

# **Trans Pregnancy**

**An International Exploration of  
Transmasculine Practices of Reproduction**

## **Law and Policy Review United Kingdom**

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## List of Abbreviations

CCG	Clinical Commissioning Group
GIC	Gender Identity Clinic
GIDS	Gender Identity Development Service (child and adolescent clinic)
GRA	Gender Recognition Act 2004
GRC	Gender Recognition Certificate
HFE Act	Human Fertilisation and Embryology Act 2008
HFEA	Human Fertilisation and Embryology Authority
LGBT	Lesbian, Gay, Bi and Trans
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
WPATH SoC	World Professional Association for Transgender Health Standards of Care

# 1. Introduction

There are several relevant pieces of UK legislation, as well as official guidance published by key public institutions, which shape the policy situation for trans pregnancy in the UK.

This review focuses on:

- identifying potential barriers to trans pregnancy
- issues in accessing fertility preservation and/or assisted reproduction
- the law around parenthood and the recording of legal parents
- the language used throughout in referring to pregnant people (and parental others) in law/policy documents.

It will also highlight some areas where vague or unspecific guidelines might lead to difficulties for pregnant trans men and transmasculine or non-binary people.

## 2. Gender Recognition Act 2004

The Gender Recognition Act 2004 (GRA) allows trans people aged over 18 in the UK to apply for a Gender Recognition Certificate (GRC), the possession of which enables them to get a birth certificate in their 'acquired gender'. This is the only means of changing gender on a birth certificate.

However, the gender marker on most other official documentation (including passports, driving licenses, and National Health Service records) can be changed without a GRC by writing to the relevant authority. By no means do all trans people in the UK apply for, or have, a GRC.

Applications for a GRC are assessed by a panel comprising members of the legal and medical professions. Section 2.1 of the GRA states that:

The Panel must grant the application if satisfied that the applicant—

- a) has or has had gender dysphoria,
- b) has lived in the acquired gender throughout the period of two years ending with the date on which the application is made,
- c) intends to continue to live in the acquired gender until death, and
- d) complies with the requirements imposed by and under section 3.

Section 3 refers to the evidence required to apply, which must include either:

- a) a report made by a registered medical practitioner practising in the field of gender dysphoria and a report made by another registered medical practitioner (who may, but need not, practise in that field), or
- b) a report made by a chartered psychologist practising in that field and a report made by a registered medical practitioner (who may, but need not, practise in that field).

The GRA only enables a change of gender from male to female, or from female to male. Non-binary and genderqueer genders (and intersex bodies) are not formally recognised.

## 2.1 Sterilisation

It is not necessary for trans people to have had, or desire to have, any bodily interventions such as hormones or surgeries that may render them sterile in order to obtain a GRC. Hence in the UK this potential legal barrier to trans pregnancy does not exist.

However, the process of panel assessment for GRCs, subject to the 'right' evidence being provided, has caused considerable dissatisfaction in the trans community (House of Commons Women and Equalities Committee, 2016). The gender recognition panel is able to reject applications, or ask for further evidence (GRA 2004, Section 3.6a) and although they are required to give reasons (GRA 2004, Schedule 1, Section 6.6) the basis on which they assess evidence can seemingly be based in narrow conceptions of what counts as 'really' trans. In some instances, gender identity specialists have sought to put off trans patients from applying for a GRC until after they have surgery (Pearce, 2018, p.69).

Of relevance here is how the stipulation that the GRC recipient 'intends to continue to live in the acquired gender until death' is interpreted in the case of a trans man who is, has been, or intends to be pregnant whilst living in his 'acquired gender'.

The case of a trans woman whose GRC application was delayed and possibly denied because she had had children whilst trans indicates that this may also be a potential unofficial barrier to trans men applying for GRCs. The activist group Action for Trans Health, who reported this case, note that 'the Gender Recognition Act does not require a trans person from abstaining from sexual activity, side effects reproductive or otherwise. This news represents a potentially unlawful and clear violation of trans people's reproductive rights' (ATH, 2014).

