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Exploring Parenting Desires and Intentions of Young Black Gay Men Living with HIV

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An abstract of
a thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Global Health
2020

Abstract

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The development of highly effective anti-retroviral drugs, the subsequent recognition of HIV as a chronic, manageable illness, and the development of advanced reproductive technologies all have potential significant implications on the parenting and fertility possibilities available to people living with HIV, as well as their parenting desires and intentions. The majority of fertility studies and resources for people living with HIV focus on heterosexual men and women, but recent studies have indicated that gay, bisexual and other men who have sex with men (GBMSM) living with HIV, and especially Black GBMSM living with HIV, also desire to have children. This paper describes the findings of a qualitative study conducted in Atlanta, GA, U.S.A that aimed to explore parenting desires and intentions of young Black GBMSM living with HIV, capture their perspectives regarding parenthood, and understand the unique challenges Black GBMSM living with HIV face in their fertility-decision making. In-depth interviews were conducted with fifteen Black GBMSM living with HIV aged 18-29 years. Participants reported varying degrees of desire to have children, and cited a variety of factors that influence their parenting and fertility decision-making, such as desire to pass on their legacy to children, and give more meaning to life, as well as their own health and level of preparedness. HIV status and sexual orientation were noted as complicating physiological factors to having biological children, and societal stigma and negative perceptions of Black gay fathers were discussed, however these were not perceived as deterrents to having children for those who were motivated to do so. Several recommendations were made for HIV care providers and clinics, including increasing access to information on childbearing options for GBMSM living with HIV and providing opportunities for education and peer support for Black GBMSM living with HIV. These findings point to a need for safer conception guidelines for this population, increased HIV care provider involvement in fertility and reproductive care, as well as additional research on policies and systems that make it challenging for Black GBMSM living with HIV to pursue and fulfill their parenting desires and exercise their reproductive rights.

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Acknowledgements

I would firstly like to acknowledge and thank my thesis committee chair, Dr. Sophia Hussen, for giving me the opportunity to explore this project, and the members of the emPOWER team, who were instrumental in helping develop this study. I am grateful to each member of this team for their kindness, patience, guidance, and for allowing me to learn from them throughout my time at Rollins.

I would be remiss not to also acknowledge the brilliant professors at Rollins who have shaped and challenged me, and the wonderful peers that I am privileged enough to also call my friends.

A million thanks to my family – Shams, Hameeda, and Arshad – as well as Dr. Natasha Hakimali Merchant, Janice D'Souza, Grace Morrow, Dhondup Tso King, and Armand Mbanya for their support, generosity, encouragement, tough love, and for being unending sources of inspiration for me.

Most importantly, I would like to acknowledge and thank the wonderful men that were a part of this study for trusting me with the absolute privilege of hearing their stories, and teaching me what it means to be truly resilient.

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List of Abbreviations

ARV – Antiretroviral therapy

cART – Combination antiretroviral therapy

GBMSM – Gay, bisexual, and other men who have sex with men

HIV - Human immunodeficiency virus

IUI – Intrauterine insemination

IVF – In vitro fertilization

MLH – Men living with HIV

PLH – People living with HIV

PMTCT – Prevention of mother to child transmission of HIV

WLH – Women living with HIV

YB-GBMSM – Young Black gay, bisexual, and other men who have sex with men

Chapter 1: Introduction

The development of highly effective anti-retroviral drugs, the subsequent recognition of HIV as a chronic, manageable illness, the development of advanced reproductive technologies, and most recently the widely accepted message "Undetectable = Untransmittable" all have potential significant implications for the parenting and fertility possibilities available to people living with HIV, as well as their parenting desires and intentions. Though these implications have been explored and articulated, at times within a reproductive rights-based framework, the focus of the majority of the literature is primarily on heterosexual men and women. In this study, we aimed to explore the parenting desires and intentions of young gay and bisexual men who have sex with men (GBMSM) living with HIV, particularly young Black GBMSM (YB-GBMSM) living with HIV, as they may have unique perspectives and conceptualizations of their own fertility desires and parenthood possibilities stemming from the set of identities they occupy, compared to non-Black and heterosexual people living with HIV. The purpose of this study is to employ qualitative research methodology to provide a deeper understanding of the desires, intentions, challenges, barriers, and conceptualizations related to parenting and fatherhood of the men, with the intention of shedding light on the need for resources, support, and reproductive justice for YB-GBMSM living with HIV.

Chapter 2: Literature Review

The period of time between the introduction of human immunodeficiency virus (HIV) to the global consciousness in the early 1980's and the present day has yielded significant advancements in how HIV can be approached and treated (AIDS.gov, n.d.). The development of combination antiretroviral therapy (cART) in particular has allowed for a condition previously considered to be fatal, to now be considered a manageable chronic illness (Schacher et al., 2005). With early initiation of and appropriate adherence to cART, individuals living with HIV have been seen to have life expectancies comparable to those not living with HIV (Teeraananchai et al., 2017). The prospect of potentially longer and healthier lives could lead individuals living with HIV to develop new goals for themselves in their lives, including goals to become parents (Cohn et al., 2018).

The improvements made in antiretroviral therapy and the possibilities it affords individuals living with HIV are especially pertinent for marginalized groups that have been the most impacted by HIV. Gay, bisexual, and other men who have sex with men (GBMSM), and in particular, Black GBMSM, have been more impacted by HIV than other groups of people in the United States (D. D. Matthews et al., 2016). Despite improvements made in HIV incidence in the United States overall, the HIV disease burden amongst Black GBMSM continues to rise. This disproportionate disease burden is explained by multiple factors including "the high per-act and per-partner probability of HIV transmission in receptive anal sex," varying sizes in network groups that can increase transmission risk, and structural barriers that make it challenging for Black GBMSM to access culturally competent and consistent healthcare (Beyrer et al., 2012).

It has previously been assumed that individuals living with HIV might have lower fertility desires (i.e., having less of an interest in becoming parents) compared to those not living

with HIV, possibly due to the lifelong nature of HIV infection and the stigmatization and discourse around HIV as debilitating and fatal. However, recent research on fertility and parenting desires and intentions of people living with HIV (PLH) indicates otherwise: PLH do have higher fertility desires and intentions than had been assumed (Berhan & Berhan, 2013; Chen et al., 2001; Nattabi et al., 2009). Notably, certain studies show that Black GBMSM living with HIV in particular report increased fertility desires and expectations compared to their non-Black and heterosexual male counterparts (Cohn et al., 2018). Existing research and resources that support the potential fertility desires of PLH are predominantly focused on heterosexual women, men, and couples affected by HIV, and the resources addressing fertility desires of GBMSM do not mention HIV (Pralat, 2015). The following sections will describe existing research and resources for PLH desiring children, and point to the need for research that specifically investigates fertility desires of young Black GBMSM (YB-GBMSM) living with HIV.

Fertility Desires and Heterosexual Women, Men, and Couples Affected by HIV

Globally, the focus on fertility desires of PLH has focused predominantly on women, given the risk of vertical transmission from mother to child during pregnancy and while breastfeeding. Improvements in prevention of mother to child transmission (PMTCT) due to effective antiretroviral therapies have driven the subsequent shift in attitudes towards women’s fertility desires, that is, increased consideration around supporting healthy future pregnancies, as opposed to pregnancy prevention (Nattabi et al., 2009). This shift in attitudes has also been driven by reproductive rights discourse, which advocates for the addressing of barriers to parenthood that may exist for reproductive-aged women living with HIV (WLH), including

structural barriers to accessing healthcare, inadequate access to health education and information, restrictive policies that make it challenging for WLH to have children, as well as social barriers such as stigma and discrimination against PLH (Segurado & Paiva, 2007).

Much of the fertility desires research conducted has also reflected a focus on WLH, and has indicated that similar barriers exist for WLH across various cultural and geographical contexts. A cross-sectional study conducted in Brazil conducted with heterosexual WLH of reproductive age and their partners found an association between younger age and reproductive practices that preserved childbearing possibilities in the future, such as reversible contraceptives (da Silveira Rossi et al., 2005). The results of this study also demonstrated that good clinical status and health of WLH or their partners did not impact women's reproductive options, though it was noted that the easy access to quality HIV care and treatment in Brazil overall, and the city where the study was conducted in particular, might explain this finding. Additionally, a qualitative study conducted in Tamil Nadu, India with reproductive-aged WLH demonstrated that low levels of antiretroviral drug (ARV) and PMTCT awareness and access negatively impacted women's fertility decisions, further pointing to the need for expanded ARV and PMTCT access. This same study also noted the impact that family support and stigma related to HIV and pregnancy can have on reproductive decision-making of WLH (Kanniappan et al., 2008). Studies conducted in South Africa further corroborate the seemingly trans-cultural stigma and community disapproval related to HIV and reproduction that WLH may face with regard to having children (Cooper et al., 2007).

