TRANS-INCLUSIVE ABORTION CARE

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

United States

Trans-Inclusive Abortion Care:
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Authors, Contributors, and Acknowledgments

This manual was adapted from the original version produced for the *Fédération du Québec pour le planning des naissances (FQPN)*, with input from *the National Abortion Federation*.

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 care, 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.

Thank you to *Cass Bliss* for your assistance in adapting the manual to the United States. Thank you to *Charli Lessard* at FQPN for your logistical and administrative support, and for your passion and dedication for this project. Thank you to *Olivia Kamgain*, *Tobias Atkin*, and *Maxime Faddoul* for your initial input and enthusiasm. Thank you to *Alyson Budd* for your thoughtful edits. Thank you to *Hélène Frohard-Dourlent*, PhD, for your insightful feedback. Thank you to *Michelle Lee* for the layout, formatting, and design of this manual. Thank you to the *Gender Spectrum Collection*. Thank you to *Rhiannon Ross*, *Kimberly Grimmick*, *Lisa Brown*, and *Alice Mark*, on behalf of the *National Abortion Federation*.

CONTENTS

WHAT'S INSIDE?

This manual has been created for professionals working in the fields of sexual and reproductive health in the U.S., 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 patients. Wherever you are in your learning, and whether you work in abortion care 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 access to safe abortion. Trans people are as diverse as your other patients. 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 issues of embodied reproduction through a justice framework. The National Abortion Federation recognizes the global, historic devaluation of cisgender women's reproduction, and we invite you to learn more about NAF's common ethical framework by reading our Ethics Statement, which you can find online at www.prochoiceorg – click on 'Health Care Professionals', then 'Educational Resources' and scroll down to 'Quality Assurance and Improvement'. We are not asking readers to ignore the reality that many cisgender women live. 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. In addition to the endnotes of this manual, we have created a Supplementary Reading List. This list gives an overview of scholarly articles on trans reproduction, but the scholarly literature on trans people's perceptions of and experiences accessing abortion care is still sparse (See Abern et al. 2018 and Light et al. 2018 for examples).[1,2]

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, genderqueer, 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/TS/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 health care, and the lives of trans people themselves, are happening on the traditional, ancestral lands of the Indigenous peoples of the United States, be they Native American, Native Alaskan or Native Hawaiian, recognizing that Indigenous people may use different language to refer to themselves and their communities. The ways in which we understand sex, gender, sexuality, and even reproduction are products of the colonization of the United States. 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 color is vastly different than that of white trans people. Trans mixed-race, Indigenous, and people of color 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 choose adoption, or to seek out abortion.

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 Care
This section is an overview of the history and current state of abortion in the U.S., followed by an explanation of why trans-inclusive abortion care is 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 patients 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 patients to read and explore.

Section 8: Trans, Sexual Health, and Reproductive Health organizations
This section is a list of American trans resources, sexual and reproductive health organizations, and other 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. LANGUAGE AS DISTRESS, LANGUAGE AS EMPOWERMENT

For many trans people, language is an important part of dealing with the world, and some trans people alter language to suit their needs and identities.[3] Trans people may use language to help make themselves understood or intelligible to others. Altering language may help alleviate distress and dysphoria over body parts, among other things. Studies on providing health care to trans people have shown that asking trans people about pronouns and other gendered language is an important element of trans-inclusive care.[4] English and other languages can 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.

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 bodies[6,7] – 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 patients 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 patient'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 father.[8] 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.

B. VOCABULARY AND GLOSSARY[11]

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 patients, and mirror the language that they use to refer to themselves;
- provide your patients 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 patients 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 ask if there are **culturally specific terms** your patient uses.

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/hers), 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 patients. **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 **transgenders** 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 signaling to potential patients that your services are for anyone who experiences a particular phenomenon.

C. 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:

❶ Apologize ❷ Reflect and learn from the mistake ❸ 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, or by providing a space for pronouns on your intake forms. **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 patients, including your trans patients, either within your facility 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 health care 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). **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.