This may not be a widespread problem as both the number of trans men applying for GRCs and the number of rejected applications is low. Rejected applications are usually attributed to an incorrect completion of paperwork rather than the panel applying inconsistent criteria (see GIRES, 2014). However, it might be more reasonable to speculate about whether the anticipated problems and the desire to conceive might put men off applying for a GRC in the first place.

## 2.2 The GRA and Parenthood

The GRA makes (brief) reference to parenthood in Section 12, which in its entirety states:

The fact that a person's gender has become the acquired gender under this Act does not affect the status of the person as the father or mother of a child.

This section refers to parentage of children born prior to a GRC application, but does not make provision for children that might be born afterwards. Natalie Gamble Associates, a law firm specialising in LGBT parenting rights, interpret Section 12 as follows:

It means that you will remain your children's legal father if you become a woman, and you will remain your children's legal mother if you become a man. There is no clear provision for transgender parents who conceive after having transitioned. Our view is that section 12 also applies to parents who conceive after a gender transition, enabling you to claim the parenthood status you would have had under your previous gender. In other words, if you give birth you can claim to legally be a 'mother' (even if you are a man), and if you provide your sperm you can claim to legally be a 'father' (even if you are a woman). Although this interpretation of the law is not legally tested in the family court, we know that the UK Home Office accepts it in respect of recognising British nationality (Natalie Gamble Associates, nd).

While this would ensure the right to legal parent status for any transmasculine person giving birth, there is no acknowledgement that someone might *not* want to be registered as a 'mother' if they are a man or non-binary.

Section 9.1 of the GRA states that:

Where a full gender recognition certificate is issued to a person, the person's gender becomes *for all purposes* the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman). [emphasis added]

It therefore follows that it is for a trans man with a GRC to have the legal sex 'of a man' and yet still be considered a 'mother'. There is therefore a potential mismatch with the language defining 'mother' elsewhere in the legislation.

While there is considerable focus on the birth certificates of trans people themselves in the GRA, there is no provision for changing gender/parent role as marked on birth certificates of trans peoples' existing children, and no clear or definite guidance given on how gender would be recorded for any subsequent children a trans person might have. A further discussion of issues around legal parents and birth certificates follows in Section 2 below.

In summary, the GRA does not impose any legal barriers to pregnancy and childbirth for individuals who hold a GRC. However, there is an absence of consideration for trans people as parents in any capacity. There is also no reference to non-binary trans people as parents (due to the absence of provisions for non-binary people in the GRA).

### 3. Legal Parents and Birth Certificates

The Human Fertilisation and Embryology Act 2008 (HFE Act) enables same-sex couples to become the legal parents of a child and deals with defining the parentage of children conceived via assisted reproductive technologies. It also provides legal definitions of ‘mother’, ‘father’ and ‘parent’ which are relevant to trans male experiences of childbearing. The Births and Deaths Registration Act 1953 covers the registration of births and recording of parents on the birth certificate.

Under the HFE Act, the meaning of ‘mother’ is as follows:

The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child (Section 33.1).

The gestational parent is consistently assumed to be female, and referred to as ‘she’ and as a ‘mother’, throughout this and other legislation. The only exception to this is on the Human Fertilisation and Embryology Authority (HFEA) website, which provides an unusually gender-neutral definition: ‘if you are the *person* who gives birth to the child, you will be their mother and legal parent’ [emphasis added].<sup>1</sup>

This seems both to suggest that the ‘person’ who gives birth might not be a woman, but also reveals how in law there is no mechanism by which a someone who has given birth can be recorded as anything other than the ‘mother’ of the child. As previously noted, then, someone who identifies and lives as male or non-binary will be placed in a legally female role in this situation.

