



TRANS-INCLUSIVE ABORTION SERVICES

*A manual for providers on operationalizing
trans-inclusive policies and practices
in an abortion setting*

Yukon



***Trans-Inclusive Abortion Services:
A manual for providers on operationalizing trans-inclusive
policies and practices in an abortion setting***

Authors, Contributors and Acknowledgments

This manual was produced for the *Yukon Sexual Health Clinic*, having been adapted from the original version produced for the *Fédération du Québec pour le planning des naissances (FQPN)*, as part of their commitment to expanding discussions of sexual and reproductive health to include trans people and their families.

This manual was produced by *A.J. Lowik*, PhD Candidate at the University of British Columbia with the Institute for Gender, Race, Sexuality and Social Justice. A.J.'s Master's Thesis focused on trans-inclusive abortion services, and their PhD dissertation explores trans people's reproductive decision-making processes. They would like to acknowledge the work of the Promoting Trans Literacies Workshop series working group at UBC, of which they are a part. This group has not only contributed to the "Vocabulary and Glossary" section, and the "Asking Questions and Making Mistakes" section, but also to A.J.'s learning on intersectional trans-inclusive feminisms.

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WHAT'S INSIDE?

This manual has been created for professionals working in the fields of sexual and reproductive health in Yukon, especially those working in abortion service provision. Perhaps you are new to the discussion of trans-inclusivity – this manual will introduce you to who trans people are, and the kinds of reproductive health needs that some trans people have. Perhaps you are working on operationalizing trans-inclusivity in your workplace – this manual will provide you with some practical suggestions on how to make your space more welcoming and prepare you and staff members to provide competent care to your trans clients. Wherever you are in your learning, and whether you work in abortion services in an administrative or clinical capacity, you will find something in these pages for you.

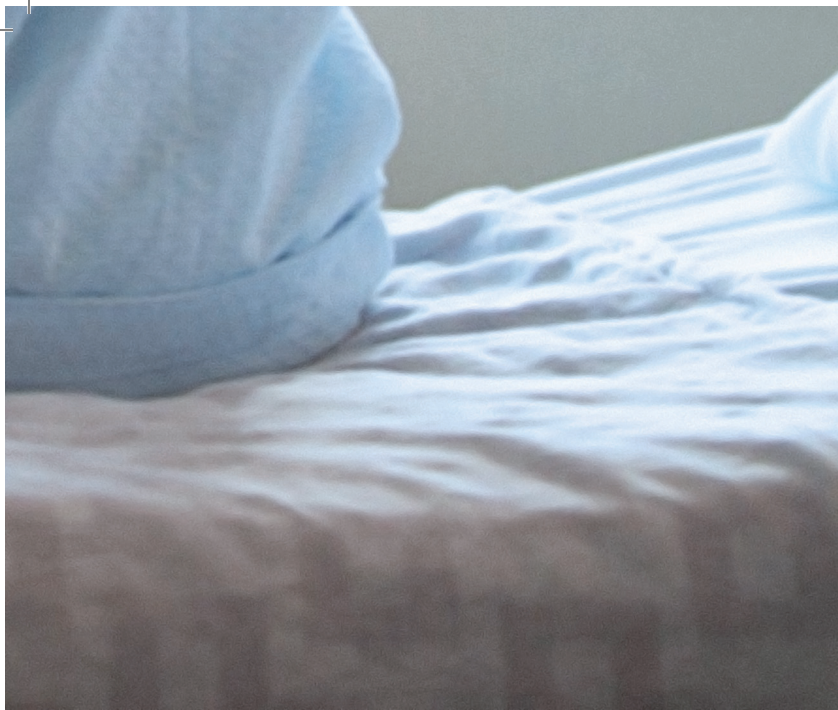
Trans people have a variety of sexual and reproductive needs, including needing access to safe abortion services. Trans people are as diverse as your other clients. This manual considers how the various identities and life experiences of trans people may lead to differences in how they understand their reproductive and sexual capacities.

We encourage readers of this manual to consider how issues of embodied reproduction (pregnancy, abortion, etc.) have been historically gendered as cisgender women's issues. The burden of reproduction, including infertility, pregnancy, abortion, lactation and the like, continues to fall on cisgender women. Globally, this reproductive labour is largely done by poor, cisgender women of colour and is devalued! We are not asking you to ignore this reality. Rather, we are challenging readers to *expand* their understanding of reproductive experiences to include trans people, and to recognize that many of the sexual and reproductive health services that cisgender women need, trans people need, too.

Scholarly research in the area of trans reproduction is scarce, but growing. It is almost entirely in English, with only a few items having been written in or translated into French. In addition to the endnotes of this manual, we have created a Supplementary Reading List for your consideration. This list gives an overview of scholarly articles on trans reproduction, but there are still no articles that explicitly consider trans people's experiences and needs for abortion care.

Even though the needs of trans people vary tremendously based on a range of factors, a number of guiding principles inform this document.

- This guide uses the term 'trans' as an umbrella term to include transgender, transsexual, non-binary, gender-queer, gender neutral/agender, and gender non-conforming identities and experiences. This umbrella is itself reductive and not without issue, but for our purposes, it serves as a shorthand and an alternative to a lengthy and cumbersome acronym (here, TG/TN/NB/GQ/GN/A/GNC, for example). Wherever appropriate, we will identify whom we are talking about specifically.
- This guide acknowledges that the work of writing this document, your work in the field of reproductive healthcare, and the lives of trans people themselves, are happening on the traditional, ancestral lands of First Nations, Métis and Inuit peoples. The ways in which we understand sex, gender, sexuality and even reproduction are products of the colonization of Canada. This guide further recognizes that some Two-Spirit (2-Spirit) people may or may not also identify as trans. To conflate Two-Spirit with trans as outlined above would contribute



to the systematic erasure of Indigenous gender variance understood and defined on its own terms. That said, given the fact that Two-Spirit people continually go unacknowledged within queer, trans, and other conversations about gender and sexual diversity, we include Two-Spirit people within this manual, whenever apt.

- This guide takes an intersectional approach, that recognizes that trans people have various identities and experiences that intersect with their identities as trans. This results in multifaceted and complex people, lives and issues. There are trans people of all ages, classes, sexualities, races, religions, cultures and abilities. Trans people are members of families both chosen and traditional. They are parents, children, and siblings. Some trans people choose and/or are able to live as 'just' men or women, and do not identify as trans at all. Others may emphasize their trans identity, in active and radical ways. This intersectional approach recognizes that the experiences of space, safety, and belonging for trans mixed-raced, Indigenous and people of colour is vastly different than that of white trans people. Trans mixed-race, Indigenous and people of colour face disproportionate instances of violence, discrimination, assault, homicide, poverty, unemployment, homelessness, and incarceration.
- Finally, this guide recognizes that there are complex factors that may lead a person to choose to parent (through biological reproduction, adoption or fostering), to put a child up for adoption, or to seek out abortion services.

SECTION GUIDE

Section 2: The Importance of Language

This section includes a glossary of terms, strategies for asking questions and making mistakes, and a discussion of why language is important when working with trans people.

Section 3: Mythbusters: Trans Reproduction Edition

This section is presented as a series of myths/facts regarding trans reproduction.

Section 4: Abortion Services

This section is an overview of the history and current state of abortion in Canada, followed by an explanation of why trans-inclusive abortion services are needed.

Section 5: Operationalizing Trans-inclusivity in the Abortion Setting

This section is divided into fictional scenarios involving issues a trans person might face in accessing abortion care and recommendations to overcome the obstacles in these scenarios. It also includes a trans-inclusive assessment tool to help you identify the areas of your clinical or administrative practice that might introduce barriers for trans clients trying to access your services.

Section 6: Conclusion

This section includes some concluding remarks and next steps.

Section 7: Resources

This section is a list of resources for you and your clients to read and explore.

Section 8: Yukon-specific Trans, Sexual Health and Reproductive Health organizations

This section is a list of Yukon-specific trans resources, sexual and reproductive health organizations and other Provincial resources that you might find useful.

Section 9: Endnotes

This final section contains all of the references that support this document and includes the link to the supplementary reading list.



THE IMPORTANCE OF LANGUAGE

A. VOCABULARY AND GLOSSARY²

This glossary is in three sections—**green**, **yellow** and **red**. The items in each section are roughly in alphabetical order.

Green items are things that you can say with confidence. These are words and phrases that are used by many trans people to refer to themselves, their bodies, families and communities.

Yellow items are words and expressions to use cautiously. These are words and phrases that are appropriate in some circumstances and contexts, and not others. We've included when to use these yellow items, and when to avoid them.

Red items should be avoided, as these are words and phrases that are highly problematic and/or discriminatory, and have been rejected by trans people.

As trans communities and people change and grow, so do the words we use. We recognize the right of any trans person to reclaim terms that have been used against them. Trans people of diverse ages, races, abilities, and other identities may also use terms that are not listed here, or understand the terms listed here differently. This glossary is not a set of fixed rules for what to say or not to say, but rather is meant to help inform the language you use.

We encourage you to:

- take a cue from your clients, and mirror the language that they use to refer to themselves;
- provide your clients with opportunities to tell you what language they use to refer to themselves, their body parts, their families, both on written forms and in person;
- ask questions if your clients use terms that you are unfamiliar with.

GREEN! (Use with confidence!)

DO use the word **cisgender** as an umbrella term to refer to all people whose gender identity and the sex they were assigned at birth do align. **DO** shorten this to **cis**.

DO use **cisnormative** to describe the assumption that all people are cisgender, and the ways that this assumption is embedded into our systems and structures.

DO use **culturally specific terms** such as **Hijra** (India), **Fa'afafine** (Samoa), **Kathoey/Ladyboys** (Thailand), **Khawaja sara** (Pakistan), and other terms used by various communities across the world to refer to non-normatively sexed and/or gendered people.

DO use **dysphoria** to refer to the profound state of uneasiness, discomfort and dissatisfaction experienced by some trans people in their sexed bodies. **DO** recognize that this can be referred to as **gender dysphoria** (i.e. the name of the current diagnosis). **DO** recognize that not all trans people experience dysphoria.

