have legal guardianship of whatever children". Participants voiced concerns over multiple policies. One of their concerns is that birth certificates that list an LGBTQ couple as the parents may not be recognized across state or county lines. Five of the eight participants mentioned concerns about second-parent adoption and felt it was an undue burden for LGBTQ individuals seeking parenthood. For example, one participant stated,

> One thing that was taken into consideration for us as well is that, federally, adoption is
> considered king as far as rights go and if I understand correctly, even if you're on the

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birth certificate, as queer parents in certain states you don't have rights unless you're an adoptive parent. So, if we did intra-uterine insemination, for us to be protected with our child leaving the state we would still have to have Erin adopt the child even if they're on the birth certificate and we're married and all of that stuff. Where couples in heterosexual relationships are able to be okay, we would have to go through a second-parent adoption to make sure if we were traveling in one of those states. And you know if something happens to me my partner could have the child taken away from them if you don't have the second-parent adoption, even if they're on the birth certificate. So, I think that's still the case in some states so that is a consideration because like either way we have to go through adoption. That's kind of an invisible stress that a lot of people may not think about because even if you go through the process, kind of in parallel or the same kind of process that a heterosexual couple might go through, you know, you still have to go through that extra hoop. And unfortunately, there are, there's plenty of legislation around gay families that is really just a vanity plate, that doesn't have substantial precedent or water to it as some other legislation does. So, you have to be careful and know what your rights are and where because you don't have the same rights everywhere".

One couple in the study felt that pre- and post-birth contracts are precarious and saw donor bank regulations such as the Birth Reporting policy to be ineffective at holding people accountable. One participant stated the United States only regulates sperm quality when it comes to using assisted reproductive technologies leaving standards of care largely up to the donor banks, fertility centers, and physicians. One participant felt assisted reproductive technologies

were exploitative and should be better regulated because the technologies show low rates of success. She stated,

> IVF is a product now, it's not necessarily a treatment in terms of the kind of complications associated with it. And most things are like that with health insurance, you know, but for something like that it's a very… it lends itself to very significant marketing ploys. So it should be covered so it's more accessible to people and I would imagine too if you are, really anybody, if you are somebody who is unable to get pregnant in the traditional sense there's, depending on your situation, but for a lot of people if you put the numbers together for how much it costs and the percentage, the chances it won't even work, I think that for a lot of people it would immediately be the deciding factor. Like if we thought about it, we're just going to make it a fleeting thought rather than something to pursue.

Four of the participants were concerned over conscious clause policies that may allow companies or doctors to refuse treatment or services to LGBTQ individuals. Two participants voiced concerns that a conscious clause policy could possibly affect their child's medical treatment.

5.4 Emerging Themes

Some of the emerging themes found throughout the eight participants' interviews involve the negotiation of kinship preferences and connections, concerns about health, and policy concerns. The participants negotiated their preferred pathway to parenthood along physical and

emotional boundaries. Each participant followed a similar pattern of negotiation, by weighing their boundaries with their partner's preferences along with their own ability to care for the needs of a child. Some of the points of negotiation include: the participant's emotional capacity to handle certain procedures involved with a specific pathway, such as attempting pregnancy or saying goodbye to a foster child; the participant's physical boundaries such as their inclination toward medical procedures; and the participant's willingness to adjust their own emotional and physical boundaries based on their partner's preferred pathway to parenthood. Some of the strategies the participants discussed to maximize kinship connections include co-nursing, using a sibling to create a genetic connection, alternating the gestational carrier, using a shared genetic donor to create siblings, establishing narratives to discuss donor involvement, and constructing a child's physical likeness to "mirror the family" through various tactics. All eight participants voiced concerns about mental and physical health whether it be in regard to their own health, the donor's health, or the child's health status. The participants were concerned about donor health status as it would impact their child's life. The participants' policy concerns are addressed in the following section.

CHAPTER 6:

DISCUSSION & CONCLUSIONS

6.1 Summary of Key Findings

The participants showed a willingness to negotiate their preferences according to their individual needs, the needs of their partner, and the child's needs. The most commonly preferred pathway for the participants was adoption, then self or partner insemination, and the use of assisted reproductive technology. Some of the factors the participants brought up when considering adoption include age, mental and physical health, sexual orientation, and custody status. Participants thought mental health, genetic health, family history, personality characteristics, physical looks, race, as well as emotional and general intelligence were all important factors in the process of selecting a donor. Some of the barriers to parenthood the participants brought up include costs, time, legal proceedings, policy, family history, disability, mental health, and fear of discrimination. The individuals in this study showed a propensity to manage and cultivate complex relationships and bonds by anticipating the needs of the people, and animals, around them.

