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Conceptions of transgender parenthood in fertility care and family planning in Sweden: from reproductive rights to concrete practices

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ABSTRACT

It is an oft-repeated trope that the recent medical advances in the field of assisted reproduction have radically transformed the ways in which we can achieve, practice and imagine parenthood. This development has enabled new forms of non-heterosexual family constellations, including same-sex nuclear families and solo-parents by choice, and as a result an increasing number of groups are mobilising politically for access to fertility treatments. Swedish transgender patients are one of these groups; after many years of political mobilisation, they are no longer required by law to go through sterilisation as a compulsory part of gender corrective surgery, and instead today, all transgender patients are offered fertility preservation through gamete freezing. This, in turn, has meant not only that Swedish fertility clinics have faced an entirely new patient group – the transgender fertility patient – but also that the cultural imagination of who can become a parent and what a family might look like is becoming further destabilised. Building on interviews with medical staff, LGBTQ-advocates and complementing qualitative data, this paper seeks to shed light on the very process by which these new rights are translated in the practical context of the fertility clinic, and also what it means, more generally, for cultural imaginations of parenting when a group whose reproductive futures were previously considered either impossible or undesirable are now ‘anticipating infertility’ and engaging in ‘family planning’ as central parts of their lifecourse and medical engagements.

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Sweden was the first country in the world to regulate what is today commonly referred to as gender reassignment or gender affirmation treatment. *The law on determination of sex in special cases (Lagen om fastställande av könstillhörighet i vissa fall (1972:19))* was instigated in 1972. It required patients to be unmarried, over 18 years old, Swedish citizens, and sterile. In practice, this meant that sterilisation became a normalised part of the treatment process, regardless of whether the patient desired the procedure or not (Author 2 2016). Although we need to consider the historical context at the time – same-sex marriage did not yet exist, and IVF-technology had not yet made fertilisation *ex-vivo* (outside of the body) possible

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– it is noteworthy that one explicit reason for sterilisation was to retain a bilineal, gender-binary, and what we today would call *cis-normative* kinship structure. In the preparatory works for the law, the need for sterilisation is explained as being ‘necessary to fully eliminate the risk of confusion in the kinship relationships’ that would occur if a transsexual person would have children post-surgery (Proposition:6, 50).

Since 2013 sterilisation is no longer a compulsory part of gender affirmation treatment.¹ Instead, this patient group is now offered fertility preservation as part of their treatment, which is subsidised and part of publicly funded healthcare. In combination with more inclusive marriage and family laws, as well as medical advancements in the field of assisted reproduction and fertility preservation, these legislative changes have significantly improved the possibilities for transgender people to become genetic parents. Building on interviews with medical staff and complementing qualitative data, this paper seeks to shed light on the very process by which these new rights are translated in the practical context of the fertility clinic, and also what it means, more generally, for cultural imaginations of parenting when ‘anticipating infertility’ and ‘family planning’ become central parts of the treatment for a group whose reproductive futures were previously considered either impossible or undesirable.

Aim and objectives

This paper investigates how, from the perspective of medical professionals and transgender advocates, the abolished sterilisation requirement and changing cultural imaginations about transgender people as (actual or potential) parents have led to new practices in the clinical setting of reproductive care. Specifically, the paper explores on the one hand the process by which the medical staff came to change their conceptions of transgender reproduction and parenting, and on the other how the professionals perceive the remaining obstacles for full implementation of transgender reproductive rights, including fertility treatment, family planning and parenting. By drawing on interviews with professionals working with issues of transgender reproduction and parenting and contextualising qualitative data, it seeks to complement existing research and official reports on patients’ perspectives (e.g. Bremer 2011; von Doussa, Power and Riggs 2015; SOU 2017:92; Armuand et al. 2017). Thereby, the paper contributes novel insights towards how transgender fertility care and family planning can be further improved, and move closer to the goal of fully implementing these newly won reproductive rights in concrete clinical practices.

