Trans Pregnancy

An International Exploration of Transmasculine Practices of Reproduction

Law and Policy Review

United States

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April 2018

Version 1.1

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL
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Note on Version 1.1:

At the time of writing, the policy landscape regarding trans issues in the United States is rapidly shifting. This document will be periodically updated to reflect this.

For the most recent version of this review, visit: https://transpregnancy.leeds.ac.uk/.

1. Introduction

In the United States, relatively little federal policy exists pertaining directly to the rights and protections of transgender people. Rather, existing federal policy focusing on sex-based protections in the Civil Rights Act of 1964 (Title VII) and the Education Amendments Act of 1972 (Title IX) has been increasingly re-interpreted by the courts to either extend or fail to extend legal protections to those who are transgender.

The policy landscape becomes ever more complex for those who are transgender as individual states and municipalities within and across them, as well as Washington D.C. and the various U.S. territories and islands, are often left to generate and define state and local-level policies. These tend to differ widely, dependent largely upon political leanings. Under the current President Donald J. Trump Administration, transgender-related rights and protections are under persistent challenge and legislation in perpetual flux.

As such, this policy review will attend to several key federal policies with relevance to transgender rights and protections in the United States, as well as the ongoing political scuffles about interpretation and application of these policies. It will also provide an overview of some state and local-level policies that have garnered media attention specifically with regards to reproductive rights and access for those who are transgender.

Importantly, given the lack of unified federal policy concerning transgender reproductive rights, along with the lack of universal healthcare provided to United States citizens, employers (through which many receive their healthcare benefits), medical insurers, and professional medical associations and their internal policy statements on transgender-related care have often had some of the most direct impacts on transgender people's access to reproductive healthcare and services. As such, this policy review will also include focus on relevant policies and statements from major employers, insurers, and nonprofit and medical professional associations connected to access to and/or provision of transmasculine people's reproductive healthcare.

2. Federal Policy

2.1 Federal Employee Health Benefits

Beginning 2011, the Office of Personnel Management issued guidance stating that transgender federal employees "should be provided appropriate preventive services in accordance with their individual medical status. For example, an individual who transitions from female to male may still need pap smears if they have not undergone a hysterectomy" (United States Office of Personnel Management, 2017a). Further, in 2016, "no carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs, or supplies related to gender transition or 'sex transformations'" (United States Office of Personnel Management, 2017a).

Note that this guidance, however, pertains directly to federal employees and that transgender individuals who are not federal employees and who are covered under their non-federal-employer's health plans may not always enjoy similar rights and benefits.

2.2 Affordable Care Act ("Obamacare")

According to the National Center for Transgender Equality (2017a):

> The Affordable Care Act (or 'Obamacare') prohibits most health insurers from discriminating based on gender identity and transgender status. Insurance companies that receive federal funding or that have one or more plans on a federal or state Marketplace have to comply with this requirement. That includes all major insurance companies and the majority of smaller insurance companies, but some small health insurance companies may not be covered.

HealthCare.gov (2017) has provided specific guidance to transgender individuals that they should ensure that their name and sex marker are consistent across their legal documents to ensure against "inconsistencies" or "data matching issues" that could delay application processing and subsequent access to medical coverage.

Since 2015, under Section 1557 of the Affordable Care Act (and through extension of rulings around gender identity discrimination as a form of sex discrimination under Title IX), discrimination "based on gender identity or failure to conform to stereotypical notions of masculinity or femininity" is prohibited in federally-funded health facilities, programs, and activities (If/When/How, 2017; Wang, Kelman, & Cahill, 2016). While the Affordable Care Act bans sex discrimination in healthcare coverage, there has been much contention about exactly what qualifies as sex discrimination (Hartofelis & Gomez, 2013; If/How/When, 2017; smith, 2016). Further, under the Donald J. Trump Presidential Administration, there have been ongoing attempts to roll back or rewrite the Section 1557 regulation and to repeal and/or replace the Affordable Care Act altogether (National Center for Transgender Equality, 2017b; Pieklo, 2017; Schleifer, 2017).