DO use **gender** to refer to the social meaning ascribed to sexed differences. This includes gender **norms, roles, stereotypes**, as well as gender **identity** and gender **expression**.

DO use **intersex** as an umbrella term for the variety of conditions in which a person is born with reproductive or sexual anatomy that does not fit the typical definitions of male or female.

DO use **misgendering** to refer to the practice of using words (nouns, adjectives and pronouns) that do not correctly reflect the gender with which someone identifies. **DO** recognize that misgendering can include **misnaming** (calling a person by the incorrect name), using the **incorrect pronouns** (for example, using he/him/his for someone who uses she/her/her), or using other incorrect gendered language (for example, using sir for someone who identifies as a woman, or calling someone's chest their breasts). **DO** recognize that whether intentional or not, misgendering has a negative impact on trans people, and persistent misgendering is an act of transphobia.

DO use **non-binary** as an umbrella term to refer to all people whose gender identity are not exclusively male or female, man or woman. These folks might identify with the following: **genderqueer, genderfluid, gender neutral, agender, androgynous, neutrois**, and others. **DO** recognize that some non-binary people identify as trans, and some do not.

DO use **people of all and no genders** to recognize that non-gender, agender, gender neutral and other non-binary trans people do not have a gender and are thus not included in statements like "people of all genders."

DO use **sex** to refer to the classification of people into the categories of **male** and **female**. This is a medical and legal assignment made at birth, based largely on the external genitals of newborn infants. **DO** use **female-assigned at birth** and **male-assigned at birth** when you need to speak about people based on their sex assignment. **AVOID female-bodied** or **male-bodied**.

DO refer to the social construction of mutually exclusive categories of male/female, man/woman, masculine/feminine, etc. as the **sex binary/gender binary**. **DO** recognize that some trans people do not identify with the gender binary.

DO use the word **trans** as an umbrella term to refer to all people whose gender identity and the sex they were assigned at birth do not align. Some trans people use **trans***, a term derived from library and online search functions, where an asterisk stands in for all possible endings to a term. The asterisk is either spoken aloud, or it is implied. **DO** recognize that some people use **man/woman of trans experience** to describe their relationship to these gendered categories.

DO use the word **transition** to refer to the process that some trans people undertake to change their bodies to better reflect their gender identities.

DO use **transphobia** to refer to the prejudice against trans people as reflected in antagonistic attitudes, feelings, institutions, policies and practices. **DO** use **transmisogyny** (the intersection between transphobia and misogyny), and **transmisogynoir** (the intersection between transphobia, misogyny and anti-Black racism), to be more specific.

DO use **Two-Spirit** or **2-Spirit** as a term to encompass sexual, gender, cultural, and/or spiritual identity within some Indigenous communities. Two-Spirit is a self-determined and intersectional term that was created by Indigenous peoples in the Canadian Prairies to reflect complex Indigenous understandings of gender and sexuality and the long history of sexual and gender diversity in Indigenous cultures.

YELLOW! (Use cautiously!)

ONLY use **gender-affirmation** or **gender-confirmation surgery** when discussing the surgical interventions that some trans people access as part of their transition. **AVOID** assuming that all trans people have, or desire to have, surgery. **AVOID** using **sex-change** or **gender change**.

ONLY use **pre-**, **post-** or **non-operative** to refer to trans people who refer to themselves this way. **AVOID** grouping all trans people into these categories. This centralizes the medical interventions that some trans people use to alter their sexed bodies. Along with transsexual, these terms have a legacy in the medicalization and pathologization of trans people that continues today.

ONLY use **tranny** in those specific instances where this term is being reclaimed, (e.g. the tranny stroll, a term used by some trans women to describe the area where they work as sex workers). **AVOID** using tranny to refer to trans people in general, as it has been used historically as a derogatory slur.

ONLY use **transsexual** to refer to trans people who refer to themselves this way. **DO** use this term if you are acknowledging its role in the past and present medicalization and pathologization of trans people. **AVOID** using transsexual as an umbrella term, as many trans people do not identify with the term. Others object to the focus this term gives to the medical interventions that some trans people use to alter their sexed bodies.

ONLY use the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** or **International Classification of Diseases (ICD)** as a tool to facilitate access of hormone replacement therapy and other gender-affirming health care for your trans clients. **AVOID** using these as sources of truth about how trans people are or should be; recognize that these provide a particularly medicalized and pathologized understanding of gender identity and expression. When using the DSM and/or ICD as tools, make sure you are using the most recent edition. **AVOID** using outdated labels and terms derived from older versions of these sources, such as transgenderism, transsexualism, gender identity disorder, etc.

RED! (Avoid using!)

AVOID using **derogatory terms and expressions** without context or without acknowledging the bias of the term or expression. This includes, among others, he/she, it, shemale, transvestite, man in a dress, hermaphrodite, berdache, or freak.

AVOID using **men** and **women** without qualifying whether you are speaking about cis or trans people, unless you are speaking about *all* men and women, including men and women of trans experience.

AVOID **transgenderers** or **a transgender**.

AVOID using **transgendered** as a noun to refer to a person. **AVOID** adding an **-ed** to other words when used to refer to an identity (i.e. intersexed, cisgendered, Two-Spirited).

AVOID the word **transformation** to refer to the process that some trans people undertake to change their bodies to align with their gender identity. **DO** use **transition**.

AVOID speaking generally of your services or space as being for **women and trans people**. This assumes that women and trans are mutually exclusive categories and makes a problematic distinction between cisgender women and trans women. **DO** instead say that your services or space are for **cisgender women and trans people**. This way, you have qualified that your services or space are designed for all cisgender women and all trans people. Alternatively, **DO** say that your services are for **“anyone who experiences _____.”** This way, you aren’t listing particular types of people, but instead are signalling to potential clients that your services are for anyone who experiences a particular phenomenon.

B. ASKING QUESTIONS AND MAKING MISTAKES

We all have questions, and we all make mistakes. These may be about the person we are speaking about or to, or about an issue or experience we do not fully understand. When mistakes are made, it is best to:

- 1 Apologize
- 2 Reflect and learn from the mistake
- 3 Move on

DO respect trans people’s **right to consent to educate**. Trans people (like other marginalized people) are often placed in the position to be the educators on trans issues, or are asked to speak on behalf of trans people. When you can, you should research an item yourself, before asking a trans person.

DO recognize the difference between a **trans scholar** and a trans person. A trans scholar is a person, regardless of gender identity, who focuses on trans theories, issues, and experiences within their research. Certain questions may be appropriate to ask a trans scholar as an expert, but would be inappropriate to ask a trans person – this might include questions where the answers are upsetting or too personal.



How to ask someone about their pronouns

DO politely and privately ask **what pronouns do you use?** **DO** offer up your own pronoun first. This can be done verbally, or by having staff wear nametags that include their pronouns. **AVOID** only offering your pronoun to people whose pronouns are not obvious to you.

DO use **they/them** pronouns, **the person's name** or **that person** if you do not know the pronouns the person uses, until you are corrected.

DO respect if a person uses **different pronouns in different settings**. Someone may reveal to you that they use one set of pronouns in private, and another set at work, or with their family.

DO acknowledge that people from diverse communities, cultures, countries, ethnic and racial backgrounds and identities may use **different pronouns beyond those available in English or French**.

DO use the **gender-neutral pronouns** that have been created by trans people to refer to themselves. This may include **ze/hir, per, hu/hus/hum, hen** (Swedish), **co**, etc.

DO practice if using gender-neutral pronouns is new to you. Practice to yourself to avoid making mistakes in front of others.

AVOID assuming anyone's pronoun based on their physical appearance, sexed body, gender expression or any other factor.

AVOID speaking generally about names and/or pronouns as **preferred** as this denotes that pronouns are optional, or merely a preference.

AVOID using **grammatical correctness** as a reason for not using gender neutral pronouns. Not only is it factually untrue that singular they/them is grammatically incorrect, it is also not a valid reason to use the wrong pronouns. Grammars change, as do languages as a whole. **DO** practice using pronouns that are new to you, if they seem grammatically or linguistically difficult.

How to make a mistake about a person's pronoun, name, or other gendered language

DO say you are sorry as soon as possible. You can acknowledge and correct your error at any time.

DO ask again if you have forgotten something about the person.

ONLY apologize again and again if you keep making the same or different mistakes. **AVOID** having to do this, by being attentive and **asking for support** in how to remember how to correctly refer to the person or issue.

AVOID providing a **reason or explanation** for your mistake.

AVOID over-apologizing for the mistake you have already apologized for.

How to correct someone who is using the wrong name and/or pronoun or other gendered language

DO stand up for trans people and be an ally.

DO privately and respectfully **correct the speaker**. **DO** say, for example, "I've noticed that you are calling [correct name/pronouns] by [the incorrect name/pronouns]. I'm not sure if you know, but [correct name] uses [correct name/pronouns]."

DO ask what you can do to **support** someone else in remembering to use the correct name, pronoun or other term to refer to a person.

AVOID calling anyone out in public about using the incorrect name or pronouns. **AVOID** judging or shaming someone for making a mistake.

AVOID outing a trans person by revealing details about their body, medical history, previous names and/or pronouns, etc. **AVOID asking someone else about a trans person's** body, medical history, previous names and/or pronouns, etc. **AVOID** gossiping with others about any of your clients, including your trans clients, either within your clinic or once you leave.

How to ask someone about what language they use to refer to themselves, their bodies, etc.

DO ask privately and politely what **language someone uses** to refer to themselves. You might say, for example “In order to provide you the best healthcare possible, I wonder, what language do you use to refer to your body parts?”

DO make note of any terminology that someone uses to refer to themselves, and then use that terminology in your future communication with them.

DO recognize that **trans people may change how they refer to their body parts** over time. **DO** ask “are you still using _____” and **DO** be prepared to change the language you use.

ONLY ask about someone's body parts in the context of providing service to their body (in this case, abortion services). **AVOID** asking questions about trans people's body parts if that information is not necessary to provide them inclusive and competent services.

AVOID talking about specific trans people's body parts, **except in your professional capacity**. **AVOID** physical or verbal reactions to people's word choices, even if they are words that you would not choose.