More recent research on fertility desires, both within and outside of the United States (U.S.) context, has also included men living with HIV (MLH), and has shown that MLH report a desire to have children at a rate that is similar to that reported by WLH (Cooper et al., 2007;

Thomson et al., 2018; Wekesa & Coast, 2014). A 2001 study examining parenting desires and intentions amongst PLH in the US found that in their nationally representative probability sample, 29% of women living with HIV desired children in the future, while 28% of heterosexual and bisexual men living with HIV desired children in the future (Chen et al., 2001). Furthermore, similar to studies that include only WLH, younger age and not having children was associated with wanting children in the future, which has been further corroborated by a meta-analysis of studies exploring fertility desires amongst PLH (Berhan & Berhan, 2013).

Furthermore, various qualitative studies and systematic reviews have been conducted with MLH in order to further understand their fertility desires and concerns, as well as their reproductive care needs. A qualitative study conducted in New York City with a group of 94 MLH in heterosexual relationships revealed that these men reported a variety of reasons and motivating factors for why they would want to have children, including desiring a sense of normalcy in their lives, wanting to add meaning to their lives, and to make others happy; this group of men also noted several potential barriers to becoming parents, such as risk of HIV transmission to HIV negative partners, poor or uncertain finances and housing, and issues related to substance abuse (Siegel et al., 2018). An additional study conducted in San Francisco found that reproductive care for MLH often centers around prevention of HIV transmission to sexual partners and condom use, and that MLH desire to have broader discussions with their providers about their reproductive choices (Weber et al., 2017).

Reproductive Rights and Resources for PLH

The focus on WLH, heterosexual MLH, and heterosexual couples affected by HIV within the realm of fertility desires research is also reflected in the reproductive rights discourse and

reproductive care resources available for PLH. The right to parenthood for PLH and ways to enact rights-based reproductive care has been discussed by various academics, physicians, and public health practitioners. Subsequently, recommendations to achieve rights-based reproductive care for PLH have included expansion of HIV care to include sexual and reproductive care, safer conception services, assisted conception strategies, (Delvaux & Nöstlinger, 2007; Mantell et al., 2009), and programmatic support for parents living with HIV (Segurado & Paiva, 2007).

Specific guidelines have also been developed that are intended to inform healthcare providers on how to appropriately guide individuals and heterosexual couples affected by HIV seeking to have children. For example, a textbook on preconceptual medicine published in the UK (Karoshi, 2012) includes a chapter dedicated to couples affected by HIV, that is serodiscordant and seroconcordant heterosexual couples, and includes strategies that can be used by couples affected by HIV to have children (Edwards & Okunwobi-Smith, 2012). Some assisted conception strategies for childbearing mentioned for serodiscordant couples in which the male is living with HIV, include insemination with donor sperm, sperm washing and subsequent self-insemination to reduce risk of HIV transmission through semen and intercourse, use of cART (e.g., treatment as prevention), and adoption.

A set of guidelines for safer conception strategies published in 2011 for the South African context and was included into national policy explicitly posits that “issues of fertility and childbearing should be seen as a part of routine HIV care,” which further supports the notion of expanded sexual and reproductive health care for PLH (Bekker et al., 2011; N. E. Davies et al., 2017). These safer conception guidelines also outline various strategies that can be used by PLH for having children, and provide healthcare providers with concrete strategies for providing preconception care, including a preconception work-up and case studies. While this text also

provides guidelines for safer conception in serodiscordant couples in which the male partner is living with HIV, there is no mention of options for non-heterosexual MLH. An update to these guidelines, published in 2018, does include a small section regarding conception options for MSM, but merely states that MSM desiring children should be advised to see fertility specialists, and cites surrogacy as an option for having biological children (N. E. C. G. Davies et al., 2018). "Canadian HIV Pregnancy Planning Guidelines" similarly only mention the need for specialist involvement and surrogacy as a path to parenthood for MSM living with HIV (Loutfy et al., 2012). Beyond this, essentially no resources seem to exist that outline preconception care explicitly for non-heterosexual men living with HIV.

Fertility Desires, GBMSM, and HIV

Understandings of fertility desire amongst gay men have previously been grounded in assumptions and stereotypes of gay men as being perpetually childless, the notion of a 'gay father' as a contradiction, and the harmful myth that children raised by gay parents are likely to be molested by their parents or parents' friends (Berkowitz, 2007; Bigner & Jacobsen, 1989). The societal perceptions and stigma towards gay fatherhood also create barriers for gay men desiring children; from outside of the gay community, the stigma is in part driven by the belief that children should be raised in a family with heterosexual parents (Clarke, 2001), while within the gay community, fatherhood has historically been seen as a connection to heterosexuality and therefore something to be rejected (Brinamen & Mitchell, 2008). In a study (Berkowitz, 2007) that examines the 'procreative consciousness' (Marsiglio, 1991) of gay men, that is, how men start to understand themselves as procreative beings, many participants associated the coming-out process with the notion that they would not become parents in the future, hence

demonstrating that the assumption and stereotype that homosexuality and fatherhood are incompatible are deeply embedded in society and often internalized by gay men (Bergman et al., 2010). Despite the damaging stereotypes and stigma that often act as barriers for gay men desiring parenthood, increased awareness of parenthood options can contribute to the development of procreative consciousness of gay men (Murphy, 2013) and their desires to pursue such options, including having biological children through surrogacy (Smietana, 2018). Research conducted with gay fathers has also shown that degendering parenting and reconceptualizing what a family can look like can further diminish harmful stereotypes that can keep gay men from pursuing parenthood and enacting their reproductive rights (Schacher et al., 2005).

Results from the 2018 American Community Survey by the U.S. Census Bureau, indicating that approximately 45,000 male same-sex couples in the U.S. raise children in their home (9.3% of the total population of male same-sex couples) (U.S. Census Bureau, 2019), demonstrate that gay men in the U.S. are in fact, having and raising children. Literature on reproductive choices of gay men has focused on adoption and surrogacy as popular options. One study conducted with gay fathers that pursued surrogacy as a path to parenthood found that 68% of the men interviewed preferred surrogacy to adoption because adoption felt less feasible and achievable, while 51% of participants reported pursuing surrogacy in order to have a genetic connection with their child (Blake et al., 2017).

Research dedicated to fertility desires of gay men has subsequently led to discussion and resource development around various parenthood options for gay men, as was the case for fertility research and resources for heterosexual men and women living with HIV. For example, the online platform and network ‘Gays With Kids’ (Gays With Kids, 2020), was developed to

provide guidance and support for gay, bisexual, and trans men desiring parenthood, and makes information about fertility and parenthood options accessible. Yet, though HIV continues to impact GBMSM at higher rates compared to heterosexual men and women in geographies such as the United States (D. D. Matthews et al., 2016) and the United Kingdom, HIV is rarely considered in fertility resources developed for GBMSM (Pralat, 2015). While resources like 'Gays With Kids' discuss fatherhood in the context of HIV in the form of blog posts and informative articles (GWK Staff, 2014), they are not comparable to the safer conception and fertility guidelines developed by medical specialists for heterosexual men, women, and couples living with HIV (Bekker et al., 2011; Loutfy et al., 2012).

The lack of consideration for HIV amongst resources for GBMSM desiring children is also juxtaposed against research that indicates "significant proportions of HIV-positive MSM want children and would use a variety of routes to having a child if the opportunity was offered to them" (Sherr, 2010), which has been further corroborated by research conducted in the United States (Cohn et al., 2018), Canada (Yudin et al., 2020), as well as the United Kingdom (Pralat et al., 2017). Additionally, this dearth in resources is apparent in studies conducted with HIV care providers in the United States, who understand the importance of counseling MLH and GBMSM living with HIV but lack consistent evidence-based preconception and safer conception guidelines with which to provide this guidance (Short et al., 2020).

Cultural Differences in Fertility Desires

Differences in the value of children and the value of being a parent can be culturally driven, hence cultural values can influence fertility desires. Culture, in this context, can refer to shared values and beliefs based on the various identities that may be claimed by a group of

people; while culture, ethnicity, and race should not be conflated, shared racial and ethnic identities and experiences are linked to shared cultural values (Gaines Jr. et al., 1997).

Differences in fertility desires based on ethnicity are demonstrated in studies conducted in Canada, which have found that African ethnicity (self-identified by participants) is associated with increased fertility desires amongst WLH of reproductive age (Loutfy et al., 2009), and that African/Caribbean/Black ethnicity is a significant predictor of childbearing intention amongst MLH (Yudin et al., 2020). Additionally, racial differences in fertility desires are apparent in US-based research. According to a 2001 study of fertility desires and intentions of PLH, Black MLH were five times as likely to expect to have children, compared to their non-Black counterparts, which might be associated with the notion that not bearing children is more concerning in non-white communities (Chen et al., 2001), and hence fertility expectations are culturally influenced. Furthermore, amongst MSM living with HIV, Black non-Hispanic race is significantly associated with desiring children (Cohn et al., 2018).