Further, in the United States, most individuals obtain access to health insurance coverage as a condition of their or a family member's employment. In 2017, only 647 employers in the U.S. provide insured medical benefits cover some or all transition-related medical costs (If/When/How, 2017). Despite assurances in the Affordable Care Act that healthcare must be provided without sex discrimination, many insurers routinely exclude coverage for transgender people's transition-related health services on the grounds that such procedures are "cosmetic" or "experimental" and that denial of such services does not constitute sex discrimination (Estevez & Taylor, 2017; If/How/When, 2017; National LGBTQ Task Force, 2017). Transgender people have also reported coverage refusals for non-transition-related healthcare services as well (If/How/When, 2017).

A frequently-overlooked aspect of transmasculine people's reproductive healthcare is one connected to reproductive justice – the ability of relevant trans men and non-binary people

to access safe, legal, trans-affirmative, and affordable birth control and abortion services, particularly for those who are working-class, poor, and/or disabled (Hartofelis & Gomez, 2013; National LGBTQ Task Force, 2017; Weerawardhana, 2016). This access is under particular jeopardy during the current Presidential Administration, under which opponents to reproductive justice aims continue to work to strip access to (and coverage for) birth control and abortion services (National LGBTQ Task Force, 2017). A number of states and nonprofits have also posed legal challenges to the Section 1557 regulation's extension to gender identity protections using the Religious Freedom Restoration Act (Pieklo, 2017).

2.3 Equal Employment Opportunity, Housing, and Bathroom/Locker Room Access in Schools

In 2010, under the President Barack Obama Administration and through an extension of sex-based discrimination protection in federal employment under Title VII, employment discrimination based on gender identity was explicitly banned in the context of federal employment (American Civil Liberties Union, 2015; If/When/How, 2017; Office of Personnel Management, Equal Employment Opportunity Commission, Office of Special Counsel, and the Merit Systems Protection Board, 2015; United States Office of Personnel Management, 2017b). Further, "in 2015 the U.S. Department of Housing and Urban Development instructed homeless shelters to respect self-identified genders" (If/When/How, 2017, p. 7).

In 2016, under the President Barack Obama Administration, guidance issued by the Department of Justice and Department of Education had interpreted Title IX sex-based discrimination protections to offer transgender students the right to use public school bathrooms and locker rooms concordant with their gender identities (If/When/How, 2017). However in 2017, under the President Donald J. Trump Administration, this guidance was revoked by a joint decision of the Department of Education and Department of Justice (If/When/How, 2017). Currently, the validity of this revocation is under judicial review and, in the interim, decisions about transgender students' bathroom and locker room access in public schools are being made on a state-by-state (and local municipality) basis (If/When/How, 2017).

2.4 The REAL ID Act, Passports, and Social Security Cards

In 2005, REAL ID Act legislation was passed by Congress in order to make it more difficult to obtain and use fake IDs (If/When/How, 2017). The legislation was resisted by some trans advocacy organizations, as its multiple document and state-matching identity verification system may lead to outing and falsely flagging trans people who have multiple state IDs with discrepant sex markers (American Civil Liberties Union, 2015; If/When/How, 2017).

In 2010, the U.S. State Department instituted a policy allowing transgender individuals, who provide proof that they are undergoing or have obtained prior clinical treatment for gender transition, to obtain a passport in accordance with their gender identity (American Civil

Liberties Union, 2015; If/When/How, 2017). Sex-reassignment surgery is no longer required and cases are assessed on a more individualized basis (If/When/How, 2017).
Social Security Administration Guidelines allow transgender individuals to change the sex marker associated with their Social Security Card, provided that they provide proof of identity, complete required paperwork, proof of U.S. citizenship or proof of immigration status and right to work in the U.S., and proof that they either:

1) are undergoing or have obtained prior clinical treatment for gender transition (this requirement is waived for those who are unwilling or unable to pursue medically-facilitated transition);
2) provide a current and legal passport with a sex marker consistent with their current gender identity, or ;
3) can provide a state-issued birth certificate (or court order for such a certificate) with a sex marker consistent with their current gender identity (If/When/How, 2017).