How to make your language trans inclusive, in general

DO use **folks, you all, everyone**, or other gender neutral language to speak to a group of people.

DO describe the person's clothing or another distinct feature when asking someone to speak, for example, in staff meetings. **DO** say, for example “the person in the red shirt in the back row,” instead of “the guy in the back row.”

DO acknowledge the potential for trans people being in the space by using expressions like “for those of us who are cisgender” as opposed to “as cis people, we...”

AVOID guys and girls, ladies and gentlemen, sir, ma'am, miss, boy. These terms make assumptions about sex and gender, as well as race and class.

C. LANGUAGE AS DISTRESS, LANGUAGE AS EMPOWERMENT

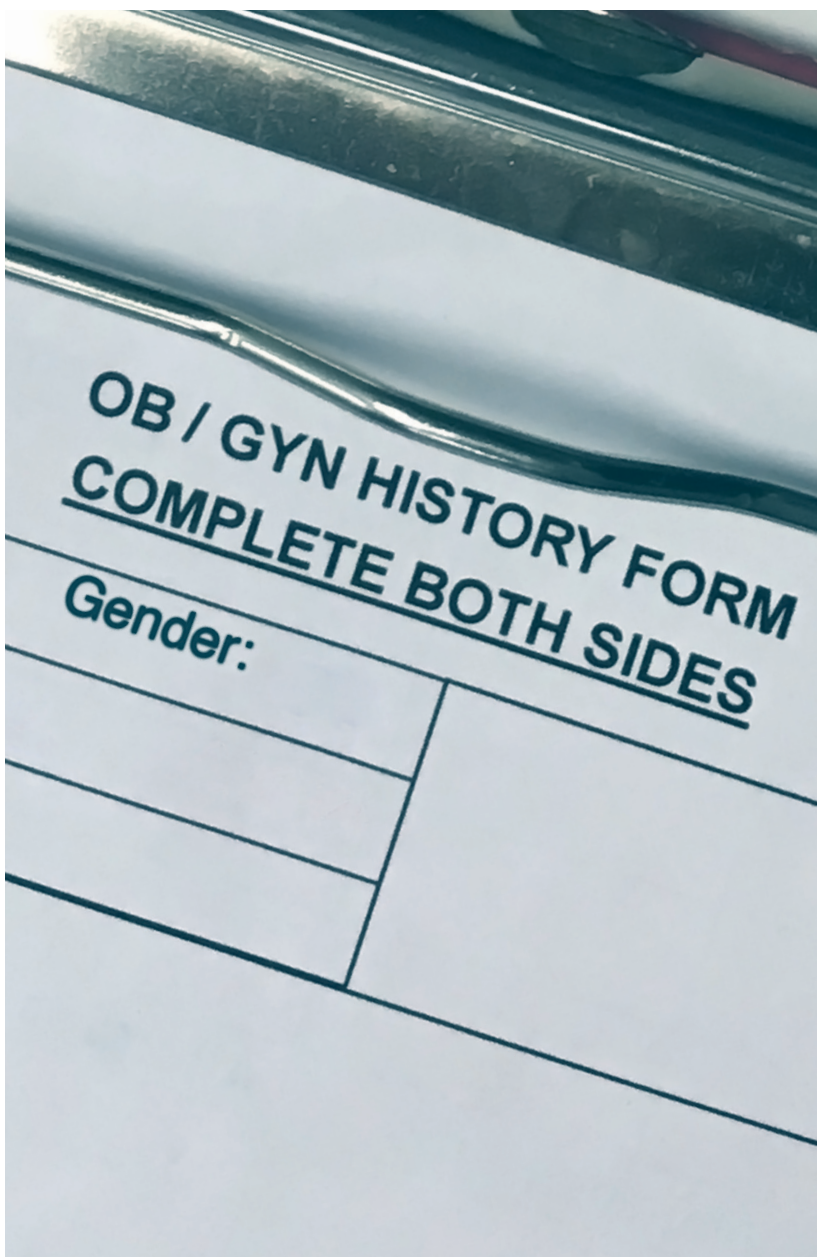
For many trans people, language is an important part of how they deal with the world, and they may alter language to suit their needs and identities.³ They use language to help make themselves understood, to make their identities intelligible to others, and to help alleviate distress and dysphoria over body parts, among others things. Studies on providing healthcare to trans people have shown that asking trans people about their pronouns and other gendered language is an important element of trans-inclusive care.⁴ However, language can also cause a lot of distress. English and French can both fall short in having words available for some things, such as for a non-binary aunt/uncle. Misgendering through language can happen in all kinds of inadvertent and subtle ways.

It can also happen because how we understand sex, gender, reproduction and parenting is deeply cisnormative.

We should avoid the unnecessary and problematic gendering of body parts (for instance, calling ovaries, fallopian tubes and uteruses parts of the female reproductive system). We might also use language such as “people with breasts,” “bodies with penises,” “pregnant people”, rather than “women with breasts,” “male-bodied” or “pregnant women.”⁵ For some, however, this may not go far enough.

Words like breast, penis, vagina, uterus, may not be how some trans people refer to their own bodies⁶⁻⁷—some common ways that body parts can be renamed includes breasts being renamed as chests, vaginas being renamed as front bums, penises being renamed as clitorises, but many others are possible. While it may not always be possible to alter official medical consent forms, you can ask your clients what language they use to refer to their body and/or mirror the language that they use and make clear notes about this in the client’s file.

Words used to talk about partnership and parenting can also fall short for trans people. It may seem straightforward—if trans people take on the parenting role associated with their gender identity, then a trans man would be a father, a trans woman a mother. While this may be true for some trans people, it is not always so simple—some trans people might identify as *both* mother and father⁸. Other trans people use newly created words, or reclaimed old ones, like *zaza*, *nini* and *cennend*. The reproductive experience of pregnancy can be rebranded as being a seahorse papa,⁹ and lactation and chest-feeding reframed as an animalistic, functional process, rather than being quintessentially womanly experiences.¹⁰ The embodied aspects of parenting can be transformed by trans people who are living in their bodies and forming families on their own terms and changing the language used to refer to these experiences is part of that transformation.





MYTHBUSTERS: TRANS REPRODUCTION EDITION

MYTH: Trans people cannot be pregnant.

.....

FALSE. Trans people who were female-assigned at birth and who do not access hormones or surgery as part of their transition can become pregnant through intercourse or the use of assisted reproductive technologies. Remember that not all trans people want hormones and/or surgery, or are able to access them. For female-assigned trans people who *have* used testosterone as part of their transition, these treatments do not result in permanent infertility, “however, there is little scientific literature describing... the effects of exogenous administration of testosterone on fertility, pregnancy, and neonatal outcomes.”¹¹ After stopping testosterone, menstruation resumes for many within six months.¹² Pregnancy then becomes possible again, provided that the person has no other fertility issues.

It is incorrect to assume that *by becoming pregnant*, a person is no longer/was never trans. In a deeply problematic 1988 study, the author chose to label the study participants as women and mothers (worse, as bad women and bad mothers), despite their identities as men and fathers¹³. Ten years later, a 1998 study found that trans men who experienced pregnancy expressed high levels of stress due to the belief shared by both medical professionals and therapists that pregnancy and birth were signs that these men were not ‘really’ trans.¹⁴

Developments in uterus transplants mean that trans women may someday soon be able to experience pregnancy – and debates about the ethics of uterus transplants have already begun.¹⁵

FACT: Trans people’s general health is significantly negatively impacted by stigma and marginalization.

.....

TRUE. Trans people are at increased risk and rates of homelessness, low self-esteem, suicide, HIV/AIDS, and also face job and housing insecurity.¹⁶ Trans people experience discrimination and transphobic violence at work, at home and in public. Many are unable to access health and other social services,¹⁷ or they may delay or avoid seeking services because of previous experiences of discrimination or fear of discrimination.¹⁸ Mixed-race, Indigenous and trans people of colour and trans people with disabilities, among others, are more likely to experience these negative health outcomes than their white, able-bodied counterparts.

MYTH: Homosexuality was removed from the DSM in 1973, and so was gender identity.

.....

FALSE. “Gender dysphoria” is the name of the current diagnosis regarding gender identity issues in the most recent version of the DSM by the American Psychiatric Association. The ICD classifies gender dysphoria as a disorder under *dual role transvestism*. The continued pathologization of some trans identities and expressions via the DSM and ICD is contentious.¹⁹ In many places, a diagnosis of Gender Dysphoria is generally required to be able to access hormones and/or surgical interventions.

The World Professional Association for Transgender Health (WPATH) sets the standards of care to be used by health care professionals who are working with trans people. The Canadian Professional Association for Transgender Health (CPATH) is the Canadian arm of WPATH.

Historically, the diagnosis of gender identity 'disorders' assumed that a 'real' trans person would not want to use their genitals, especially their reproductive system, in accordance with the sex/gender they renounced.²⁰ Unfortunately, trans people seeking access to hormones or surgery may continue to be discouraged by some therapists and other medical professionals from using their bodies in ways that seem to run counter to their 'new' gender.^{21 22}

MYTH: Trans people are free to reproduce without restrictions.

FALSE. Trans people's reproductive capacities are restricted in many ways, in various places in the world. Historically (and still today in many places), trans people have been required to undergo treatments that render them infertile (such as gender affirming surgery) in order to be able to change the sex marker on their identity documents.^{23 24}

Lawmakers are frequently concerned with ensuring that trans people transition *permanently*,²⁵ which is often done by requiring sterilization as a condition of legal gender recognition (i.e. being able to have the correct gender marker appear on identity documents). This is done indirectly, by mandating gender affirming surgeries, where sterility is the secondary and unnamed outcome of these genital surgical treatments. It is sometimes also done explicitly, such as in Germany, where "surgically irreversible infertility" was a condition of legal gender recognition before being repealed as discriminatory in 2010.

