Access to Assisted Human Reproduction (AHR) Services for Trans People in Ontario

by

Sarah James-Abra

A thesis submitted in conformity with the requirements for the degree of Master of Social Work
Factor-Inwentash Faculty of Social Work
University of Toronto

© Copyright by Sarah James-Abra 2012
Access to Assisted Human Reproduction Services (AHR) for Trans People in Ontario

Sarah James-Abra

Master of Social Work

Factor-Inwentash Faculty of Social Work
University of Toronto

2012

Abstract

There is a dearth of research that explores the lives and experiences of trans-identified parents. The goal of this study was to explore the experiences of trans people who sought or accessed AHR services in Ontario between 2007 and 2010. Qualitative data that was collected from 7 qualitative interviews with 9 trans people and their partners was analyzed for the present analysis. Results from this study indicate that AHR providers do not possess sufficient knowledge about trans people, trans identities and trans lives to adequately address the needs of trans service users. Specific provider practices that trans people experienced as being unhelpful are illuminated and implications for improving clinical practices are discussed.
ACKNOWLEDGMENTS

This thesis came to fruition due to the intellectual, emotional and material support I received from several people whom I would like to thank. To Dr. Lori Ross and Dr. Shelley Craig, for their continual guidance, support and encouragement during the past year. I could not have weathered the storm without them. To Dr. David Brennan, for his constructive feedback and valuable insights. To Dr. Sheila Neysmith, for tirelessly responding to my e-mail inquiries and for her participation on my defense committee. And finally, to Renáta, for being my rock.
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS**........................................................................................................................................... iii

**TABLE OF CONTENTS**................................................................................................................................................ iv

**LIST OF TABLES**.................................................................................................................................................... vii

**LIST OF APPENDICES**........................................................................................................................................ viii

**CHAPTER ONE**.......................................................................................................................................................... 1

1 **Introduction**........................................................................................................................................................................... 1

1.1 Background............................................................................................................................................................................. 2

1.1.1 *Trans People in Ontario*................................................................................................................................................... 2

1.1.2 *Trans People in the Workplace*........................................................................................................................................ 3

1.1.3 *Discrimination and Harassment*..................................................................................................................................... 4

1.2 Trans-led Families.................................................................................................................................................................... 5

1.3 Reproductive Options for Trans People............................................................................................................................. 7

1.4 Trans People and Assisted Human Reproduction........................................................................................................ 9

1.5 Trans People and Health Care........................................................................................................................................... 11

1.6 Theoretical Framework.......................................................................................................................................................... 14

1.7 Current Study....................................................................................................................................................................... 16

**CHAPTER TWO**............................................................................................................................................................. 18

2 **Method**........................................................................................................................................................................... 18

2.1 Methodological Approach.................................................................................................................................................. 18

2.2 Participants........................................................................................................................................................................ 20

2.3 Recruitment....................................................................................................................................................................... 20
CHAPTER THREE .......................................................................................................................... 26

3 Results........................................................................................................................................ 26

3.1 Influence of Gender Identity on Decision to Build a Family Through the use of AHR Services......................................................................................................................... 26

3.2 Gender Transition and the Creation of a Family Through the use of AHR........ 28

3.2.1 Impact of Gender Transition on Fertility Planning......................................................... 29

3.2.2 The Absence of Information on the Effect of HRT on Fertility................................. 31

3.3 Accessing AHR Services........................................................................................................ 34

3.3.1 Researching Reproductive Options................................................................................ 34

3.3.2 Selecting an AHR Clinic................................................................................................... 35

3.4 Interactions With AHR Providers........................................................................................ 37

3.4.1 Problems with Clinical Documentation......................................................................... 38

3.4.2 “Their baseline is that women get pregnant and men give sperm” – The Impact of Providers’ Cisnormative and Heteronormative Assumptions.. 41

3.4.3 Fertility Counseling.......................................................................................................... 45

3.4.4 Positive Experiences with Providers................................................................................ 48

3.5 Strategies for Navigating Instances of Transphobia and Cissexism............................... 49

CHAPTER FOUR .................................................................................................................................. 52

4 Discussion..................................................................................................................................... 52

4.1 Decision to Choose AHR Over Other Methods................................................................. 54

4.2 The Absence of Information on Trans Health Issues......................................................... 55
4.3 Positive Experiences with AHR Providers ................................................................. 58
4.4 Self-Advocacy ............................................................................................................ 58
4.5 Implications for Reproductive Planning and Access to Information about Trans Parenting .......................................................... 59
4.6 Implications for Service Provider Education ......................................................... 61
4.7 Providing Culturally Competent Care to Trans People and their Partners .......... 62
  4.7.1 Implications for AHR Service Providers .......................................................... 62
  4.7.2 Implications for Social Work Practice ............................................................ 63
4.8 Study Limitations and Directions for Future Research ........................................ 65

CHAPTER FIVE ................................................................................................................ 68

5 Conclusion .................................................................................................................... 68

REFERENCES .................................................................................................................. 69

APPENDIX A .................................................................................................................... 78

APPENDIX B .................................................................................................................... 79
Table 1  Selected Participant Demographic Information

Table 2  Key Themes
# List of Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A</td>
<td>Creating Our Families Recruitment Flyer</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Creating Our Families Qualitative Interview Guide</td>
</tr>
</tbody>
</table>
CHAPTER ONE

1 Introduction

An emerging body of literature explores lesbian, gay and bisexual (LGB) individuals’ experiences of becoming parents through the use of Assisted Human Reproduction (AHR) services, such as sperm banks and fertility clinics. In contrast, relatively little is known about transgender people’s experiences of using or attempting to access AHR. The present study aims to address this gap in knowledge through an analysis of interviews with trans people who have recently used or attempted to access AHR services in Ontario, Canada. Unlike LGB people, who typically access AHR services only at the point of family creation, transgender individuals may also access AHR services to preserve reproductive material prior to initiating their gender transition. Transgender people are among the most marginalized and stigmatized groups in present day society (Bauer, et al., 2009; Shelley, 2008) and as such, it is important to acknowledge the different ways in which their experiences may both intersect and diverge from those of LGB people.

Trans is used as an umbrella term to refer to individuals whose lived experience of their gender diverts from what is considered socially or culturally appropriate for people of their perceived sex (Bauer et al., 2009; Fassinger & Arseneau, 2007). Transgender may refer to “transsexual, transitioned, transgender and genderqueer people as well as some two-spirit people” (Bauer et al., 2009, p. 348-349). However, not all people who may be defined by the term “transgender,” identify themselves as such. Throughout this paper, “trans” will be used as shorthand when referring to transgender people.
1.1 Background

1.1.1 Trans People in Ontario

It is difficult to determine the number of trans people living in Canada. Trans-identified people are not routinely counted in national statistical data (Vanderleest & Galper, 2009). Further, studies examining the lives and experiences of trans-identified people tend to rely on convenience samples (Clements-Noelle, Marx, Guzman, & Katz, 2001) or focus only on those individuals who have sought sex reassignment surgery (SRS) or hormones (Bauer et al., 2010). Statistical data from research conducted in the Netherlands are often cited in the literature, which suggest that the prevalence of female-to-male (FTM) transsexualism is 1 in 30,400 and 1 in 11,900 for male-to-female (MTF) (Bakker, Van Kesteren, Gooren, & Bezemer, 1993, as cited in Bauer et al., 2009). Based on these calculations, there should be approximately 615 trans people living in the province of Ontario, Canada. However, a recent survey of trans people in Ontario revealed that more than 615 transgender and transsexual people currently receive health care services from a community health centre located in downtown Toronto (Bauer et al., 2009). These findings suggest that the statistical data from the Netherlands may provide an inaccurate representation of the number of trans people living in Canada and the frequent use of these numbers in the literature may perpetuate the notion that trans identities are less common than they are.

The most recent and comprehensive information about trans people living in the province of Ontario was collected for the Trans PULSE research project. Trans PULSE was a community based research project, which sought to investigate the impact of social exclusion and discrimination on the lives of trans people living in Ontario. A total of 433 trans people age 16 or older participated in the project between April 2009 and May 2010 (Bauer et al., 2010). The
majority of respondents were between the ages of 16-24 (34%) and 81% were born in Canada. Although the majority of the province’s trans-specific resources are available in the Greater Toronto Area (GTA), 68% of trans people live outside of this area. The sexual orientations of trans people were diverse: 31% identified as queer, 30% identified as heterosexual and 30% identified as bisexual or pansexual. Female-to-males were more likely to identify as queer (46%) and male-to-females commonly identified as bisexual or pansexual (40%) (Bauer et al., 2010). Twenty-seven per cent of Trans PULSE respondents reported being parents, the majority of whom (40%) were MTF identified.

1.1.2 Trans People in the Workplace

Results from the Trans PULSE study demonstrated that although the majority of Ontarian trans people have a post-secondary education (36%), 50% of participants reported a personal annual income of $15,000 or less. The disparity between Ontarian trans people’s level of education and annual income is at least partially explained by workplace discrimination and the unique barriers that trans people face when seeking employment. Twenty-three percent of participants in the Trans PULSE project reported that they are able to pass as cisgender less than 50% of the time (Bauer et al., 2011). Cisgender refers to individuals “who are not transgender” (Serano, 2007, p. 33). Individuals’ inability to pass increases the likelihood that they will experience workplace harassment and discrimination from colleagues and employers. Trans people also face challenges around the disclosure of their gender identity in the workplace (Bauer et al., 2011). When applying for job opportunities, prospective candidates are generally required to provide proof of their past work experiences as well as their education and relevant credentials. In order to provide this documentation, trans people must navigate the complicated task of accessing documents that may have been created prior to their social and medical
transition process. As a result, they are faced with difficult decisions regarding the ways in which they can limit disclosure of their gender identity to future employers. Twenty-eight percent of Trans PULSE participants reported that they were unable to attain references from previous employers with their current name and gender (Bauer et al., 2011). Disclosure of one’s trans identity is not only stressful but it may potentially result in harassment and discrimination (Bauer et al., 2011; Lombardi, Wilchins, Priesing, & Malouf, 2001). Trans people may endure physical or verbal assault, intimidation from coworkers, violation of their personal privacy or termination of their employment as a consequence of disclosing their gender identity (Lombardi et al.). Trans people’s experiences in the workplace and their ability to attain gainful employment may influence their access to AHR services, as these services are cost prohibitive.

1.1.3 Discrimination and Harassment

Trans people are vulnerable to harassment and abuse because their gender presentation does not adhere to dominant understandings of what is acceptable for persons of their perceived biological sex. The Trans PULSE project found that 33% of trans people had experienced verbal harassment or threats during their lifetime, while 47% had experienced physical or sexual assault during their lifetime (Scanlon, Travers, Coleman, Bauer, & Boyce, 2010). Trans people’s experiences of violence and harassment are positively correlated with their suicidal behaviours (Clements-Nolle, Marx & Katz, 2006; Scanlon et al.). Those individuals who reported experiences of physical or sexual assault because of their gender identity on the Trans PULSE questionnaire were seven times more likely to have attempted suicide within the past year than trans people who had not experienced trans-related violence or harassment (Scanlon et al.).

The prevalence of attempted and completed suicides among trans communities is the most startling indicator of the impact of discrimination and social exclusion on the health and
lives of trans individuals. Results from the Trans PULSE project indicate that among trans Ontarians age 16 years or older, 77% have seriously considered suicide during their lifetime and 50% have seriously considered suicide due to their gender identity (Scanlon et al., 2010). Trans youth age 24 years and younger were twice as likely than adults age 25 years or older to have contemplated suicide within the past year and were nearly three times as likely to have attempted suicide within the past year (Scanlon et al.). The findings from the Trans PULSE project are consistent with other literature that has examined the prevalence of suicide and gender-based discrimination (e.g., Ainsworth & Spiegel, 2010; Lombardi et al., 2001; Clements-Nolle et al., 2006). For example, Clements-Nolle et al. examined predictors of attempted suicide among 515 trans people living in San Francisco, California. The authors found that the prevalence of attempted suicide was 32%.

1.2 Trans-led Families

There has been limited exploration of the lives and experiences of trans parents in the literature. The majority of research on trans parenting has focused on the psychological wellbeing and sexuality of the children of trans parents (e.g., Cameron, 2006; Green, 1978; White & Ettner, 2007). A comprehensive review and critique of this literature can be found elsewhere (see Pyne, 2011a and Pyne, 2011b). As demonstrated by the discussion above, discrimination, harassment and violence has a profound impact on individuals whose gender identity does not conform to widely held cultural beliefs. However, little is known about the ways in which these factors influence the lives of trans parents.