2.5 US Census and Gauging the Size of the Transgender Population

In a review published in the esteemed medical journal, *The Lancet,* which garnered attention and further media circulation by the World Health Organization (Balakrishan, 2016), Reisner and colleagues (2016) proposed key initiatives for moving transgender health (and research focusing on transgender health) forward on a global scale. These initiatives focused upon: ensuring that we have accurate estimates of the size of the transgender population across the world; understanding that transgender health, stigma, and human rights are intertwined; elucidating specific forms of stigma and human rights violations transgender people across the world face; ensuring that transgender people are able to legally access and receive adequate healthcare services; and taking a more holistic research approach to transgender health that includes transgender individuals as full participants rather than as subjects (Reisner et al., 2016). In 2017, the United States seemed poised to make progress on at least one of these key initiatives—developing more accurate estimates of the size of the transgender population in the United States.

Early in 2017, the United States Census Bureau released a draft of proposed 2020 Census and American Community Survey questions for Congressional review. In the appendix of this document (United States Census Bureau, 2017, p. 73), questions on sexual orientation and gender identity were proposed for possible inclusion for the first time in the history of the Census.

Media outlets were quick to report on this striking new development (Dinan, 2017b). Within hours, however, the United States Census Bureau, under the new President Donald J. Trump Administration, issued a quick reversal (Dinan, 2017a), insisting that the initial inclusion of these questions in the appendix had been inadvertent and that there was “no federal data need” to gather such information (Thompson, 2017). As such, the questions would not be included on the 2020 Census.

Outcry from the public, LGBTQ advocacy organizations, and Congressional Democrats swiftly followed and, in September 2017, it was announced that the United States Census Bureau would include a question on sexual orientation on at least one of the surveys it administers (Wang, 2017). The proposed question is not, however, slated for inclusion on either the 2020 Census or the American Community Survey. Further, there is no planned inclusion of any questions on gender identity on any United States Census Bureau survey as of this writing.

2.5 Hate Crimes, Criminal Justice and Incarcerated Populations

Since 2009, gender identity had been included under the federal hate crimes law, "which means that the federal government assists local law enforcement in investigating and prosecuting crimes where the victim was targeted because of their gender identity, and people who commit such crimes may be subject to tougher penalties" (American Civil Liberties Union, 2015, pp. 15-16).

Since 2011, federal policy has stipulated that transgender prisoners have a right to formal medical evaluation to determine whether or not they require medical treatment for gender dysphoria. If it is determined that they do, they must be provided with such services and treatment, including access to hormonal and surgical treatments (American Civil Liberties Union, 2015). According to the Department of Justice, transgender prisoners must also be given consideration (under the Prison Rape Elimination Act) of where they will be detained, "taking into account factors like personal preference and safety needs, not solely based on their genitals" (American Civil Liberties Union, 2015, p. 18).

Importantly, more research is needed to address whether or not trans men and non-binary inmates, who become pregnant either before or during incarceration are receiving appropriate and trans-affirmative pregnancy care.

3. State Policies

3.1 Gender Identity and Non-Discrimination

In the United States, only nineteen states and Washington D.C. have banned gender identity-based discrimination (If/When/How, 2017). Further, a number of states have proposed or implemented legislation that directly negatively impacts transgender people and/or strips them of their rights. For example, in 2016 North Carolina passed House Bill 2 ("HB2"), which requires trans people "to use bathrooms in schools and other public facilities that correspond with the gender assigned to them at birth" (If/When/How, 2017).