In 2015, the organization Transgender Europe reported that 23 states in Europe continue to require sterilization as a condition of legal gender recognition²⁶. This, despite a statement by WPATH in 2010 declaring these requirements as discriminatory,²⁷ and a 2014 interagency statement regarding the elimination of forced, coercive or otherwise involuntary sterilization that explicitly names these requirements as discriminatory and abusive.²⁸

In the Yukon, trans people are no longer required to undergo gender affirmation surgeries or procedures of any kind in order to amend their identity documents and legally change their sex on their birth certificates. However, this was not always the case. The Vital Statistics Act was amended on June 13, 2017 to remove this requirement. On the same day, the Human Rights Acts made it illegal to discriminate against a person on the grounds of gender identity and expression.

Further, while assisted reproductive technologies have stretched the boundaries on what is considered normal and possible in terms of human reproduction,²⁹ access to these technologies has historically been restricted to only those deemed fit enough to benefit from them. Like trans people, single, lesbian, widowed and older cisgender women, along with gay couples and racialized,

mixed-race people have too often been prohibited from accessing these technologies³⁰.

MYTH: Trans people do not desire reproductive parenthood.

FALSE. Although the research is limited, recent studies indicate that trans people are already parents. In one 2002 study, 40% of trans women indicated that they had children, and another 40% indicated that they desired children.³¹ A 2012 study showed that 54% of trans men desired children, and another 22% reported already having at least one child.³² A 2014 Ontario study found that 77.9% of trans people who were parents, were biological parents to their children.³³

For some trans people, losing reproductive capacities is a small price to pay for transition.³⁴ Indeed, in one survey, 90% of trans women indicated that loss of fertility was not a significant enough reason to delay transition.³⁵ It is important to note that being unable to realize the dream of having children is, for some trans women, an act of violence that requires our attention as people concerned with reproductive justice.³⁶ We need to envision a reproductive future where trans women (especially trans women of colour) can form families on their own terms.³⁷

Some trans people are informed of, and comfortable with, the infertility that accompanies hormonal and/or surgical transition. Others are not informed about their loss of fertility, and they cannot or do not access preservation technologies like sperm and egg banking prior to their hormonal and/or surgical transition.^{38 39} Still others regret that they are unable to parent genetically-related children after having received hormone therapy and/or genital surgeries.⁴⁰

MYTH: The children of trans people are negatively impacted by their parents' trans identity.

FALSE. There is a small body of literature debating the ethics of assisting trans people in becoming parents, for example by promoting access to egg and sperm banking as well as assisted-reproductive technologies.⁴¹ One position is that if trans people are mentally ill (as requiring a diagnosis from the DSM would suggest), then there is reason to believe that they may be unfit parents.⁴² However, studies suggest that there is no ethical justification for denying trans people access to their reproductive capacities, or to accessing assisted reproductive technologies, fertility preservation technologies, etc.

Children of trans people may face a period of adjustment if their parent transitions, but that adjustment is no different from other family transitions and changes, such as divorce. Indeed, it is the level of conflict, rather than questions of gender identity or transition, that impact how that adjustment is experienced.⁴³ Unfortunately, conflict is often linked to ongoing discrimination

and stigma faced by trans parents, such as being excluded from parenting materials and resources or experiencing violence in public recreation centres.⁴⁴ Importantly, "...there is no empirical evidence demonstrating that the well-being of the children of trans people is compromised by virtue of their parents' gender identity..."⁴⁵

More positively, research shows that trans parents and children participate in mutual care practices⁴⁶ and that parents utilize strategies to protect their children from transphobia.⁴⁷ Trans parents can be role models to their children for authentic living and self-advocacy⁴⁸ and they can teach their children how to challenge gender norms.⁴⁹

FACT: Trans people experience sexual assault and rape.

TRUE. There are reports of trans people with female-assigned bodies who have been sexually assaulted, raped and forcibly impregnated in a form of 'corrective rape' meant to force womanhood onto those who are understood as gender deviants.⁵⁰ Trans people with male-assigned bodies are also sexually assaulted, raped and even murdered, sometimes when someone 'discovers' that they have a penis.

Some trans people may seek out pregnancy assessment and abortion services following a sexual assault or rape. Just as abortion service providers are grappling with how to be trans-inclusive, sexual assault organizations have been engaged in these same conversations. In some cases, sexual assault spaces explicitly exclude trans people, often trans women specifically.

When a trans woman named Kimberly Nixon applied to be a volunteer at Vancouver Rape Relief and Women's Shelter, she was initially hired and then fired⁵¹. She was told she did not have the proper qualifications, namely having experienced life as a woman since birth. Nixon brought forth a human rights claim, and the Supreme Court of Canada ultimately held that Vancouver Rape Relief and Women's Shelter was protected under Section 41 of the Human Rights Code, which allows organizations to have women-only policies when they only serve the interests and needs of women. This case demonstrates the challenges of providing trans-inclusive care in sexual assault and rape service settings, when Section 41 can be interpreted in such a way that trans women are excluded from its frame. It is unclear how or whether Vancouver Rape Relief could serve the needs of non-woman-identified trans clients. Yet, all trans people (regardless of their body) can experience sexual assault and rape; many may need sexual assault and rape crisis services or abortion services. WAVAW, a Vancouver rape crisis centre, has committed to expanding their services to include trans, Two-Spirit, and gender diverse survivors of sexual assault. For more information, you can visit their website at: <http://www.wavaw.ca/wavaws-new-inclusion-project>

FACT: Reproductive experiences can impact feelings of gender dysphoria for trans people.

TRUE. Pregnancy is often imagined as a defining aspect of womanhood. One participant in a 1998 study on trans men who had experienced pregnancy in Germany expressed a hope that pregnancy would help him sort out his gender identity, and ultimately 'turn him into' a woman.⁵² For some trans people assigned female at birth, the thought of carrying a child themselves is seen as a horrible possibility incongruent with their gender identities.⁵³ Other experiences, such as menstruation and chest growth during puberty, are also distressing for similar reasons.⁵⁴

Even for trans people who choose pregnancy as their path to parenthood and/or who choose to chest feed their children, these experiences can be (but are not always) linked to some degree of inner conflict and increased feelings of dysphoria.⁵⁵ This is due both to the hormonal and embodied aspects of these experiences and to the ways these are socially, culturally, and legally understood as fundamentally the experiences of cisgender women. As a result, medical providers, family, friends and strangers may question the person's gender identity in light of the decision to become pregnant, leading to more frequent experiences of confusion and misgendering.⁵⁶

Pregnant and lactating cisgender women are at increased risk of abuse,⁵⁷ and pregnant and lactating trans people are similarly at increased risk. Arguably, their risk of violence is significantly higher, because they are seen as violating supposedly 'natural' parental roles and gender norms. Indeed, while chest-feeding his children, Winnipeg-based father Trevor MacDonald was met with suspicion, disgust and accusations of child abuse.⁵⁸ In another case, a trans man reported being violently assaulted in an ambulance by the EMTs, when they figured out that he was a pregnant man.⁵⁹



ABORTION SERVICES

A. ABORTION SERVICES IN CANADA

Currently, there are no criminal laws restricting access to abortion in Canada. While this has been the case since the Supreme Court’s ruling in *R. V. Morgentaler* in 1988, the path to the decriminalization of this medical procedure has not been straightforward. The same can be said of the efforts to ensure its accessibility to all people in Canada.

In its 1988 ruling, the Supreme Court of Canada struck down section 351 of the Criminal Code which restricted access to abortion in Canada by requiring individuals to gain the approval of a “therapeutic abortion committee” (TAC) to terminate a pregnancy. This portion of the Criminal Code was found to be in violation of section 7 of the Canadian Charter of Rights and Freedoms because it infringed upon an individual’s right to security of the person. Following the Morgentaler decision, Bill C-43 was crafted to fill the legal vacuum created by the ruling that section 351 was unconstitutional. The bill would have made it a criminal offence to induce an abortion unless it was done “by or under the direction of a medical practitioner who was of the opinion that, if the abortion were not induced, the health or life of the female person would likely be threatened.” While the bill’s definition of health was a wide one, the bill included the possibility of imprisonment as a penalty for violations. The proposed law passed the House of Commons but was ultimately struck down in the Senate after a tied vote.

In 1989, the Supreme Court of Canada further ruled in the case of *Tremblay v. Daigle* that only the pregnant individual could make the choice of terminating a pregnancy and that no other individual had a legal say in their choice to either carry the pregnancy to

completion or have an abortion. Since, attempts have regularly been made by backbench Conservative MPs to reopen the abortion question through, for instance, attempts to grant legal personhood to fetuses, but these have all failed.

Access to abortion in Canada

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In 1995, building on the legal changes regarding abortion, Health Minister Diane Marleau deemed it a medically necessary procedure as childbirth and pregnancy affect the health and lives of women. This formulation reflects the historical, gendered language of the decision that assumes that only women experience pregnancy. As a medically necessary procedure, abortion services must therefore be fully accessible and financially covered by provincial and territorial health insurance plans when performed in hospitals and clinics. While this change should have made abortion easily accessible across the country, in reality there remains a lack of abortion services in many parts of the country, as well as significant barriers to those who wish to access abortion in Canada.

The low number of abortion providers in Canada contributes to the poor availability of services and adds to barriers related to geographic location. Only one in six hospitals offer abortion services in Canada—approximately 90 to 100 hospitals in total provide abortions. Coverage in many provinces and territories is uneven and in many cases, poor; 7 out of 13 provinces/territories in Canada have fewer than three abortion providers. Most abortion service providers are found in major urban areas within 150 kilometres of the United States border. Individuals located further north or in rural areas are often forced to travel

considerable distances to access abortion. Even when a provider is located closer to home, gestational limits may require individuals to travel further to a clinic that can accommodate them, resulting in unexpected travel time, accommodation and travel costs, lost wages and/or childcare/eldercare costs. In Canada, no physician provides abortion over 24 weeks, although some may make an exception if there is serious indication of fetal anomalies or a risk to the pregnant individual. In many provinces, abortion is only accessible up to 14 weeks. Those requiring access to abortion beyond 24 weeks must travel to the United States, where fewer than five clinics provide abortions beyond this gestational limit.

Currently in Yukon, both surgical and medication termination options are available. Surgical terminations are available through the Reproductive Care Clinic on a bi-weekly basis up to and including 12 weeks 6 days. Medical terminations using Mifegymiso are available up to 63 days. Anyone beyond 12 weeks 6 days gestation is referred to BC Women's Hospital in Vancouver, BC.