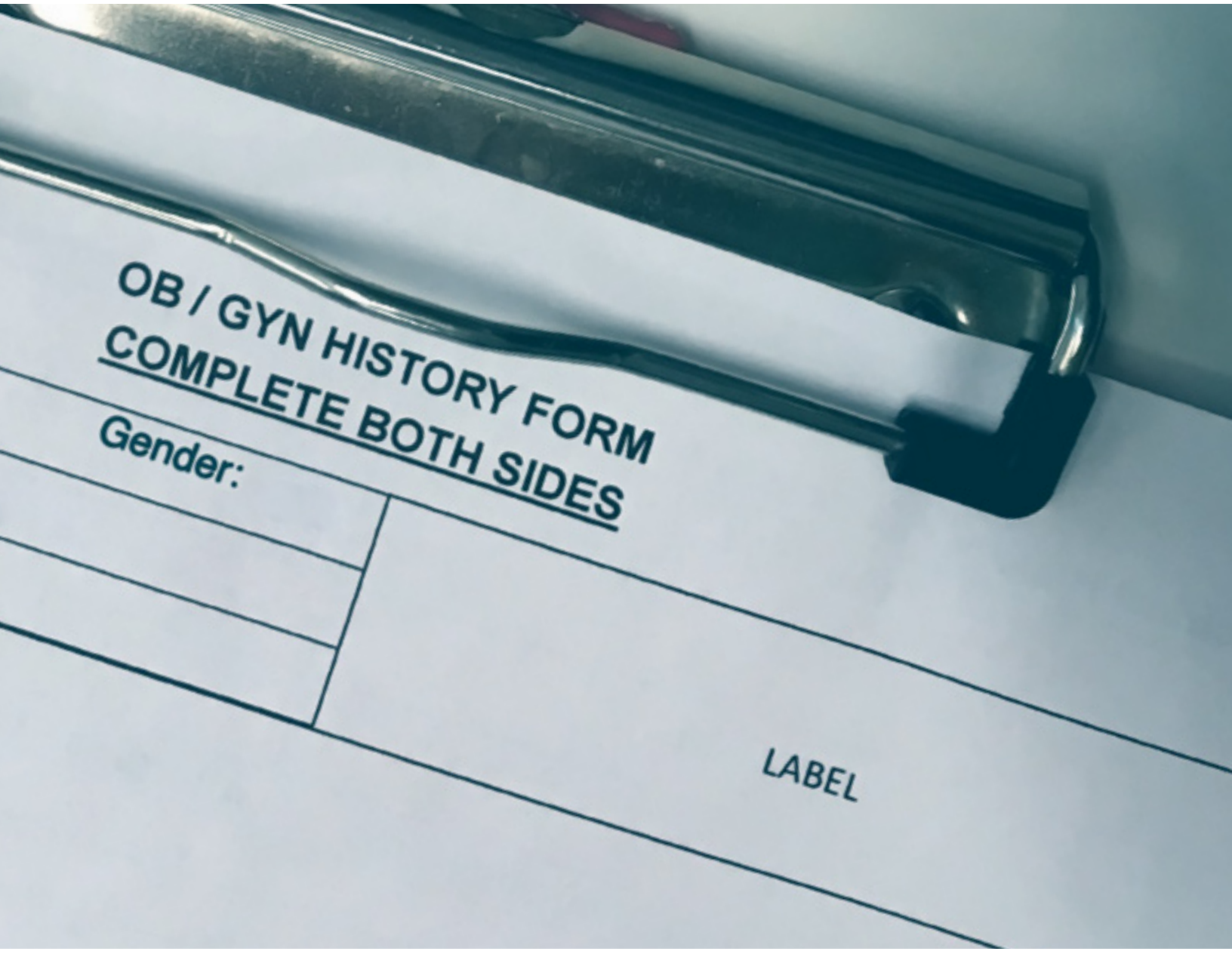
How to make your language trans inclusive, in general

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.



MYTHBUSTERS: TRANS REPRODUCTION EDITION

MYTH: Trans people cannot be pregnant.

FALSE.