Only six states (California, Colorado, Oregon, Vermont, Connecticut, Maryland) and Washington D.C. have offered state-specific interpretations of the gender identity non-discrimination clause of the Affordable Care Act (If/When/How, 2017). In these states, insurers must broadly cover transition-related services; insurer coverage for such services outside of these states and Washington, D.C. remains inconsistent (If/When/How, 2017).

3.2 Name Changes, Sex Markers and Sterilization

Legal name changes and changes to sex markers on birth certificates are processed at the local municipal level,and state policies vary considerably on what is required to legally change one's name and/or sex marker on a birth certificate. Legal name changes generally require an individual to file a court petition and to publish a notice of legal name change in their local newspaper in advance of their court hearing. While neither required nor common, some judges have purportedly requested that transgender applicants for legal name change provide medical documentation related to their transition (American Civil Liberties Union, 2015). Changing the sex marker on one's birth certificate is generally more complicated than legally changing one's name.

In many if not most states, transgender individuals must provide proof of gender-transition-related surgical treatment in order to have the sex marker on their birth certificate changed. A number of states even require sex reassignment surgeries that would result in sterilization. Some trans and reproductive justice advocates view such policies as a form of state-sanctioned, anti-trans, forced sterilization, especially for those trans people who are unable to afford the cost of harvesting and retrieving eggs or sperm prior to such surgeries (National LGBTQ Task Force, 2017).

Further, some states refuse to change sex markers on their birth certificates at all (e.g., Idaho, Ohio, and Tennessee) and others will only issue an "amended" certificate of birth (e.g. Alabama) which essentially flags the components of the birth certificate that have been amended, thereby not allowing transgender people in those states to have privacy with regard to their history of gender transition (American Civil Liberties Union, 2015).

Further complicating these matters, obtaining a birth certificate with a sex marker that corresponds to one's gender identity has not always translated to full legal status as a member of that sex category. For example, prior to federal legal recognition of same-sex marriage in the United States following the 2015 Obergefell v. Hodges Supreme Court decision, some judges refused to consider an amended or legally-changed sex marker on a birth certificate when determining the validity of a marriage to someone of the "opposite" sex (American Civil Liberties Union, 2015).

3.3 Parental Rights

Parental legal rights, often tied to marital status, have largely been a matter attended to by the states and local municipalities as well. Federal legal recognition of same-sex marriage expanded marital and, hence, parental possibilities.

There continues to be, however, widely discrepant policies regarding who counts as a mother or father on legal documents such as birth certificates (Cascio, 2014; Taffet, 2015). Some legal rulings in parent custodial cases have exhibited discriminatory rulings against transgender parents under the assumption that children raised by transgender parents are placed under harm or potential harm (American Civil Liberties Union, 2015). Recent legal rulings have determined that designators such as "mother" and "father" should be replaced or addended to include "Parent 1" and "Parent 2," while others have reversed or contested such rulings (Taffet, 2015).

4. Nonprofit and Professional Medical Association Policies and Guidance

Medical care providers are on the front line for providing reproductive healthcare services to transgender clients. Unfortunately, transgender individuals often report issues with healthcare providers' anti-trans stigma, discrimination, and ignorance (Cascio, 2014; Estevez & Taylor, 2017; If/When/How, 2017; National Center for Transgender Equality, 2012; National LGBTQ Task Force, 2017; Richards, 2014; smith, 2016).

Given the need for culturally-competent and trans-affirmative reproductive health services for trans men and non-binary people, a number of nonprofit and professional medical associations have developed policy statements and/or guidance around this population. These nonprofit and professional medical associations hold particular relevance in the United States given the consumer marketplace-focused, decentralized, and diffuse provision of medical care services in the absence of a universal healthcare system for citizens at the present time.