Another interesting finding is the role the participant's parents played in a discussion of parenthood. At the end of the interviews, two of the participants brought up how their parents responded to the participants 'declaration of coming out. Both participants said when they came out as queer to their parents, the parents' main concern was that they would not be able to have a child. Another participant mentioned that while both of the couple's parents are supportive of the

couple's decision to pursue parenthood, in the beginning the participant's father told the couple he preferred for them to seek adoption. I feel these responses reveal a generational perception that LGBTQ people do not reproduce or have families. This is telling of the general climate the participants and other LGBTQ individuals have grown up in. Even though ARTs have been around for decades, the idea that LGBTQ individuals can and will have healthy families is still not the general perception.

There remains a lack of trusted, comprehensive resources for LGBTQ individuals to make informed decisions about family planning. As Kissil & Davey (2012) also remark, I believe this is due to a reluctance of our state legislators to address policy concerning LGBTQ individuals or the use of ARTs in an equitable partisan fashion, for fear of backlash (Casper & Morgan, 2004). The reluctance to pass legislation offering the same protections for LGBTQ individuals indicates legislators do not acknowledge the value of healthy queer families. Family planning efforts should focus on empowering all parents to make the most informed choices for their families regardless of relationship status, race, ethnicity, or economic background.

6.2 Contributions of Findings to Literature

The self-identified queer individuals in this study brought up similar strategies that participants in other kinship studies have discussed including matching, alternating, using the same genetic donor to create siblings, and using stories to maximize their kinship connections. Other strategies the participants in this study brought up include using a sibling to create a genetically related child, inducing lactation so that both partners may nurse, tandem nursing, and co-species parenting. The participants revalue their reproductive futures by using these strategies to construct their own standards of meaningful kinships. This is evident in the participants desire

to secure guardianship through their awareness of second-parent adoption, adherence to birth reporting policies, and a commitment to intimacy. Despite the small size of the study, the participants showed a wide variety of approaches to arrange various biological, genetic, legal, and social lines of kinship to their children and from their children to the networks around them. The variety of participant preferences only affirms and validates the need to have family programs that acknowledge multiple pathways to arrive at parenthood.

6.3 Applied Dimensions and Recommendations

6.3.1 Policy Concerns

In order to address the policy concerns of the participants, this section looks at anti-discrimination laws, state custody laws, and laws surrounding the use of assisted reproductive technologies. Florida does not have an explicit state-wide non-discrimination policy to protect LGBTQ individuals (Florida Civil Rights Act of 1992). Several counties in Florida have established non-discrimination ordinances that extend protections to LGBTQ individuals especially in regard to employment. In 2014, Hillsborough County legislators voted to amend the Hillsborough County Human Rights Ordinance No. 00-37 to put non-discrimination protections in place for LGBTQ individuals in regard to employment, public accommodations, and housing (Municode, 2012). While some states directly give religious organizations the right to discriminate on the basis of sexual orientation, Florida does not directly address one way or another whether religiously affiliated private adoption agencies have the right to discriminate against LGBTQ individuals who would like to adopt (Bewkes et al., 2018). The lack of policy protections for LGTBQ individuals living in Florida is not only a barrier for LGBTQ individuals

seeking parenthood, it also impacts the present and future of children waiting to be a part of a family (Bewkes et al., 2018).

The 2019 *Florida Statutes* Chapter 63 on 'Adoption', as well as 2019 *Florida Statutes* Chapter 742 on the 'Determination of Parentage', lacks inclusive wording. While Florida allows LGBTQ couples who are married to be listed on their child's birth certificate, other states may not recognize the birth certificate as a Determination of Parentage (Equality Florida, 2017; FLA. STAT. § 742, 2019). Local LGBTQ advocacy groups suggest LGBTQ parents complete a second- or stepparent adoption because all states are required to recognize court-ordered adoption papers (Equality Florida, 2017).