Methodology

The empirical data consists of seven interviews with seven professionals², as well as secondary data, including an observation of a half-day of lectures on transgender issues, analysis of two governmental reports, a website on transgender reproduction and parenting, information materials and medical forms. Interviewees were recruited by what best can be described as ‘strategic snowballing’. Initial contacts were made with two ‘key informants’, one at the unit for transgender care and one at the unit for reproductive medicine at the Karolinska University hospital in Stockholm. The key informants provided useful information about other professionals engaged in transgender care, sometimes including specific contact details. All interviewees were contacted by e-mail, and received a description of the

research plan before agreeing to take part in the interview. The interviews lasted between 30 and 80 minutes (on average around 60 minutes). The interviewees have been purposefully selected to construct a dataset that provides a broad range of professional perspectives on transgender reproductive care in contemporary Sweden (Gray 2002: 101). All interviews were recorded, transcribed and coded in MAXQDA.

Interviewees, ethical considerations and anonymisation

All seven interviewees are central professionals in the field of transgender rights, fertility and/or parenthood. All of the medical professionals work at the Karolinska University Hospital in Stockholm at one of the two units involved in treatments related to transgender reproduction (the unit for transgender care and the unit for reproductive medicine). The two other professionals work with family matters at the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL), a national non-profit organisation working for LGBTQ-rights.³

Cecilia Dhejne, who is consultant and specialist in psychiatry and sexual medicine at ANOVA (the unit for transgender care) has been interviewed twice: once in 2015 by the first author and again by the second author in 2017. The other interviewees, 'Orvar' (consultant in andrology and sexual medicine), Kenny Rodriguez-Wallberg (consultant and specialist in obstetrics and gynecology at the unit for reproductive medicine), 'Beatriz' (midwife at the unit for reproductive medicine), 'Agneta' (associate professor and specialist in gynecology at the unit for reproductive medicine), and Veronica Berg Hulthén and Anna Nordqvist (RFSL) were all interviewed by the second author in 2017. All interviewees were interviewed individually, except for Veronica and Anna, who were interviewed together. Cecilia, Kenny, Veronica and Anna have been active in public debates on transgender reproduction and are therefore, unlike 'Orvar', 'Beatriz' and 'Agneta', not anonymised. All interviewees have consented to be cited for publication, and have been given the opportunity to read a previous draft of this paper to approve their quotes. The study was partly financed by the Swedish Research Council. The study was conducted in accordance with the principles of the CODEX website (Vetenskapsrådet) and Södertörn University.

Background: Transgender reproduction and non-cis parenting

A review of existing research including 51 studies from Europe and North-America (none of which were conducted in the Swedish context) shows that it is common for transgender individuals to be parents, but proportionally less so than in the general population. It also shows that transgender parents are more often subjected to discrimination in contact with authorities (e.g. adoption processes, issues concerning custody) (Stotzer, Herman and Hasenbush 2014; also cited in: SOU 2017:92, 244). There is also a growing number of studies on transgender fertility preservation, mainly from medical and bioethical perspectives, arguing for increased access to fertility medicine (see e.g. Murphy 2012; Nixon 2014; Chen et al. 2017). One study discusses barriers to high quality healthcare for pregnant men in the US-context, recommending improvements such as electronic medical records and staff training, and identifies the needs for increased knowledge about the post-partum period (e.g. the need to tackle feelings of isolation) (Berger et al. 2015). Another US survey-based study on transmen's experiences of pregnancy and birth confirms that this patient group often desires to have children

and are prepared to achieve this goal by going through pregnancy, but also that they express a wish for better information about options for fertility preservation and treatment, as well as access to trans-friendly healthcare providers (Light et al. 2014).

A number of studies analyse the cultural representations of pregnant men, and in particular of Thomas Beatie⁴ – a transman who has gained international recognition precisely for his pregnancy – have been published. Damien Riggs has analysed expressions of ‘mundane transphobia’ in the Oprah Winfrey talk show, whereby Winfrey in interviewing Beatie utilises a variety of gender-normative rhetorical tropes that renders Beatie as ‘not quite’ a father and ‘not quite’ a man (Riggs 2014). Jasper Verlinden has argued that although the significance of this episode of the Oprah Winfrey show is sometimes overestimated, it was indeed a ‘watershed moment’ for cultural representations of male pregnancies and transgender identity (2012: 109). As we shall see, Beatie’s international visibility also played a crucial role for the medical professionals interviewed for our study. Riggs has also analysed transmen’s self-representations in online media such as blogs, concluding that their narratives demonstrate that it is possible to renegotiate cultural conceptions of pregnancy and fatherhood and that biology and identity are not necessarily connected. Therefore, he argues that health care staff ‘must acknowledge how gender norms shape individual health care needs’, and take into account both similarities and differences between pregnant women and pregnant men (Riggs 2013). Michael Toze has discussed how the ‘cultural unthinkability’ of pregnant men has impacted UK healthcare policy, for example by encouraging hysterectomy, even though sterilisation has never been explicitly required by UK legislation (2018).