4.1 World Professional Association for Transgender Health (WPATH)

The World Professional Association for Transgender Health (WPATH), originally named the Harry Benjamin International Gender Dysphoria Association (HBIGDA), is best known for its development of *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Pertaining largely to advisement around medically-facilitated gender transition, the *Standards of Care* recommend that patients provide medical professionals with one letter from a mental health professional prior to the initiation of hormone therapy, one letter from a mental health professional for top surgery, and two letters from a mental health professional for genital surgeries (If/When/How, 2017). Medical professionals

providing transition-related hormone and surgical therapies are not required to abide by WPATH recommendations and some trans advocacy groups and medical professionals view the recommendations as unnecessary gatekeeping (If/When/How, 2017).

The *Standards of Care* were first developed in 1979 and the most recent (seventh) revision was published in 2011. This 112-page manual offers just over one page of guidance specifically on reproductive healthcare, focusing largely upon the importance of medical professionals' consideration of their trans patients' fertility preservation options prior to initiation of hormone therapy and/or surgical procedures involving reproductive organs. The *Standards of Care* also underline the dearth of existing research on transgender-specific reproductive healthcare. Importantly, the *Standards of Care* note that "transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason" (World Professional Association for Transgender Health, 2011, p.51). Further, a 2016 Position Statement on "Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." defined gender transition-related hormonal and surgical procedures as explicitly non-cosmetic, non-experimental, and medically-necessary (World Professional Association of Transgender Health, 2016).

4.2 Planned Parenthood

Planned Parenthood is a nonprofit organization that provides access to reproductive healthcare and sexual health information and services.

In 2006, affiliate group Planned Parenthood of the Southern Finger Lakes released a transgender healthcare guide, "Providing Transgender-Inclusive Healthcare Services." [1] While not an official organizational policy per se, this manual offers guidance on offering trans-inclusive and trans-affirmative healthcare. For example, the guide addresses the importance of providing trans-inclusive intake forms, using preferred names and pronouns, providing unisex restroom facilities, and use of trans-affirmative language for body parts. The guide also addresses the responsibility of providers to pursue additional training and education regarding transgender healthcare, including becoming more informed about potential drug interactions and side effects that may occur when transgender patients are taking particular hormones or hormone blockers.

The guide takes a holistic approach to understanding trans-affirmative healthcare, noting the critical importance of healthcare provider attention to the potential role of violence, poverty, lack of insurance (and underinsurance), HIV and STIs, tobacco and substance use and abuse, suicidal ideation and attempts, limited research on trans health, and limited access to appropriate mental and physical healthcare in the lives of trans people. Ultimately,

[1] https://www.plannedparenthood.org/files/4414/0606/9716/PPSFL_Providing_Transgender_Inclusive_Healthcare_Handbook.pdf

the guide provides suggested information and resources for both providers and patients of transgender healthcare services.

Notably, the guide does not focus, per se, on the provision of particular healthcare services and it does not specifically address the reproductive healthcare needs of trans men—including access to breast/chest care, pap smears, pelvic exams, STI testing and treatment, infertility treatment, contraception, hysterectomy, hormone treatment, abortion, and prenatal, antenatal, childbirth, and postnatal care.

Planned Parenthood is included in this review because its services have been so vital in providing reproductive healthcare in the United States, particularly to poor and underserved populations and communities. Further, federal and state funding and support for the continuing provision of comprehensive reproductive health services in the United States, including those provided by Planned Parenthood, have been increasingly under fire as opponents of these services invoke Targeted Regulations of Abortion Providers (aka "TRAP laws"), the Hyde Amendment, and the federal Religious Freedom Restoration Act to argue against them in the courts (National LGBTQ Task Force, 2017).

4.3 American Medical Association (AMA)

Like many other reproductive healthcare providers outlined in this review, the AMA advocates following the WPATH *Standards of Care* (If/When/How, 2017).