The other parent (there can only be a maximum of two legal parents in the UK) can either be a ‘father’ (presumed male) or a ‘parent’ (usually the same-sex partner of the mother or father). In either case the father/parent does not have to be genetically related to the child. These categories also apply when the child’s birth is registered, which is legally required under the Births and Deaths Registration Act 1953, and in guidance provided by the gov.uk website.<sup>2</sup>

However, Sections 42 and 43 of the HFE Act (those that make provision for a mother’s female partner – whether married, civil partnered or not – to be a legal parent of a child) have necessitated the following ‘interpretation of references to father etc’:

Any reference (however expressed) to the father of a child who has a parent by virtue of section 42 or 43 is to be read as a reference to the woman who is a parent of the child by virtue of that section (Section 53.2).

In effect, rather than amend existing legislation (such as the Births and Deaths Registration Act 1953) ‘father’ can now be read as applying to a female person.

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<sup>1</sup> <https://www.hfea.gov.uk/treatments/explore-all-treatments/becoming-the-legal-parents-of-your-child/>

<sup>2</sup> <https://www.gov.uk/register-birth/who-can-register-a-birth>

However, the same ‘interpretation’ is not applied to references to ‘mother’, so as to include male gestational parents of children. In addition, Section 38.1 of the HFE Act notes that, ‘where a person is to be treated as the father of the child by virtue of section 35 or 36, no other person is to be treated as the father of the child’, thus seemingly precluding the possibility of a child having two fathers, even if one of them gave birth to it.

This failure to consider or accommodate trans parents is indicative of the limitations of the HFE Act: while it certainly represents a step forward for the legitimacy of same-sex couples’ parenting rights, it does less for trans people.

**People who give birth, but who are not or do not identify as women, therefore face the following obstacles** when registering that child’s birth:

- A trans man without a partner would be registered as the mother, as it is only possible to not include a father/parent on a birth certificate, there must always be a ‘mother’.
- Trans men with female partners would be registered as the ‘mother’ and their partner as the other ‘parent’, as per a same-sex female couple. Here the assumption would be that both parents were female.
- Trans men with male partners (regardless of whether or not they were genetically related to the child) would be registered as the ‘mother’ again, and their partner as the father as per an opposite sex couple.
- Non-binary or transmasculine people who do not identify as male would also be registered as the ‘mother’. Non-binary partners of the gestational parent could potentially be registered as ‘fathers’ or the more appropriately non-gendered ‘parent’, depending on their assignment at birth and/or their biological/genetic relation to the child.

The process by which a same-sex male couple become the legal parents of a child entails getting a parental order to transfer legal parenthood from a surrogate mother, to the male partners. In the case of a gay male couple where one (or both) partners were trans men and one of them had given birth, this model would not be applicable or necessary, and while a trans man who did not give birth may be recorded as a father on a birth certificate, the man who gave birth would not. Even if a trans man or non-binary person applied for a parental order for a child they have given birth to, they may be recorded as the gender-neutral ‘parent’ of the child, but not as a father.

This may or may not be a significant issue for trans men or non-binary people who become pregnant in the UK (there has been no empirical research on this topic to date). However, it does mean that there is no formal record of how many trans men or non-binary people have given birth in the UK, because they will have been registered as the ‘mother’.

The (tedious) detail provided here is intended to illustrate how trans people who give birth fall between the gaps in all existing legislation on legal parenthood, including that which relates to same-sex couples. At all times the definitions of ‘male’ and ‘female’, ‘mother’ and ‘father’ in this legislation are cis-normative and assume that the individuals

in question will have the reproductive capacities of cis males/females. For trans men with GRCs this contradicts the previously quoted Section 9.1 of the GRA:

Where a full gender recognition certificate is issued to a person, the person's gender becomes *for all purposes* the acquired gender. [emphasis added]

## 4. Fertility Guidance and Treatment

There is no specific law or piece of legislation that directly addresses trans people's fertility. However, there are relevant guidelines and policies set out by the National Health Service (NHS), the National Institute for Health and Care Excellence (NICE) and the Human Fertilisation and Embryology Authority (HFEA) that pertain to provision of gender identity services and fertility treatments.