There is still a lack of qualitative interview studies on transgender reproductive care and parenthood. One notable Canadian example, however, is offered by James-Abra et al. (2015), who interviewed 40 transgender individuals and their partners. In this study, only two couples described their contact with medical staff as predominantly positive, insofar as that the latter had offered a warm and trans-friendly clinical environment and used gender-neutral terminology. The negative experiences reported by the majority of respondents included the use of cis- or heteronormative language and assumptions, problems with documentation, and being denied certain treatments. Thus, in its conclusions, this study called for staff training, and recommended that transgender patients be included in the process of improving care. In the European context, UK Sociologist Sally Hines (2006, 2007) has conducted important qualitative research on transgender individuals’ partnering and parenting practices, the latter related to coming out processes in relation to already existing children. Henry von Doussa, Jennifer Power and Damien Riggs (2015) have conducted an interview study with Australian transgender adults, some of whom were parents. They found on the one hand that normative understandings about gender and parenthood shaped the imaginations and desires of parenthood of their interviewees, but that on the other these norms were re-negotiated and contested by them.

There is one study to date that has investigated the issue of fertility preservation (freezing of eggs) for transmen in the Swedish context.⁵ The study reports that the 15 respondents did experience some distress in relation to fertility preservation: because of the associations made between reproductive organs and tissue and the gender assigned by birth, the procedures involved negatively impacted some patients’ gender dysphoria. The fact that fertility preservation delays or temporarily stops other treatments (due to waiting lists and/or pausing testosterone treatment) often added further distress. The study found, however, that the patients had coping strategies to help them to go through the treatment. It also

recommended staff to use gender-neutral vocabulary, so as to decrease the risk of negatively impacting the patients' gender dysphoria (Armuañ et al. 2017).

Theoretical starting points: Biomedicalisation, de-naturalisation and re-conceptualisation

Each new technology of assisted reproduction constitutes a 'dislocatory break' with existing hegemonic discourses of reproduction and parenthood (Laclau 1990; Tinnerholm Ljungberg 2015, 225). Although some of these 'breaks' are more 'dislocatory' than others, what they have in common is that they in one way or another break with culturally dominant ideas of what reproduction 'is' and what forms of reproduction are possible. Therefore, they also have the potential to de-stabilise which forms of reproduction are considered 'normal' and 'desirable'.

As a consequence, in order to become established as commonly used practice, every new invention is necessarily followed by processes of what Charis Thompson calls *normalisation* and *routinisation* of medical practices (Thompson 2005, 80). In Sweden, and many other places, assisted reproductive technologies that were once considered 'unnatural' or 'undesirable' are now legally regulated and routinised in fertility clinics and maternity wards, including non-heterosexual forms of reproduction such as donor conception for lesbian couples and single women. Following this, the biomedicalisation of reproduction has destabilised 'the dichotomy between heterosexual and homosexual experience and the institution of the family, the grounds upon which dichotomous gender is reinforced and maintained' (2007, 3). But, as implied in the term normalisation, each such process generates a new 'normal' as well as new norms (Thomson 2005, 80).

One such new norm that has been discussed by scholars of biomedicalisation is the increased emphasis on health (rather than illness) and individual (rather than public) responsibility that has followed in its wake (Clarke 2003, 171–2). With regards to fertility preservation specifically, this tendency has been acknowledged in relation to so-called 'social egg-freezing' whereby women freeze their eggs in anticipation of age-related infertility, a phenomenon Lauren Jade Martin (2010) has called 'anticipated infertility'. By extending fertility treatment to groups of people that are not actually yet diagnosed as infertile, she argues precisely that there has been a discursive shift in emphasis from 'reproductive illness' to 'reproductive health'. With these developments, she argues, it 'also becomes an *obligation* of those experiencing anticipated infertility to ensure their future reproductive capacity' (2010, 531, emphasis added). Similar criticisms of fertility preservation as contributing to a 'reproductive imperative' have been raised by Jack Halberstam, who has questioned the queer radical potential of Beatie's story, arguing that it rests too much on a 'universalist' narrative that normalises 'everyone's' desire to become a parent (2010, 78). Indeed, as Faircloth and Zeynep (2017) argue, the current culture in both assisted reproductive technologies and parenting is one that requires increased reflexivity and accountability from users, who must not only engage with increasing medical and technological expertise but also negotiate their relationship to normative expectations. For the purposes of this paper, and considering the long struggle to abolish the requirement for sterilisation as a 'natural consequence' of gender affirmation treatment, we argue that the risk of such a reproductive imperative is less relevant to our study than the need for increased recognition of transgender individuals as (potential) parents – and hence (potential) fertility patients.