In 2016, the A*merican Medical Association Journal of Ethics* published an article on fertility preservation and transgender reproductive choice (Mitu, 2016). With direct reference to transgender men's reproductive healthcare, this article engaged with the topics of: egg harvesting and retrieval; trans men as gestational parents and using gestational surrogates to carry their genetically-related offspring; issues of access (including material constraints and the high cost and limited insurance coverage of some transgender reproductive health services); the existence of anti-trans stigma and discrimination among medical professionals; and needed services in the areas of "contraception, conception, abortion, and childbirth-related health problems" (Mitu, 2016, p. 1122). The focus on contraception may be particularly important given the not-uncommon and incorrect presumption that hormone therapy (testosterone administration) alone, for trans men, always results in anovulation (Amato, 2016).

Mitu (2016, p. 1123) offers further guidance:

> The discourse on transgender reproduction and parenting should not be reduced to the discourse of fertility preservation or assisted reproductive technologies…Rather, social stigma and structural and legal barriers should be eliminated for all procreating and family-making options for the transgender population. Barriers should also be eliminated for multidisciplinary collaborative efforts to address transgender reproductive issues.

Mitu (2016) is a groundbreaking publication insofar as the highly-influential American Medical Association directly proposes transgender reproductive health and choice as critical issues with regard to medical ethics.

4.4. American College of Obstetricians and Gynecologists (ACOG)

The Code of Professional Ethics of the American College of Obstetricians and Gynecologists (2011a) states: "the principle of justice requires strict avoidance of discrimination on the basis of… perceived gender". Its "Committee Opinion on Health Care for Transgender Persons" further affirms that: "ACOG opposes discrimination based on gender identity" (The American College of Obstetricians and Gynecologists, 2011b).

ACOG has released a number of Committee Opinions with direct relevance to transgender reproductive healthcare. These have focused on endorsing WPATH *Standards of Care* (2011b), providing general information about healthcare for transgender individuals (2011b, 2011c), and creating welcoming and positive environments for transgender adolescents (2016).

Notably, none of the ACOG Committee Opinions engages substantively with trans men's reproductive healthcare needs outside of those focusing on standard gynecological (i.e. pap smears and breast and pelvic exams), transition-related care (e.g., administration of hormones), or prevention of unwanted pregnancy (i.e., contraception) and sexually-transmitted infections. Discussion of abortion, fertility preservation, and pregnancy, childbirth, and postpartum care specifically for trans men is notably absent from these communications.

4.5 American College of Nurse-Midwives (ACNM)

Given, in part, the challenges in accessing trans-affirmative and trans-informed reproductive healthcare from traditionally-trained physicians, some trans people proactively seek reproductive healthcare from nurse-midwives.

Historically, midwives in the US have focused on providing reproductive healthcare from a distinctly feminist perspective, differentiating this profession from the perspectives and approaches of reproductive health practitioners trained in more traditional medical models. Midwifery care also tends to take a more holistic approach to pregnancy, focusing on prenatal, antenatal, and postnatal periods as well as bonding and attachment between infants and caregivers. In this way, midwifery may be particularly well-suited to engage in under-researched topics in trans men's reproductive care—for example, lactation and/or chest feeding following birth.

While the feminist traditions and commitments of midwifery might position it as an ideal alternative for provision of culturally-competent and trans-affirmative reproductive healthcare, midwifery's focus on women and mother-centered care provision also presents

significant challenges for some populations of potential clients (Jezer-Morton, 2017). The place of trans men within such practices, for example, has recently been called into question.

In 2012, the American College of Nurse-Midwives (ACNM) released a position statement on transgender/transsexual/gender variant healthcare. In this position statement, the ACNM officially endorsed the WPATH 2011 *Standards of Care*. Rather than offering specific guidelines on reproductive healthcare practice with transgender clients, the ACNM (2012) point to the dearth of existing research on this topic: "the under-reported and under-researched reproductive healthcare needs of gender variant individuals are of particular interest to midwives. Qualitative studies and anecdotal evidence confirm that gender variant individuals desire parenting roles and can and do create biological families."