In an effort to address the gap in knowledge about trans families, Pyne (2011c) conducted the Transforming Families project. Pyne facilitated four focus groups with 18 trans parents in Toronto, Ontario between November and December 2010. Participants discussed the challenges
that they encounter as trans parents and highlighted many of the strengths that they offer as parents. Participants’ narratives varied depending on whether they had initiated their gender transition before or after the birth of their children. Those who began their gender transition after creating a family articulated their concerns about the potential negative impact of their transition on their children. Despite their concerns, many participants felt that they were better able to care for both their own needs as well as the needs of their children after coming-out and initiating their transition process. In this way, transitioning became something that they did for, rather than to, their children. Although many trans parents experienced significant challenges after transitioning, several participants reported that their relationships with their children gradually improved with time.

Trans parents who created their families after they had transitioned reported challenges and decision-making processes that were unique to their situation. One participant stated that their process of transition fostered their desire to become a parent because they could not see themselves as parent until after their transition. None of the participants involved in the project pursued adoption as a method for creating their families due to fears that transphobic attitudes would present a significant barrier to successful adoption (Pyne, 2011c). Instead, the participants and their partners utilized AHR services to create their families. After the birth of their children, the parents encountered institutional barriers that prevented them from declaring their parentage. The current format of birth certificates in Ontario do not acknowledge a trans woman’s relationship to her child as a biological mother who contributed sperm or a trans man’s relationship to his child as biological father who gave birth (Pyne, 2011c). These significant barriers illuminate the ways in which trans people problematize conventional understandings of parenthood because their bodies do not adhere to binarisms of sex and gender.
Perhaps the most significant contribution of the *Transforming Family* project is its discussion of trans parents’ strengths. A common theme that emerged from many of the parents’ narratives was that, due to their experiences as gender non-conforming people, their children would learn to live authentically and would hopefully grow up to be unashamed of who they are as people. Many of the parents shared that through their own process of coming-out and developing their sense of self, they had learned the value of self-reflection. This process fostered self-awareness that was fundamental to who they became as parents and as people, which they perceived as an invaluable gift to share with their children. The parents also felt confident that their children would advocate on behalf of others because they would develop a greater understanding of social injustices than some of their peers (Pyne, 2011c).

### 1.3 Reproductive Options for Trans People

As previously mentioned, trans people generally access AHR services for one of two reasons. First, prior to, or during their transition process, trans people may wish to preserve gametes or reproductive tissues for future use. Second, AHR services may be utilized at the point of attempting to have children. Given the lack of clinical evidence regarding the long-term effects of hormone therapies (refer to section below on Trans People and Health Care), it has been recommend that trans people receive counseling regarding their fertility options prior to initiating hormone therapies (De Sutter, 2001; De Sutter, 2009; De Sutter, Kira, Verschoor & Hotimsky, 2002; Hembree et al., 2009).

In general, reproductive options for trans women include cryopreservation of testicular tissue and cryopreservation of sperm. To date, the efficacy of testicular tissue cryopreservation remains unknown and no live births have resulted from this method (Snyder & Pearse, 2011). As a result, cryopreservation of sperm offers the most viable option for trans women wishing to
preserve their reproductive material (De Sutter, 2009; Snyder & Pearse). Cryopreservation of ovarian tissue, embryos and oocytes (eggs) are options potentially available to trans men who wish to preserve genetic material. The benefit of ovarian tissue cryopreservation is that it does not require follicle stimulation, which can be both a painful and invasive procedure. Additionally, and it can be conducted during oophorectomy (the surgical removal of one or both ovaries) (De Sutter, 2001). However, like the cryopreservation of testicular tissue, ovarian tissue cryopreservation is an investigational method that has not resulted in live births (De Sutter, 2009; Neal, 2011; Snyder & Pearse). In addition, cryopreservation of ovarian tissue is not a viable option for trans men over the age of 30 because studies have found that ovarian tissues contain too few follicles (De Sutter, 2009). Oocyte banking has proven to be a very delicate process and eggs are vulnerable to chromosomal damage during the thawing process (De Sutter, 2001). As a result, oocyte cryopreservation involves costs associated with the removal and storage of oocytes with no guarantee of viability. Jain and Paulson (2006) report that the live birth rate for oocyte-cryopreservation is only 32.4%. Therefore, embryo cryopreservation remains the evidence-based best practice at this time (De Sutter, 2009; Jain & Paulson; Snyder & Pearse). However, embryo cryopreservation is often unrealistic for many trans men because it necessitates the creation of embryos before people are ready to become parents. This barrier is especially significant for trans men who initiate their gender transition during adolescence or early adulthood. Embryo cryopreservation also presents financial barriers for individuals who may need to access cryopreserved sperm in order to create embryos in addition to the costs associated with storage of the embryos.
1.4 Trans People and Assisted Human Reproduction

To date, an examination of transgender and transsexual people’s experiences using or attempting to access AHR remains absent from the literature. Instead, fertility specialists have debated the ethics of assisting trans people to become parents (Baetens, Camus, & Devroey, 2003; Brothers & Ford, 2000; De Sutter, 2001; Jones, 2000; Murphy, 2010). Brothers and Ford (2000) initiated the debate by reporting on a case where a trans man and his cisgender female partner attempted to access donor insemination. The authors questioned whether trans people are mentally fit to parent and suggested that considering the wellbeing of trans people’s future offspring is paramount. Citing the work of Green (1978), the authors concluded that trans people and their partners should be assessed using the same criteria as cisgender, heterosexual couples requesting access to AHR. In response to Brothers and Ford (2000), Jones (2000) argued that trans people are “refractory to psychiatric therapy” and often display “antisocial” and “aberrant” behaviour (p. 987). Jones referenced anecdotal evidence of a trans person who had engaged in petty theft both before and after receiving SRS to support his claim. Jones concluded that trans people should be evaluated on an individual basis but that the majority of trans people should be denied access to services.

Baetens et al. (2003) discussed the ways in which they evaluated the requests of seven trans people and their partners who wished to access AHR services at the Centre for Reproductive Medicine of the Dutch-speaking Brussels Free University. The authors recommended that AHR services should be limited to FTM trans people and their cisgender female partners and supported this claim by suggesting that FTMs exhibit fewer concurrent psychiatric disturbances and greater economic and relationship stability than MTFs. Additionally, Baetens et al. suggested that trans people should complete their medical transition
process prior to becoming parents in order to ensure the emotional stability of their children. Absent from the authors’ discussion were multiple considerations including the needs and desires of trans people themselves, the ways in which medical transition may effect their fertility and the fact that not all trans people wish to medically transition.

De Sutter (2001) became the first to acknowledge that debates among fertility experts over trans people’s ability to function as effective parents without negatively influencing the development of their children were insulting to trans people (p. 612). In keeping with the argument that all people have equal right to create a family (Schenker & Eisenberg, 1997 as cited in De Sutter, 2001) De Sutter argued that fertility experts should consider the ways in which they may assist trans people in creating a family. Acknowledging that hormonal treatments for trans people often result in infertility, De Sutter suggested that trans people should be provided with an opportunity to preserve reproductive material (e.g., oocytes, embryos, sperm or ovarian tissue) prior to initiating hormone treatment. In response to Baetens et al. (2003), De Sutter (2003) suggested that it might be doctors’ duty to fulfill trans people’s wish to become parents in order to combat “bigotry and prejudice that still exists among uneducated people” (p. 382). De Sutter reasoned that trans people have the same basic right to parenthood as any other members of society and that differential treatment for trans people requesting access to AHR will only perpetuate the marginalization of transgender and transsexual individuals.

In contrast to the literature on trans people and AHR, a growing body of research has examined the experiences of cisgender lesbian and bisexual people’s experiences using AHR services. Key findings from this research indicate that heterosexist barriers often prevent lesbian and bisexual women from accessing supportive fertility care (Chabot & Ames, 2004; Luce, 2010; Ross, Steele & Epstein, 2006a; Ross, Steele, & Epstein, 2006b). For example, if using
sperm from a known donor, Health Canada requires that the sperm be tested and quarantined for six months and the prospective parents are required to pay for the cost of testing and storage (Ross et al., 2006a). This regulation is not only cost prohibitive but it delays parents’ process of trying to conceive. Additionally, many lesbian and bisexual women are subjected to multiple tests and examinations that are tailored toward women with known infertility when they present at fertility clinics (Ross et al., 2006b).

While the wellbeing of children conceived using AHR technologies should be taken into consideration, the expectation that trans people should conceive, gestate and raise children without any problems ever occurring is completely unreasonable. Risks occur for all parents. Murphy (2010) argues that “the knowable risks” in the case of trans parenting “do not set this kind of parenting apart from others” (p. 55). Social discourses pertaining to who or what is perceived as normal or abnormal should not dictate who is eligible to become a parent (Murphy). In the absence of any sound empirical evidence demonstrating that the wellbeing of the children of trans people is severely compromised by virtue of their parents’ gender identity, the continuation of such argumentation is groundless and only serves to perpetuate transphobia and cissexism1.

1.5 Trans People and Health Care

Within health care, trans people encounter discrimination on structural, institutional and interpersonal levels (Lombardi, 2007). Health research, policies, infrastructure and documentation are embedded in cissexism and consequently fail to acknowledge “trans identities, trans bodies, and trans lives” (Bauer et al., 2009, p. 355). There are several ways that

1 Serano (2007) defines cissexism as “the belief that transsexuals’ identified genders are inferior to, or less authentic than, those of cissexuals (i.e., people who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned)” (p. 12).
cissexist assumptions both passively and actively influence the provision of care to trans people and their partners.

First, doctors frequently do not possess the knowledge and skills required to address the unique health care concerns of trans individuals. A recent study published by the Journal of the American Medical Association revealed that only 30% of 132 allopathic medical schools in Canada and the United States cover issues related to gender transition and SRS. In addition, 33% of allopathic and osteopathic schools reported that students were not required to complete any clinical hours for LGBT content (Obedin-Maliver et al., 2011). Similarly, Corliss, Shankle and Moyer (2007) reported that only 9 (8.8%) of 35 schools of public health in the United States and Puerto Rico had offered a course within the past two years that had covered lesbian, gay, bisexual, or transgender health topics that extended beyond a discussion of HIV and AIDS. Further, a recent review of eight common nursing textbooks found no reference to trans-related concerns (Eliason, Dibble, & DeJoseph, 2010). Not surprisingly, providers’ insufficient knowledge greatly compromises the quality of care that trans people receive (Sperber, Landers, & Lawrence, 2005) and inhibits access to hormones and surgeries (Sanchez, Sanchez, & Danoff, 2009). Many trans people report having to educate their physicians about trans-related health care including surgical procedures or hormone regimens (Bauer et al., 2009). Some trans people report having to rely on Internet chat rooms and support groups for current and accurate information about their health (Sperber et al.). In recent years, resources have been developed to inform and guide health care providers’ provision of care to trans people, such as the World Professional Association for Transgender Health’s (WPATH) (2011) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (hereafter referred to as

Second, trans people and trans bodies are too often overlooked by health-related research. Consequently, there is a dearth of new knowledge being produced that can inform providers’ provision of care to trans communities. Little is known about the long-term effects of common hormone treatments for both FTM and MTF people (Bauer et al., 2009). The correlation between hormone replacement therapies and cancer risk is debated in the literature but research findings remain largely inconclusive. Trans women may be at risk for the development of breast cancer due to prolonged estrogen use (Hembree et al., 2009). There is conflicting evidence in the literature regarding the necessity for trans men to pursue hysterectomy (surgical removal of the uterus) and oophorectomy in order to circumvent the risk of endometrial (Futterweit, 1998) and ovarian cancers (Hembree et al.). Of particular concern to the present analysis are the research findings—or lack there of—pertaining to the impact of hormone therapy on fertility. Hembree et al. and De Sutter (2001) suggest that the prolonged use of estrogen by MTFs may result in irreversible loss of sperm production. The authors report that no research has been conducted on the restoration of sperm production following the termination of estrogen. Similarly, the effects of prolonged exposure of the ovaries to testosterone are unknown. Hembree et al. postulate that testosterone may result in permanent loss of fertility but research has yet to be conducted in this area. Clearly, this lack of knowledge production has great implications for providers’ provision of care to trans people and the ways in which trans people are treated during their transition has unknown implications for their future capabilities to reproduce.

Finally, trans people encounter barriers when attempting to access health care services due to cissexism and transphobia. Trans people continue to be denied services due to providers’
discomfort with their gender identity (Bauer et al., 2009; Lombardi, 2007; Namaste, 2000; Shelley, 2008). In some cases, trans people may avoid health care services altogether due to fears of maltreatment or past negative experiences (Namaste). When accessing services, providers may assume that the sex designation on a trans person’s health-related documentation is incorrect if their external appearance is discordant with what is considered culturally appropriate or ideal for persons of their perceived sex (Bauer et al., 2009). Trans people who are able to pass as cisgender may be able to choose when and where they disclose their gender identity. However, a decision not to disclose may result in inappropriate medical procedures or disclosure may occur inadvertently through tests or physical examinations (Bauer et al., 2009). In contrast, a decision to disclose one’s gender identity may result in maltreatment or denial of services (Lombardi). Some trans people report that health care providers have continued to use pronouns that were inconsistent with their gender identity even after they had disclosed (Lombardi). Bauer et al. (2009) argue: “The onus should not be on trans people to make themselves visible in vulnerable situations … especially in a time of need or distress” (p. 357). During patients’ initial visit to a health-related setting, providers must consider what demographic information is absolutely necessary to collect and how that information will be used (Lombardi).