The process for referral for abortion is undergoing transition. Currently, either a physician or a nurse practitioner must provide a referral for a surgical termination; there is no self-referral option. This has created undo barriers and a burden of care on those needing abortion services. This is changing and a new process as well as a new location for the Reproductive Care Clinic is hoped to be up and running by fall 2018. Those in need of an abortion are able to self-refer for medical termination, either to their family physician or to the Yukon Sexual Health Clinic. Currently there is no universal coverage for Mifegymiso in Yukon, however this is likely to change in the near future.

Provincial inequities

There are several other discrepancies across provinces and territories in Canada that affect the ability to access abortion services. New Brunswick is the only province in Canada where medication abortions, and surgical abortions performed in a hospital are fully covered by provincial insurance while clinic abortions are not. Reproductive rights advocates are currently campaigning to repeal the section of New Brunswick's Medical Services Payment Act that stipulates that surgical abortions must be performed in a hospital setting to be covered through provincial insurance. In Prince Edward Island, on-island abortions only became permitted in late 2016 following decades of activism and the threat of a lawsuit against the province by advocacy group Abortion Access Now PEI. Islanders were previously sent to either New Brunswick or Nova Scotia for their abortions. One abortion provider now practices on-island.

In addition to the uneven accessibility of service providers depending on location, for years, the inclusion of abortion on the List of Excluded Services under the Reciprocal Billing Agreement

in Canada left many people without access to abortion services unless they paid out of pocket, if they found themselves needing an abortion while away from their home province. Despite its removal from the list in 2015, reciprocal billing still does not apply evenly across provinces and territories.

Who is most impacted by the existing barriers?

Barriers to abortion services are not experienced equally. They disproportionately impact marginalized people, especially those who are low-income, people of colour, immigrants, refugees whose precarious immigration status prevents or delays them from accessing public healthcare, and those who do not speak English or French. Research has specifically shown a link between high levels of poverty and low access to sexual and reproductive healthcare⁶⁰. People who cannot afford contraception are more likely to require abortion care and people who live in Aboriginal and rural communities are less likely to have an abortion provider nearby.

Access to abortion services is also limited by the lack of inclusivity in the services offered. Discrimination or a lack of explicit inclusive practices in the provision of services can cause people to delay or avoid necessary healthcare services often to the point of putting their overall health at risk. When it comes to getting their reproductive health needs met, the picture is bleak for young people, for incarcerated people, for trans and gender non-conforming people, for people of colour including Indigenous people, for people with disabilities and for people who have a BMI of 41 and over.

Ensuring equitable access to the full range of reproductive health services, including abortion, means being mindful of and actively working towards eliminating the complex barriers faced by diverse populations and actively working towards eliminating these barriers.



B. ABORTION SERVICES FOR TRANS PEOPLE

The Abortion Rights Coalition of Canada now includes 'transgender people capable of pregnancy' in its mission statement, a noteworthy and important shift in the field.⁶¹

Trans people may benefit from some of the other services offered by abortion clinics and hospitals beyond surgical and medication abortions, including birth control counselling, STI testing, treatment and test of cure and post-abortion counselling, to name a few. Service providers can also provide their trans clients with information about trans-inclusive health centres, domestic violence services, and other services. Trans people who were assigned female at birth and/or who have cervixes, and those trans people who have had vaginoplasty surgery, including a surgically-constructed cervix, also need pelvic and gynecological exams, including cervical cancer screenings. It is important to remember that while certain surgeries are available in Canada, some trans people also travel abroad for surgery. Health professionals need to be prepared to provide service to people who have had a variety of surgeries, including those not available in Canada. Abortion clinic staff may be in a position to remind their clients of the importance of these exams, (re)connect them to health services and provide them with resources (for example, see the Check It Out, Guys! Campaign listed in the Resources section of this manual).

In addition to the barriers described in the previous section, there are specific barriers to abortion services that trans people face; the main barrier continues to be the reluctance of providers to frame their services in trans-inclusive ways. This is most obviously the case for clinics with women-only policies, where providers are asked to reconcile their 'women-only' frameworks with the possibility of serving clients who do not identify as women.

There are two main issues that arise in women-only clinical spaces when it comes to trans-inclusivity. First, the inclusion of trans women and girls needs to be addressed. There is an urgent need to acknowledge trans women *as women* and to include their experiences and perspectives into feminist politics⁶², and into women's spaces. The *Trans Inclusion Policy Manual for Women's Organizations*,⁶³ for example, is entirely devoted to considering how to include trans women into women-only spaces. Reluctance to include trans women into women-only spaces and feminism is arguably often based in misinformation as well as discriminatory attitudes and opinions that assume that the inclusion of trans women poses a potential threat to the cisgender women who use the space.⁶⁴

On the other hand, it is important that we consider trans-inclusivity beyond the inclusion of trans women. An abortion clinic that identifies itself as a women-only space may, for example, encourage trans women to apply for work but may still discourage trans men and non-binary folks from doing so. Obviously, some services (like abortion services) are services for the body and need to serve all people who have certain body parts. A view of trans-inclusivity that focuses exclusively on including people based on their gender identity will be inadequate. If trans men and non-binary folks can be clients, abortion services should consider them as potential employees, as well. Having staff members that reflect the diversity of your clients is important as it clearly communicates your commitment to trans-inclusive services to potential clients and to the community at large.

In the Yukon, billing for therapeutic abortion services require that the client be classified as female on their health card. To expedite payment for clients who do not have an F on their health card, please contact the Manager of Registration, Claims and Medical Travel, who can locate the claim, and adjudicate it manually. If a person is over 12 weeks pregnant and needs to travel outside of the Yukon for abortion services, it would be up to each jurisdiction's discretion to handle this potential billing discrepancy.





OPERATIONALIZING TRANS-INCLUSIVITY IN ABORTION PROVISION

A. SCENARIOS AND RECOMMENDATIONS TO OVERCOME OBSTACLES TO TRANS-INCLUSIVE ABORTION CARE.

This section tells the story of trans people accessing abortion services. In March 2012, Rainbow Health Ontario published a fact sheet on reproductive options for trans people, including a brief statement about trans abortion access. It reminds abortion service providers that they need to be prepared to provide support and advocacy for any client seeking to terminate a pregnancy, noting that “abortion providers assume that the people accessing their services will be cisgender women and will need to know the correct pronoun, name, and terminology to use for your client.”⁶⁵

This section considers access issues including and beyond names, pronouns and terminology and explores the full experience of accessing abortion services from looking up information on available abortion services all the way to any post-abortion services that the individual may need. Although these scenarios are hypothetical, they reflect the research on trans people’s experiences of accessing healthcare.

Michael’s Struggle to Find a Trans-Inclusive Abortion

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Scenario:

Michael takes an at-home pregnancy test after his period is late, and finds that he is unexpectedly pregnant. He turns to the Internet to find information on abortion services. Every clinic’s website assumes that the client is a woman, and some are women-only spaces. Since

Michael doesn’t identify as a woman, he decides against the women-only clinics and picks another to call for an appointment. The person who answers the phone is polite, but almost immediately says that they need to speak to the client herself, and could she please come to the phone. Michael tries to explain that he is a trans man, and that he needs the abortion. The person on the other end does not seem to understand. He needs to explain that he was assigned female at birth, that his provincial healthcare would name him Michelle and list his sex as female, but that his name is Michael and he identifies as a man, that he is pregnant and would like an appointment. Eventually, he is able to book an appointment.

Obstacles:

Michael does not see himself in the imagery and wording of the various clinics’ websites, and makes a medical decision based on where he assumes he will be most welcome and understood. He also wants to respect the cisgender women who prefer a space reserved for people who identify as women. The person answering the phone is prompted by a male-sounding voice to ask for ‘the client herself,’ and Michael needs to explain and justify his need for an appointment by disclosing his genital status, gender identity and discrepancies between his identity and the information on his health insurance documents. This may not be information he is comfortable disclosing to

someone over the phone, or to someone who is not his health care provider. He has no confidence in the trans-specific cultural competence of the clinic, but needs their particular medical competence, and so he will keep the appointment.

Recommendations:

- Clinic websites, pamphlets and other documents should acknowledge that trans people need abortion services. This can be done by:
 - Amending language so that services are for ‘anyone experiencing an unplanned or unexpected pregnancy.’
 - Including a statement that the clinic is for cis women as well as trans people in the clinic’s mission statement or on the ‘about us’ page.
 - Including images of trans people and families.
- Instead of asking to speak to ‘the client herself,’ a male-sounding voice could be a prompt to ask ‘am I speaking with the person that the appointment is for?’ This way, Michael could say yes and feel encouraged that he wasn’t immediately assumed to be the partner, parent or friend of the client. Framed this way, Michael would have some confidence that the clinic is aware that some men need abortions, too – and that you can’t always tell someone’s sex assignment or gender identity by their voice.
- Staff should be trained on how to respond to a trans client who discloses that they are trans on the phone. Once Michael had identified himself as the prospective client, the booking procedure should have been followed as per usual. Since Michael disclosed his trans identity, the staff member could also politely ask what pronouns Michael uses, and make a note of this in his chart.

Barkat’s Experience with Misgendering

Scenario:

Barkat is a genderqueer person, and they arrive for their appointment with their partner, Ivan. They sit in a corner of the waiting room and fill out the paperwork – next to their name, they write ‘they/them pronouns’ and draw a circle around it. They notice the mini rainbow flags lining a few of the plants, and are hopeful that the experience will be a good one. The consent documents talk about vaginas and list the risks as effecting a certain percentage of women. When Barkat is called from the waiting room, Ivan starts to follow. The counsellor says “I’m sorry, you’ll have to wait here for now, but I’ll get her back to you in about 20 minutes.” Barkat waits until they

are in the counselling room to point out the ‘they/them pronouns’ note on the chart, and the counsellor quickly apologizes, circling it again. The counsellor asks about birth control, and Barkat explains that they use condoms, but not always. The counsellor provides a quick overview of possible alternative methods, constantly referring to the vagina and the penis. Barkat indicates that they are too young to be a parent, and the counsellor replies that ‘motherhood is hard work.’ Barkat returns to the waiting room, and shares the experience with Ivan.