Understanding culturally influenced beliefs around fertility is foundational to the provision of culturally competent reproductive care (Nattabi et al., 2009). An example of this can be seen in research on couples' infertility conducted in South Africa, which demonstrated that due to the importance and value placed on children and on fatherhood in various South African cultures, fatherhood is considered a crucial aspect of being a man, and therefore, infertility and childlessness can be a cause of stigmatization in society and emotional distress (Dyer, 2004). This has important implications for healthcare providers, who, without understanding the cultural underpinnings of the value of children and fatherhood, as well as the emotional and mental health consequences of childlessness, may not appropriately prioritize the fertility desires of men.

Though there is evidence to suggest that fertility desires of Black PLH, and specifically Black GBMSM living with HIV, may be culturally influenced, there is a lack of research that focuses on understanding the perspectives on fertility and fatherhood of this population. Looking to established literature on perspectives on fatherhood of Black men in general can help address this knowledge gap, however much of the existing literature on Black men and Black fatherhood in general is limited to tropes and characterizations of Black fathers as "absent" and "irresponsible" (Coles, 2009). This work fails to consider the structural and institutional racism faced by Black men (Connor & White, 2007), and ultimately presents uncritical and false narratives about Black fathers.

Much like research dedicated to understanding perspectives on fertility and fatherhood of gay men, similar research seeking perspectives of Black men is sparse and contradicts widely accepted assumptions and narratives. A study published in 2016 that explores notions of fatherhood and masculinity amongst Black men in the US indicates that Black fathers and their sons value and uphold notions of responsibility for themselves and their family, as well as providership (Allen, 2016). The findings of this study corroborate literature that presents varied narratives, historical analyses, and complexities of Black fatherhood and tells the story of "the power of fathering in the African American experience" (Connor & White, 2007).

While these narratives and perspectives on Black fatherhood, taken together with narratives and perspectives on gay fatherhood, and fatherhood while living with HIV, can help illuminate the fertility and parenting desires of Black GBMSM living with HIV, they may not necessarily reflect the perspectives, experiences, and challenges of individuals that embody all of these identities simultaneously. If ultimately Black GBMSM living with HIV are to enjoy and exercise their reproductive rights in the same manner as all other people living with HIV, their

fertility or parenting desires, intentions, and challenges must first be understood. An exploratory study that aims to do exactly this is a crucial first step to developing culturally competent and inclusive reproductive care grounded in reproductive justice.

Chapter 3: Methods

This study was developed in the context of a larger parent study exploring social capital and HIV engagement in care among YB-GBMSM living with HIV. Initially, a series of questions regarding parenting desires, intentions, and childbearing strategies was designed and incorporated into the baseline pre-intervention survey for study participants. These questions were then used to identify and recruit potential participants for the sub-study focused on parenting desires. Eligibility criteria for the parent study included: age 18 – 29, Black race, and self-reported positive HIV status. A purposive sampling strategy was used to identify individuals with varying degrees of parenting desires and intentions. Fifteen participants that identified as non-heterosexual, cis-gender men, self-reported a desire and intention to have children, as well as those that reported some ambivalence, or some desire to have children but reported not feeling it is feasible for them, were invited to interview. Interviews were conducted by multiple members of the larger research team, all of whom are trained and experienced in qualitative interviewing and working with the YB-GBMSM population. Interviews were conducted at the Grady Infectious Disease Clinic and at Emory University. Participants were compensated with a $25 Visa gift card for their time and efforts. The study was approved by the Emory Institutional Review Board and the Grady Research Oversight Committee.

Development of Research Tools

Screening questions

The series of questions was designed to capture self-reported information on childbearing intentions, desires, preferred strategies, etc., in order to capture quantitative data regarding this topic, while also providing precursory information on potential participants to guide purposive

sampling. Specifically, the survey questions asked whether or not participants currently have children and have attempted to have children, as well as the extent to which they would like to have children in the future (parenting desire), believe they will be able to have children, actually intend to have children in the future (parenting intention), the strategies for childbearing they would want to try, and whether they have discussed their options with their doctor. These questions were reviewed by multiple members of the research team to ensure clarity of questions and associated response choices. Questions related directly to childbearing strategies and options were carefully reviewed to ensure that each option – especially childbearing options of surrogacy, intrauterine insemination (IUI), and in vitro fertilization (IVF) – was clearly explained in non-academic language. Furthermore, the options that men living with HIV have to father children were discussed with a fertility specialist prior to designing the questions to ensure the accuracy of the options presented.

Semi-Structured In-Depth Interview Guide

The in-depth interview guide focused on the following domains: barriers to childbearing, familial and personal relationships, self-perceptions, societal/community perceptions, and specific childbearing strategies. These domains were chosen based on relevant themes noted in existing literature on fertility desires of PLH and other sociological research on fathering perspectives of gay men. The interview guide was shared with multiple members of the research team to ensure clarity of questions and inclusive language. The information provided by a consultant fertility specialist regarding existing childbearing strategies for men living with HIV was also utilized within the interview guide when participants were asked about their thoughts on potential childbearing strategies, which strategies they would or wouldn’t be open to, and which seemed more or less feasible.

The guide was piloted with research team members to further assess the guide for clarity of structure and language. Furthermore, the guide was adjusted to not assume the same degree of parenting desires and intentions would be held by all participants, given that even participants that reported a strong desire to have children in the future could hold varying perspectives on intention and capability.

Screening and Recruitment

During the first phase of recruitment, only participants that reported wanting children to some degree in the future, according to screening data, were recruited irrespective of what they reported their childbearing intention and capability to be. However, after conducting several interviews with men that reported a strong and enthusiastic desire to have children, it was recognized that the perspectives of those more ambivalent about having children, or those that reported not wanting children at all, were missing. Hence, more participants with ambivalent or alternative views on childbearing/parenting were recruited. As the in-depth interview guide had already been adjusted to assume that participants would have different views on childbearing and parenting, additional adjustments were not required to accommodate participants with varying perspectives.

Reflexivity

Personal reflexivity was a key component of all processes involved in the methodology, especially given that the student research assistant is not a part of the study population and occupies identities different than those that participants might occupy. The student research assistant identifies as a South Asian-American heterosexual woman, hence differing from the

identities that may be claimed by Black GBMSM living with HIV. In order to ensure that bias in the study was not created due to such differences, all tools used to collect data were developed alongside and reviewed by members of the research team that occupy identities closer to those occupied by study participants. The student research assistant also worked closely with research team members to ensure cultural sensitivity was considered during the interviewing process, and discussed with team members when cultural aspects, for example, aspects of queer culture, were brought up by participants that the student research assistant was not fully familiar with.

Analysis

After interviews were transcribed by the student research assistant, they were uploaded to the MAXQDA software, which was used to manage the analysis. The memo function in MAXQDA software was utilized by the student research assistant in order to take notes on the data, conduct a preliminary review of the data, and for the purpose of developing a codebook. Memos and notes were then used to develop an initial codebook by the student research assistant, which was reviewed by the primary investigator/advisor. The primary student research assistant, as well as an additional student research assistant that was familiar with the topic of fertility desires amongst GBMSM living with HIV, then independently coded the same two interviews using the initial codebook, and later discussed coding patterns and code definitions. This process ensured inter-coder reliability and agreement, and also allowed further refinement of the codebook, prior to coding the full set of interviews, which was completed by the primary student research assistant. After coding was completed, thick descriptions were written of codes or sets of codes that appeared to contain substantive data. A thematic analysis approach was also used to extract themes that were pertinent to the research question, but not fully encompassed within

singular codes. Thick descriptions of codes and themes were written to capture the breadth, depth, nuance, and context within the data, and were validated with the data itself. Some descriptions encompass topics explicitly pertaining to the HIV status of the study population, but also intertwine with the life courses and material elements of our participants' experiences, and so align with the exploratory nature of the research question. The thick descriptions are therefore presented as the study's results.

Chapter 4: Results

Initial survey questions incorporated into a larger baseline survey for participants in the parent study inquired about parenting desires, intentions, and perceived capability of having children. The ages of the 15 participants interviewed for this study ranged from 22 to 29 years. All participants reported being unmarried, however 4 participants at time of interview reported having a romantic partner. Eleven participants self-identified their sexual orientation as 'gay/homosexual/same gender loving (SGL)', three identified as 'Bisexual,' and one participant identified as 'free spirit/no preference'. No participants reported that they had previously attempted to have children, and only one participant reported having discussed options to have children with his doctor. When asked whether they would want children in the future, seven of them reported 'definitely yes', three reported 'probably yes', two reported 'probably no', and three were 'unsure.' Three of the participants that reported ambivalence towards having children in the future, that is, anything other than 'definitely yes,' cited their HIV status as a complicating factor. Out of the total 15 participants, seven reported they were open to having sexual intercourse with a woman as a childbearing strategy, six were open to co-parenting, eight were open to surrogacy, 11 were willing to try adoption, eight were open to foster care, and 11 were open to using intrauterine fertilization (IUI) and/or in vitro fertilization (IVF). One participant reported he would not be willing to try any of these childbearing strategies.