1.6 Theoretical Framework

Hegemonic understandings of sex and gender are rooted in a system of binarisms that render unintelligible the bodies, identities and experiences of transgender and transsexual people. These binarisms structure the social environments in which we live (Fausto-Sterling, 2000). In order to establish a comprehensive understanding of the pervasive marginalization of trans people, Namaste (2000) proposed the theory of erasure: “a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes
transsexuality as impossible” (p. 4-5). Building upon this definition, Bauer et al. (2009) argues that erasure is comprised of two distinct yet mutually reinforcing domains: informational erasure and institutional erasure (p.352). Informational erasure refers to the pervasive absence of knowledge about trans people and the assumption that no such information exists despite evidence to the contrary in some instances (Bauer et al., 2009). Institutional erasure refers to the lack of acknowledgement of trans bodies and trans identities at a structural level in the form of policy development as well as the erroneous belief that these policies are not necessary (Bauer et al., 2009).

The dearth of statistical data on the number of transsexual and transgender people and their families illustrates the theory of erasure. Currently, the Census of Canada, which collects demographic information from Canadian residents, does not account for gender variant or trans-identified people and their families. The census exclusively collects information on the number of males and females living in Canada (Bauer et al., 2009; Canada Gazette, 2010; Statistics Canada, 2006). This gap in knowledge not only renders trans people and their families invisible but it also impedes the development of new policies and regulations that would protect the rights of trans individuals. Bauer et al. (2009) argue that the lack of accurate information about the size of the trans community contributes to health care providers’ inadequate knowledge about trans people because it perpetuates the assumption that they will infrequently encounter trans people and their families.

The ongoing invisibility of trans parents in lesbian, gay, bisexual, transgender and queer (LGBTQ) parenting research is also explained by the theory of erasure. Too often researchers include “T” in the scope of their research without specifically exploring the experiences of transgender parents or examining the ways in which their experiences differ from lesbian, gay,
bisexual and queer parents (Pyne, 2011a). In doing so, researchers promote the notion that LGBTQ parents’ experiences are uniform, thereby glossing over the intersectionalities of sexuality, gender and identity and the ways in which these factors affect the lives of LGBTQ parents. Past research on “same-sex” parenting has also commonly conflated sex and gender as synonymous entities. This research is problematic for trans people given that the term, “transgender,” refers to gender identity, rather than sexuality. Lesbian, gay, bisexual and queer parents have a gender identity just as trans people have a sexuality (which may be lesbian, gay, bisexual and or queer, among others) (Pyne, 2011a).

1.7 Current Study

Due to cissexism and transphobia, existing literature examining trans people’s use of AHR services has focused on ethical debates surrounding trans people’s right to access reproductive technologies in order to have children. As a result, little is known about potential barriers that prevent trans people from accessing supportive fertility care, their experiences with fertility specialists and the ways in which AHR services could be improved to better meet the needs of prospective trans parents. The authors of the present study aim to address this gap in knowledge by exploring the experiences of trans people in Ontario who report accessing or consideration of accessing AHR services. The concept of erasure will provide the theoretical framework for the present analysis and will inform the authors’ exploration of the research question, which was based on the expectation that erasure will be exemplified by both trans people’s encounters with health care providers as well as their decision to avoid existing services due barriers that they either anticipated or encountered (Namaste, 2000). In keeping with the theory of erasure, the authors hold that the problem of trans marginalization must be understood within “broader cultural and political contexts” rather than as the result of “individual acts”
(Bauer et al., 2009, p. 350). Through the present analysis, the authors hope to highlight and better understand the mechanisms that both support and sustain the barriers experienced by trans people in society.
2 Method

The data analyzed for the present study were collected as part of the Creating Our Families research project, which was led by Creating Our Families Research Team at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario, Canada. The Creating Our Families project was a pilot study that sought to explore the experiences of LGBTQ individuals in Ontario who used AHR services or who pursued the use of AHR services but did not proceed due to perceived or encountered barriers. The present analysis draws on the data collected from qualitative interviews with trans-identified people. The Research Ethics Boards at the Centre for Addiction and Mental Health and the University of Toronto approved the present research.

2.1 Methodological Approach

The Creating Our Families research project incorporated a community-based participatory research (CPBR) approach in order to ensure that the research project was responsive to the needs of the communities involved. Community based participatory research is “grounded on principles of collaboration, community empowerment and social change in which community of interest participates not as ‘research subjects’ but as research collaborators and agents of change” (Access Alliance Multicultural Health and Community Services, 2011, p. 13).

Throughout the Creating Our Families project, academic experts in sexual and gender minority parenting worked in partnership with a community based LGBTQ parenting organization: the LGBTQ Parenting Network in Toronto, Ontario. Both academic and community partners

2 Members of the Creating Our Families Research Team included: Dr. Lori Ross, Dr. Leah Steele, Rachel Epstein, Stu Marvel, datejie green, Lesley Tarasoff and Scott Anderson.
collaborated on identification of the research question, development of the methodological approach and interpretation of the data.

The research question that guided the Creating Our Families project was identified as a community priority by Rachel Epstein, the coordinator of the LGBTQ Parenting Network, through her work with members of the LGBTQ community. The LGBTQ Parenting Network has a longstanding relationship with Dr. Lori Ross as well as the members of Dr. Ross’s research team in the department of Social and Epidemiological Research at CAMH. In collaboration with other community partners and researchers, Ms. Epstein and Dr. Ross work to examine the health and mental health service needs of LGBTQ individuals, with the goals of enhancing the quality of services received and improving access to care (e.g., Ross, Epstein, Anderson & Eady, 2009; Steele, Ross, Epstein, Strike & Goldfinger, 2008; Yager, Brennan, Steele, Epstein & Ross, 2010). Additional community engagement was facilitated by the involvement of an Advisory Committee for the duration of the study.

The Advisory Committee was comprised of representatives from fertility clinics in Ontario, LGBTQ community members and the staff, students and Investigators involved in the Creating Our Families research project. The Committee met four times between April 2010 and October 2011. These meetings took place throughout the various stages of participant recruitment and data collection. Staff involved with the Creating Our Families project chaired the Advisory Committee meetings. The conversations and debates that took place during these meetings informed the ways in which data collected for the Creating Our Families project was interpreted by the research team.
2.2 Participants

A total of 118 prospective participants contacted the Creating Our Families research team between June 10, 2010 and May 25, 2011, to learn about the study or to express an interest in participating and 108 of these individuals or couples completed a brief telephone-screening questionnaire to determine their eligibility to participate. In order to participate, individuals had to satisfy the following inclusion criteria: 1) Sexual orientation/gender identity: self-identify as lesbian, gay, bisexual or a related term (e.g., queer) and/or self-identify as transgender, transsexual or a related term (e.g., genderqueer); 2) Geographical location: at the time of data collection, be living within the province of Ontario, Canada; 3) Experience with AHR services: report accessing or consideration of accessing AHR services in Ontario within the past 3 years; 4) Age: 18 years of age or older at the time of data collection; and 5) Language: sufficiently fluent in English to understand the consent form and participate in the interviews.

2.3 Recruitment

Potential participants were recruited through online networks (e.g., LGBTQ and health listservs); via flyers, which were mailed to over 2000 service providers and organizations (e.g., fertility providers, HIV/AIDS service organizations, midwifery clinics, pediatric clinics); and in person at Pride celebrations across Ontario. Recruitment flyers invited LGBTQ individuals who had used a fertility clinic or sperm bank in the past three years or who had considered using a fertility clinic or sperm bank but did not because they either encountered barriers or feared that they might to contact the research team in order to learn more about the study (refer to Appendix A for a sample of the flyers). When potential participants contacted the research team, they were provided with detailed information about the study and completed a telephone-screening interview. The research team then conducted purposeful sampling from the pool of interested and
eligible participants in order to select individuals for interviews. If selected, individuals were asked for their consent to schedule an in-person interview. When applicable, the partners of potential participants were also encouraged to participate in the interview if they had taken part in the pursuit of AHR services.

Of the 108 individuals and couples screened for eligibility, 8 people were ineligible to participate because they had either accessed AHR services prior to 2007 or they declined to participate for various reasons (e.g., relationship issues). A total of 40 qualitative interviews were conducted with a purposive sample of 66 individuals was selected from remaining 100 potential interested and eligible potential participants. Participants were selected based on their sociodemographic characteristics such as age, sex, gender, geographic location, race and/or ethnicity. As mentioned above, data analyzed for the present analysis was taken from the Creating Our Families interviews that involved trans participants. Out of the 40 interviews that were conducted for the Creating Our Families project, 7 involved trans people and their partners. A total of 11 people (3 individuals and 4 couples) participated in these 7 interviews, 9 of which identified as trans. Although individuals were eligible to participate in the Creating Our Families project if they had considered—but had not accessed or used—AHR services, all of the trans participants happened to have accessed or attempted to access AHR services. Selected demographic characteristics of these 9 trans participants are summarized in Table 1.
Table 1. Selected Participant Demographic Information

<table>
<thead>
<tr>
<th>Variable</th>
<th>N = 9 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Identification</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Female</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Trans Woman</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Trans Man</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Trans Other</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Lesbian</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Queer</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Straight</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td><strong>Partner Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Commonlaw</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Single</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>26-30</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>31-35</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>36-40</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>41-45</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td><strong>Racial/Ethnic Background</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>6 (66.7)</td>
</tr>
<tr>
<td>Black African</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td><strong>Highest Level of Education Completed</strong></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>University</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Post-graduate</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td><strong>Annual Household Income</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; $80,000</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>&gt; $80,000</td>
<td>3 (33.3)</td>
</tr>
</tbody>
</table>

3 For some of the demographic questions, such as gender identity, sexual orientation and partner status, participants had the option of selecting more than one response or no response. Therefore, not all categories add up to 100%.

4 Includes Jewish
All of the participants (100%) resided in metropolitan cities in Ontario. One person (11.1%) identified as having a disability and two (22.2%) people reported having chronic illnesses. Only one person was born outside of Canada (11.1%) and none of the participants reported that they had tested positive for HIV.

2.4 Procedure

Written informed consent was obtained from the participants prior to their interview. In situations where partners participated in the interview together, one consent form was obtained from each person. On the consent form, participants were given the option of participating in the study either confidentially or anonymously. If confidential participation was selected, proper names were rendered generic during transcription (e.g., the names of participants, friends, family and non-professional community members), whereas other identifiable references were transcribed as spoken (e.g., names of clinics, professionals, practitioners, service providers, educators, geographic locations, workplaces, children’s schools and medical facilities, services and procedures). In contrast to confidential participation, all proper names and identifiable references were removed from anonymous interviews during transcription. In addition to the consent forms, every participant was asked to complete a brief demographic questionnaire and an anonymous survey of costs incurred through the process of accessing AHR services.

The qualitative interviews were conducted at a private and quiet location of the participants’ choice. In the majority of cases, the selected location was the participants’ house. Interviews ranged from 56 to 107 minutes in length and followed a semi-structured interview guide comprised of open-ended questions relating to participants’ decision to create a family and the ways in which they encountered AHR services throughout this process (refer to Appendix B for a copy of the interview guide). For example, participants were asked to describe how they
arrived at the decision to explore AHR services as a possibility of building their families, how they got a referral to an AHR clinic and if they chose to disclose their gender identity to providers at the clinic (if applicable). Probes were developed for each of the research questions and were used when necessary. Four members of the Creating Our Families research team conducted the interviews. All of the interviewers were LGBTQ-identified and the majority also had experience with AHR services themselves. The interviews were audio recorded and transcribed verbatim. The interviewer later verified transcripts for accuracy.