The Fertility Clinic Success Rate and Certification Act (FCSCRA) of 1992 is the only federal policy that addresses the use of assisted reproductive technology in the United States (Mamo, 2005; Kissil & Davey, 2012). The FCSCRA and its initiatives aim to document national ART rates and outcomes. The Society for Reproductive Medicine dictates guidelines for the use of ARTs in the US; however, it is mostly left up to the clinics to decide things such as who is able to become a donor and how the donor materials are put to use.

Florida does not require health insurance companies to cover ARTs, even though federal policy requires insurance companies to cover costs pertaining to pregnancy and childbirth ("What Marketplace Health Insurance Plans Cover," n.d.). In addition, the way insurance companies label the use of assisted reproductive technologies as "Infertility Treatment" could be a potential barrier for LGBTQ individuals pursuing parenthood since LGBTQ individuals may only face "social infertility" which may not be recognized as a medical diagnosis elective for coverage ("See 2018 Plans & Prices," n.d.). Because Florida did not extend Medicaid coverage after the Affordable Health Care act passed in 2010, many people go without insurance coverage,

so even if insurance companies are held to a higher standard of care, access to one's preferred pathway to parenthood may still be limited. These policies, initiatives, and guidelines prove to be inadequate at providing protections for LGBTQ individuals seeking a family and at addressing the barriers and inequities LGBTQ individuals and families continue to face.

6.3.2 Participant and Study Recommendations

How can states and local communities create inclusive family planning programs and initiatives to meet the needs of LGBTQ individuals who are looking to start a family? The participants in this study offered a variety of program suggestions especially in reference to ART coverage and the foster-adoption process. All participants felt insurance companies should at least cover a percentage of the costs associated with the use of assisted reproductive technologies. Six of the eight participants thought the use of assisted reproductive technology should be fully covered. One participant felt insurance policies should cover at least 75% of the costs associated with using assistive reproductive technologies, but ideally, they would like it to be covered 100%. This same participant also thought there should be a limit on the number of children who are born by the use of assisted reproductive technology. The participant suggested a limit of three children per family. Three participants voiced concerns over the adoption process and felt initiatives should be put in place to make foster placements and adoptions less emotionally difficult and stressful for potential parents and children. Some of the other suggestions by participants include setting up family building workshops for LGBTQ individuals and initiating a legal fund that could offset some of the additional legal obligations and costs queer families may encounter.

This study has compiled a list of recommendations based on policy and program suggestions by reporting agencies, the study participants, and other researchers who are studying kinship. These strategies aim to create inclusive family programs and initiatives to improve the lives of LGTBQ individuals and families living in Florida. Attempts to develop anti-discrimination laws at the federal level for LGBTQ individuals in the US have not yet been successful. Until there are explicit non-discrimination policies in place for LGBTQ individuals at the national level, grassroots efforts should focus on putting protections in place at the state level. Although Florida recognizes LGBTQ guardianship on the basis of a birth certificate, it is important that all states recognize the proceedings of the birth state, so that families are not torn apart across state lines.

National policy needs to be developed to regulate the use of assisted reproductive technologies within a broader framework. The existing ART reporting system can be a powerful analytical tool and system of accountability. One suggestion is for The Society for Reproductive Medicine to enlist the help of biological anthropologists to not only develop adequate national guidelines for the use of assisted reproductive technologies, but to also work with donor banks and fertility centers to interpret any short- and long-term consequences of current best practices. Some examples of the clinical and donor bank practices that biological anthropologists are particularly trained to deal with include birth reporting policies, the handling of biological materials, and creating sensible limits on the use of the human reproductive biomaterials.

Federal policy could be more inclusive by amending the Affordable Care Act to incorporate the use of assisted reproductive technologies as a part of pregnancy and childbirth services covered under essential health benefits. Policy focusing on the coverage of assisted reproductive technology should also reconsider the definitions of infertility diagnoses in order to

enable LGBTQ individuals to receive the healthcare they need to begin healthy families. Until the coverage of ARTs is addressed at a federal level, Florida Legislators should work with health insurance companies to develop policy requirements for at least the partial coverage of assisted reproductive technologies. Another suggestion is that as a state that does not require coverage of ARTs, perhaps the state could offer temporary assistance for individuals who would qualify for Medicaid coverage if pregnant to pursue pregnancy, such as buying the supplies needed to perform at home insemination or purchasing donor sperm.