Obstacles:

Barkat has to take it upon themselves to add a place for their pronouns on their medical forms. Even then, the counsellor does not take note of this information and misgenders Barkat in the public waiting room. Even though the counsellor circles the pronouns again, Barkat is not confident that the next person they will speak to will take note of the pronouns. The consent documents and the birth control counselling did not use the language for body parts that Barkat and Ivan use. While Barkat can likely decipher the information about how to use the different birth control methods, they are more likely to discard the advice, assuming that the risks as described only apply to cisgender people. The use of ‘motherhood’ as opposed to the gender neutral ‘parenthood’ also represents an instance of misgendering.

Recommendations:

- Include a space for pronouns on medical intake documents, and if left blank, prompt the client for their pronouns by having staff use themselves as an example (“Hi, I’m Alex, I’m the nurse here. I use he/him/his pronouns. What pronouns do you use?”)
- Have staff members practice speaking with a diverse range of pronouns, or without using any gendered language.
- Images like rainbows and positive-space campaign symbols indicate to queer and trans people that they are welcome. Do not use these images unless the staff are prepared to provide inclusive services for all queer and trans people.
- While consent documents cannot be changed for medico-legal reasons, it is possible to attach a small note to the forms that states, “We recognize that you may use different language to refer to your body, body parts, and the body and body parts of your partner(s). Please let us know what words you use to refer to your body.” This way, Barkat could have written down that they use ‘front bum’ for their female-assigned genitals, and Ivan uses ‘clitdick’ for their male-assigned genitals, and the

counsellor could have altered their discussion of the various birth control methods to reflect this language.

- Ensure that your training documents and internal staff policies avoid using gendered language. These set the tone for new employees.
- Be mindful of the ways that pregnancy, abortion and parenting are gendered. Replace statements about mothers/motherhood/fathers/fatherhood with references to parents and parenthood.

Moon's Isolation from Others

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Scenario:

Moon has changed into his medical gown and is told to wait in the preoperative waiting room with the other clients—an ultrasound is next. Right away, Moon notices another client shifting uncomfortably in their chair, staring at him. The other client gets up, and leaves the room. Moments later, a nurse arrives and asks Moon to follow her. He is asked to sit alone in a counselling room instead of the preoperative waiting room, for the sake of his privacy. Moon gets the sense that his masculine-presentation made the other client uncomfortable, and he feels segregated. After the procedure, he is brought to the shared recovery room where six chairs are set up side-by-side, with privacy curtains between them. The client who made the complaint is in the chair furthest from him. Although none of the other clients' privacy curtains are drawn, the nurse checks on him, and then draws the curtains around his chair tightly closed.

Obstacles:

Moon is isolated from the other clients under the pretense of protecting his privacy and confidentiality. He is not asked whether this is something he requires, nor is this option of a private experience offered to any other client, including the complainant. Moon feels like the clinic prioritized placating the complainants' transphobia, rather than prioritizing Moon and ensuring he had a safe and judgment free appointment.

Recommendations:

- Train staff to be prepared for complaints or issues raised by other clients about a trans person in the space. This could include statements such as "this clinic provides services for anyone who needs them. That person is a client here." Any further complaints are dealt with in a similar fashion as incidents of racism or other client-to-client prejudice.
- If there are serious concerns for the safety or privacy

of a trans person, staff can be trained to ask the trans person if they would like to wait in a private space and have the privacy curtains always drawn in the shared recovery room. Be prepared for the client to say no.

Kit's Emergency Room Transphobia

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Scenario:

Kit is fifteen and came out as trans three years ago. His period stopped weeks ago, but he thought nothing of it. He didn't realize he was pregnant until a few days ago, when he fainted at school and was taken to the hospital. In the emergency room, he found out that he was 22 weeks pregnant. The nurse was shocked, and said as much. "Did you notice that your periods were gone? Did your boyfriend not wear condoms? You're such a cute girl, even though you dress like a boy." Kit needs an abortion but doesn't know how to access one. He didn't feel like he could ask the nurse. When he goes home, he searches online and finds nothing.

Obstacles:

Kit is like many other trans youth, and has not yet been educated on his own reproductive capacities. He sees his lack of period as a good thing—he's a boy, and doesn't want periods. He feels judged by the nurse for not recognizing he was pregnant and his gender identity is dismissed. The nurse's perception of pregnancy and abortion is that these are experiences unique to cisgender women, and she assumes that Kit is a tomboy. She also assumed that Kit's partner is a boy. Kit is left feeling like going through with the pregnancy is his only option, and that it's his fault—if he was a girl, he would have known.

Recommendations:

- Trans youth are frequently at a disadvantage when it comes to sexual and reproductive health. Considering the lack of appropriate educational opportunities and materials for trans youth, primary care providers can ensure they provide important information to their trans clients about their reproductive capacities and sexual health. Campaigns could be developed that reflect the experiences of trans youth to address this gap. If Kit had received trans-specific sexual and reproductive education, he would have had the information and support necessary to either prevent his pregnancy or to have detected it earlier.
- Health professionals working in abortion clinics and elsewhere need to recognize the diversity of trans experiences, and that pregnancy (abortion, lactation,

menstruation, semen production, menopause, etc) are not unique to cisgender men and women. Trans people can be pregnant, breastfeed or chest-feed, produce sperm, menstruate and the like, without this experience undermining their gender identity.

Maxime Avoids the Clinic, Ends Up in Ambulance

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Scenario:

Maxime is at home, and it's been two days since they took misoprostol. Because they did not want to be misgendered, they decided to avoid a hospital or clinic altogether and purchased the medication online. Suddenly, they start bleeding heavily and their pain is so intense that they decide to call an ambulance. Almost immediately, the paramedics start talking about and to Maxime like they aren't there – "Maxime, we're going to take great care of you. It looks like she's experiencing some post-abortive bleeding, pressure is 80/50. Are you dizzy, Maxime? You didn't want your baby? Dispatch, this is Mark, we've got a 35-year old woman here, possible complications from an abortion, we'll be on our way in 2 minutes. Okay, Maxime, we're taking you to the Women's Hospital. They are a few minutes further away, but it is the best place for you."



Obstacles:

Like other trans people, Maxime avoided healthcare professionals for fear of having a negative experience. Maxime was experiencing a normal amount of bleeding for a medical abortion. However, they were not in contact with an abortion provider who could have informed them about what to expect and what symptoms to monitor; an abortion provider might also have provided Maxime with a phone number to call in case of complications. Maxime panicked at the unexpected bleeding and called an ambulance. They were then consistently misgendered by the ambulance staff, and taken to a women's hospital even though it was further away, increasing the likelihood that they would experience further negative experiences. Not knowing how dire their bleeding was, Maxime didn't understand why a women's hospital that was further away was the best option.

Recommendations:

- More trans-specific information and more trans-inclusive health services, including reproductive health care like abortion services, could have ensured that Maxime would have accessed the care they really needed, in a timely way. Trans people frequently avoid or delay accessing health services for fear of transphobia and in this case, Maxime sought emergency care because they didn't know that they were experiencing normal post-medical abortion symptoms. Trans-inclusive information is needed on websites providing abortion services.
- Women-only spaces are complicated for trans people. These spaces frequently provide services for people female-assigned at birth, they are framed as being exclusively for people who identify as women (which may ultimately include some people who were male assigned at birth). Trans-inclusive policies and practices that consider both identities and bodies are necessary. This may require rethinking women-only policies or women-centered mission statements and frameworks.

B. TRANS INCLUSIVENESS ASSESSMENT

After reviewing this manual, the following scale⁶⁶ can help you get started on assessing the level of trans inclusiveness in your clinic or organization. Some items refer to institutional entry points into trans-inclusivity, while others are instructional, interpersonal, personal or can inform the hospital or clinic’s branding. It is recommended to have a variety of people employed at your organization fill out the assessment, to be able to determine if the answers are consistent and demonstrate a shared understanding and culture of trans-inclusivity. Inconsistent answers might mean that more structures are needed to ensure that staff members are supported in enacting trans-inclusive policies; they can also help identify gaps in knowledge, lack of awareness of internal trans-inclusive policies and guidelines, the need for specific trainings or supports and the barriers clients may experience in accessing the organization’s services.

1= Strongly Disagree 2= Disagree 3= Agree 4=Strongly Agree DK= Don’t know NA= Not applicable

Focus Area	1	2	3	4	DK	NA
Hospital/clinic board of directors/executive director has clear policies, guidelines, administrative regulations or other directives for working with gender diverse, trans and transitioning staff members. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic board of directors/executive director has clear policies, guidelines, clinical procedures or other directives for working with gender diverse, trans and transitioning clients. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has a hiring policy that encourages trans people to apply for positions. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has forms and if relevant, the necessary conduits to allow clients to notify staff of their pronouns and whether they use a name different than their legal name. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has washrooms designated as gender neutral. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has a policy ensuring the privacy/confidentiality concerns of trans clients. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has guidelines and supports to ensure staff are able to address clients who have concerns over the presence of a trans client in the space, including in the change room, washrooms, waiting room and recovery room. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic has posters and other imagery that feature a diversity of genders and that communicate that the space is trans-positive. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic provides staff with scripts to ensure the booking of appointments and other administrative tasks are trans-inclusive, use gender neutral language and do not rely strictly on gendering clients. (Institutional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic staff are aware that a client with an M on their healthcare documents will have their billing claim rejected by the Ministry of Health, and are prepared to call the Ministry and explain the situation on behalf the client. (Instructional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Focus Area	1	2	3	4	DK	NA
Hospital/clinic staff and administrators are properly trained on providing trans-inclusive abortion services, including trans-inclusive sexual health education. (Instructional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic staff and administrators are afforded opportunities to engage in professional development opportunities that would allow them to increase their competency for working with trans clients. (Instructional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic staff honours the requests of trans clients to be referred to by the name and pronoun they wish to use. (Interpersonal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic staff are prepared to ask trans clients what language they use to refer to their body parts, and are prepared to mirror that language in all interactions, including where possible, in official nursing/physician's notes. (Interpersonal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic staff are prepared to address transphobia, whether the comments or behaviour are made by other staff members or by clients. (Instructional, Interpersonal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic website includes a mission statement, purpose or values and/or list of objectives that explicitly includes providing abortion services for trans people. (Branding)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The hospital/clinic's name suggests that clients of all genders are welcome (i.e. does not explicitly reference women). (Branding)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital/clinic website is consistent in its use of gender inclusive language, including in translated versions of any document made available via the website (consent forms, descriptions of appointments, etc.). (Branding)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel comfortable discussing the complexity of gender as it relates to sexual and reproductive healthcare in my role as [administrator, nurse, physician, counsellor, receptionist, etc.] (Internal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would feel comfortable intervening if I were to witness transphobic comments or behaviour by other staff members, or by clients. (Internal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At our hospital/clinic, it is safe for me to be myself (Interpersonal, Internal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At our hospital/clinic, it would be safe for an employee to come out as trans – physically, emotionally and in their professional capacity (Institutional, Interpersonal, Internal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have done my own internal work exploring gender and how gender intersects with the issues that we encounter at the clinic/hospital, including pregnancy, sexual assault, sexual health, ideas around parenting and family structures, etc. (Internal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are there any other aspects of your clinic/hospital or organization that speaks to the presence or absence of gender and trans-inclusive practices?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Based on the questions included in this assessment tool, what are areas where practices and policies can be changed organization-wide to create more trans-inclusive conditions for both clients and employees?