Our interviews yielded rich discussions on the following themes, described in detail below: influences to childbearing, the impact of HIV and health on fertility desires and decision-making, strategies for childbearing, societal perceptions of YB-GBMSM living with HIV as fathers, the notion of 'readiness' prior to having children, and recommendations for healthcare providers and public health organizations regarding addressing reproductive and fertility needs

of YB-GBMSM living with HIV. Pertinent quotes highlighting these themes are also presented in the appendix.

Influences on childbearing

Participants discussed a variety of reasons for their desire to have or not have children or become parents in the future, factors that might influence their intention to have children, as well as factors that may influence when and how they might have children.

Motivating Factors

A strong and oft-mentioned factor that belies a strong desire to have children in the future is parenthood being a component of individual self-concept. Several participants noted that having a child has always been part of their self-concept and how they have envisioned their future lives. This component of self-concept can also be validated by family and friends who verbalize their confidence in one's ability to be a good father in the future; this can, in turn, reinforce one's own self-concept with regard to the roles they play within their family and friend dynamics, such as the role of a father figure or protector. One participant noted that as he has gotten older and has found himself in his late 20's and with a partner, that having children has now become a desire and consideration, and part of his self-concept for the near-future; he further stated that because he is the last male in his family, he would like to have a child that can carry on his family name, noting that is what his late grandfather would have wanted, as well.

Partnership and the desire to pass on biological genes to children were also cited as motivating factors. One participant in particular stated that in the future when he is married to a potential male partner, he would like to have his own biological child using his sperm, so that it is not just his partner who would have the opportunity of passing down his genes to kin. For

those not currently interested in having children, they may still open to this possibility in the future if they find themselves in a romantic partnership with someone that does want to have children.

The notion of passing something down to kin is not just important in a biological and genetic sense, but also in terms of passing down knowledge, life lessons, and love. Having children in the future was seen as an opportunity to make more meaning of challenging life experiences by passing down the lessons that were learned through those challenges. Nurturing a loving parent-child relationship, and teaching children how to love was also considered by some as a way to create meaning in life by giving their children something they may not have had.

Exposure to children at various stages in life impacted the desire to have children. Several participants reported having grown up around children and developing bonds with them, or even helping raise their own younger siblings, which gave them an appreciation for children. Witnessing the growth of nieces and nephews and aiding in their mental and emotional development by participating in their lives was also frequently discussed as a motivating factor for wanting to become a parent. One participant noted that while he did not at all want to have children as recently as several years ago as he found them to be aggravating, exposure to young children during a previous relationship made him also want to have children in the future, despite still feeling that children can be aggravating and add stress to his life.

For some participants that felt a strong desire and intention to have children in the future, being able to set a precedent and be a role model for other YB-GBMSM living with HIV was also a motivating factor of sorts. It was noted that if there was greater visibility of gay fathers living with HIV, and especially Black gay fathers living with HIV, it might encourage other YB-GBMSM living with HIV to pursue parenthood, or at least show that this was possible. The men

that wanted to be able to set the example for their peers also saw parenthood as an opportunity to educate others outside of their communities by challenging norms of who can be a father and what a family can look like.

Barriers to childbearing

Factors that diminished fertility desires included personal perceptions about ability to raise children, along with material realities that may prevent one's ability to have children to begin with. Participants that mentioned that they do not feel equipped to be a parent or cannot see themselves as a parent discussed not feeling ready or prepared for reasons both historical and contemporary. Being raised in environments in which a lack of parental and familial support was experienced made it difficult for some to form robust bonds with and learn from parents, which has resulted in lack of confidence in one's own ability to care for a child in the way the child would need. It was noted that lacking a father figure specifically brings into question whether it would be possible to be a father to a child without having experienced that. On the other hand, some participants that noted similar experiences in their childhood discussed that because they themselves did not grow up in supportive or financially and emotionally stable environments, that they want to have children so that they can provide better environments and support for a future generation.

Additional reasons for not wanting to have children include not feeling financially prepared to go about the process of having children or raise them, feeling emotionally and mentally unprepared to raise children, contemporary struggles with drug use, and also not wanting added responsibilities which might limit time to enjoy one's own life. While these reasons were cited as factors that diminish the desire to have children, some also interpreted existing barriers as temporary. For example, financial instability and emotional unpreparedness

were seen as elements that will change over time and with age, at which point having children might feel like a more desirable and realistic option. Additionally, the desire to be able to have children in the future was seen as motivation to overcome circumstantial barriers; some participants discussed that they are actively trying to prepare themselves and situate themselves in their lives so that they can start having children without feeling financially and emotionally overburdened.

HIV status was frequently cited as an initial barrier for having children, due to it being a physiological complication for reproduction. Notably, upon initial diagnosis of HIV, one of the major potential consequences that men considered is that the it may no longer be possible to have healthy biological children. Though it was also noted with some additional education and research, it became clear that having healthy children that were HIV negative could still be an option, and also that there are many options and methods for GBMSM living with HIV to have children. However, some participants noted that they were not fully aware of the entire gamut of childbearing and parenting options available to gay men living with HIV, and were wary of the potential cost of some of these options. HIV also has additional impacts on participants' decisions and thoughts regarding having children; some stated that because of their HIV status, they were unsure as to whether they would be able to find a surrogate or woman willing to carry their biological child. Some also reported challenges in finding potential long-term partners with whom they would want to parent, noting HIV can be a factor that determines who their long-term partner is and whether their long-term partner is also someone living with HIV. One participant that identifies as bisexual noted that the methods and options that may be available to him when he wants children in the future are also determined by whether he has a male or female partner in the future, which may also be influenced by his own HIV status.

Cost was repeatedly a consideration and expressed as a tangible barrier to having children. The cost of sperm-washing, IVF, or surrogacy is prohibitive for those wanting biological children. Even outside of the realm of having biological children, the process of adoption was thought to be lengthy and expensive, and one that requires prospective parents to have proof of a certain amount of accumulated wealth in order to qualify as a candidate to be an adoptive parent, which can also be prohibitive.

HIV and Health Impact

HIV and overall health were discussed in a variety of contexts and intertwined with decision-making and potential strategies around childbearing, and the role it would play in their parenting. Several participants discussed that when they first received their HIV diagnosis, one of the consequences they considered and lamented was that they may not be able to have healthy biological children in the future due to the risk of HIV transmission. Others noted that their status has not impacted their desire or decision to have children at some point in their lives, though they might have questioned briefly whether they would be able to due to their status. Though conducting internet research on various childbearing possibilities for PLH has been helpful for several participants in un-internalizing the message that they cannot have biological children, concrete challenges to having biological children while living with HIV still exist. Difficulty in finding a surrogate (or a woman with whom sexual intercourse could be had for the purpose of childbearing and potentially co-parenting with) who would be open to carrying a child for someone living with HIV was cited as a significant challenge for GBMSM living with HIV.

Societal perceptions of individuals living with HIV was discussed as a potential barrier to having children, as well as something that could impact their future family. Participants noted that the perception of HIV in general is sometimes associated with sickness and imminent death, and that these are often the messages that young people receive surrounding HIV. One participant stated that if the constant messaging in society is that individuals living with HIV are not able to take care of themselves and therefore cannot take care of others and are likely to pass HIV to their children if they had them, such messages may be internalized and ultimately impact fertility desires for the future. Some expressed that in the context of being a parent in the future and having a family, it is likely that their respective families would experience judgment from society; though negative societal perceptions may not be related to HIV status if status is unknown, these judgments would be intertwined with judgments made about Black men, in addition to gay men raising children, and that HIV adds another layer to how these messages might be presented and internalized.

Furthermore, attaining good personal health and appropriate management of HIV care are seen by some as prerequisites to becoming parents. Various aspects of personal health that are considered as important to address prior to having children include physical health, mental health, as well as spiritual health. Some explicitly stated that with regard to HIV, they would like to achieve undetectable status prior to having children, as this makes it more likely that they will remain in good health for the sake of their children. Additional personal health goals prior to having children included drinking less alcohol, smoking cessation, improving nutrition, becoming more physically active, and working on personal mental health. The participants that discussed such goals noted that they would both lead to improved personal health, and ultimately allow them to be better parents for their future children.

Managing personal health and HIV care was also discussed in the context of being a parent. When participants discussed what they envision their parenting futures to be, some reported that they anticipated an increase in their stress levels when they eventually have children, and that management of stress would be crucial while being a parent. One participant noted that parenting stress might be especially risky for those living with HIV, as stress can interfere with HIV medication regimen. When discussing how else HIV could play a role in their parenting, several participants stated that HIV would not impact their parenting, because they anticipate having their HIV managed to the extent that they would only need to keep a minimal number of doctors' visits for HIV-specific care. One participant stated he was hopeful about new options for medications or a potential cure in the future that would make managing HIV while parenting easier.