- Trans people who were female assigned at birth can become pregnant.
- Not all trans people want to use hormones and/or surgery and even some who do are unable to access them.
- For female-assigned trans people who have used testosterone as part of their transition, the 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." [12]
- 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.
- Developments in uterus transplants mean that trans women may someday soon be able to experience pregnancy.[13]

MYTH: Trans people's general health is not significantly negatively impacted by stigma and marginalization.

FALSE.

- Trans people are at increased risk of experiencing homelessness, low self-esteem, suicide, HIV/AIDS, and job and housing insecurity which negatively impacted their general health.[14]
- Many are unable to access health and other social services,[14] or they may delay or avoid seeking services because of experiences or fear of discrimination.[15]
- Mixed-race, Indigenous, trans people of color, and trans people with disabilities, among others, are more likely to experience negative health outcomes.

MYTH: Homosexuality was removed from the Diagnostic and Statistical Manual (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 International Classification of Diseases (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.[16] In many places, a diagnosis of gender dysphoria is required to access hormones and/or surgical interventions.
- 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.[17] 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.[18,19]

MYTH: Trans people are free to reproduce without restrictions.

FALSE.

- Trans people's reproductive capacities are restricted in many ways, 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 change the sex marker on their identity documents.[20,21]

- Lawmakers frequently advocate that trans people transition *permanently*,[22] often accomplished by requiring sterilization as a condition of legal gender recognition (i.e. to have the correct gender marker 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 in 2010.

- In the United States, there are both federal and state policies which dictate the requirements for amending sex/gender markers on identity documents and records. Prior to 2013, the Social Security Administration included a surgical requirement: trans people needed to have physician certified gender affirming surgeries, sometimes specifically 'bottom' surgeries that would render the person sterile, to be eligible to change their sex/gender marker on their Social Security records. However, many states still maintain this requirement for trans people requesting a change in sex/gender marker on their identification records, such as birth certificates and driver's licenses. The National Center of Transgender Equality is consistently working to improve these laws on both a state and national level. For more information on requirements by state, please visit the identity documents resource on their website at www.transequality.org/documents.

- While assisted reproductive technologies have stretched the boundaries on what is normal and possible in terms of human reproduction,[23] access to these technologies has historically been restricted to only those deemed fit to benefit from them – and trans people, among others, have been all too often prohibited from accessing these technologies.[24]

MYTH: Trans people do not desire reproductive parenthood.

FALSE.

- Recent studies indicate that many 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.[25] A 2012 study showed that 54% of trans men desired children, and another 22% reported already having at least one child.[26] A 2014 study found that 77.9% of trans parents were biological parents to their children.[27]

- For some trans people, losing reproductive capacities is a small price to pay for transition.[25] Some 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.[23,24] Still others regret that they are unable to parent genetically-related children after having received hormone therapy and/or genital surgeries.[24]

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

FALSE.

- 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, similar to 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.[28] Unfortunately, conflict is often linked to ongoing discrimination and stigma faced by trans parents.[28] 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…" [27]

- Research shows that trans parents and children participate in mutual care practices[29] and that parents utilize strategies to protect their children from transphobia.[30] Trans parents can be role models to their children for authentic living and self-advocacy[31] and they can teach their children how to challenge gender norms.[32]

MYTH: Trans people do not experience sexual assault and rape.

FALSE.

- 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 perceived as gender deviants.[33]

- 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 care 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 and domestic violence spaces explicitly exclude trans people, often trans women specifically.[34]

MYTH: Reproductive experiences have no impact on feelings of gender dysphoria for trans people.

FALSE.

- Pregnancy is often imagined as a defining aspect of womanhood. For some trans people assigned female at birth, the thought of carrying a child themselves is seen as a distressing possibility incongruent with their gender identities.[35] Other experiences, such as menstruation and chest growth during puberty, are also distressing for similar reasons.[36]

- Even for trans people who choose pregnancy as their path to parenthood and/or choose to chest feed their children, these experiences can be linked to some degree of inner conflict and increased feelings of dysphoria.[36] 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.[7]

ABORTION CARE

A. ABORTION CARE IN THE U.S.

Barriers to abortion care in the United States are not experienced equally. They disproportionately impact marginalized people, especially those who are low-income, people of color, immigrants, refugees whose precarious immigration status prevents or delays them from accessing public health care, and those who do not speak English. Research has specifically shown a link between high levels of poverty and low access to sexual and reproductive health care.[37] 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 care in the United States is 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 health care 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 color including Indigenous people, for people with disabilities, and for people who have a BMI of 41 and over. Minors are also disproportionately impacted by states laws, especially those regarding parental involvement and barriers presented by the need to travel to access abortion.