### 4.1 Fertility Guidance at Gender Identity Clinics

In the UK trans people are able to access gender identity services through the NHS. The process involves being referred from one's GP to a specialist Gender Identity Clinic (GIC), of which there are seven in England, four in Scotland, one in Wales (opening fully in 2018) and one in Northern Ireland. All the clinics operate in accordance with the World Professional Association for Transgender Health Standards of Care (WPATH SoC). Within the WPATH SoC one of the responsibilities of hormone-prescribing physicians is to:

Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility ... Therefore, reproductive options should be discussed with patients before starting hormone therapy' (Coleman et al, 2011: p.191).

The WPATH SoC further states that patients should be informed about options for cryopreservation of eggs/sperm or embryos (p.197). There is also a reference to the possibility of male pregnancy:

Stopping the testosterone briefly might allow for ovaries to recover enough to release eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (Coleman et al, 2011: 197).

This international guidance is echoed in an article authored by numerous clinicians at UK clinics which states that:

Before starting either [oestrogen or testosterone], however, it is important to explore implications for fertility. This might include discussion of gamete storage. The GP is usually best placed to advise on local availability of gamete storage services (Ahmad et al. 2013: p.180).

Although these references are brief, the point is that this information *is* available. However, a survey of GIC websites indicated that only the London and Belfast clinics currently provide information online about the effects of hormone treatment and/or surgery on fertility. The London GIC, for example, discusses fertility reduction as a ‘risk’ of hormone treatment, stating:

Hormone therapy can reduce fertility and may eventually render people completely infertile. Your specialist will discuss the potential impacts of hormone treatment on fertility before starting treatment. They will also discuss with you the option of storing eggs or sperm (known as gamete storage) in case you want to have children in the future. We advise that people seeking hormone therapy decide whether they wish to retain fertility before beginning treatment as there is no guarantee that fertility will return to normal if hormones are stopped. Please see the Human Fertilisation and Embryology Authority website for information about local fertility services ([gic.nhs.uk/services/hormones](http://gic.nhs.uk/services/hormones), nd).

Once again, while there is no formal barrier to trans reproduction and/or pregnancy put in place, there is equally a lack of publicly available information or support<sup>3</sup>.

The London GIC website does not mention fertility in relation to any surgical procedures, but does state the following about hysterectomy and salpingo oophorectomy:

There are many reasons people may seek hysterectomy as part of their gender care. One of the medical reasons we refer people is that the risk of endometrial hyperplasia is increased when someone has been taking synthetic testosterone for 2 years. If someone does not wish to have hysterectomy it is advised that they have ultrasound tests every 2 years to monitor the risk. ([gic.nhs.uk/appointments/surgery-referrals](http://gic.nhs.uk/appointments/surgery-referrals), nd).

It is unclear from this whether people taking testosterone are routinely encouraged to have hysterectomies to alleviate the risk of endometrial hyperplasia or not, and if they are whether this is because it is assumed they will not want to bear children. It is also not stated whether there would be any discussion about childbearing/fertility at this point.

The current protocol for gender identity services provided by NHS England (2013) more proactively asserts that trans men be recommended a hysterectomy and bilateral salpingo-oophorectomy after a period of time undergoing testosterone therapy.

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<sup>3</sup> In a consultation conducted by NHS England (2017) on gender identity services in the UK, Schedule 2.15 of the Non-Surgical Services specification includes the following statement:

The individual must be provided with early advice about the likely impact of medical interventions to physical health. Where loss of fertility is likely the Provider will provide a general description of the options for conservation of reproductive potential, and, where appropriate and with the individual’s consent, make a recommendation to the GP that they pursue a referral to a fertility service for cryopreservation of eggs or sperm for possible use in future fertility treatment (gamete storage). Responsibility for commissioning gamete storage rests with the individual’s Clinical Commissioning Group.

This does not appear to alter the existing guidelines, based on the WPATH SOC (Coleman et al, 2011).

Continuous use of testosterone therapy in trans-men with an intact uterus increases their risk of developing endometrial hyperplasia and malignancy. Trans-men should be informed of this before commencing testosterone therapy and be strongly recommended to have a hysterectomy and bilateral salpingo-oophorectomy after receiving continuous testosterone therapy for 2–5 years. (NHS England, 2013, p. 17).