Others added that perhaps HIV would play a role in the kind of education they would want to provide to their children, and also how overprotective they would feel towards them. One participant reported that he desired to raise his children to be more aware of personal physical health including sexually transmitted infections and HIV, so that they can grow up to be better informed; several participants noted that they would want to provide their children with health education because they themselves had not received it from their parents. One participant stated that though he would want to make his children more aware of STIs including HIV, that he does not want to create stigma around it, or stigmatize individuals living with HIV, as he himself was raised around HIV-related stigma. Additionally, some participants noted they might feel overprotective of their child due to their own adverse life experiences such as abusive relationships and sexual assault, which played a role in their own HIV diagnoses. A couple of participants noted that they would eventually want to inform their children of their own HIV

status, however, there was also some fear associated with disclosure of status. One participant noted that he would wish to disclose his status to his children in a way that does not worry his children, but rather helps them understand another aspect of his life, and ultimately leads them to conclude that their father is capable of thriving despite living with what could potentially be a devasting condition.

Strategies

Having biological children was considered by many as their primary choice for parenting strategy. Though some participants did not explicitly declare that their preference is to have biological children, passing on genes and a legacy to children was considered valuable. One participant noted that if he were to have a partner of the same gender in the future and they decided to have a biological child, that the participant would want to use his own sperm as opposed to his partner's so that the child would be biologically tied to him.

Due to a preference for biological children, surrogacy was discussed frequently as a potential option; participants referred to surrogacy as both a woman they would have carry their child using her own egg, or through in vitro fertilization (IVF) through use of another woman's egg. More often than not, when discussing surrogates, participants used this concept to refer to a woman with whom they might have sexual intercourse or utilize intrauterine insemination (IUI) for the purpose of a pregnancy. Despite reluctance and discomfort associated with the possibility of having to have sexual intercourse with a woman in order to have a child, some participants stated that this would realistically be their primary option compared to using assisted reproductive technologies for having biological children, given that it seems to be the most cost-effective method. Intrauterine insemination (IUI) was considered as a possible alternative to

having sexual intercourse. IVF was also thought to be too complicated and expensive for it to be a viable option. The risk of HIV transmission to a potential surrogate or woman that would carry the child as well as to biological children was acknowledged and cited as a constant worry, however those that were aware of methods that prevent transmission – such as the use of pre-exposure prophylaxis (PrEP), undetectable HIV viral load, sperm-washing methods – were confident that they could have healthy biological children.

Finding a potential surrogate was an additional obstacle, primarily due to HIV status. Some noted that while some of their close friends have expressed that they would be open to carrying a pregnancy for them, they were not aware of the participant's HIV status, which participants believed would likely be a complicating factor. As suggested by various participants, a strategy to circumvent or address this issue might be to create an online database or community of women that would be open to being a surrogate or carrying a child for gay men living with HIV, which would serve to make it easier for men wanting to have children to have that conversation with potential surrogates without the anxiety that can come with discussing status and anticipating a potential surrogate to decline. One participant in particular noted that while he would prefer to have a surrogate, he feels that having a surrogate would impact the race of his child; he explained that he feels it is unlikely he would be able to find a Black woman to be his surrogate or carry his child due to his belief that Black women are overall more wary of engaging sexually with a gay man, and especially a gay man living with HIV.

Logistics and legal implications of surrogacy was a topic that elicited varied responses. While some men were very clear that they would not want the mother or the surrogate of the child to continue being a part of the child's life, others were more open to the possibility of co-parenting or expanded family. However, some legal implications of surrogacy were unclear, such

as restrictions and limitations around asking surrogates, especially if it is the surrogate's biological child, to relinquish parental rights. There was some awareness that surrogacy can be a costly endeavor – both because the surrogate might be paid and certain legal services would need to be involved – however the cost of surrogacy compared to other options was also unclear for many.

Adoption was mostly considered as a last resort to having children, though some expressed as much willingness to utilize this as a childbearing strategy as they would any other strategy. Adoption was also described as a viable option for older gay men living with HIV that might experience fertility issues. Cost was still concern and a barrier, due to the financial investment required for the adoption process itself, along with the financial stability required of parent candidates to qualify for adoption. Foster care was considered to be an option, albeit one with its own challenges, particularly related to the potentially temporary nature of it which might lead to emotional disruption for parents and children. However, one participant noted that because of his own experiences in the foster care system as a child, that he would be open to fostering children in the future. Overall, participants expressed openness towards nearly all childbearing strategies. Though having biological children was favored, more value and emphasis were placed on becoming a parent and raising a child, and so the various strategies were discussed as means to reach the goal of being a parent.

Societal perceptions

Societal perceptions of gay men having children can influence the fertility desires of GBMSM living with HIV, as well as with their parenting futures. Participants not only discussed

how societal perceptions impact them and other GBMSM living with HIV, but also potential reasons for why these perceptions exist.

Per participants, there is a pervasive belief in general society that if gay parents are to raise children, that their children would also be gay. Similarly, there is also a belief that if men living with HIV have children, the children will have HIV as well. Several men felt that these beliefs are driven by misinformation and ignorance in society regarding sexual orientation and HIV, and that stigmas related to sexual orientation originate from certain strong religious beliefs that consider homosexuality to be a sin. Some added that they still feel there is an association with gay men and pedophilia, which not only adds to societal stigmatization of gay men, but to their own personal fears about raising children while being gay. They noted that the association of gay men and pedophilia, as well as lack of meaningful engagement with gay communities, are additional reasons general society might hold such beliefs.

Societal perceptions are also likely to impact parenting and familial interactions in the future. Fear of being targeted while in public with a partner of the same gender and children might result in altered behavior of GBMSM while in public, such as showing less affection towards their partner so as to avoid drawing negative attention and criticism driven by perceptions of gay men and families with same-gender parents. Some participants were also concerned their children might experience bullying by their peers while they are in school, if other students were to know that their children's parent/parents is/are gay. One participant stated that because he anticipates this sort of bullying, that he would want to raise his children to be aware of the different kinds of families that exist, outside of the heteronormative construct of a family.

Though most participants acknowledged that various societal perceptions that do not favor, and sometimes demonize gay parenting – and particularly parenting while gay, Black *and* living with HIV – are pervasive, they also reported that such perceptions no longer impact their fertility desires. Several men noted that their personal experiences with adversity, including bullying and judgment regarding their sexual orientation, as well as discrimination in broader society associated with being a Black man and a gay man, has resulted in them no longer wanting to let society determine their decisions. Some participants noted that the negative perceptions held by larger society around parenting while gay and living with HIV sometimes also occur in their own families, and that if they were to bring home a child, some of their family members may be confused by the decision, but still ultimately supportive. However, participants also stated that while having family support for their decision to have children would be valuable, lack of guaranteed support from family or society was not considered to be a deterrent to having children.

Readiness

The notion of 'readiness' and what it takes to prepare to have children was discussed by participants irrespective of their fertility desires for the future. Readiness was defined in various ways and measured by several different personal indicators encompassing internal and external factors relevant to each participant, ranging from changes in health behaviors to attaining financial and emotional stability. Participants overall, regardless of how they defined readiness, articulated that it was important to be ready to become a parent, in order to ensure that they themselves, and other YB-GBMSM living with HIV wanting children, could afford to have children through the methods they choose and also be well-positioned to take care of them in the

future. Components of ‘readiness’ included financial security, physical and mental health, emotional maturity and relationships.

Financial security

A prominent component of readiness dealt with attaining financial security. Several participants stated that they would like to be more stable in their jobs and career, and some also aim to create businesses of their own, prior to having children. Those that want to establish their own businesses stated that they would not only like to provide for their future family, but also want to leave something behind for their children. Owning a business was also associated with having autonomy over one’s own time, and therefore idealistically having more time to spend with children instead of being a parent that is not able to pick children up from school, attend events, or spend quality time with family. Additional components of future financial security included completing undergraduate or graduate education in order to be on a career trajectory that could lead to financial security. Furthermore, participants that had done a bit more research on their own into what options are available to them if they wanted to have children noted that finances are essential in being able to afford the methods through which they would want to have children. Personal financial security was also valued because there is no way to know whether future romantic partners will be financially secure, and so ensuring personal security allows the option for having children in the future. Financial security was also noted to be important so that in the event that future children may have additional needs related to their health, development, or education, those needs could be accommodated and afforded.

Having stable housing and health insurance were mentioned as components of readiness, as well. Several participants specifically articulated that they would want to own their own home prior to having children. Owning a home seemed to represent attainment of financial security.

For some, it was important to ensure there was a large enough physical space to comfortably accommodate a family with multiple children. One participant in particular referred to experiences of housing and financial insecurity in his own childhood, and stated he would not want his child to have the same experiences, and hence would want to own a home to ensure the kind of stability his family did not always have in his childhood.