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 CARE FOR TRANS PEOPLE

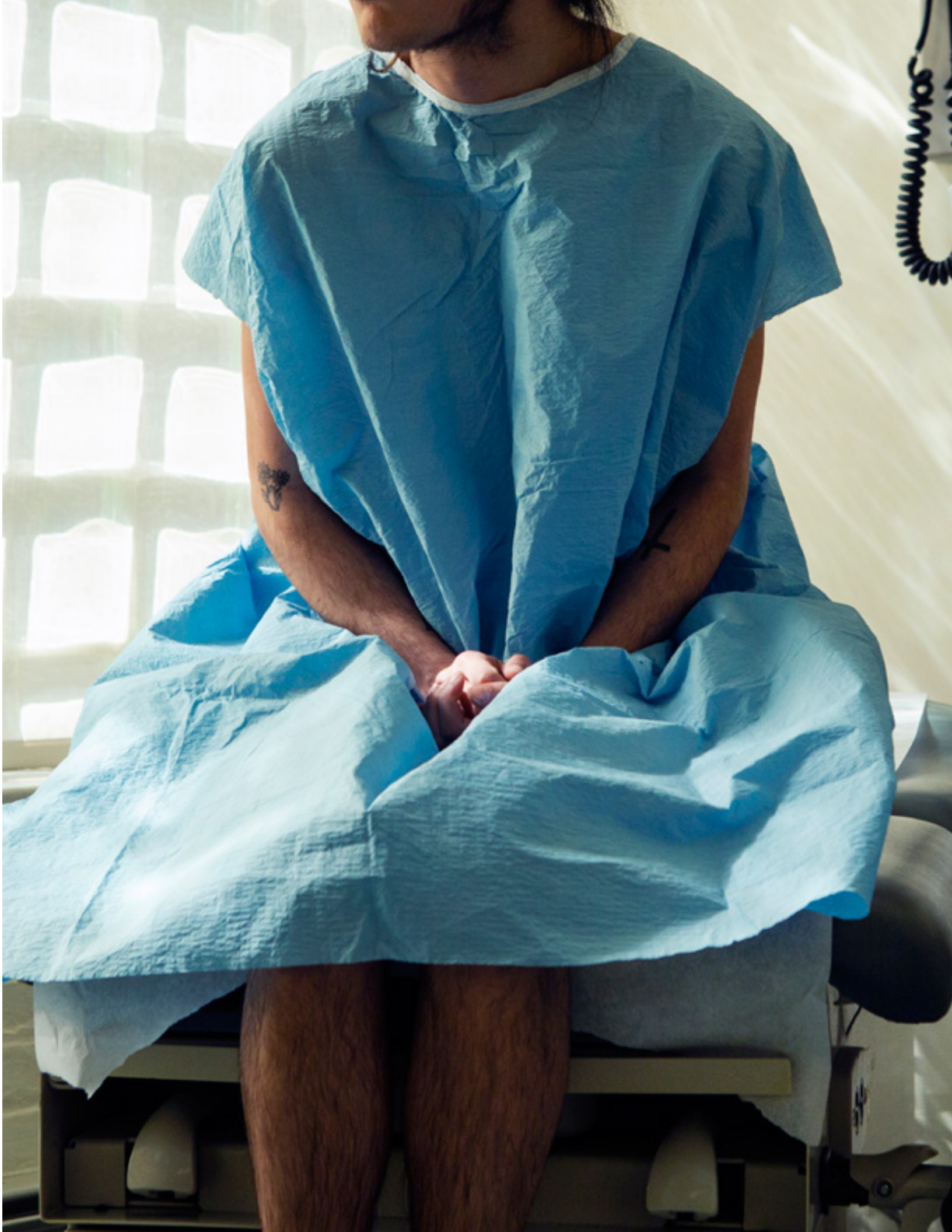
A number of abortion-related agencies and organizations in the United States now explicitly mention trans people in their mission statements or use the gender-neutral language of *pregnant people* or *people seeking abortions* in their literature, a noteworthy and important shift in the field.