Based on the questions included in this assessment tool, what aspect of your own work could be improved or changed to contribute to a trans-inclusive space for both clients and employees?

How consistent are the answers to this assessment tool across the organization?

Did this assessment tool reveal any areas of specific concern or unanticipated barriers that need to be addressed, that you hadn't already considered?

What are some of your organization's strengths that can be built upon, to offer a more trans-inclusive space, and to ensure that the services you offer are trans-inclusive?

CONCLUSION

Thank you for taking the time to read through this manual. We hope that you've found it informative and helpful. As service providers, you are in an excellent position to do the work of creating trans-inclusive abortion services and making your clinic, hospital or workplace a welcoming space where trans people can receive competent care.

If you are interested in adapting this guide for use in another Province or Territory, the majority of the manual could be reproduced without changes. Two sections could be amended:

- Section 3 – add province-specific information regarding the current process for amending identity documents and whether this process requires genital surgeries that would render the person infertile.
- Section 8 – add province-specific sexual and reproductive health organizations.



RESOURCES – FOR YOU, FOR YOUR CLIENTS TO READ

Action Canada for Sexual Health & Rights – Action Canada is a pro-choice charitable organization working nationally and internationally towards increasing access to quality sexual and reproductive health information and services and to comprehensive sexuality education in Canada and globally. Action Canada houses the Access line, a 24-hour Canada wide toll free number that provides information on reproductive and sexual health and referrals on pregnancy options. They also manage the Norma Scarborough Emergency Fund to assist people in building access plans that address the complex barriers they face.

www.actioncanadashr.org

Action Santé Travesties et Transsexuel(le)s du Québec – ASTTeQ is a community trans health group that launched a trans health guidebook for health care and social service providers called Taking Charge. It is available in both English and French.

www.santetranshealth.org/jemengage/en

Check it Out, Guys! – A campaign created by trans men, allied-health providers and the Sherbourne Health Centre to talk about pap tests for trans men. Their website includes a tip sheet for providing pap tests to trans men and the 13 suggestions listed therein would serve useful to abortion clinic nurses and physicians.

www.checkitoutguys.ca

Global Day of Action for Access to Safe and Legal Abortion: Bust-the-Myth Infographic – This infographic is concerned with addressing the myth that only women need access to safe and legal abortions. It identifies some of the challenges trans folks face when accessing abortion services, including patriarchal norms, wrongful gender stereotypes, sexism and cissexism.

www.september28.org/wp-content/uploads/2015/08/Infographic-7-final.png

I'm a Man, and I Had an Abortion – This blog was written by a trans man, who experienced an unwanted pregnancy and sought out abortion services.

www.bellejar.ca/2015/10/14/guest-post-im-a-man-and-i-had-an-abortion

LGBT Family Coalition – The Lesbian, Gay, Bisexual and Trans-identified (LGBT) Family Coalition advocates for the legal and social recognition of LGBT families. They are a bilingual group of LGBT parents and future parents exchanging information, sharing resources and having fun together with their children.

www.familleslgbt.org

LGBTQ Parenting Network – The LGBTQ Parenting Network is a program of Sherbourne Health Centre. They support lesbian, gay, bisexual, trans and queer parenting through training, research, resource development and community organizing. They work with individuals, organizations, and communities from the local to the international. The “Trans Parenting” portion of their website includes a section on the Trans Family Law project and the Transforming Family project report, a community-based research project about trans people’s parenting experiences.

www.lgbtqpn.ca

Primed?: A Sex Guide for Trans Men Into Men – The first sexual health resource written by and for gay, bi and queer trans men. It was first published in 2007, and updated in 2015. Based on an Ontario-wide assessment of the sexual health needs of gay, bi and queer trans men, Primed? prioritizes our diverse bodies, desires, and sexualities. This resource will spark discussion about the many ways that trans men have sex and how we interact with our gay/queer men’s communities.

www.rainbowhealthontario.ca/resources/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them

A French version of this guide, entitled *Primed?: Un guide sexuel pour les hommes trans qui aiment les hommes* is available here:

library.catie.ca/PDF/ATI-20000s/24655.pdf

Rainbow Health Ontario Fact Sheet: Reproductive Options for Trans People— This fact sheet offers information about reproductive options for trans people interested in hormone therapy or surgeries. Knowing and discussing reproductive options is a necessary component of consent to transition-related care, and is a significant component of the World Professional Association for Transgender Health's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2012/09/RHO_FactSheet_REPRODUCTIVEOPTIONSFORTRANSPeOPLE_E.pdf

Trans Pregnancy and Abortion Resource— The goal of this American blog is to provide inclusive, relevant information on a full range of reproductive options for transgender people. This includes, but is not limited to information on gender neutral pregnancy and abortion, trans-specific pregnancy and abortion information and information on trans-friendly providers.

<http://t-par.tumblr.com>

Transforming Family Documentary— Directed by Rémy Huberdeau, Transforming Family is a documentary film that jumps directly into an ongoing conversation among trans people about parenting. It is a beautiful snapshot of current issues, struggles and strengths of transsexual, transgender and genderfluid parents (and parents to be) in North America today. It has been translated into six languages, and is available in English, French, Latin American Spanish, Portuguese, German, Russian and Japanese. This short film has been turned into a full length documentary entitled Transgender Parents.

www.vimeo.com/44619131 and www.transgenderparentsdoc.com/transformingfamily

Trans Bodies, Trans Selves: a resource for the transgender community— Resource guide for transgender people, covering health, legal issues, cultural and social questions, history, theory, and more. It is a place for transgender and gender-questioning people, their partners and families, students, professors, guidance counselors, and others to look for up-to-date information on transgender life. Chapter 12 is about sexual and reproductive health.

<http://transbodies.com>

YUKON-SPECIFIC TRANS, SEXUAL HEALTH AND REPRODUCTIVE HEALTH ORGANIZATIONS

YUKON SEXUAL HEALTH CLINIC

Whitehorse Medical Clinic Building
406 Lambert Street, Whitehorse
867-393-6635

COMMUNITY NURSING STATIONS

Website: www.hss.gov.yk.ca/communitynursing.php
Phone: 867-667-8324
Toll Free: 1-800-661-0408 x 8324

YUKON COMMUNICABLE DISEASE CONTROL

Phone: 867-667-8323
Toll Free: 1-800-661-0408 x 8323
Fax: 867-667-8349

ALL GENDERS YUKON

Website: www.queeryukon.com

ENDNOTES

The following are the endnotes that support the facts of this manual. If you are interested in reading further on these issues, we have created a supplementary reading list that includes all of these items and more. You can download the supplementary reading list on the FQPN website, here: http://www.fqpn.qc.ca/?attachment_id=3871.

- 1 Colen, S. (1995). Like a mother to them: Stratified reproduction and West Indian childcare workers and employers in New York. In F. D. Ginsburg & R. Rapp (Eds.), *Conceiving the new world order: The global politics of reproduction* (pp. 78-102). Berkeley: University of California Press.
- 2 This glossary is taken directly from the Promoting Trans Literacies workshop series supplementary resource, created by trans-identified students at the University of British Columbia. It has been updated and amended from the Sept 2016 version of the glossary, available here: http://grsj.arts.ubc.ca/get-involved/promoting-trans-literacies/supplementary-resource-handout-2016_09_26/. The guiding principles and 'making mistakes' sections of this manual are also informed by the Promoting Trans Literacies supplementary resource.
- 3 Jolles, M. (2012). Between embodied subjects and narrative somaesthetics. *Hypatia*, 27(2), 301-318.
- 4 Berger, A. P., Potter, E. M., Shutters, C. M., & Imborek, K. L. (2015). Pregnant transmen and barriers to high quality healthcare. *Proceedings in Obstetrics and Gynecology*, 5(2), 1-12.
- 5 Spade, D. (2011). About purportedly gendered body parts. *DeanSpade.Net*, Retrieved from <http://www.deanspade.net/2011/02/03/about-purportedly-gendered-body-parts/>
- 6 MacDonald, T., Noel-Weiss, J., West, D., Walks, M., Biener, M., Kibbe, A. & Myler, E. (2016). Transmasculine individual's experiences with lactation, chestfeeding, and gender identity: A qualitative study. *BMC Pregnancy and Childbirth*, 16(106), 1-17.
- 7 Ware, S. M. (2009). Boldly Going Where Few Men Have Gone Before: One Trans Man's Experience. In R. Epstein (Ed.) *Who's Your Daddy? And Other Writings on Queer Parenthood* (pp. 65-72). Toronto, ON: Sumach Press.
- 8 Califia-Rice, P. (2000). "Family Values: Two dads with a difference – neither of us was born male." *The Village Voice*, June 20. <http://www.villagevoice.com/2000-06-20/news/family-values/>
- 9 Pelletier, G. & Green, F. (2015). Introduction. In F. Green and G. Pelletier (Eds.), *Essential Breakthroughs: Conversations about Men, Mothers & Mothering*, pp. 1-13. Bradford, ON: Demeter Press.
- 10 Lowik, A. (2015). The Ties that Bind are Broken: Trans* Breastfeeding Practices, Ungendering Body Parts and Unsexing Parenting Roles. In F. Green and G. Pelletier (Eds.) *Essential Breakthroughs: Conversations about Men, Mothers & Mothering*, pp. 205-221. Bradford, ON: Demeter Press.
- 11 Light, A. D., Obedin-Maliver, J., Sevelius, J. & Kerns, J. (2014). Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstetrics and Gynecology* 124(6): 1120-1127.
- 12 *Ibid.*
- 13 Lothstein, L. (1988). Female-to-male transsexuals who have delivered and reared their children. *Annals of Sex Research*, 1, 151-166.
- 14 More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies*, 7(3), 319-328.
- 15 Murphy, T. (2015). Assisted Gestation and Transgender Women. *Bioethics* 29(6): 389-397.
- 16 Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in AIDS Care*, 20(5), 348-361.
- 17 *Ibid.*