Physical and mental health

Individual and internal factors that participants considered to be indicators of readiness were related to physical and mental health. Several participants, including those that want to have children and those do not, noted that it would be important for both themselves and others wanting to have children to cease habits such as drug use and smoking; they noted that engaging in these behaviors would be harmful to children, such as exposure to secondhand smoke, and would ultimately not be conducive to creating an optimal environment for raising children. One participant noted that his parents smoked around them when he was a child, and that this is not behavior he would want to carry forward if he was to choose to become a parent. Improving mental health was an oft-mentioned component of readiness, and was considered necessary in order to prepare oneself for the additional stressors that would inevitably come with becoming a parent. One participant stated that he would want to work on his mental health to ensure he would be mentally prepared to be fully present in a child’s life. Another participant noted that mental health support is especially key for gay men living with HIV, as stress, including the stress that can come with being a parent, could potentially interfere with HIV medication adherence.

Emotional maturity and relationships

Maturity was also discussed by several participants, and though how maturity might manifest differed for each participant, it was seen as something that would lead to responsible decision-making, which was considered crucial in being a parent. Some participants noted that before they decide to have children, they want to begin spending less time with friends in bars and clubs late at night. Participants also mentioned that becoming more mature would mean learning to make decisions that are not entirely self-serving, as being a parent would require them to be responsible for someone else, put the needs of others first, and make rational decisions as opposed to emotional ones. One participant noted that for him, making rational decisions also encompasses choosing the right partner with whom he would want to start a family, though several participants also noted that a romantic or life partner is not necessary for them to want to start their family. Not viewing partnership as a requirement or pre-requisite to having children or a family is driven for some by their own experiences of being raised in single-parent households. Maturity also seemed to be measured to a degree by age; one participant noted that as he has grown older and is in his late twenties, he feels less hesitation and reluctance towards the drastic changes that having a child could bring to his life, while another noted that he might feel more ready, mature, and settled enough to have children around the age of forty. A participant in his early twenties also noted that though he is very sure that he wants children, he acknowledged that he would not want to be a parent at this time in his life.

Though all participants discussed this concept of readiness in some way, the relationship between readiness and fertility desires is not definite and linear. For example, several of those that reported wanting to have children in the future also noted that they were already taking steps to ensure they will be ready to have children, whereas those that reported lack of desire to have

children in the future expressed a lack of confidence that they would be able to be ready to become parents in the future. Yet, there were also participants who asserted that they are currently working to improve their own circumstances (financially, emotionally/mentally, physically), and that deciding whether or not they would like children in the future is contingent on whether they are actually able to improve their present circumstances. Some also commented that they believe barriers to having children for other young Black gay men living with HIV might include a lack of maturity characterized by selfishness and lack of desire to settle down with a partner. Financial insecurity was also discussed as a particular barrier for Black gay men living with HIV; some participants alluded to the systemic barriers Black men in particular may face as they work towards financial security.

Recommendations

The recommendations provided by participants focused on education and access to information, individual level change, and community level culture change. Several participants suggested that information regarding childbearing and parenting options – which might include methods such as IVF, adoption, etc. – should be made readily available and easily accessible for men living with HIV. One participant noted that this is even more crucial for gay men living with HIV, particularly men in a partnership, explaining that often times having biological children may not be a potential reality for a couple if their conceptualization of childbearing is limited to heteronormative ideas of producing biological kin, that is, the sexual involvement of a cis-man and cis-woman. Furthermore, participants had a variety of suggestions for how this information could be disseminated, including in doctors' offices in the form of pamphlets and conversations with care providers, television advertisements, as well as support groups with other Black gay

men living with HIV who have utilized various strategies to have children. Some participants noted that a format similar to the B6 program (the parent study intervention) – an activity and discussion-oriented, interactive weekend program focused on building social capital within the community of YB-GBMSM living with HIV in Atlanta, GA – with the addition of an informational session on childbearing options for gay men living with HIV could be an impactful way to disseminate information, while also allowing gay men living with HIV to ask questions about their childbearing and parenting options openly. Additionally, one participant noted that participating in HIV related research studies has been crucial for him in being able to learn about scientific progress and participate in conversations about HIV, and that additional research is something he would like to see.

Additional concrete recommendations provided by participants included increased advocacy by the medical community and additional help with finding potential surrogates. One participant noted in particular that though there are the cost of assisted reproductive technologies and adoption is a significant barrier, and that perhaps advocacy around insurance coverage or subsidizing use of these options could assist YB-GBMSM living with HIV in achieving their desires to start families. Additionally, several participants mentioned that though surrogacy might be a potential preferred method for having children, their HIV status and sexuality might complicate their search for a surrogate, and therefore some assistance with finding surrogates open to such situations would be of use. One participant suggested a phone application, website, or advertisements designed to help match gay men living with HIV with women that are open to carrying a pregnancy for them.

While participants provided a variety of concrete recommendations for what healthcare providers and clinics could do for YB-GBMSM living with HIV wanting to have children, it is

also worth noting that several of these recommendations were also spoken about in the context of individual and community change and transformation. For example, one participant noted that it is not only important to educate YB-GBMSM living with HIV that they have options available to them if they would like to start families, but that it is crucial that this be discussed as early as the time of diagnosis. He further noted that because an HIV diagnosis can alter a person's perceptions of themselves and potentially drastically limit what they see for their own future – which can in turn create turmoil and lead to mental health issues, substance use, etc. – that providing alternative possibilities early on might help in mitigating issues that can arise at the individual level. In addition, it was recommended that programs like B6 and other support groups be formed for YB-GBMSM living with HIV where participants can discuss relationship-building, family-building, and provide support for those wanting to become parents. This group format would provide a space where crucial conversations amongst peers could be had, and would also create visibility for Black gay fathers living with HIV, thereby helping build a culture in which parenting while Black, gay, and living with HIV is normalized.

Chapter 5: Discussion and Implications

The purpose of this study was to explore the parenting desires and intentions of YB-GBMSM living with HIV. The results have not only captured the reasons why YB-GBMSM living with HIV might or might not desire to have children, but have also demonstrated the complex multi-level considerations involved in constructing a potential reality where YB-GBMSM living with HIV can become parents. Furthermore, the results of this study have shown that the multitude of identities that our participants occupy – Black men, gay or bisexual, and living with HIV – all interact with one another as these men consider their own past, present, and future with regard to their procreative decision-making. The degree to which each of these identities is claimed, occupied, and prioritized naturally differs from individual to individual, however all of these identities contribute to the material realities that YB-GBMSM living with HIV traverse as they consider and act on their own fertility and parenting desires. The following sections will discuss the findings of this study in the context of existing literature, some novel perspectives of the participants, the implications of these findings, limitations of this study, and future directions.

Fertility Desires and Intentions of YB-GBMSM Living with HIV Compared to Other PLH

Study participants reported a myriad of factors that influence their desires and decision to have children, some of which align with what has been previously seen in fertility desires research with PLH. As discussed in prior literature, the men in this study also reported a desire to have children in order to add meaning to their lives (Sherr, 2010), further their own and their family's legacy (Antle et al., 2001), and overcome their own difficulties by raising children

better than how they felt they were raised (Siegel et al., 2018). Furthermore, the men felt that fatherhood would be a lifechanging experience (Antle et al., 2001) and a way to create their own families, especially if they have or anticipate having a romantic partner (Siegel et al., 2018).

Participants' desires to create and provide for their families corroborates research that demonstrates that fatherhood and providership are highly valued by Black men (Allen, 2016), and supports the idea that culturally driven values can influence parenting desires and expectations (Chen et al., 2001; Hoffman & Manis, 1979). Additionally, like other MLH (Siegel et al., 2018), participants discussed their own preparation for having children, which included improving their own physical health through maintaining adherence to HIV medication and smoking/drug cessation, as well as attaining financial stability prior to having children. While the individual desire to prepare and feel ready prior to pursuing parenthood is not novel to the study population, the men in our study also touched on the fact that structural barriers within society can negatively impact them as Black men as they prepare for parenthood, and make it more difficult for them to achieve the financial stability required to pursue fertility options and provide comfortable conditions for their children. It has been established that systemic and institutionalized racism within the U.S against Black communities presents a significant barrier to attaining and maintaining socioeconomic stability, which can also have adverse psychological effects particularly on Black men (Connor & White, 2007). These same systems contribute to the increased vulnerability of Black GBMSM to HIV, while also making healthcare and HIV care difficult to access (Levy et al., 2014). Though other PLH also experience a variety of barriers to achieving good health and security, it is important to acknowledge that YB-GBMSM living with HIV operate in a context with multiple layers of inequality as Black men,

gay/bisexual men (Carroll, 2018), and as individuals living with HIV, and therefore face added challenges to fulfilling their fertility and parenting desires.