2.5 Data Analysis

Qualitative analysis was performed using a descriptive phenomenological approach. The goal of phenomenological research is to describe the meaning of a particular event or phenomenon through interpretation of individuals’ lived experiences. This goal is achieved by identifying descriptions of a phenomenon, which, in the case of the present study, is trans people’s experience of accessing or seeking AHR services. Once identified, descriptions are clustered into discrete categories (Creswell, 2009; Starks & Brown Trinidad, 2007). Several stages were involved in conducting this process for the present analysis. First, the transcripts were reviewed to identify key phrases and statements. Second, these key phrases and statements were compiled into a list, to establish key concepts among the various interviews (Auerbach & Silverstein, 2003). These preliminary findings were used to generate a set of analytic thematic codes. Third, the researchers reread each transcript and noted instances where each thematic code emerged. When necessary, codes were modified to accommodate new emerging themes. Fourth, coded transcripts were entered into NVivo 9 text management software to generate reports of the text contained within each thematic code. These reports were then used to write theme memos for each code. Several themes were identified when analyzing the data, many of
which were common to all people’s experiences of navigating AHR services including the selection of a known or unknown sperm donor, high cost of services and familial support during the process of trying to conceive. Only discussions that were unique to trans people’s experiences of seeking or accessing AHR services were included in the present analysis.
CHAPTER THREE

3 Results

Participants’ descriptions of their experiences of seeking or accessing AHR services were grouped based on the approximate chronological order in which they occurred. Table 2 summarizes the themes that emerged from our analysis.

Table 2. Key Themes

<table>
<thead>
<tr>
<th>3.1</th>
<th>Influence of Gender Identity on Decision to Build a Family Through the use of AHR Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>Gender Transition and the Creation of a Family Through the use of AHR</td>
</tr>
<tr>
<td></td>
<td>3.2.1 Impact of Gender Transition on Fertility Planning</td>
</tr>
<tr>
<td></td>
<td>3.2.2 The Absence of Information on the Effect of HRT on Fertility</td>
</tr>
<tr>
<td>3.3</td>
<td>Accessing AHR Services</td>
</tr>
<tr>
<td></td>
<td>3.3.1 Researching Reproductive Options</td>
</tr>
<tr>
<td></td>
<td>3.3.2 Selecting an AHR Clinic</td>
</tr>
<tr>
<td>3.4</td>
<td>Interactions with AHR Providers</td>
</tr>
<tr>
<td></td>
<td>3.4.1 Problems with Clinical Documentation</td>
</tr>
<tr>
<td></td>
<td>3.4.2 “Their baseline is that women get pregnant and men give sperm” – Impact of Providers’ Cisnormative and Heteronormative Assumptions</td>
</tr>
<tr>
<td></td>
<td>3.4.3 Fertility Counseling</td>
</tr>
<tr>
<td></td>
<td>3.4.4 Positive Experiences with AHR Providers</td>
</tr>
<tr>
<td>3.5</td>
<td>Strategies for Navigating Instances of Transphobia and Cissexism</td>
</tr>
</tbody>
</table>

3.1 Influence of Gender Identity on Decision to Build a Family Through the use of AHR Services

Participants’ gender identities influenced the decision-making processes that led them to explore the use AHR services in various ways. Some participants opted for AHR over other ways of building families for many of the same reasons that cisgender people do. For example, some participants discussed their strong desire to have a biological connection to their children and to see themselves reflected in their children:
I have some of my very good friends, … who are actually adopted themselves, guilting me … [by saying,]: “Well, why’s it not good enough? Why can’t you just adopt?” It’s because I want to have a baby, right? I can respect that their family is beautiful and that, for them, and for their parents, it was the right move. I don’t … wanna adopt right now. I want to have a baby. (Participant 39)

Additionally, trans participants expressed their desire to become pregnant and carry their own baby:

It’s a desire. I can’t explain it. Like, if you feel like you want to … have the experience of carrying a child, it’s biological. It’s not something you can necessarily just put away.

(Participant 104A)

One couple’s experiences as trans people were specifically relevant to their choice to create a family through the use of AHR over other methods:

The feeling of what will protect my rights as a parent was certainly part of [my decision] and I talked about also having gone from feeling like I was so terrible, who would ever want to share biology with me, to feel kind of okay about myself and that that was certainly part of it as well. Also, not having to deal with home studies may have played a small part of that for me and not … wanting to explain our lives and world and really feeling judged—and a home study really is a process of being judged—might have also been in there. But I will also say that I was interested in, [learning] how … we do this as low tech as possible? Like, what is the minimum medical intervention that we could use? (Participant 40B)

The participant’s partner went on to elaborate further on this point:
So we sort of thought you know, … let’s see if we can go with the formula that we know has a high likelihood of success: fresh sperm. You know, really fresh, like, “Thanks for the cup, see you in ten minutes!” And I think also as trans people who have been in a lot of ways kind of at the mercy of the medical system, staying away from it to whatever degree possible felt like a good idea. (Participant 40A)

Modern reproductive techniques offer trans people and their partners an opportunity to have their own genetic children if they wish to do so. Trans people may be apprehensive about creating a family through adoption due to anticipated transphobia, as illuminated by the narrative of one participant. Participants’ desire to have biologically related children highlights the importance of providing trans people equal opportunity to access AHR services and indicates that physicians should discuss reproductive options with all trans people, especially in situations where infertility may result from treatment (De Sutter, 2009; De Sutter et al., 2002).

3.2 Gender Transition and the Creation of a Family Through the use of AHR

Trans people and trans bodies transcend hegemonic understandings of who is capable of conceiving a baby and who is fit to raise a child. Due to the absence of literature on trans parents’ and trans people’s experiences of seeking and/or accessing AHR, little is known about the ways in which one’s experiences as a trans person influences one’s decision of how to create a family. Similarly, the literature does not yet explore the unique impact of gender transition on one’s process of becoming a parent.
3.2.1 Impact of Gender Transition on Fertility Planning

The majority of participants spoke to some degree about the ways in which their gender transition impacted their process of creating a family through the use of AHR services. Although not all trans people choose to medically transition their gender through the use of hormones or surgeries, the majority of participants in the present study had started hormone replacement therapy (HRT) and in some cases, had been taking HRT for several years. One participant discussed how his partner’s decision to stop HRT in order to get pregnant was very difficult:

I know for you, [partner], too, it was a lot about for you to have kids would mean going off of testosterone and stopping that whole transition process in some ways. So ... it was a little bit complicated. (Participant 104B)

This point was further clarified by his partner:

Yeah, and I had started transitioning really early. Not early in my life but early ... compared to most people I know. [People that] started transitioning six or seven years after me ... pass completely, whereas I don’t at all because I’ve been off of hormones for so long now. So, it was hard … that was a hard decision. (Participant 104A)

The desire on behalf of some participants to medically transition led them to seek AHR services so that they could have a biological child at some point in the future:

I’ve always known that I wanted to have children. It’s one of my… really important goals. And, not any time soon but, because of my situation, transitioning medically … I became aware of the fact that if I wanted to maintain my reproductive options I had to go ahead and get my sperm frozen [pause] or it would be gone and that’s what brought me
into the reproductive clinic. (Participant 39)

Complications arose for this participant who accessed AHR services for the purpose of banking sperm for future use. In keeping with standard procedures at the clinic, the participant’s sperm was tested for viruses prior to freezing. The participant was informed that her sperm had tested positive for cytomegalovirus (CMV)—a virus that is commonly found among North American adults and is acquired through bodily secretions, blood and tissue. Although the virus causes lifelong infection, most individuals will not display signs and symptoms unless the virus comes out of latency due to environmental stressors or illness (Parham, 2009; Spano, Gatti, Nascimento, & Leite, 2004). The clinic was willing to proceed with freezing her sperm but explained that it would need to be stored in an isolated freezing container due to the presence of the virus. This isolated storage cost an additional $2000. The participant described how this unexpected complication forced her to make a very challenging decision:

They said you have these two choices: you can either pay this extra money or wait three months to see if the virus clears up. So, because I didn’t have the extra money at the time—it embarrasses me to admit that but that’s the case—… I decided to wait. So I went back to work. I can’t remember if I decided to stop taking my [HRT] meds, reduce my meds or keep taking my meds, but I do remember … that the process of making the decision was very painful for me … I had a lot of stress [pause] I would go to work and I couldn’t focus on my work because I was [questioning] … what do I sacrifice? [pause] Do I sacrifice transitioning for now? Or [do I sacrifice] having a baby or the risk of … not being able to have a baby? It was a huge amount of stress for me. (Participant 39)
While some of the participants expressed a clear desire to preserve their fertility during their process of transitioning, this was not a concern for all of the trans people interviewed. For example, one participant discussed how his endocrinologist—who was also a fertility specialist—never explored reproductive options with him before he transitioned. The participant stated that cryopreserving gametes or embryos was never something that he desired and as a result, not having been presented with these options did not negatively impact him. However, for those participants who did wish to have their own children, the decision to stop transition in order to reproduce was emotionally stressful, as demonstrated by the participants’ narratives above.

3.2.2 The Absence of Information on the Effect of HRT on Fertility

The absence of research on the effects of HRT on fertility impinged upon participants’ reproductive planning as well as their interactions with service providers. Participants reported that they were unable to explore their reproductive options during their gender transition due to the pervasive lack of research examining the effects of HRT on fertility. Participants spoke about how they attempted to access information both by conducting their own research on the Internet and by discussing their fertility with their physicians:

I went on the Internet and I did a lot of research about … the HRT I wanted to pursue, and I did research about what would be the result for my reproductive capability from having this medical treatment … only of course, to my disappointment, there weren’t any real studies done. I had to look for anecdotal evidence from communities that I was able to access [pause] and specific individuals that had been treated before and then my doctor. (Participant 39)
I wanna lay everything out on the table and get as much information as possible … if I have the option to maybe … do something with, with these organs [pause] I just would like to know. You know what I mean? But if there is no option, and if the organ is, because of being on testosterone for three years … if it’s not healthy anymore, whatever. … I’ve accepted that … But deep down inside, you know, not everybody can have their own kids, that’s the way of life, but if I can have that, I would like equal opportunity and access to this. (Participant 105)

One participant reported that her physician communicated his uncertainty about whether the participant would be infertile as a result of testosterone-blocking medications that she had been taking:

By the time I went to my doctor … he said, “Well, I guess you will, and in fact, may already be sterile from doing this, and you need to go and [pause] if you’re planning on reproducing, if you want to have viable sperm in the future, you should investigate the reproductive options now.” I said, “Okay, alright.” (Participant 39)

Providers’ insufficient knowledge about the effects of HRT was also communicated by providers’ unhelpful or incorrect recommendations to participants about changes that they should make in their hormone regimens:

So regarding my hormone [regimen], [our doctor at the AHR clinic] recommended that I stop taking any hormones. Specifically, Finasteride, [which] is a … very specific anti-androgen that some trans women take and it basically prevents hair-loss. It doesn’t affect
sperm quality. It only blocks a very specific part of testosterone receptors in the body so that it prevents hair-loss … but she wanted me to discontinue this. (Participant 8B)

When discussing their fertility options with physicians, participants reported that it was difficult for them to determine whether service providers were reluctant to explore their reproductive options with them due to transphobia or whether providers simply lacked the information necessary to provide helpful guidance:

There’s a mentality that, “Well, if you’ve been on testosterone for that amount of time, you can’t do anything with those organs.” That’s what I’m being told. But my ultrasound states that everything’s healthy. But [providers] say conflicting things … If there’s been damage, I wouldn’t proceed … if things really aren’t healthy, then I don’t wanna take a risk … and to do anything. … [O]ne gynecologist just looked at me and thought I was crazy … I get this sense that [providers believe that] what I’m doing is not humane or something. (Participant 105)

The contradictory messages that this participant received from providers left him to question whether he was capable of preserving viable gametes for future use. Despite numerous attempts to explore his reproductive options with different physicians and AHR providers, he was unable to determine whether his use of HRT had rendered him infertile. As demonstrated by participants’ experiences, providers’ lack of knowledge about gender transition and its effects on reproductive health prevents trans people from having equal opportunity to have biological children of their own.
3.3 Accessing AHR Services

Due to the paucity of information on trans people’s experiences of creating a family through the use of AHR services, participants discussed various formal and informal sources of information that they consulted prior to their attempts to access services at a clinic. The information gathered by participants was then used to inform their decisions about what services they wished to access and what clinic(s) offered the services they sought.

3.3.1 Researching Reproductive Options

One participant described his experience of conducting research online about the AHR services offered by clinics in Ontario. The participant had been taking HRT for several years and was concerned about the potential negative effects of HRT on his reproductive organs. In order to avoid any ill effects of HRT on his health, the participant was considering having a hysterectomy but wanted to preserve his eggs before having his reproductive organs removed. He successfully found a clinic that advertised the service that he was seeking on their website but the procedure was only offered for cancer patients.

Other participants discussed how their decisions about where to access AHR services were informed by anecdotal accounts from other trans people who had created a family through the use of AHR services:

A lot of [the information we gathered was] anecdotal from other people we knew who were already involved in fertility processes and then we were able to kind of clarify, through internet research, what … we thought were the processes that were good to start with. (Participant 40A)
A transgendered friend of mine and his partner had a child and how they did it was they went to our doctor … who does … our hormones for us [because he] is also … a fertility specialist. [My friend] went through them and that’s how I know that that’s how you could do it. Otherwise, I would have had no idea where to go [or] how to do this. So it was from him and his experience and that was kind of how I knew what to do.