However, these recommendations from the London GIC and NHS England do not appear to be grounded in an existing evidence base; rather, they appear to reflect hypothetical concerns (Coleman et al, 2011; Toze, 2018).

As of January 2018, guidance on fertility preservation for ‘individuals transitioning from female to male gender’ is provided by professional membership organisation the British Fertility Society in their document *Fertility preservation for medical reasons in girls and women*.<sup>4</sup> This guidance appears to be aimed primarily at gender identity specialists and counsellors working with transmasculine people. It notes that transitioning individuals may wish to store gametes to retain the possibility of becoming a genetic or biological parent, and recommends that:

- implications of medical transition for fertility be discussed when planning treatment
- if appropriate, fertility preservation should be performed as early as possible in the treatment pathway
- counselling be offered prior to both fertility preservation and the use of stored material (Ephia et al, 2018).

## 4.2 Accessing Fertility Preservation and Assisted Reproductive Technologies

Patients are directed elsewhere by gender identity specialists if they want to pursue fertility preservation before starting hormone treatment. The GICs do not provide this service; rather, patients are referred back to their GP with a recommendation they are referred on to special fertility clinics (National LGB&T Partnership, 2017).

The NHS does fund some fertility treatments, but all are subject to eligibility criteria, which differ between the regional commissioning bodies such as the Clinical Commissioning Groups (CCGs). CCGs are the ‘clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area’. There are 207 CCGs in England alone, and separate NHS arrangements for Wales, Scotland and Northern Ireland. Commissioners are guided by the National Institute for Health and Care Excellence (NICE). This body issues recommendations on what treatment should be treated on the NHS and for who.

There are no clear guidelines for either trans people or GPs about whether trans people are eligible for fertility preservation (see also National LGB&T Partnership, 2017). The latest NICE guidelines in this area (September 2017) state,

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<sup>4</sup> <https://www.tandfonline.com/doi/full/10.1080/14647273.2017.1422297>

where treatment is planned that may result in infertility (such as treatment for cancer), early fertility specialist referral should be offered (CG156, section 1.2.13.8).

On CCG websites this service is often listed as available to people with ‘cancer or other illnesses’ (e.g. Tower Hamlets CCG, 2014) It is unclear whether someone planning to take cross-sex hormones would be eligible under these criteria, and whether or not they are excluded may be a matter for interpretation.

Trans people requiring access to other fertility treatments such as IUI, IVF and donor sperm/eggs are similarly subject to NICE guidelines as interpreted through individual CCG eligibility criteria. In general CCGs, make IUI and IVF available to single women and couples, including same-sex couples, and being trans or having undergone hormone therapy is never mentioned in eligibility criteria (see for example Leeds CCG, Tower Hamlets CCG).

One widespread criteria applied by CCGs is that fertility treatment should not be provided to people who have previously undergone sterilisation procedures. For example, Tower Hamlets CCG ‘will not fund treatment for couples where subfertility is the result of a sterilisation procedure in either partner’ (2014, p.6). Speculatively, cross-sex hormone treatment could be construed as a ‘sterilisation procedure’, but once again there is no explicit reference to trans people in either the NICE guidelines or the CCG policies consulted for this review.

### 4.3 Private Treatment

Private options may be available for procedures not funded by the NHS, but at a price. Egg collection and freezing, for example, costs £2,500-£5,000, with storage at £150-£400 a year (HFEA). Self-funded treatments may also be necessary for those who have previously managed to store eggs/embryos before starting testosterone when they come to use them later on, or if they want to continue to store eggs beyond the 10 years funded on the NHS (National LGB&T Partnership 2017). Someone wanting to access donor sperm, or eggs would also likely have to pay for this privately.

### 4.4. Human Fertilisation and Embryology Authority Guidance

Both private and NHS fertility clinics are regulated and licenced by the HFEA. The Authority’s website offers some of the only official guidance available on trans people’s access to fertility services in the UK.