Trans people may benefit from some of the other services offered by abortion providers beyond surgical and medication abortions, including birth control counseling, STI testing, treatment and test of cure, and post-abortion counseling, to name a few. Service providers can also provide their trans patients with information about trans-inclusive health centers, 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. 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 the United States. Staff working in abortion care may be in a position to remind their patients of the importance of these exams, (re)connect them to health services, and provide them with resources.

In addition to the barriers described in the previous section, there are specific barriers to abortion care 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 providers with women-only policies, where providers are asked to reconcile their 'women-only' frameworks with the possibility of serving patients 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 politics,[38] and into women's spaces. The *Trans Inclusion Policy Manual for Women's Organizations*,[39] 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.[40]

On the other hand, it is important that we consider trans-inclusivity beyond the inclusion of trans women. An abortion facility that identities 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) 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 patients, abortion providers should consider them as potential employees, as well. Having staff members that reflect the diversity of your patients is important as it clearly communicates your commitment to trans-inclusive services to potential patients and to the community at large.



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.

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

Michael's Struggle to Find a Trans-Inclusive Abortion

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 providers. Every provider's website assumes that the patient is a woman, and some are women-only spaces. Since Michael doesn't identify as a woman, he decides against the women-only facilities 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 patient 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 private insurance 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 providers' 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 patient 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 provider, 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 care. This can be done by:
  - Amending language so that services are for 'anyone experiencing an unplanned or unexpected pregnancy.'
  - Including a statement that the facility is for cis women as well as trans people in the mission statement or on the 'about us' page.
  - Including images of trans people and families.
- Instead of asking to speak to 'the patient 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 patient. Framed this way, Michael would have some confidence that the provider 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 patient who discloses that they are trans on the phone. Once Michael had identified himself as the prospective patient, 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 counselor 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 counseling room to point out the 'they/them pronouns' note on the chart, and the counselor quickly apologizes, circling it again. The counselor asks about birth control, and Barkat explains that they use condoms, but not always. The counselor 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 counselor 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 counselor does not take note of this information and misgenders Barkat in the public waiting room. Even though the counselor 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 counseling 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 patient 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 counselor 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

Scenario:

Moon has changed into his medical gown and is told to wait in the preoperative waiting room with the other patients—an ultrasound is next. Right away, Moon notices another patient shifting uncomfortably in their chair, staring at him. The other patient 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 counseling room instead of the preoperative waiting room, for the sake of his privacy. Moon gets the sense that his masculine-presentation made the other patient 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 patient who made the complaint is in the chair furthest from him. Although none of the other patients' 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 patients 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 patient, including the complainant. Moon feels like the provider 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 patients about a trans person in the space. This could include statements such as "this facility provides services for anyone who needs them. That person is a patient here." Any further complaints are dealt with in a similar fashion as incidents of racism or other patient-to-patient 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 patient to say no.

Kit's Emergency Room Transphobia

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 patients 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 facilities 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.

Henry's Anxiety about Internal Exams

Scenario:

Henry is a trans guy in his early thirties and while he is clear about his choice to have a medication abortion, he is nervous about the ultrasound. He doesn't like internal exams, and frequently skips his yearly Pap Smear because having anyone touch his pelvis or genitals makes him really upset. He tells the counselor at the abortion facility about his anxiety, and she offers him anti-anxiety medication and makes a note of this in his chart. The nurse inadvertently overlooks the note in Henry's chart. She says, "I'm going to insert this wand into your vagina," and does not adequately prepare Henry before touching him first with her hand, and then with the wand. Henry panics and asks the nurse to stop.

Obstacles:

Some trans people may avoid health care where a provider will need to touch parts of their body that cause them dysphoria and may be particularly distressed by internal exams. Henry panics at being touched without warning, and he feels that his anxiety over internal exams was not taken seriously. Not only that, Henry does not use the word vagina for this part of his body and hearing this part of his body described as a vagina is very upsetting for him.