(Participant 78)

Several participants and/or their partners learned about the process of creating a family through the use of AHR services by attending the “Transmasculine People Considering Pregnancy” course: a joint program offered by the The 519 Church Street Community Centre and the LGBTQ Parenting Network. This course offers transmasculine people—and their partners—information about the medical, social, financial and legal aspects of becoming parents. The number of trans participants involved in the present study whose process of creating a family was influenced by the content of the “Transmasculine People Considering Pregnancy” course highlights the importance of such resources for prospective trans parents.

3.3.2 Selecting an AHR Clinic

After conducting research via the Internet about the AHR clinics in close proximity to where they lived, many participants proceeded to contact the clinics directly to arrange an initial appointment:

I went to [a private, fee-for-service clinic in the Central West Region of Ontario] and I found out about them online—just Google searching. (Participant 39)

---

5 The term, transmasculine, is sometimes used when referring to trans individuals that are on the female-to-male gender spectrum (Hansbury, 2005).
In contrast, other participants consulted a physician about their desire to have children and requested a referral to an AHR clinic. One participant recalled how, in the absence of information on trans people’s experiences at AHR clinics, his physician drew on the experiences of lesbian-identified cisgender women to inform their decision about where to refer him:

So we actually got a referral to a fertility clinic [for] cycle monitoring, a histosonagram, blood work. … I said to my doctor … “I have reason to believe that there might be issues around conception, pregnancy and carrying to term. Let’s start with checking with what’s there.” … She said, “Fine, do you know where you want to go?” And I said, “No, do you have any recommendations?” And she said, “Well, I’ve been sending lesbian couples to this guy and they seem to be happy with him, do you want to give him a shot? And if that doesn’t work, we’ll try to send you somewhere else.” (Participant 40B)

One trans male couple reported that their referral to a fertility clinic was “flagged” by the staff at the clinic because they questioned why two men would be interested in accessing services. Consequently, the couple’s family physician arranged to have a nurse from their practice travel to the clinic to educate the staff about trans people and pregnancy. As a result, the family physician had an opportunity to directly address barriers that the couple encountered when accessing services, thereby taking on the burden of educating the providers rather than having this responsibility fall to the service users themselves.

One trans male participant reported that he and his cisgender female partner did not require a referral to a fertility clinic because his endocrinologist, who had been monitoring his hormone replacement therapy for a few years, was also a fertility specialist:

One day when I was in the … office for a regular checkup, I mentioned it to my
[endocrinologist] and … I asked … you know, “What [is] the waiting list like? Is it going to be a year or something? We’d like to get on the list.” And he’s like, “No. Since you’re already a patient, then [your partner can] just come along and we [can] have an appointment within a couple of months.” (Participant 78B)

While the majority of participants in our study successfully accessed AHR services, one participant was repeatedly denied access to information and services related to the possibility of cryopreserving his eggs for future use. The participant reported that, when he disclosed his gender identity to administrative staff over the telephone, he was told, “We don’t do … [that] sort of thing here” (Participant 105). He went on to articulate his frustration with this response:

I understand that maybe nothing can be done with that, [and that] there [are] no guarantees, but I just want that option [because] … you never know … with [technological advancements]. You just don’t know. So can’t I just bank it, preserve it and go from there? And I’m not even being allowed access to that. And I’m not even being allowed access, like I said, to a consultation, just to gather information or to see what other options are available. (Participant 105)

3.4 Interactions With AHR Providers

Research regarding the health care system has broadly demonstrated that cissexism and transphobia greatly impact the quality of care that trans people receive (eg. Bauer et al., 2009; Lombardi, 2007; Namaste, 2000; Shelley, 2008). The present study is consistent with these findings, in indicating that many AHR providers possess inadequate knowledge about trans identities and trans bodies, and that providers often make cisnormative and heteronormative assumptions. Cisnormativity is a term used to describe the pervasive belief that all people are
cissexual; that all people assigned male at birth will identify as men and that all people assigned female at birth will identify as women (Bauer et al., 2009). Similarly, heteronormativity is a term used to describe the hegemonic belief that all individuals are romantically and sexually attracted to persons of a different sex. Given that heterosexuality is premised on the notion that all people are either male or female, heteronormativity and cisnormativity function as mutually reinforcing societal assumptions. In this study, providers’ cisnormative and heteronormative assumptions were communicated both actively and passively to participants throughout their encounters with AHR clinics.

3.4.1 Problems with Clinical Documentation

Trans people’s bodies, sexualities and identities disrupt dichotomous divisions of sex and gender and consequently are not adequately acknowledged by health care providers. This is exemplified participants’ experiences with completing documentation at AHR clinics. The majority of participants described having to alter the intake forms so that their clinical documentation correctly reflected their sexuality and gender identity. Cissexist assumptions were implicitly communicated through the lack of acknowledgement of trans identities on administrative intake forms. Given that there was no space on clinical documentation for trans participants to disclose their gender identity, participants primarily discussed the ways in which they attempted to navigate heterosexist assumptions on the forms:

40B: I do remember having to alter the intake forms that were really set up for a heterosexual couple.

40A: We just crossed things out.

40B: Yeah we did, we just crossed things out all over the place and wrote in different
answers.

104A: Yeah. We changed the forms to both be, “Mister”

104B: Yeah, we changed them a lot.

104A: “Sex” I would change it and say “trans”, [or] “transsexual”

They gave me forms to fill out and the first question on the form was, “Are you married, single or gay?” … I was really alienated by the fact that there’s forms no one seems to have updated since 1980. And I said [to my doctor], “Do you understand that … it’s not appropriate to ask in 2008 … if you’re married, single, or gay? Those are not three [independent] categories!” (Participant 39)

In one instance, providers’ heterosexism prevented one participant from designating a close friend as their next of kin on their intake forms because the forms were designed for cisgender heterosexual couples:

The forms were designed to let you indicate what you wanted to happen to the sperm in the event that you died, for example. But it wasn’t in freeform, it was more like … “If yes, then fill out 2B” type of thing, right? … I wanted [my good friend] to take over control, you know, in the event that something happened to me, regardless of my hypothetical future marital status, because I trust her and she is the one that I would want to determine what happens, you know? But, that was almost impossible. (Participant 39)
The administrative intake forms failed to acknowledge participants’ identities to such an extent one participant questioned the degree to which their altered forms would function as legal documentation:

And you know, this is *supposed* to be something which is potentially used as legal evidence and … I have to question whether something like this would even stand-up [in court] because of how completely [sigh]. My form ended up being a bunch of crossed-out questions and … paragraphs written in the margins. (Participant 39)

Problems with clinical documentation were particularly highlighted by the experiences of two participants due to the ways in which the failure to acknowledge their gender identity on their documentation influenced the quality of care that they received. For example, one participant described how service providers failed to acknowledge her gender identity by incorrectly listing her sex as “male” on her chart:

There were tons of factual inaccuracies in all our documentation and everything. I mean, I had a health card that lists me as female, correctly, and on their charts they always had me listed as male … so we told them that that’s actually not correct according to my documentation and everything. And … instead of apologizing and trying to remedy the situation, they were defensive about how difficult it would be for them to do that—to change their records and so on. So they wrote down basically that [my partner] was a heterosexual woman—which she’s not—and that I was the father … who has … sperm problems or something! (Participant 8B)

This quote illustrates the ways in which providers’ transphobic response to the participant’s gender identity simultaneously erased her experience as both a trans woman and as a lesbian-
identified prospective parent. Another participant described difficulties that he encountered because his provincial health insurance card had not been modified to reflect his chosen name. As a result, administrative staff included both his legal name as well as his chosen name on the front of his chart:

So then they would— even though on my chart it would say [my chosen name] and then my legal name beside it in brackets, and they had highlighted [my chosen name] and put it in bold, people would still call me by my legal name. (Participant 104A)

The participant reported that he eventually approached the clinic staff and requested that his legal name be removed from the front of his chart. The participant explained to providers that if they required his legal name for the purposes of filing provincial health insurance claims, they could look within the file to locate this information. In keeping with this suggestion, his legal name was eventually removed from the front of his chart. However, after this change was made, nurses proceeded to pronounce his chosen name in a feminine manner:

[The nurses] started calling my … [chosen name] … cuz it’s the only name on there. So they would feminize it and call me [incorrect pronunciation … or incorrect pronunciation], like anything other than [my name] cuz it couldn’t be [my name] which was sort of bizarre. (Participant 104A)

3.4.2 “Their baseline is that women get pregnant and men give sperm” – The Impact of Providers’ Cisnormative and Heteronormative Assumptions

Participants’ identities were often rendered invisible throughout their interactions with AHR providers due to intersecting frameworks of cisnormativity and heteronormativity (as defined above). The processes through which participants’ sexualities and gender identities were
negated by providers’ assumptions varied depending on individuals’ reasons for seeking AHR services. For example, a lesbian-identified trans woman and her cisgender female partner reported that service providers treated them as though they were a cisgender, heterosexual couple:

They were very interested in us making an effort to get pregnant at home [through coitus], which wasn’t anything that we had expressed an interest in. (Participant 8A)

The couple had planned on conceiving by using sperm that participant 8B had cryopreserved prior to initiating her gender transition several years ago. Their fertility doctor at the clinic never accessed the cryopreserved sperm. Instead, the doctor encouraged participant 8B to produce fresh sperm samples, which she happened to be capable of doing at the time due to changes in her HRT regimen. The couple was unsure why the fertility doctor wanted to inseminate using fresh sperm samples. Participant 8A speculated that the doctor might have felt that they would have better luck with fresh sperm. They were also unsure about the quantity of banked sperm and how many attempts they could have using what was banked. Participant 8B discussed how she felt that the providers at the clinic “were coercive and didn’t listen well” because producing fresh sperm was neither her preference nor what the couple had originally asked for when they initiated treatment at the clinic. Throughout their experience, the couple felt that the providers questioned why they were accessing AHR services because they were perceived and being both heterosexual and cisgender and therefore, capable of conceiving “naturally.”

Another trans participant was also encouraged to conceive through coitus when a doctor assumed that he was a cisgender, heterosexual woman:

The day of the insemination … I was seeing a doctor that wasn’t my doctor—cuz my
doctor was away that day— and he didn’t know me from Adam. So he … just assumed that my partner was a non-trans guy and that I was a woman. And so he said, “Have sex today, have sex tomorrow, have sex the day after. And then come back and see us”.

(Participant 104A)

While participants’ experiences of being instructed to conceive through coitus illuminate providers’ cissexist and heterosexist assumptions, these experiences also highlight the broad assumptions that health care providers hold about all patients’ sex and gender. In the majority of circumstances, a physician’s approach to working with a patient is predicated on the belief that all individuals are cissexual and that they relate to their bodies in the same way. As one participant articulated, many service providers continue to perceive their patients through a biological essentialist lens:

The issue was that, I think for some people, … it’s just easier to revert to what they’re familiar with and their baseline is that women get pregnant and men give sperm— even though that’s only true half of the time—so I think, for a lot of them, it was just a lot easier to just revert to that. (Participant 104A)

Within a biological essentialist framework only those individuals who contribute gametes are perceived as being the parents of the prospective child. One participant felt that this framework ultimately rendered his partner invisible because he did not contribute gametes:

In a way, [my partner] became more and more invisible because once he wasn’t giving sperm […] I end up being the patient. Whereas, I think for other couples who are going that are a man and a woman and the man, for whatever reason, can’t produce sperm, then … the couple are the patient. But because there wasn’t anything physically that they were
doing with [my partner] then he was just, like, scraps. (Participant 104A)

This participant also discussed ways in which providers were unable to acknowledge his gender identity, as demonstrated by their perception of him as a prospective mother:

And one of the nurses— like the head nurse there— she’s really nice. She’s so friendly. But … she just could not get my gender. No matter how many times she was … spoken to about it. I spoke to her about it. And I can remember her saying, “Oh you know, this cycle isn’t that good. You know, if it was my daughter, I’d tell her don’t do it this cycle.” Or, you know, “You’re going to be a mom! That’s fantastic!” … She just couldn’t get it. (Participant 104A)

In some instances, providers’ lack of education about trans identities, cissexism and transphobia led them to be explicitly dismissive of the participants and their gender identity:

So the doctor, [name], as [my partner] said, she was really not educated, I guess, about what it was to deal with trans clients. So, for example, she— when we were going over our medical history—she kind of dismissed, and this is a verbal … a literal quote verbatim: “Your transgender stuff.” [That] was basically my medical history. First of all, I never identified myself as transgendered … I more identify as TS\textsuperscript{6} … so she kind of invented that term. And, you know, the idea of, “stuff” just … negates the experiences as well. (Participant 8B)

Well, I started being up front [when calling AHR clinics] and [disclosing to them that I

\textsuperscript{6} Transsexual
am trans] because I knew well, you know, it’s gonna come out, like – obviously I’m gonna have to have to disclose it to, to someone, so it’s like, what’s the point in … hiding it, right? They’re gonna know. But then it got to the point where [pause] I was kinda experimenting afterwards in not mentioning it, ‘cause you’re dealing with reception [at the clinic when you call for information]. And [they were] more willing to help when I wasn’t bringing up transgender: “You just get the referral, oh yes.” You know? “We’ll have ya in and we’ll do an evaluation.” Completely different tune. (Participant 105)

The above quote illustrates that some AHR clinics in Ontario provide differential access to treatment on the basis of one’s gender identity.