The web page *Information for trans and non-binary people seeking fertility treatment*<sup>5</sup> very clearly sets out how ‘medical treatments for gender dysphoria’ might affect fertility and explains fertility preservation options for people at different stages of medical transition. It explains options which include transmasculine pregnancy, and the language

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<sup>5</sup> <https://www.hfea.gov.uk/treatments/fertility-preservation/information-for-trans-and-non-binary-people-seeking-fertility-treatment/>

used is non-binary inclusive. This HFEA guidance is the fullest and most detailed information available online and indicative of the lack of formal barriers to transmale pregnancy<sup>6</sup>.

The HFEA has also recently introduced consent forms that do not reference gender, and are working on further legal guidance (e.g. on what details about patients/donors' gender identity should/can be disclosed and when) and information on emotional support during fertility treatment (Verdin, 2017).

#### **4.5 Fertility in young trans people**

The above information refers primarily to adults over the age of 18. Trans people aged less than 18 may be under the care of the Gender Identity Development Service (GIDS). In the clinical commissioning policy followed by GIDS (2016), one of the clinical criteria for treatment requires that patients understand the impact that cross-sex hormones may have on their fertility. There is no information about fertility on the GIDS website. As with adults, under 18s would have to seek fertility information/treatment via their GP and/or fertility clinic (National LGB&T Partnership 2017).

There are specific fertility issues for people who have been on hormone blockers prior to hormone treatment. If puberty is not advanced enough for eggs to be collected prior to starting hormone blockers then it is possible to collect ovarian tissue. However, the HFEA warn that, 'These treatments are experimental and there have only been a very small number of resulting live births worldwide following replacement of the ovarian tissue' (HFEA, 2017). Additionally, very few clinics offer this sort of treatment.

## **5. Antenatal and Labour Services**

In NHS guidance for antenatal and labour services, there is no mention of trans pregnancy in any of the 'special health needs' you might need to discuss with your midwife, but equally there is nothing to suggest that care would be denied to a pregnant trans and/or non-binary person (NHS, 2015).

Similarly, the NICE guidelines for antenatal care state they are for 'women who are pregnant, their families and carers' and speaks of 'woman-centred care' (CG62, 2017) and makes no mention of the needs of trans and/or non-binary patients. Throughout, the language refers to pregnant people as 'women' and uses female pronouns ('she'/'her').

The NICE guidelines for intrapartum care for healthy women and babies (CG190, 2017) recommends the following in relation to communication during birth:

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<sup>6</sup> This information was made available in August 2017 and elsewhere on the HFEA website are traces of less trans-inclusive (possibly older) guidance. The page on egg freezing lists one of the reasons for storing eggs as 'you're planning to have a sex change operation', and then continues to only talk about 'women' storing eggs. This language implies that prior to a 'sex change operation' anyone wanting to store eggs would be regarded as female.

Treat all women in labour with respect. Ensure that the woman is in control of and involved in what is happening to her, and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide her through her labour (Section 1.2.1).

While this language is heavily gendered and not trans inclusive, it clearly provides a basis for the respectful treatment of trans men and non-binary people during labour, for example through the correct use of pronouns and asking the person in labour how they would prefer to be referred to.

In 2016 the British Medical Association issued new guidance on inclusive language in the workplace, which made the link between languages used by doctors and in clinical settings and a commitment to equality and diversity, particularly with regards to the protected characteristics set out in the Equality Act 2010. One of these protected characteristics is 'gender reassignment'. The guidance attracted widespread media attention (much of it sensationalist) due to the following statement in the section on pregnancy and maternity:

A large majority of people that have been pregnant or have given birth identify as women. We can include intersex men and transmen who may get pregnant by saying 'pregnant people' instead of 'expectant mothers' (BMA, 2016).

To date this is the only example of such inclusive language found in compiling this review, and has, as yet, not been taken up by the NHS or NICE in their guidelines or communications around matters relating to pregnancy and birth. Similarly there is no information on trans inclusion available on the Royal College of Midwives website, nor that of the National Childbirth Trust (the UK's largest 'charity for parents', which runs widely-attended antenatal classes and new parent groups). The National Childbirth Trust website does include a section on 'LGBT' parents, but its content focuses entirely on lesbian mothers/parents.