The policy statement (ACNM, 2012) further asserts that breast and pelvic care for trans people "is typically straightforward but in some cases requires additional training." The ACNM position statement further commits to enhanced training and education of trans healthcare providers and attention to the structural and systemic dimensions of trans reproductive healthcare. For example, ACNM supports "legislation and policies that prohibit discrimination based on gender expression or identity and measures to ensure full, equal, and unrestricted access to health insurance coverage for all care needed by gender variant individuals."

4.6 Midwives Alliance of North America (MANA) and Woman-Centered Midwifery (WCW)

In 2014, the Midwives Alliance of North America (MANA) revised their Core Competencies. The revision included gender-inclusive language. An example of gender-inclusive language in the context of trans men's reproductive healthcare might include shifting from language such as "mother" or "pregnant woman" to language such as "pregnant individual" and "birthing parent."

While many applauded this change toward greater inclusivity, another group of midwives – Woman-Centered Midwifery (2015) – issued an open letter to MANA expressing their reservations. According to the letter, which invited others to sign: "Pregnancy and birth are distinctly female biological acts; only women and female-bodied people can give birth…. We urge MANA to reconsider the erasure of women from the language of birth." MANA (2015) subsequently posted their response, as well as rebuttals from other sources (Birth for Every Body, 2015), to the WCW open letter on their website.

This internal debate among midwives underlines the point that reproductive healthcare for transmasculine people is often a contested minefield, even in spaces that would seem most likely to offer support and understanding.

5. Additional Research Gaps and Future Directions

As transgender individuals obtain increasing social, familial, and medical professional acceptance and support, they are likely to begin to transition at younger ages. While hormonal suppression is often viewed as the gold standard for transgender healthcare among transgender youth, it poses some unique challenges for those who may wish to become biological parents.

There is currently no way to harvest and retrieve eggs and sperm from those who have not yet undergone natal puberty (Amato, 2016; Estevez & Taylor, 2017). This means that young people who have engaged in hormonal suppression would be required to suspend suppression, undergo natal puberty, engage in gamete harvesting and/or retrieval, and then continue with hormonal suppression and/or supplementation in order to pursue biological parenthood (Amato, 2016; Estevez & Taylor, 2017). Such a trajectory may carry significant personal and interpersonal instability as well as consequences for health and wellbeing. To this end, more research is needed on the pathways to parenthood for transgender individuals who pursue hormonal suppression and/or transition in youth. Further, additional research on assisted reproductive technologies might explore methods for achieving gamete maturation without requiring transgender individuals to undergo natal puberty. Entities responsible for drafting policies associated with gender transition amongst youth should take these issues under consideration.

Existing literature also points to the need for additional research, best practice guidelines, and policies addressing optimal prenatal, antenatal, childbirth, and postnatal practices and care for trans men who give birth (Obedin-Maliver & Makadon, 2015). Because many providers are generally under-educated when it comes to providing care for their trans patients, patients have developed their own tools for connecting themselves and others to trans-affirmative reproductive healthcare providers. For example, the website Trans Birth[2] was developed to connect trans people to midwives, doulas, obstetricians, gynecologists, and other reproductive healthcare providers who are committed to providing welcoming and trans-affirmative childbirth services.

It is clearly time to move beyond questions as to whether or not trans people should have the right to have biological children, and instead begin to look at the processes and mechanisms that generate favorable and unfavorable reproductive experiences and outcomes. Examples of particular topics on which future researchers might focus include: the impact of transition-related hormone treatment on fertility, pregnancy, lactation, postpartum recovery, and fetal/infant outcomes; trans-affirmative birthing care practices; chest feeding and other methods for providing infant nutrition; the role of partners and families (including families of choice) in supporting trans prenatal, pregnancy, childbirth, and postpartum care; and development of effective trans-affirmative education and training programs and policies for reproductive healthcare providers.

[2] http://www.transbirth.com

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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**.