3.4.3 Fertility Counseling

The Assisted Human Reproduction Act (AHRA) (Department of Justice Canada, 2007) states that counseling services must be provided to individuals accessing third-party reproduction services. In a document that outlines practice guidelines for AHR counsellors, the Canadian Fertility and Andrology Society Counselling Special Interest Group (CSIG) (2009) suggests that the purpose of AHR counseling is to provide support for individuals and couples with fertility problems and to aid them in navigating psychosocial challenges associated with building a family through the use of AHR such as stress and uncertainty, feelings of grief and loss and interpersonal conflict. The underlying assumption throughout these practice guidelines is that individuals and couples who access AHR services are experiencing involuntary childlessness.

Four couples interviewed for our study accessed third party gametes. However, only two couples were required by a service provider to attend counseling. While it is unclear why the remaining participants were not required to attend fertility counseling, one couple may have been
exempt because they did not access gametes through the clinic. Instead, they inseminated at home with a known sperm donor.

One couple reported that their doctor insisted that fertility counseling was a legal requirement of the clinic. However, their doctor did not clarify why it was mandatory or whether all couples were mandated to attend counseling in situations where one of the parents would not be biologically related to the prospective child. From talking with other patients at the clinic, the couple later learned that not all patients that were accessing third-party reproductive material at that clinic were asked to attend counseling. This discovery led them to question what had prompted their doctor to insist that counseling was a legal requirement of the clinic:

Was it mandatory that we go through counseling even though it wouldn’t have been mandatory if [my partner] was a non-trans man and I was a non-trans woman? It would not have been mandatory. (Participant 104A)

Under the AHRA regulations, this participant and his partner would have been asked to attend counseling because they were accessing third party gametes. However, in the apparent absence of a consistent process for referring patients to a fertility counselor, this participant understandably questioned why he and his partner were mandated to attend counseling when others seemingly were not.

When counseling was mandated by the fertility clinic, participants reported that their interactions with the counselors at the clinic were positive in nature:

We were told to see a counselor for an hour and we explained to the counselor the scenario. And she said, “It sounds like you’ve thought about it and planned it and you’re
of clear mind and I see no reason why you shouldn’t continue.” I didn’t realize that she was any kind of gatekeeper. I assumed that everybody talks to her [but my partner told me], “That’s not true. We’re being sent to her because we’re queer.” I dunno. I figure it was just a clinic thing that everyone has to talk to her. (Participant 74)

It is important to note that participants who were asked to attend counseling accessed AHR services at the same clinic. The participants’ positive interactions therefore likely occurred with the same counselor.

As demonstrated by the participants’ narratives above, providers did not clearly explain the intended purpose of fertility counseling to the participants. This lack of clarity led participants to speculate whether the counselor could potentially deny them accesses to services. In addition, despite having had a positive experience with their counselor, one couple expressed their frustration that they were mandated to attend the counseling in the first place:

I really resented that we had to do this because it was just completely discrimination because, to me, if you’re not gonna make everybody do this, maybe every single person who’s going to become a parent … on the planet [pause] if they don’t have to do this, why do we have to do this to somehow justify that we’re stable enough to consider this? Like, this is so [pause] we’re so other and outside of the norm that therefore there must be [pause] you must have to test us and check to make sure that we’re sane enough to be able to do this. (Participant 104A)

It is evident from the quote above that the participant did not believe that the use of third party gametes should warrant counseling and that he felt like he was being asked to demonstrate his suitability to become a parent by attending counseling. Additionally, it is interesting to note that
in both instances where participants were asked to attend counseling, either the participants or their partners perceived that they were made to attend counseling because they were trans and/or queer.

3.4.4 Positive Experiences with Providers

While the majority of AHR providers displayed a lack of knowledge and high degree of discomfort with trans people and their desire to create a family through the use of AHR, some participants encountered staff at fertility clinics who were warm and accepting of trans people and their partners:

One of the radiologists [pause] she totally got it. She was really nice. She always was. She just called me “sweetie” cuz I guess [pause] there, it’s like they’ll call you “mummy” or whatever. But she’s like, “Hey sweetie,” you know? Like, rather than calling me a gender-specific thing. (Participant 104A)

It’s interesting, I feel like the phlebotomist’s response to us was that we always showed up together, we were always clearly sweet on each other and tender with each other and she really likes couples who really want to be parents and who like each other become parents. And there were certainly some ultrasound techs who were you know, perfunctory, nobody ever said anything negative. I didn’t get called, “she” or “her.” … It wasn’t … bad but there were certainly ultrasound techs who clearly didn’t think we were great and weren’t excited about us becoming parents. The phlebotomist really did seem to think we were great and was totally excited that we wanted to become parents.

(Participant 40B)
In one instance, a trans man and his cisgender female partner had an extremely positive experience creating a family because the trans partner’s endocrinologist was also a fertility specialist. As a result, the doctor was well educated about trans-related health care and the clinic fostered a trans positive environment:

I think, for that kind of medical experience, that’s about the most positive we could’ve had. Cuz it was [my trans partner’s] doctor who knew him. And everyone in that office like, the receptionist is amazing, … lovely, very low-key, like not over-the-top but just it’s professional, it’s accepted, it’s fine. It’s not an issue. So I think, for me, on the partner end, it was nice because I wasn’t having to drag [my partner] somewhere that might be uncomfortable or having to reassure you or anything. It was like that was [my partner’s] space that [he showed to me], you know? [My partner] could show me where the door was, kind of thing. (Participant 78A)

3.5 Strategies for Navigating Instances of Transphobia and Cissexism

As previously discussed, doctors are often ill-prepared to work with trans individuals because they receive little training related to the specific health care needs of trans people, which influences the quality of care that trans people receive (Sperber et al., 2005). Due to personal and community knowledge about trans people’s experiences with health care providers, one couple discussed the ways in which they advocated for themselves during their encounters with AHR providers:

I think a lot of queer and trans people have had such negative experiences with medical practitioners—and I mean that really broadly—that they come in feeling really hesitant, come in feeling like they are already going to be treated badly and I think there is a real
difference between if you come in and act entitled, if you help a medical professional understand what their job is and how to do their job well and what you need. … So the question is, “What do you think is the most appropriate referral for a couple of trans guys?” Not, “Do you think this ok? Do you think this is the right thing to do? How should I figure this out?” The question is: “What the most appropriate referral?”

(Participant 40B)

While Participants 40A and 40B took a very active role in educating their providers and advocating for themselves, other participants discussed how they avoided confrontation with providers for various reasons. For example, one participant stated that he was “willing to let a lot slide” regarding the extent to which providers acknowledged and respected his gender identity because his primary concern was getting pregnant:

For queer-trans reasons, I wasn’t very concerned. I thought, whatever they call me I just want their help. And if they want me to be female, I don’t think I’m gonna say anything [or] if they want to call me the wrong name. I was counting on [my partner] to do some advocating for me. But … the priority was having the kid and if they treated me respectfully or took my concerns seriously, I was less worried. (Participant 74)

This participant acknowledged that he felt that it is hard for him to “objectively” judge the degree to which providers were welcoming of his trans identity because of what he referred to as “a bit of an inferiority complex.” In contrast to this participant, a second participant discussed how he initially was vigilant about correcting providers’ use of incorrect pronouns as well as providers’ use of his birth name. However, he stated that he eventually felt that it was easier to ignore providers’ lack of trans sensitivity, rather than correct them:
But, by the end—you know, it’s so early in the morning, you’re going every single day—by the end, I just brought a book and just tried to tune it out because it was easier than fighting every single time that I went there. (Participant 104A)

Additionally, this participant discussed how his decision to avoid confronting providers’ cisnormative and heteronormative assumptions was due, in part, to concerns that his self-advocacy would negatively impact the quality of care that he received:

I was very careful. … I could have been way more vocal about them getting my gender right [and] getting my name right. I could have been way more vocal about a lot of things. But, I needed them and, at the end of the day, every single day, they’re gonna stick a needle in my one vein. And they’re also going to probe me for the transvaginal ultrasounds. So, … I was outspoken as I could be, without making things too much more difficult for me.

( Participant 104A)

The participant’s hesitancy to advocate for himself highlights the extent to which the power imbalance between the participant and his providers influenced his decision to vocalize his concerns.
CHAPTER FOUR

4 Discussion

To our knowledge, this is the first study to explore the experiences of trans people who sought or accessed AHR services. While existing literature debates the ethics of assisting trans people to become parents through the use of AHR, our study demonstrates that the lived experiences of trans people move well beyond the scope of this literature. Trans people are having children through the use of AHR services. This reality necessitates a shift toward exploring the experiences of both trans parents and prospective parents as well as the ways in which AHR services can be improved to better meet the needs of this population. Some of the challenges that trans participants encountered were analogous to those experienced by cisgender LGBTQ individuals: the high cost of using AHR services; the medicalization of conception due to the presumption that individuals accessing reproductive technologies are doing so for reasons of infertility; providers’ heteronormative assumptions; and barriers associated with the use of known sperm donors (Ross et al., 2006a; Ross et al., 2006b). The experiences of trans participants also diverged from those of cisgender individuals in significant ways including the reasons that motivated some trans people to build their families through the use of AHR technologies rather than other methods; the challenges that trans people encountered when accessing AHR services due to cisnormativity and the absence of research on HRT and fertility; and the ways in which self-advocacy influenced the quality of care that they received.

Data from this study support Bauer et al.’s (2009) assertion that processes of erasure are rooted in, and supported by, cisnormativity. Participants encountered numerous challenges as
they attempted to navigate cisnormative health care environments that disallowed the possibility of trans bodies, identities and experiences. Participants’ narratives illuminated both passive and active forms of erasure, which occurred within the two domains outlined by Bauer et al.: informational systems and institutional policies (p.352). Examples of passive erasure included service providers’ lack of knowledge about trans-related health concerns, the exclusion of trans identities on administrative forms and the absence of formal policies that acknowledge trans identities. In contrast, examples of active erasure were highlighted by providers’ use of incorrect names and pronouns when referring to trans clients and one participant’s experience of being repeatedly denied access to AHR clinics. Results from the present analysis highlight the ways in which both active and passive forms of erasure inhibit trans people’s access to AHR services and influence the quality of care that they receive.

While the majority of trans participants interviewed for this study were ultimately able to access services, one individual was not only denied access but he was also prevented having an opportunity to consult a provider about his reproductive options. This participant discussed how providers responded to him more positively when he did not disclose his gender identity, indicating that some AHR clinics in Ontario provide differential access to prospective patients on the basis of gender identity. The *AHRA* currently legislates that: “persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status” (Department of Justice Canada, 2007, section 2, para. 5). Our findings clearly indicate that the *AHRA*’s non-discrimination clause is not being adhered to by all fertility clinics in Ontario. Amendments should therefore be made to the *AHRA* to explicitly prohibit discrimination on the basis of one’s gender identity. In keeping with the objectives of the *Canada Health Act* (Department of Justice Canada, 1985) all persons should
have equal access to health care services. This recommendation is made with the acknowledgement that the non-discrimination clause in the AHRA is currently not enforceable—with the exception of other avenues through which people could make human rights complaints—due to the absence of a provincial or federal governing process for AHR clinics in Canada. Therefore amending the AHRA’s nondiscrimination clause may be insufficient without the development of governing procedures or structures through which to regulate the practices of AHR clinics in Canada. Along with the regulation of AHR clinics, it may also be beneficial to develop a formal process that would enable service users to register formal complaints about AHR provider practices. While these recommendations are broad and extend beyond the specific needs of trans service users, they have the potential to improve the provision of AHR services to all individuals.