Recommendations:

- It is important to provide trans people with as much control as possible during these parts of the appointment – this might include: providing the patient with the ultrasound wand, a speculum or rod to touch, asking the patient whether they would like to have the process described as it happens, and asking the patient if there are different words for their body parts that they would like staff to use. The *Check It Out Guys! Campaign* at checkitoutguys.ca has a "Tips for Providing Paps to Trans Men" resource that you may find helpful.

B. TRANS INCLUSIVENESS ASSESSMENT

After reviewing this manual, the following scale[41] can help you get started on assessing the level of trans inclusiveness in your facility or organization. Some items refer to institutional entry points into trans-inclusivity, while others are instructional, interpersonal, personal, or can inform the facility'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 patients 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
This facility's 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)	○	○	○	○	○	○
This facility's board of directors/executive director has clear policies, guidelines, clinical procedures, or other directives for working with gender diverse, trans, and transitioning patients. (Institutional)	○	○	○	○	○	○
This facility has a hiring policy that encourages trans people to apply for positions. (Institutional)	○	○	○	○	○	○
This facility has forms and, if relevant, the necessary conduits to allow patients to notify staff of their pronouns and whether they use a name different than their legal name. (Institutional)	○	○	○	○	○	○
This facility has washrooms designated as gender neutral. (Institutional)	○	○	○	○	○	○
This facility has a policy ensuring the privacy/confidentiality concerns of trans patients. (Institutional)	○	○	○	○	○	○
This facility has guidelines and supports to ensure staff are able to address patients who have concerns over the presence of a trans patient in the space, including in the change room, washrooms, waiting room, and recovery room. (Institutional)	○	○	○	○	○	○
This facility has posters and other imagery that feature a diversity of genders and that communicate that the space is trans-positive. (Institutional)	○	○	○	○	○	○
This facility 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 patients. (Institutional)	○	○	○	○	○	○

This facility's staff and administrators are afforded opportunities to engage in professional development opportunities that would allow them to increase their competency for working with trans patients. (Instructional)	○ ○ ○ ○ ○ ○
This facility's staff honors the requests of trans patients to be referred to by the name and pronoun they wish to use. (Interpersonal)	○ ○ ○ ○ ○ ○
This facility's staff are prepared to ask trans patients 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)	○ ○ ○ ○ ○ ○
This facility's staff are prepared to address transphobia, whether the comments or behavior are made by other staff members or by patients. (Instructional, Interpersonal)	○ ○ ○ ○ ○ ○
This facility's website includes a mission statement, purpose or values and/or list of objectives that explicitly includes providing abortion care for trans people. (Branding)	○ ○ ○ ○ ○ ○
This facility's name suggests that patients of all genders are welcome (i.e. does not exclusively reference women). (Branding)	○ ○ ○ ○ ○ ○
This facility's 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)	○ ○ ○ ○ ○ ○
I feel comfortable discussing the complexity of gender as it relates to sexual and reproductive health care in my role as [administrator, nurse, physician, counselor, receptionist, etc.] (Internal)	○ ○ ○ ○ ○ ○
I would feel comfortable intervening if I were to witness transphobic comments or behavior by other staff members, or by patients. (Internal)	○ ○ ○ ○ ○ ○
At our facility, it is safe for me to be myself (Interpersonal, Internal)	○ ○ ○ ○ ○ ○
At our facility, it would be safe for an employee to come out as trans—physically, emotionally, and in their professional capacity (Institutional, Interpersonal, Internal)	○ ○ ○ ○ ○ ○
I feel that I have done my own internal work exploring gender and how gender intersects with the issues that we encounter at the facility, including pregnancy, sexual assault, sexual health, ideas around parenting and family structures, etc. (Internal)	○ ○ ○ ○ ○ ○

Are there any other aspects of your facility or organization that speaks to the presence or absence of gender and trans-inclusive practices?

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 patients 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 patients 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 care and making your facility or workplace a welcoming space where trans people can receive competent care.