Also similar to what other MLH desiring children have expressed, some participants in this study reported fear related to HIV transmission to a surrogate or their child (Cooper et al., 2007), and had some confusion about ways to safely have biological children (Mindry et al., 2013). The men in this study had varying degrees of knowledge with regard to prevention of vertical transmission of HIV and the various childbearing options available to them, including methods for safer conception. While some men knew that it is absolutely possible for them to have biological children without transmitting HIV to a surrogate or their child, they were not entirely certain about the exact steps required to achieve this. On the other hand, some participants were not fully aware of the ways in which HIV transmission to their child could be prevented. This uncertainty is not unique to these participants, as HIV care providers have also reported feeling unsure about safer conception methods or how to advise male patients, and especially gay male patients, desiring children (Mindry et al., 2013; Short et al., 2020). The same literature additionally points to the creative pathways to parenthood that may be employed by GBMSM living with HIV; just as the men in this study report co-parenting with a gestational surrogate or a female friend as viable childbearing options, other GBMSM living with HIV have also expressed interest in these same childbearing strategies in order to circumvent the complexities and cost associated with egg donors, surrogates, and other assisted reproductive technologies (Short et al., 2020).

Support from family is a component of childbearing while living with HIV that seems to impact the men in this study somewhat differently compared to other PLH. Several YB-GBMSM in this study reported that while it would be nice to have familial support towards their decisions

to become parents, as well as when they are actually parents, it is not an essential part of their decision-making with regard to pursuing parenthood. They also reported anticipating stigma or lack of support from greater society towards their families, given the negative stereotypes towards Black men in general and gay men raising children, however did not perceive this as something that would deter them from having children or building their families. In contrast, prior studies with WLH in India (Kanniappan et al., 2008) and South Africa (Cooper et al., 2007) have indicated that societal stigma against parenting while living with HIV and lack of family support negatively impact the fertility desires of women living with HIV, but that fertility desires are also affected by the gendered expectation of motherhood.

It is possible that differences in gendered expectations in varied cultures and localities, along with heteronormative understandings of 'family' can interact to produce differences in how support and stigma impact fertility desires of PLH. For example, while WLH, especially those that are married, living in South Africa may experience gendered expectations to conform to the norm of having children (Cooper et al., 2007), the gendered norm and expectation for GBMSM in the U.S is to not have children (Brinamen & Mitchell, 2008), and so having children particularly while also being HIV positive and Black challenges several norms. Many of the men in this study pointed out that multiple aspects of their identity – being a Black man, gay, and living with HIV – are constantly under scrutiny and subject to negative societal perceptions, and that undergoing the discrimination and adversity that comes with such perceptions has taught them to disregard these negative expectations and norms as they navigate their own personal lives. This study, along with existing literature demonstrate that YB-GBMSM living with HIV in the U.S and WLH in South Africa are both affected by stigma and gendered norms, but the ways in which these elements seem to mediate and interact with their fertility desires differ.

Partnering is another factor of childbearing and parenting that was discussed in a more nuanced way by the participants of this study when compared to perspectives captured in existing literature. Though only 4 of 15 participants in this study were in romantic relationships during the time of interview, several more discussed that they would like to be in relationships in the future and that this would interact with their parenting desires as well. They discussed both partnership and children as desired parts of their future, and also noted the benefits of raising children with a partner as opposed to as a single parent. One participant who was not interested in having children on his own stated that if his future partner desired children, he would be open to it. However, several men also stated that their motivation and desire to have children exists independently of their relationship status, meaning they would like to have children irrespective of whether they are or will be in a partnership, and would be open to raising children as single parents if necessary. While existing literature notes that fertility desires of PLH and in particular, MLH can be driven by being in a relationship, it focuses mostly on heterosexual MLH in relationships (Chen et al., 2001; Newmeyer et al., 2011; Sherr, 2010; Siegel et al., 2018) and seems to neglect perspectives of single MLH desiring parenthood. Research on fertility desires of gay men in general however, does provide perspectives of single gay men pursuing fatherhood (Berkowitz, 2007; Murphy, 2013), and reveals various challenges they face as they have children, such as legal challenges of adopting as a single gay father, being labeled as a pedophile within society, or not being fully accepted in the gay community. Our results indicate that the procreative consciousness of several YB-GBMSM living with HIV is very much active, despite societal barriers to parenthood and widespread assumptions of lack of procreative desire.

Limitations

Although participants were purposively recruited so that a variety of perspectives and opinions regarding parenting and childbearing could be captured, it is still likely that some characteristics of our participants influenced the recruitment process as well as the data itself. Firstly, many of the participants that agree to participate in the larger parent intervention as in the source population for this sub-study, were recruited from an HIV clinic, hence they are linked to HIV care and more likely to be aware of HIV care options compared to those not linked to care. These men might have different perspectives on childbearing and parenting compared to those that are not linked to any sort of care or willing to partake in HIV-related research or interventions. Furthermore, the men that agreed to an interview for this sub-study might have been those that were willing to discuss childbearing and parenting because it is something they have already considered, or because it is something they want to prioritize and discuss; hence the recruitment could have excluded men that have no interest in discussing these topics. However, we attempted to account for this limitation by iteratively purposively recruiting men who, based on screening data, explicitly reported ambivalence regarding childbearing and parenting, or reported not wanting children.

Implications

The results of this study show that there exist many similarities in fertility and parenting desires between YB-GBMSM living with HIV and other PLH, suggesting that the childbearing motivations and desires of YB-GBMSM living with HIV must be considered by healthcare providers just as the childbearing desires of other PLH are considered. Though the perspectives illuminated in the results of this study do not represent the thoughts and experiences of all YB-

GBMSM living with HIV, they do corroborate previous research that suggests that GBMSM, including Black GBMSM, living with HIV desire parenthood and are open to various methods of having children and building their families (Cohn et al., 2018; Sherr, 2010). If the reproductive rights of this population are to be respected, further research and resources, similar to those created for heterosexual men and women living with HIV, must be developed that consider the unique challenges of YB-GBMSM living with HIV desiring children while also providing opportunities for counseling and safer conception.

Safer conception counseling as well as access to assisted conception methods has been recommended for men, women, and couples living with HIV desiring to have children, in order to prevent the vertical transmission of HIV while also protecting reproductive rights of PLH (Delvaux & Nöstlinger, 2007). Such guidelines are even more crucial for GBMSM living with HIV, who have reported some confusion regarding their options for having children. Furthermore, there is not always an obvious option for how to have a child as there is for heterosexual couples, and having a biological child might require a variety of assisted reproductive methods and technologies such as sperm washing, IUI, IVF, etc. The demand for the development of safer conception guidelines has initiated efforts to compile the existing evidence (L. T. Matthews et al., 2018), however gaps in implementation science and country-specific guidelines persist. A country-specific guideline, similar to that developed for the Canadian context (Loutfy et al., 2012), should ideally take into account the resources and technology available and address policy-level barriers that may prevent same-sex couples or gay men affected by HIV from utilizing various conception methods (Creative Family Connection, n.d.). Guidelines should also outline when legal advice and contracts might be required, such as

in the case of managing a gestational or genetic surrogacy and attaining parental rights (Blake et al., 2017).

HIV and other healthcare providers play a crucial role in the appropriate use of these guidelines. It has been recommended that not only should expanded reproductive care be integrated into HIV care, but that HIV care providers also continuously assess their patients' childbearing desires (L. T. Matthews et al., 2018). Particularly for HIV providers working with YB-GBMSM, our participants recommended that childbearing options be discussed early on for the positive development of the self-concept of newly diagnosed YB-GBMSM living with HIV. Doing so would also combat misinformation regarding childbearing options for this population, help decrease stigma associated with having children while living with HIV, and set a foundation for culturally competent reproductive care (Nattabi et al., 2009; Short et al., 2020; Weber et al., 2017).

Patient education on childbearing options is another integral component of addressing misinformation and stigma. In previous studies with MLH, recommendations were made for the development of educational materials such as brochures, pamphlets, along with support and education groups led by healthcare providers so that MLH could make informed decisions as they enact their fertility desires (Weber et al., 2017). Participants in this study made similar recommendations, emphasizing that support and education groups be created specifically for Black GBMSM living with HIV, while also suggesting that existing group interventions for YB-GBMSM living with HIV be utilized for this purpose. Men in this study discussed the need for greater representation of more men that share their identities (i.e., Black GBMSM role models) pursuing fatherhood. This is especially salient, considering that the image of gay fatherhood that is most pervasive is that of white, middle to upper class men (Moscowitz, 2013). Overall,

education on fertility options and support systems for YB-GBMSM living with HIV as they navigate the path to fatherhood may play a role in addressing "multi-minority stress" that can be experienced by gay fathers of color, and gay fathers that occupy identities that are marginalized in society (Armesto, 2002; Carroll, 2018).

Apart from actions that can be undertaken by patients and healthcare providers, the findings of this study also indicate that broader research on structural and policy-level barriers to parenthood for YB-GBMSM living with HIV must be conducted. For example, surrogacy and adoption laws for gay men and same-sex couples within the United States are inconsistent across different states (Berkowitz, 2007; Creative Family Connection, n.d.), however it is unclear whether or how HIV status might factor into these laws. Legal issues related to surrogacy or conceiving a child with a woman might be exacerbated in contexts where HIV criminalization laws are still upheld (L. T. Matthews et al., 2018). Furthermore, policy analyses might allow for discriminatory practices against all PLH, and particularly GBMSM living with HIV, pursuing parenthood to be revealed and addressed. While some literature does address legal and ethical issues associated with preventing WLH from accessing assisted reproductive technologies (Lyerly & Anderson, 2001), similar work that considers the rights of GBMSM living with HIV must also be done. This work also coincides with calls to develop assisted reproductive technologies that consider GBMSM living with HIV (Pralat et al., 2017).