4.1 Decision to Choose AHR Over Other Methods

Our results indicate that trans people choose to have children through the use of AHR for many of the same reasons that cisgender lesbian, gay, bisexual and queer individuals do. For example, trans people’s desire to have biological offspring necessitates the use of assisted reproductive technologies and their process of becoming pregnant often follows a lengthy and thoughtful decision-making process (Mitchell & Green, 2007). In our study, one trans couple articulated two additional reasons for accessing AHR services that were specific to their experiences as trans people. First, their decision to access AHR services was due, in part, to anticipated transphobia and discrimination during an adoption home study might prevent them from successfully adopting. This finding is consistent with Pyne (2011c) who also found that trans people may avoid adoption due to anticipated transphobia. Second, due to the ways in which trans people have historically been “at the mercy of the medical system” (Participant
40A), the couple attempted to avoid the medicalization of conception—to the extent that this was possible—by purposefully selecting the reproductive services that they accessed. As a result, the couple went to a fertility clinic primarily for the purposes of cycle monitoring and conducted a home insemination with the use of a known sperm donor.

The trans couple’s concerns about transphobia within the adoption system are not unfounded given that recent studies indicate that adoption workers may possess insufficient knowledge about gender identity as it relates to trans people’s suitability as parents. For example, Ross, Epstein, Anderson et al. (2009) found that some adoption workers in Ontario are apprehensive about placing children with non-heterosexual nuclear families due to the perceived absence of appropriate male and female role models. This notion stems from the cissexist belief that there are two separate and discrete genders and implies that children’s development may be negatively impacted by the absence of “proper” gender role models. As a result of cissexism, heterosexism and homophobia, trans people are less likely to be viewed by adoption agencies as suitable parents (Ross, Epstein, Goldfinger & Yager, 2009). While a comprehensive review of trans people’s experiences with adoption extends beyond the scope of the present analysis, the findings from these studies illustrate that adoption workers require additional training related to gender identity and trans identities (Ross, Epstein, Anderson et al.).

4.2 The Absence of Information on Trans Health Issues

Trans participants identified a dearth of information and knowledge pertaining to trans lives and trans issues as a barrier to accessing AHR services. Participants discussed the ways in which they sought information related to various health topics, including transition and family planning (e.g., reproductive options that are available to trans people who wish to bank gametes or reproductive tissue for future use and the potential long-term effects of HRT on fertility) as
well as trans people’s experiences of accessing AHR services, only to discover that this information did not exist. Provider knowledge has also been identified in previous studies as one of the most commonly reported barriers to health care for trans people (e.g., Sanchez et al., 2009). Bauer et al. (2009) argues that informational erasure passively occurs both through the lack of knowledge on trans identities, trans lives and trans bodies as well as the deficient production and dissemination of new research focused on trans people’s experiences. In addition, our data suggest that as a result of this lack of information, many health care providers involved in the AHR system (including, but not limited to, doctors, nurses, fertility specialists, gynecologists and mental health processions) are ill prepared to work with trans people and their partners. For example, several participants discussed instances where they had to educate their providers about their bodies and gender identities.

This finding is consistent with literature that examines trans health care in both the United States and Canada, which demonstrates that trans people are often left to educate physicians about the provision of their health care (Bauer et al., 2009; Sperber et al., 2005). This problem largely stems from institutionalized cissexism, which has resulted in the absence of trans-related content in textbooks and curricula for health care professionals. Institutionalized cissexism refers to the ways in which social institutions are rooted in the notion that there are two discrete and differentiated genders: male and female. As a result of institutionalized cissexism, bodies and identities that transcend these two categories are perceived as aberrant and defective and are consequently not acknowledged in institutional policies, protocols and infrastructure (Bauer et al., 2009). For example, the expectation that all people are cissexual is apparent in educational curricula and texts for health care professionals. As mentioned in the Introduction, only 30% of 132 allopathic medical schools in Canada and the United States cover
issues related to gender transition and SRS (Obedin-Maliver et al., 2011) and eight of the most commonly used nursing textbooks include no reference to trans-related concerns (Eliason et al., 2010).

Both cissexist and heterosexist ideologies were illuminated by challenges that trans people encountered at AHR clinics in relation to administrative forms and government-issued documentation. During their initial encounters at AHR clinics, many participants reported that they altered administrative intake forms because the forms were designed for heterosexual cisgender couples. We interpret this finding as an indication of the prevalence of heterosexism and cissexism within the institution of medicine. Bauer et al. (2009) argues that cissnormativity is so deeply rooted that the possibility of trans identities is strikingly nonexistent, as demonstrated by participants’ experiences in our study. The invisibility of trans identities on clinical documentation influenced the quality of care that some participants received. For example, one participant reported that providers referred to him by his legal name, rather than chosen name, and used incorrect pronouns, even after the participant’s efforts to correct them. Similarly, another participant was incorrectly identified as “male” on her file at the clinic, even though the sex designation on her government-issued health documentation had been changed to female. The experiences of participants in this study are consistent with previous findings indicating that trans identities are erased at an institutional level through the absence of trans-friendly health care environments and some providers’ unwillingness to acknowledge trans identities by using incorrect pronouns when referring to trans patients (Bauer et al., 2009; Sperber et al., 2005).
4.3 Positive Experiences with AHR Providers

Despite these negative experiences, some participants also articulated positive experiences with AHR providers. Positive interactions were characterized by providers’ use of gender-neutral terminology, demonstration of warmth and support toward trans people and their partners and providers’ familiarity with trans identities and trans related health concerns. This finding is consistent with characteristics identified by Eady, Dobinson, and Ross (2011) that contributed to positive interactions between bisexual people and mental health providers. Eady et al. found that bisexual people’s positive encounters with mental health providers were characterized by providers’ use of open-ended questions, willingness to pursue education in order to enhance their understanding of bisexual identities and positive or neutral reactions to people’s disclosure of their sexuality. In an earlier study, Saulnier (2002) reported that lesbian women’s positive experiences with health care providers were also influenced by providers’ ability to understand the participants’ concerns within larger social, political and cultural contexts. These positive provider practices identified by participants in both this and other studies serve as a model of care that all health care professionals should begin to work toward.

4.4 Self-Advocacy

Findings from our study indicate that strategies employed by participants to navigate instances of transphobia and cissexism appear be associated with the quality of care that they received. Specifically, those individuals who advocated for themselves throughout their encounters with AHR clinics tended to report more positive experiences than those who did not. For example, one couple described their strategy of explaining to people how they expected to be treated. During their interview, the couple also expressed their high degree of comfort with confronting providers when they failed to act in a respectful manner. As a result of their
persistence and self-advocacy work, this couple felt that their interactions with providers were predominantly positive in nature. The researchers were unable to identify other existing literature that examines the impact of patient self-advocacy on the quality or provision of care in health-related settings.

The participants’ experiences may indicate that trans people who feel comfortable advocating for themselves and who are willing to challenge providers’ erroneous assumptions may be more likely to have their trans-specific needs met by the AHR system. Trans community education and skill building in this regard may be worthwhile. At the same time, it is important to recognize that trans people who wish to build a family through the use of AHR services are in a vulnerable position of needing access to those services. As a result, they may be hesitant to challenge providers for fear that they may be denied services or that their encounters with providers may become too uncomfortable. Further, we do not mean to imply that trans communities and individuals should be responsible for educating service providers about their health needs, nor that individuals who do not take an active role in advocating for themselves are at fault or responsible for their negative experiences with providers. Rather, trans community education and skill building should go hand in hand with appropriate trans-related training for service providers. Given that our data suggest the majority of AHR providers do not possess the skills or knowledge necessary to provide culturally competent care to trans people and their partners, service provider education should be a key priority.

4.5 Implications for Reproductive Planning and Access to Information about Trans Parenting

Given that many trans people may wish to have children and that feminizing and masculinizing therapies may result in infertility (De Sutter, 2001; De Sutter, 2009; De Sutter et
al., 2002; Hembree et al., 2009), physicians should explore reproductive options with trans patients prior to initiating HRT or before trans patients undergo surgical procedures to alter or remove reproductive organs. The WPATH (2011) Standards of Care recommends that health care professionals should discuss reproductive health with all trans people, even in situations where patients may not be interested in having children at the time of treatment. Additionally, the WPATH suggests that trans women should be informed about the option to cryopreserve sperm for future use, whereas trans men should be informed about the possibility of oocyte or embryo freezing. Despite these recommendations, not all of our participants had an opportunity to discuss their reproductive options prior to initiating their gender transition. Implications for service provider education are discussed below.

In addition to learning about their reproductive options, our data indicate that trans people and their partners require better access to information about the ways in which they can become parents through the use of AHR services as well as where to access services in their area. Individuals who wish to preserve genetic material prior to initiating their gender transition require information about their reproductive options as well as what services clinics are willing to offer. For example, trans men may wish to explore the possibility of banking oocytes or embryos, whereas trans women may wish to bank sperm. Clinics can advertise whether they are willing and prepared to work with trans people on their websites, in addition to providing a detailed list of the services that they offer. In addition, primary health care providers should be prepared to discuss reproductive options with trans people, especially at the time of gender transition.

Parenting courses such as “Transmasculine People Considering Pregnancy” also provide a way to share knowledge and support to trans people who are interested in having children.
within trans communities. As previously mentioned, this course is offered jointly by The 519 Church Street Community Centre and the LGBTQ Parenting Network in Toronto, Ontario, and it explores issues pertinent to prospective trans parents including information on the medical, social, financial and legal aspects of becoming parents. However, this is the only known formal group for trans people considering pregnancy and it may not be feasible for such courses to be offered in smaller communities. It may be possible to transcend geographical barriers by disseminating the “Transmasculine People Considering Pregnancy” course resources through the Internet. Online seminars or discussion forums may also provide a way to share existing knowledge about trans parenting to those individuals living within rural or isolated communities.

4.6 Implications for Service Provider Education

As illustrated throughout the present analysis, providers do not possess the knowledge necessary to adequately address trans health issues. This is a reflection of institutionalized cissexism and transphobia, which has left individual practitioners poorly equipped to work effectively with trans people. There are various ways in which to address this gap in knowledge. First, information about trans-related health concerns can be incorporated into educational curricula and textbooks for health care professionals including, but not limited to, physicians, nurses, medical technicians, occupational therapists, physiotherapists, social workers and midwives. Information to incorporate might include an explanation of the differences between biological sex, sexuality and gender identity; an overview of terminology including transgender, transsexual, MTF and FTM; a description of the impact of societal transphobia and cissexism on the physical and mental health of trans communities; information about hormone regimens and surgical procedures for trans people; and a guide to the ways in which service providers can provide culturally competent care to trans people and their partners (see below for a description
of cultural competence) (Vanderleest & Galper, 2009). In addition to increasing the amount of dedicated instruction time for trans-related content in educational curricula, Vanderleest and Galper suggest that literature outlining how to implement this material in schools is also greatly needed. Second, continuing education credits can be provided for workshops and seminars on trans health (Bauer et al., 2009). Finally, Rainbow Health Ontario (RHO) offers a variety of training and education opportunities about LGBTQ health including conferences, seminars, classroom presentations and CME clinical sessions. A complete description of the different resources can be found on the RHO website:

4.7 Providing Culturally Competent Care to Trans People and their Partners

4.7.1 Implications for AHR Service Providers

The findings from this study highlight the need for culturally competent service providers. The AHRA/LGBTQ Working Group (2008) defines cultural competency as, “an engaging, life-long journey of expanding your horizons, thinking critically about power and oppression, and behaving appropriately” (p. 5). When working with trans people and their partners, service providers can communicate their cultural competence in numerous ways. First, to aid in overcoming cisnormative assumptions, administrative intake forms can be designed to allow patients an opportunity to indicate what pronouns and first name they prefer to be referred to by. Second, providers can employ the use of gender-neutral language when working with prospective trans patients and their partners. This includes recognizing that not all people who become pregnant consider themselves “mothers” or use female pronouns. Additionally, not all individuals contributing sperm refer to themselves as “fathers” or use male pronouns. Third,
consistent with recommendations made elsewhere (see Ross et al., 2006a; Ross et al., 2006b; Sperber et al., 2005) providers should not assume that all consumers of AHR services are heterosexual-identified. Lastly, providers’ acknowledgement of trans identities can be communicated indirectly to patients by creating a trans-friendly environment through the designation of gender-neutral washrooms and the provision of pamphlets with trans-related content in clinic waiting rooms. For a detailed list of actions that organizations can take to improve their services, refer to Rainbow Health Network’s Educational Toolkit (Rainbow Health Network, 2009): [http://www.rainbowhealthnetwork.ca/node/24](http://www.rainbowhealthnetwork.ca/node/24)

4.7.2 Implications for Social Work Practice

Given the growing popularity of inter-professional health care teams, social workers are likely to encounter trans people and their partners within a variety of contexts during their careers. Two contexts in which social workers’ professional interactions with trans people may relate to fertility planning are primary health care and AHR settings. Within primary care settings, social workers may counsel trans people when they initiate their gender transition process. Trans people may enter psychotherapy prior to transition in order to explore questions about their gender identity and to discuss concerns about the ways in which transition may impact their life and relationships with peers, coworkers, family members and partners, as well as their intentions related to family planning. Within AHR settings, fertility doctors may require trans people and their partners to see a counselor prior to permitting access to AHR services. As previously discussed, the AHRA (Department of Justice Canada, 2007) states that counseling services must be provided to individuals accessing third-party reproduction services at fertility clinics. Given that many trans individuals must access third party gametes in order to create a family, they may be mandated to attend counseling. Social workers should therefore be culturally
competent about trans people, trans identities and trans communities in order to provide appropriate and respectful support and guidance (AHRA/LGBTQ Working Group, 2008; Carroll, Gilroy, & Ryan, 2002; Chen-Hayes, 2001; dickey & Loewy, 2010).