- 18 Rapid Response Service. (2014). *Rapid Response: Facilitators and barriers to health care for lesbian, gay and bisexual (LGB) people*. Toronto, ON: Ontario HIV Treatment Network.
- 19 Gorton, N. (2013). Transgender as Mental Illness: Nosology, Social Justice, and the Tarnished Golden Mean. In S. Stryker & A. Aizura (Eds.) *The Transgender Studies Reader 2*, pp. 644-654. New York, NY: Routledge.
- 20 Cromwell, J. (1999). *Transmen and FTMs: Identities, Bodies, Genders and Sexualities*. Chicago, IL: University of Illinois Press.
- 21 More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies*, 7(3), 319-328.
- 22 T'Sjoen, G., Caenegem, E. V. & Wierckx, K. (2013). Transgenderism and reproduction. *Current Opinion in Endocrinology, Diabetes and Obesity*, 20(6), 575-579.
- 23 Surkan, K. J. (2013). FTM in the fertility clinic: Troubling the gendered boundaries of reproduction. Paper presentation at *Probing Boundaries of Reproduction: Origins, Bodies, Transitions, Futures, 1st Global Conference*, May 12-May 13, Prague, Czech Republic.
- 24 Verlinden, J. (2012). Transgender bodies and male pregnancy: The ethics of radical self-refashioning. In M.M. Hampf & M. Snyder-Korber (Eds.) *Machines: Bodies, Genders and Technologies*, (pp. 107-136). Heidelberg.
- 25 Sharpe, A. N. (2007). A critique of the Gender Recognition Act 2004. *Bioethical Inquiry*, 4, 33-42.
- 26 TGEU Transgender Europe – maps and other resources available online at <http://tgeu.org/>
- 27 World Professional Association for Transgender Health (2015, January 19). *2015 WPATH Statement on Identity Recognition*. Retrieved from <http://www.wpath.org>
- 28 World Health Organization. (2014). Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO. Retrieved <http://www.unfpa.org/resources/eliminating-forced-coercive-and-otherwise-involuntary-sterilization>
- 29 von Doussa, H., Power, J., & Riggs, D. (2015). Imagining parenthood: The possibilities and experiences of parenthood among transgender people. *Culture, Health & Sexuality*, 17(9), 1119-1131.
- 30 Murphy, T. (2012). The ethics of fertility preservation in transgender body modifications. *Bioethical Inquiry*, 9, 311-316.
- 31 De Sutter, P., Verschuur, K. K., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: a survey. *International Journal of Transgenderism* 6(3), 215-221.
- 32 Wierckx, K., Van Caenegem, E., Pennings, G., Elaut, E., Dedecker, D., Van de Peer, F., Weyers, S., De Sutter, P. & T'Sjoen, G. (2012). Reproductive wish in transsexual men. *Human Reproduction*, 27, 483-487.
- 33 James-Abra, S., Tarasoff, L.A., green, d., Epstein, R., Anderson, S., Marvel, S., Steele, L.S. & Ross, L.E. (2015). Trans people's experiences with assisted reproduction services: A qualitative study. *Human Reproduction*, 1-10.
- 34 De Sutter, P., Verschuur, K. K., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: a survey. *International Journal of Transgenderism* 6(3), 215-221.
- 35 Nixon, L. (2013). The right to (trans)parent: A reproductive justice approach to reproductive rights, fertility, and family-building issues facing transgender people. *William and Mary Journal of Women and the Law*, 20(1), 73-103.
- 36 Cárdenas, M. (2016). Pregnancy: Reproductive Futures in Trans of Color Feminism. *TSQ: Transgender Studies Quarterly* 3(1-2): 48-57.
- 37 *Ibid.*
- 38 Murphy, T. (2012). The ethics of fertility preservation in transgender body modifications. *Bioethical Inquiry*, 9, 311-316.
- 39 von Doussa, H., Power, J., & Riggs, D. (2015). Imagining parenthood: The possibilities and experiences of parenthood among transgender people. *Culture, Health & Sexuality*, 17(9), 1119-1131.
- 40 Murphy, T. (2012). The ethics of fertility preservation in transgender body modifications. *Bioethical Inquiry*, 9, 311-316.
- 41 Baetens, P., Camus, M., & Devroey, P. (2003). Should requests for donor insemination on social grounds be expanded to transsexuals? *Reproductive Biomedicine Online*, 6, 281-286.
- 42 Murphy, T. (2012). The ethics of fertility preservation in transgender body modifications. *Bioethical Inquiry*, 9, 311-316.
- 43 Pyne, J., Bauer, G., & Bradley, K. (2015). Transphobia and other stressors impacting trans parents. *Journal of LGBT Family Studies*, 11(2), 107-126.
- 44 *Ibid.*

- 45 James-Abra, S., Tarasoff, L.A., green, d., Epstein, R., Anderson, S., Marvel, S., Steele, L.S. & Ross, L.E. (2015). Trans people's experiences with assisted reproduction services: A qualitative study. *Human Reproduction*, 1-10.
- 46 Hines, S. (2006). Intimate transitions: Transgender practices of partnering and parenting. *Sociology*, 40, 353-371.
- 47 Pyne, J. (2012). *Transforming family: The struggles, strategies and strengths of trans parents*. Toronto, Ontario, Canada: Sherbourne Health Centre.
- 48 Pyne, J. (2013). Complicating the truth of gender: Gender literacy and the possible worlds of trans parenting. In F. Green & M. Friedman (Eds.), *Chasing rainbows: Exploring gender fluid parenting practices* (pp. 127-144). Toronto, Ontario, Canada: New Demeter Press.
- 49 Ryan, M. (2009). Beyond Thomas Beatie: Trans Men and the New Parenthood. In R. Epstein (Ed.) *Who's Your Daddy? And Other Writings on Queer Parenthood* (pp. 139-150). Toronto, ON: Sumach Press.
- 50 Lothstein, L. (1988). Female-to-male transsexuals who have delivered and reared their children. *Annals of Sex Research*, 1, 151-166.
- 51 Boyle, C. (2011). A human right to group self-identification? Reflections on Nixon v. Vancouver Rape Relief. *Canadian Journal of Women and the Law*, 23(2), 488-518.
- 52 More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies*, 7(3), 319-328.
- 53 Obedin-Maliver, J. & Makadon, H.J. (2015). Transgender men and pregnancy. *Obstetric Medicine*, 0(0), 1-5.
- 54 Davy, Z. (2011). *Recognizing transsexuals: Personal, political and medicolegal embodiment*. Ashgate Publishing Limited: Surrey.
- 55 *Ibid.*
- 56 Ware, S. M. (2009). Boldly Going Where Few Men Have Gone Before: One Trans Man's Experience. In R. Epstein (Ed.) *Who's Your Daddy? And Other Writings on Queer Parenthood* (pp. 65-72). Toronto, ON: Sumach Press.
- 57 Van Esterik, P. (1994). Breastfeeding and Feminism. *International Journal of Gynecology and Obstetrics* 47 Supplement, 41-54.
- 58 Lowik, A. (2015). The Ties that Bind are Broken: Trans* Breastfeeding Practices, Ungendering Body Parts and Unsexing Parenting Roles. In F. Green and G. Pelletier (Eds.) *Essential Breakthroughs: Conversations about Men, Mothers & Mothering*, pp. 205-221. Bradford, ON: Demeter Press.
- 59 Graff, E.J. (2015). Real Men Give Birth. *Gay with Kids*. Retrieved <https://gayswithkids.com/real-men-give-birth/>
- 60 United Nations Economic and Social Council. (2016). General comment no. 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights). Retrieved http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en
- 61 Abortion Rights Coalition of Canada Mission Statement – <http://www.arcc-cdac.ca/mission.html>
- 62 Scott-Dixon, K. (2006). *Trans/forming Feminisms: Transfeminist Voices Speak Out*. Toronto, ON: Sumach Press.
- 63 Darke, J. & Cope, A. (2002). Trans Inclusion Policy Manual for Women's Organizations. *The Trans Alliance Society*. Vancouver, BC.
- 64 Gottschalk, L. H. (2009). Transgendering Women's Space: A Feminist Analysis of Perspectives from Australian Women's Services. *Women's Studies International Forum* 32: 167-178.
- 65 Rainbow Health Ontario, CAMH, LGBTQ Parenting Network. (2012). "RHO Fact Sheet: Reproductive Options for Trans People." Toronto, ON. Retrieved http://www.rainbowhealthontario.ca/admin/contentEngine/contentDocuments/Reproductive_Options_for_Trans_People_final.pdf
- 66 This assessment is based on the Gender Inclusive Assessment by Gender Spectrum, regarding frameworks for gender inclusive schools. Retrieved <https://www.genderspectrum.org/resources/education-2/>



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