While this study has demonstrated that several YB-GBMSM living with HIV desire parenthood and are open to several methods of having children, several gaps remain. Additional in-depth research aimed at understanding the role of Black male identity in procreative desires of YB-GBMSM living with HIV could further reveal cultural influences to procreative desire, and provide additional information for the development of culturally competent reproductive care.

Comprehensive legal and policy analyses are also needed if fertility and parenting desires of this population are to be carried out. Work that addresses systemic issues in the U.S. against Black communities must also be continued. Further research that specifically considers all the identities occupied by YB-GBMSM living with HIV desiring parenthood is essential.

Chapter 6: Conclusion

YB-GBMSM living with HIV, much like other people living with HIV, report a variety of factors that influence their decisions regarding becoming parents. They face unique challenges on their path to parenthood, however also possess unique perspectives and strengths. The results of this study indicate the need for fertility and parenting resources and further research designed specifically with the identities of YB-GBMSM living with HIV in mind. While the specific implications and recommendations explored in this study do not necessarily address systemic issues that often make it more challenging for YB-GBMSM living with HIV to pursue parenthood, they provide a pathway to center and uplift perspectives and identities that are typically marginalized, and create opportunities for equitable HIV and reproductive care.

Tables

Table I: Illustrative Quotations	
Topic	**Illustrative Quote**
Stigma and Societal Perceptions	"It is very hard – first of all, its hard to be a Black man in America. Its also hard, its *very* hard to be a gay Black man. Um, because you inherited these standards of masculinity, of how you should be, what kind of man you should be like…To be a gay Black man, having kids, like, people just don't necessarily see that. Especially if you're positive, like, "you're sick, how are you gonna take care of your kids, you can't even take care of yourself. Look what happened to you." And I think that's probably one big thing that plays a role, like look at the fact of they can't remove that status away from that person… 'Cause its gonna be, "oh, that child's gonna be positive." Because a lot of people don't have the knowledge that every child is not gonna be born positive from someone who's positive…but unfortunately, as much as we know on this side, those of us who are living with HIV know how much it's not that big of – too much of a major factor, its not something that at large is known, so. Like I said its hard to be a gay Black man, but then when you add HIV into it, that's a whole another thing." *(28 y/o, Bisexual, Not partnered, Wants children: 'Definitely yes', Intends to have children: 'Definitely yes')* "…I think its just the stigma behind it. Its like, well, people aren't educated and they don't know the full extent, or as knowledgeable about the disease as people *could* be. And so the lack of education prevents them from you know, encouraging, you know, gay men or bisexual men with HIV from having kids. Because people are like, "oh my, they shouldn't have kids." Well, you know its already seen as you know, abnormal for a gay man to have kids in general, and now its even worse…The stigma is even exacerbated because they have this condition and this disease… Just, like, society as a whole, just, just when same sex couples have kids. So just, I don't know, that's just societal norms and expectations. I mean, ideally, um, I think they should change (chuckles). But you know, change comes, you know, typically slower than you would like it to…Just societal norms, and just the stigma of the disease itself I want to say are like, two major barriers that gay or bisexual men with HIV face, as far as like having kids…" *(23 y/o, Bisexual, Partnered, Wants children: 'Probably no', Intends to have children: 'Probably no')*
Physical and Mental Health	"I: What do you feel like are barriers and challenges to young men living with HIV to having children? P: The stress component. The um…probably just the stress. I think stress has to be minimized. When you're positive, you're living, you just can't be stressed. Because you get stressed, you get depressed, you don't want to take your meds, you don't want to socialize, isolate yourself, and that's how, you know your health declines." *(28 y/o, Gay, Partnered, Wants children: 'Definitely yes', Intends to have children: 'Probably yes')*

	"I: Tell me a little bit about what your HIV care might look like in this potential future when you have kids. P: Um, I most definitely want to be at a undetectable level. Um, I think I have been doing good with taking my medications regularly, but with so much stress from, and that's another reason why I don't want children right now, um I have a lot of stress on me from people. Um with so much stress already on me, it makes me just so broken down, and tired, um…to the point that I'm running away from people. And um, its very tiring to do so." *(27 y/o, Gay, Not partnered, Wants children: 'Probably yes', Intends to have children: 'Definitely yes')*
Self-Concept and HIV	"So, living with HIV, my first, one of my first thoughts – well not my first thought, probably my 6th or 7th thought, was um, how can I do this? How will I have a healthy child? Major, major, *major* part of me deciding whether or not I'll have children. How will I keep my child healthy? Um, so that was a *huge* deterrent from the family avenue. And I've gotten a little bit more education on that, so um, it's still a possibility. I have decided that it's still a possibility. Um, and really kind of defying the odds…" *(28 y/o, Gay, Partnered, Wants children: 'Definitely yes', Intends to have children: 'Probably yes')*
Purpose and Value of Children	"My life would've been a total like, you know, it would've been better – I'm not sayin' my life, it sucks right now, but I don't really have responsibility, and not having a purpose, or even, you know, something to leave behind. When I get older, I'm gonna start thinking about things like this. What do I have to leave behind, and that's when its really gonna hit me at." *(29 y/o, Gay, Not partnered, Wants children: 'Probably no', Intends to have children: 'Probably no')*
Readiness and Preparation for Parenthood	"Me, myself, having children at some point. Um. I think it would be great. Um I want to have a lot of support. Um, I want children right, well right now I'm not in the place for children. I'm not financially stable, like I would like to be, and stuff like that. But I do see myself with children at some point in my life." *(28 y/o, Gay, Not partnered, Wants children: 'Definitely yes', Intends to have children: 'Definitely yes')* "Um, being a homeowner. I don't want to be renting a place… with kids. Um, having health insurance, um, myself. Life insurance and, you know, a lot of the things that I don't have right now, per se. um, I want my mental stability to be, you know, where it should be, in order to you know, care for somebody else. So um, I don't want to be a smoker. I don't want to be one of the parents and they come in, and the kids come in, and you roll them a blunt, and, "kids go in your room – smoking." I don't want to be that parent, so, you know. Right now, I'm a smoker, so (laughs)." *(27 y/o, Gay, Not partnered, Wants children: 'Probably yes', Intends to have children: 'Probably yes')*

Recommendations for Clinics and Healthcare Providers	"I: How do you think that healthcare providers and clinics can help Black gay men living with HIV who are interested in having children? P: Start, um, discussing it. Suggesting it. Asking the question, "have you ever thought about it?" Give them the education that they need. Give them the resource, um, on some things, you know. Being that good coach as a provider for that patient, you know, let that patient know, hey there's still options out there. You can do this, you know. I think, um, discussion will be good to be able to talk to a provider. And then have a provider who is encouraging you. Who is willing to help you out. Who's actually caring to make sure that, you know, I'm caring for my patient, I really - and this, it'll show. Because, not only the provider will show that they're a good provider, but they caring about your health, as well as your desire. Something that you really want as a gay man, you know." *(28 y/o, Gay, Partnered, Wants children: 'Definitely yes', Intends to have children: 'Definitely yes')* I: So, how do you think that healthcare providers and clinics can help Black gay men living with HIV who are interested in having children? P: Education – provide them the resources and the knowledge. Like bring somebody here, have like a, not even like a seminar, or you know, like some, I guess – I don't want to say some forum, or some platform here, but maybe on like a certain day they have you know, an allotted time or session in one of like, the waiting areas…or in some room, basically with someone there, um providing information, whether it be via a pamphlet, its you know, some website that they can be referred to. Or people on social media, some, you know, Instagram page, or Facebook page, a person can see, that way they can find the information there, and you know, be informed that way. I mean, because the thing is, I'm quite sure people want to have kids. But they're you know, reluctant or hesitant to do so because of the lack of information. And they're probably also reluctant and nervous about it because they have the condition. So you know, I feel like if they at least have the information, that would kind of you know, help alleviate some of the stress and tension about being like, "okay, so I *am* able to have a child, and these are the options that I'm able to you know, pursue." Or, "these are the avenues that I can take in order to, you know, yield this result. Like I want a kid, so, okay, who do I talk to?" *(23 y/o, Bisexual, Partnered, Wants children: 'Probably no', Intends to have children: 'Probably no')* "I: …So how do you think that healthcare providers and clinics can help black gay men living with HIV who are interested in having children? P: …Offer up the idea as a reality. Like a lot of us just don't believe it's a reality. A lot of us just don't think it's a possibility." *(28 y/o, Gay, Partnered, Wants children: 'Definitely yes', Intends to have children: 'Probably yes')*

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