Local organizations and stakeholders should work together to provide centralized resources for LGBTQ families looking for family-building assistance. A supportive LGBTQ family assistance program will recognize multiple pathways to arrive at parenthood. One strategy to empower LGBTQ individuals to pursue their preferred pathway to parenthood is to offer family-building workshops (Crawshaw & Montuschi 2013). The workshops could train community members on certain procedures involved with pursuing parenthood such as how to navigate various pathways, legal procedures, and state policies. Another suggestion is for stakeholders to come together to create local and national resource guides for LGBTQ individuals to locate any community, medical, and legal services needed to start building a family. There should also be a reasonable attempt to provide personal counseling for LGBTQ individuals pursuing parenthood to help interpret parent profiles, donor profiles, and possible outcomes for the child.

The participants in this study and other kinship studies have demonstrated resilience by developing different strategies to maximize and fortify kinship bonds, despite facing uncertainties. These strategies could be integrated into the curriculum of family-building programs by offering family-building activities and events. Fostering family and community

connections could help to build healthier families and stronger community networks. Community members and legislators can demonstrate their commitment to providing a better future for all families in the US by using their resources to aim for more inclusive policies and programs.

6.4 Limitations and Future Directions

This is not a randomized study and therefore does not hold any statistical significance. This research is not generalizable to the entire population of LGBTQ individuals living in the U.S. or even in Florida because of differences in state and county legislation and other local contexts; however, the data in this study adds to the small amount of literature on the family building needs of queer individuals living in the southern United States. While the semi-structured interview provides a more effective format to explore a range of discussion topics, it also lacks internal validity. The majority of participants in this study are queer White women who have at least some college education and who all have health insurance. More research is needed to understand how LGBTQ individuals of different cultures, races, and ethnicities living in the US would like to utilize family building resources. Also, future research should aim to include participants with a wider range of education backgrounds, socioeconomic statuses, disabilities, and should include individuals without insurance coverage. It is important to continue to document the ways queer individuals wish to seek parenthood in order to build relevant programs that are inclusive of all LGBTQ individuals.

6.5 Conclusion

Will Florida continue to be one of the last states to revise their policies and extend protections to include LGBTQ individuals? Policy takes time to pass because there are only

certain windows of legislature activity. Community programs can be built into existing community organizations; however, this can also take time. The LGBTQ community continues to be caught in between gaps in policy that may result in lifelong and possibly generational consequences. This type of reproductive governance where policy and initiatives fail to meet the needs of all families results in stratified reproductive outcomes and opportunities for LGBTQ individuals and their families. The barriers and additional expectations for queer people to become parents are mentally, emotionally, and physically burdensome. Acknowledging there are multiple pathways to arrive at parenthood and that parenthood is not singularly a biogenetic phenomenon, is a start to reforming family policy. Broad efforts should be made to develop a culturally, socially, emotionally, and biologically encompassing standard of ethics surrounding reproductive and kinship practices. Reproductive and family issues should be at the forefront of ethics discussions because these matters involve biological labor and may result in generational consequences. It is irresponsible not to address these issues in a cooperative way at a broader scale. Family programs and policies that do not create culturally relevant solutions especially for issues surrounding race, sexuality, and socioeconomic status are programs and policies that will continue to set communities up to fail.

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APPENDIX A:

USF INSTITUTIONAL REVIEW BOARD APPROVAL

USF
UNIVERSITY OF
SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
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November 6, 2018

Emily Baker
Anthropology
Tampa, FL 33612

RE: **Expedited Approval for Initial Review**
IRB#: Pro00037725
Title: Attitudes and Preferences of Family Building Practices for Self-Identified Queer Women
            Living in Tampa Bay

Study Approval Period: 11/5/2018 to 11/5/2019

Dear Ms. Baker:

On 11/5/2018, the Institutional Review Board (IRB) reviewed and **APPROVED** the above
application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
Protocol #0037725 Version #1 10/30/2018

Consent/Assent Document(s)*:
Adult Consent Version #1 10/12/2018.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the
"Attachments" tab. Please note, these consent/assent documents are valid until the consent
document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which
includes activities that (1) present no more than minimal risk to human subjects, and (2) involve
only procedures listed in one or more of the categories outlined below. The IRB may review
research through the expedited review procedure authorized by 45CFR46.110. The research
proposed in this study is categorized under the following expedited review category:

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(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) business days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Chairperson
USF Institutional Review Board

INTERVIEW QUESTIONNARE

Attitudes and Preferences of Family Building Practices for Queer Women

Demographics

1. What is your age?

2. How would you describe your race/ethnicity?

3. What is your highest level of education?

4. If you feel comfortable, please state your biological sex given at birth.

5. Please describe your gender identity.

6. Could you describe your sexual orientation?

7. What is your current relationship status?

8. Have you always lived in Tampa? If not, how long have you been a resident?

9. Do you currently have health insurance?

10. Please describe your desire to be a parent one day.

Beliefs and Attitudes

1. What are some of the ways you know of that are available to queer women to start a family?
    For each method the participant mentions, follow up with the following: "You mentioned (*specify method the participant mentions*), what do you see as possible advantages to using this method? What do you see as possible barriers, or disadvantages, to using this method"?

2. Are you aware of these methods? (*List any methods the participant did not mention in the first question of this section. Discuss any methods the participant states they are familiar with, describe methods the participant says they have not heard of. Ask the same prompts from Question #1 of this section for each method*).

Pile Sort

Each index card will list one of the following pathways to parenthood: Adoption, Fostering, Self-
- or Partner-Insemination, Direct Insemination, IVF, IUI, ROPA, Traditional Surrogacy, and
Gestational Surrogacy. Sort the index cards into two piles, one pile should be options you would
consider trying and the other pile should be options you would not consider. If you would
consider all of them, then there is no need to sort into two piles.

1. *After the participant sorts index cards into pathways to parenthood they would consider and
pathways they would not consider, ask*, "What are some reasons you chose (insert methods the
participant placed in their "would consider" pile), and not (insert methods the participant placed
in their "will not consider" pile")?

Ranking

Looking at the pile of methods you would consider, please rank the methods according to your
preferences, starting with the most preferred method as #1.

1. *After the participant sorts index cards by preferences, follow-up with the prompts*, "Why do
you prefer (insert method #1) over (method #2)?" and "Why do you prefer (insert the second
lowest ranking item) over (the lowest ranking item)?".

Kinship Preferences

(*Based on responses from the previous exercise, for example if the participant is not willing to
consider adoption, then don't ask #4*).

1. Who do you prefer to be pregnant? (Self, Partner, Either, Both, Other) Why?

2. Who do you prefer to be the egg donor? (Self, Partner, Either, Both, Other) Why?

3. What are your thoughts if you are able to choose to provide your child with breast milk? *If the
participant would consider choosing to provide breast milk ask*, "Would you prefer for you, your
partner, or a third party to provide the breast milk"?

4. What factors do you consider important when adopting a child?

5. What factors do you consider important when selecting a donor?

7. If you were to use a donor to create your family, would you prefer for them to be anonymous
or known? If known, how much interaction do you imagine the donor would have with your
family?

Open--Ended Questions

(*Based on responses from previous questions*)

1. How do you define family?

2. Why do you want or do not want to have a family?

3. What policies are you aware of that may be relevant concerning the pathways to parenthood we have discussed?

4. What do you know about your insurance coverage, or insurance coverage in general, regarding assisted reproductive technologies?

5. What do you think about the following policies that are relevant to Florida (specify policies they may not have mentioned)? After hearing about these policies, would you change any of your previous considerations regarding any of the methods we have discussed?

5. Currently, there are no state-sponsored resources to assist LGBTQ individuals to build a family, do you know of any community resources that would be relevant?

6. What do you think would be important resources to help build healthy LGBTQ families in Tampa Bay and in Florida?

Applied Questions

1. Do you want any more information on the following? (Getting Pregnant, Being Pregnant, Birth Control/Sterilization Medicaid, Adoption, Fostering, LGBTQ Mental Health, LGBTQ Sexual Health, Community Programs, Local Social Media Forums, Breastfeeding, Insurance Coverage regarding ARTs, Insurance Coverage regarding Maternity Care, Laws and Policies (Adoption, Fostering, ARTs, Surrogacy, etc.), None, Other: _____).

2. How/where would you prefer the information collected through this research project to be disseminated? (Workshop, Advertisement, LGBT event, LGBT Health Centers like Metro Wellness, Sex Education Curriculums, Presented at Academic Conferences, Presented to Legislators, or Other)