RESOURCES—FOR YOU, FOR YOUR PATIENTS TO READ

Center of Excellence for Transgender Health—Increasing access to comprehensive, effective, and affirming health care services for trans communities, including a learning center, community-based research programs, primary care protocols, and clinical services with UCSF Transgender Care.

http://transhealth.ucsf.edu and https://transcare.ucsf.edu

Birth Control Access Across the Gender Spectrum—This article written by Meera Shah, MD for Bedsider.org explores birth control options using trans-inclusive language.

www.bedsider.org/features/1070-birth-control-across-the-gender-spectrum

Birth For Every Body—An explicitly trans-inclusive midwifery collective, including a statement regarding the need for gender-inclusive midwifery practices, written in light of letter from Woman-Centered Midwifery to the Midwives Alliances of North American, expressing their concern over MANA's use of gender-inclusive language.

www.birthforeverybody.org

Check it Out, Guys!—A campaign created by trans men, allied-health providers and the Sherbourne Health Center 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 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 care, including patriarchal norms, wrongful gender stereotypes, sexism, and cissexism.

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

Human Rights Campaign LGBTQ Parenting Resources—Human Rights Campaign works to secure legal equality, fairness, and respect for LGBTQ couples and our children. This resource page includes items relating to adoption, surrogacy, navigating school, paid leave, language and pronouns, and child welfare agencies.

www.hrc.org/explore/topic/parenting

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 care.

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

LGBT Parenting in the United States—A report from the William Institutes UCLA School of Law by Gary J. Gates, February 2013.

https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-parenting-in-the-united-states/

LGBTQ Parenting Network—The LGBTQ Parenting Network is a program of Sherbourne Health Center. 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

National LGBT Health Education Centre, A Program of the Fenway Institute — Dedicated to the lifelong learning of those in health care and health education, offering online learning modules, webinars, grand rounds and live education, and training programs with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, and transgender people.

https://www.lgbthealtheducation.org/

Primed²: 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, Primed² prioritizes their diverse bodies, desires, and sexualities. This resource will spark discussion about the many ways that trans men have sex and how they 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 *Primed²: 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

Reproductive Health Access Project — A National non-profit working directly with primary care providers, helping them integrate abortion, contraception, and miscarriage into their practices.

https://www.reproductiveaccess.org/

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

TRANS, SEXUAL HEALTH, AND REPRODUCTIVE HEALTH ORGANIZATIONS

NATIONAL ABORTION FEDERATION

1090 Vermont Avenue NW, Suite 1000
Washington, DC 20005
202-667-5881
naf@prochoice.org
prochoice.org

PLANNED PARENTHOOD FEDERATION OF AMERICA

1-800-230-7526
Media: 212-261-4433
www.plannedparenthood.org
Chat online, via text or find a local office on their website

WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

www.wpath.org

THE NATIONAL LGBTQ TASK FORCE

With offices in Washington, DC,
New York, NY, and Miami, FL.
www.thetaskforce.org

ADVOCATES FOR YOUTH

1325 G Street NW, Suite 980,
Washington, DC 20005
202-419-3420
advocatesforyouth.org

GLMA HEALTH PROFESSIONALS ADVANCING LGBTQ QUALITY

1133 19th Street NW, Suite 302,
Washington, DC 20036
202-600-8037
info@glma.org
www.glma.org

PHYSICIANS FOR REPRODUCTIVE HEALTH

info@prh.org
prh.org

SOCIETY OF FAMILY PLANNING

255 South 17th Street, Suite 2709,
Philadelphia, PA 19103
866-584-6758
info@societyfp.org
www.societyfp.org

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 Abern, L., Nippita, S., & Maguire, K. (2018). Contraceptive use and abortion views among transgender and gender-nonconforming individuals assigned female at birth. *Contraception*, 98(4), 337-337.

2 Light, A., Wang, L., Zeymo, A. & Gomez-Lobi, V. (2018). Family planning and contraception use in transgender men. Contraception, 98(4), 301-318.

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 health care. *Proceedings in Obstetrics and Gynecology, 5(2),* 1-12.

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11 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.

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2019