## 6. Equalities Legislation

Pregnancy and maternity is a protected characteristic under the Equality Act 2010. The Equality Act states that:

17.2 A person (A) discriminates against a woman if A treats her unfavourably because of a pregnancy of hers.

17.3 A person (A) discriminates against a woman if, in the period of 26 weeks beginning with the day on which she gives birth, A treats her unfavourably because she has given birth. (Section 17)

Pregnant people are similarly referred to with female pronouns and as ‘a woman’ in all sections of the Equality Act. The same is true for the government guidance on maternity leave and statutory maternity pay.

There may be potential issues for transmasculine people with their employers with respect to having to prove they are pregnant (as all pregnant people must do) in order to qualify for maternity pay. However, if they were under the care of a doctor or midwife this should be obtainable in the usual way via a letter or MATB1 certificate (gov.uk). There is nothing to indicate these rights would be denied to a pregnant trans man or non-binary person.

### **6.1 Pregnancy as a protected characteristic in Gender Identity Clinics**

An equality impact assessment was conducted as part of an NHS England consultation on adult gender identity services, which is ongoing at the time of writing.

NHS England wants to make sure we understand how different people will be affected by our proposals so that Gender Identity services are appropriate and accessible to everyone who needs them. In particular we have considered the following ‘protected characteristics’: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; ethnicity; religion or belief; sex; and sexual orientation. Please see Appendix A for the Equality and Inequalities Impact Assessment (Consultation Guide, p.11).

With regards to pregnancy and maternity the assessment states that:

NHS England is of the view that the proposed service specifications do not discriminate against individuals who share this protected characteristic as there are no impacts to this group of people (Section 51, p.29).

The implication of this statement is not clear. It may be that the authors intended to state that the provision of gender identity services does not discriminate against pregnant people. However, it may also be the case that NHS England believe that the population of people accessing gender identity services will not overlap with the population of people likely to get pregnant (‘no impacts to this group of people’). If so, the needs, and indeed existence, of trans pregnancies are being neglected.

## **7. Conclusions**

The findings of this policy review indicate that there are no formal barriers to trans men, transmasculine and/or non-binary people becoming pregnant or being the legal parent of any child resulting from the pregnancy. They should also not be discriminated against in the provision of NHS fertility treatment or antenatal care.

However, there is generally an absence of consideration of trans pregnancy in the current legislation, official guidance and policy. This means there are areas of uncertainty around

which policies may or may not apply to pregnant trans people. Consequently, their ability to navigate systems may depend heavily on their ability to advocate for themselves, and in finding sympathetic or understanding healthcare professionals.

Large sections of UK policy in this area have recently been amended to include same-sex parenting. While this change is sometimes presented as relevant to 'LGBT' parents in general, it is often the case that the different needs and experiences of 'T' parents, especially pregnant trans people, have not been considered or accounted for.

In terms of the language used throughout the policy reviewed, pregnant people are always assumed to be female and are referred to as such. The NHS and NICE guidelines on infertility treatment routinely use gendered language and the legal categories for parenthood continue to be cis-normatively gendered.

Finally it might be worth noting that two recent reviews of transgender equality (House of Commons Women and Equalities Committee, 2016) and the provision of gender identity services (NHS England 2017) make no mention of trans male pregnancy as an area where considerable work needs to be done to make services more inclusive. The relative lack of information from GICs also contributes to the overall picture of vague information at best – and absent information at worst – with regards to the existence of trans pregnancies in the UK.

## References

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### About the Trans Pregnancy Project

This international research project aims to address the social, legal and health care implications of, and for, people who become pregnant and/or give birth after transitioning.

The project explores the experiences of transmasculine people (including trans men and non-binary individuals) who become pregnant after transition, attitudes towards future pregnancy among young transmasculine people, and the legal and policy context in which transmasculine people might become pregnant and give birth.

For further information, please visit our website: <http://transpregnancy.leeds.ac.uk>.



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