In the case of social workers’ professional encounters with trans people and their partners, culturally competent practice necessitates that professionals acknowledge the social, political and structural factors that create barriers for trans people and subsequently inhibit their access to resources. For example, mental health professionals have historically acted as gatekeepers in relation to trans people’s ability to access hormones and surgery (American Counseling Association, 2010; AHRA/LGBTQ Working Group). Additionally, practitioners should be aware of the ways in which their personal cultural identities, values and beliefs may influence their understanding of individuals from communities that are different from their own (AHRA/LGBTQ Working Group).

Cultural competence may be demonstrated in various ways, depending on the setting in which counseling is provided. In primary health care settings, social workers can communicate their cultural competence to clients in many of the same ways that have been suggested for AHR service providers (refer to the “Implications for AHR Service Providers” section above). Additionally, professionals should familiarize themselves with the options that are available for trans people who wish to medically and socially transition, including the various processes that trans people must complete before being approved for surgical procedures related to their gender transition (as outlined by the WPATH’s Standards of Care), information about which procedures are paid for by provincial health care insurance plans in Canada, and how trans people get approved for provincial funding for surgical procedures.
In AHR settings, social workers should recognize the ways in which the counseling needs for trans people may differ from those of cisgender, heterosexual, infertile, service users (AHRA/LGBTQ Working Group, 2008). The AHRA/LGBTQ Working Group, in a position paper in response to the AHRA (Department of Justice Canada, 2007), has identified that AHR clinics are often the primary point of access for conception for trans people (as well as may lesbian, gay, bisexual and queer people). As a result, trans people may be less likely then heterosexual service users to struggle with feelings of guilt, anger and shame associated with their inability to conceive on their own (AHRA/LGBTQ Working Group). If mandated to attend counseling before accessing AHR services, trans people may experience counseling as yet another form of gate-keeping in relation to important life changes that they wish to experience.

4.8 Study Limitations and Directions for Future Research

The present analysis provides valuable insight into the experiences of trans people who have sought or accessed AHR services in Ontario. To our knowledge, this study is the first to explore trans people’s experiences with AHR services, thereby making an important contribution to the research literature in this area. Despite the strengths of this analysis, some important limitations should be considered when interpreting our results. First, while the sample size used for this study was within the range typically suggested for phenomenological studies (Guest, Bunce, & Johnson, 2006; Starks & Brown Trinidad, 2007) it was relatively small and represented a broad range of experiences. The size of our sample had implications for theoretical saturation. Specifically, we were able to determine that AHR service providers are frequently unable to adequately address trans people’s needs; the pervasive absence of information about trans-related health concerns and trans parenting inhibits trans people’s access to AHR services; and cisnormative and heteronormative assumptions are both implicitly and explicitly
communicated to trans people and their partners throughout their encounters with AHR providers (e.g., clinical documentation and the use of incorrect pronouns and names). Given that the majority of participants were trans men who accessed AHR in order to have children, theoretical saturation was not attained with regards to the experiences of trans women as well as the experiences of trans people who access AHR services in order to cryopreserve gametes for future use. Additional research is needed to better understand these experiences. Second, the majority of participants lived within the Greater Toronto Area or other large urban cities and therefore had access to a broad range of services and community supports. Further studies are needed to explore factors that may influence trans people’s access to AHR services in rural areas of the province. Third, the data presented in this study are derived solely from interviews with trans people and their partners. As a result, our interpretation of trans people’s experiences at AHR clinics does not explore the experiences and perceptions of AHR providers. Future research would benefit from the involvement of administrative staff, physicians, medical technicians, nurses and mental health workers at AHR clinics. Finally, the Creating Our Families project was conducted by researchers at CAMH, an institution that is not well regarded by some trans people who have had to access its Gender Identity Clinic in order to be approved for provincial funding for sex reassignment surgeries. The researchers’ affiliation with CAMH may have therefore influenced some trans people’s decision not to participate in the study. Despite these limitations, we believe that the present analysis adds to the literature, as it is one of the first studies to illuminate the experiences of trans people who wish to have children through the use of AHR and it highlights directions for future research in this area.

To address the limitations of this study, future research with a larger, more diverse sample will aid in illuminating the unique challenges that trans people encounter when accessing
AHR services as well as the ways in which to improve the quality of services that they receive. Ideally, a more diverse sample would include greater representation of trans people who live in rural areas, who have accessed or attempted to access AHR services in order to preserve gametes for future use and who are from low socioeconomic and/or diverse racial/ethnic backgrounds. The involvement of AHR providers in future studies could investigate providers’ own levels of understanding of trans people and trans identities and the degree to which they feel prepared to work with trans people and their partners. These findings could be used to guide education and training programs for health care providers in the field of AHR.
CHAPTER FIVE

5 Conclusions

This study provides an initial examination of the experiences of trans people who sought or accessed AHR services in Ontario between 2007 and 2010. Our findings indicate that the experiences of trans people who access AHR services are different from those of cisgender individuals in significant ways including the reasons that motivate some trans people to build their families through the use of AHR technologies; the challenges that trans people encounter when accessing AHR services due to cisnormativity and the absence of research on HRT and fertility; and the ways in which self-advocacy appears to influence the quality of care that trans people receive. Cisnormative assumptions influenced trans people’s access to AHR clinics and their interactions with AHR providers in numerous ways including the lack of acknowledgement of trans identities on administrative paperwork, the use of incorrect pronouns when referring to trans people and the absence of trans-friendly clinic environments. Despite these challenges, some trans people also described positive experiences with individual AHR providers where providers used gender-neutral terminology or were familiar with trans health issues.
REFERENCES


Bauer, G., Boyce, M., Coleman, T., Kaay, M., Scanlon, K., & Travers, R. (2010, July 16).
from http://www.transpulse.ca

We’ve got work to do: Workplace discrimination and employment challenges for trans
http://www.transpulse.ca


Canadian Fertility and Andrology Society Counselling Special Interest Group (CSIG). (2009,
April 20, 2012 from
09_.pdf

pr/p1/2010/2010-08-21/html/order-decret-eng.html

Cameron, P. (2006). Children of homosexuals and transsexuals more apt to be homosexual.

*Journal of Biosocial Science, 38*(3), 413-418.

Carroll, L., Gilroy, P.J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender
variant clients. *Journal of Counseling and Development, 80*, 131-139

making in lesbian couples planning motherhood via donor insemination. *Family


De Sutter, P. (2003). Donor inseminations in partners of female-to-male transsexuals:


Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42(1), 89-101. doi:10.1300/J082v42n01_05


Pyne, J. (2011b). The kids won’t be alright: Cisnormative assumptions in research with the


APPENDIX A

Creating Our Families Recruitment Flyer

Are you lesbian, gay, bisexual, trans, or queer?

Have you used a fertility clinic or sperm bank in Ontario in the past three years?

- OR -

Have you considered using fertility clinics or sperm banks but didn’t because you faced barriers or thought you might?

- Our goal is to learn about the experiences of LGBTQ people with assisted human reproduction services in Ontario.
- Participation includes a 1 hour interview.
- Compensation will be provided.
- Wheelchair accessible interview space, ASL available

For more information or to participate please contact us:

Phone: 1-866-371-6667 or (416) 535-8501 x 7384
E-mail: creating_families@camh.net

Creating Our Families
The Research Project

The Creating Our Families Research Project

ARE YOU LESBIAN, GAY, BISEXUAL, TRANS, OR QUEER?

Have you used a fertility clinic or sperm bank in Ontario in the past three years?

- OR -

Have you considered using fertility clinics or sperm banks but didn’t because you faced barriers or thought you might?

- Our goal is to learn about the experiences of LGBTQ people with assisted human reproduction services in Ontario.
- Participation includes a 1 hour interview.
- Compensation will be provided.
- Wheelchair accessible interview space, ASL available

For more information or to participate please contact us:

Phone: 1-866-371-6667 or (416) 535-8501 x 7384
E-mail: creating_families@camh.net

Creating Our Families
The Research Project
APPENDIX B

Creating Our Families Qualitative Interview Guide

1. Tell me about how you (you and your partner, your co-parent) came to the decision to have kids. In this study, we’re interested in hearing about people’s experiences with assisted human reproduction (AHR) services. AHR services include things like donor insemination, in vitro fertilization, egg donation and other services that are typically offered through fertility clinics, doctor’s offices and sperm banks.

2. How did you come to consider AHR services as a possibility in building your family?

   A) Did you consider or try any other options for having children?

   B) When you were making your decision to use AHR services, where did you go for information about AHR? (How did you find out where to go for information?

      i) Was there any particular information you couldn’t find or had difficulty finding?

      ii) Did you come across any specific information for LGBT people about AHR?

   C) (If used services) What services, processes or programs did you make use of?

      Who used them? Was it you, your partner, your co-parent, a donor, a surrogate or someone else?

3. What did you imagine [the service] would be like?

   A) Were you looking forward to your first visit? Feeling apprehensive?

   B) Did you have any specific worries or concerns?

If the participant accessed any services, proceed to question 4. If they did not access services, skip to question 10.
4. Tell me about the first steps you took when you decided to access AHR services.
   
   A) How did you get a referral?
   
   B) How did you decide which AHR clinic to work with? (Did you have a choice?)

5. Tell me about your first interactions with \textit{the service}.
   
   A) Did you feel welcomed, uncomfortable, etc.?
   
   B) Did they have any LGBT-specific resources?

6. Tell us about the process after that.
   
   A) What providers were involved in your care?
   
   B) Who went with you to your appointments
   
   C) Can you remember a particularly good or bad experience with your provider or clinic that you would like to share with us?
   
   D) Thinking back on your experiences, would you say you faced any particular challenges or difficulties in accessing AHR services? (Were these barriers related to your sexual orientation or gender identity? How?)
   
   E) Was there anything that happened during the process that was really helpful to you?
   
   F) \textit{[If applicable—FERTILITY INTERVENTIONS]} Was it ever recommended that you take fertility drugs, or have any other interventions related to your fertility? How did you feel about that? (Did you feel like you were given a choice whether or not to have these interventions? Did you have all of the information you needed to make a decision? Did you feel like you were in control of your care?)
G) [If applicable—COMING OUT] How did you decide whether or not to out yourself to your AHR service providers? (At what stage did you decide to come out? Did you come out to everyone or only to some providers? What kind of reactions did you get when you came out? Did you ever feel you had to conceal your sexual orientation, gender identity or family configuration? Why did you feel that way? What was that like for you?)

H) [If applicable—LEGAL ISSUES] Were there any legal issues that arose?

9. Were you offered or required to have a counseling visit prior to receiving AHR services? (If yes, did you have one?)

   A) What was your experience with the counseling process?
   B) What did you talk about?
   C) Was there anything about the counseling session that was particularly helpful?
   D) Anything that seemed unhelpful or inappropriate to you?
   E) [If applicable] Was there any concern expressed about having different-sex role models for your children?

For those who DID NOT access services, proceed to question 10. If the participant did access services, skip to question 12.

10. So I understand from the information you gave us over the phone that you ultimately did not use AHR services. Can you talk about the factors that led to that?

   A) Did you choose not to use services, or was that decision made for you by someone else? (Who? Why?)
   B) Were there any issues specifically related to your sexual orientation or gender identity?
C) Were there any issues related to cost of services? Other practical issues?

11. Did you continue to try to build a family after AHR services were no longer a possibility for you?
   A) [If yes] How did you go about doing that?
   B) [If no] Why did you decide to stop?

12. Thinking back on your experience, do you feel that you had any unique experiences or needs related to your identity as a [Insert relevant identity/identities (eg. lesbian, gay man, bisexual person and/or trans person)]?
   A) What about other identities that are important to you? [Probe: age, race/ethnicity, social class, disability]
   B) [If participant lives outside of the GTA or Ottawa]: Do you think there is anything unique about your experiences with AHR services because you live here? [Probes: Did you have to travel to access services? How far? What was that like for you?]

13. Based on your experiences, if you had five minutes with someone who could really make change in the AHR system, what would you recommend to them?

14. Is there anything we haven’t covered that you feel is important for us to know about?