From normalisation to routinisation in transgender reproductive care

As Author 1 (2013) has argued in a previous study, a crucial political strategy in the debates that ultimately led to abolishing the requirement for sterilisation was to normalise the desire of transgender individuals to have their 'own' children, most notably by drawing on hegemonic and culturally recognisable discourses of parenthood (especially motherhood) and involuntary childlessness, as well as the publicly acknowledged condemnation of previously practiced forms of involuntary sterilisation. As we shall see, the same two themes are prevalent in Cecilia's memories from the time when she herself started to question the legitimacy of the sterilisation requirement and instead began to reconceptualise transgender patients as potential parents.

'A normal family': Normalising transgender reproduction

Cecilia, who has worked with transgender patients since 1999 and today is an outspoken advocate for transgender reproductive rights, describes that the issue of reproduction was mainly considered a 'non-issue' for her and her colleagues in the clinic until the years around 2005–2006. Prior to this time, it was simply so normalised that gender affirmation treatment would automatically exclude future reproduction.

However, as organisations such as RFSL began to raise the issue of sterilisation politically and a new governmental investigation was awaited, things also started to change in the clinic. One notable difference from previous years, she says, was that around 2005, an increasing number of patients seeking full treatment (including surgery) began procrastinating on sending in their applications for changing their legal gender to the Legal Council. They wanted to 'wait a little'. 'And' explains Cecilia, 'finally we began to understand that they were waiting for a new legislation'.

A specific event that she recalls, and comes back to in both of our interviews, is a memory that perhaps can best be described as a 'watershed moment'. This is a meeting in the clinic, whereby a parent of one of her patients asked whether the planned surgery would mean that she would lose the prospects of ever becoming a grandmother. (Meeting patients' parents can be part of the diagnostic process.) When parents started to ask 'Will I not be able to become a grandparent?', she realised that she had to respond 'No, you can't, because we have a *law* that states that your child is not allowed to reproduce.' 'That's what I was supposed to say! That's what I *had* to say!'; she emphasises.

One thing that stands out in her account is the affective grip of the generational narrative, whereby sterilisation becomes de-normalised and re-described as an undesirable or even unacceptable practice that breaks generational lineage and introduces an unnecessary loss in the family (the loss of future grandchildren). But this process of de-normalising sterilisation, she says, was not sudden, but emerged gradually over time. She describes how she and the rest of the staff working at the unit for transgender care in Stockholm began to discuss the consequences of abolishing sterilisation in their regular meetings. The possible emergence of pregnant men was discussed specifically. Initially, many had thought the idea to be strange, and questions had cohered around the possibility of a transman 'still being trans' if accepting or desiring to be pregnant. Would a person wanting to be pregnant still 'really' be a man?

Interestingly, another 'watershed moment' described by Cecilia involved a visit by Thomas Beatie, who coincidentally was invited to give the opening speech at Stockholm Pride in 2011.

Some members of the medical team heard the speech, and when a patient suggested that they should try to arrange a meeting with him, many medical professionals showed an interest. In the end, around 15 medical professionals gathered to meet with Thomas Beatie in the RFSL building. This meeting is described as having made a big difference for Cecilia and her colleagues insofar as it helped those in the team who had been sceptical to understand that in fact, the issue of male pregnancy was not necessarily so strange. Significantly, this meeting served a crucial role in normalising male pregnancy. Meeting Beatie's family made a big impact on the team. Cecilia recalls that 'they had three children, and those kids were running around and seemed just like any other little rascals (*busungar*)', again demonstrating the normalising effect of describing families of transgender persons as being 'just like any other family'.

Cecilia also remembers that Beatie had 'explained very patiently to' them that they had 'wanted children and his wife could not [carry] them because she had had her uterus removed' and that 'he might not have loved being pregnant but it was important for them to have genetically related children, so he decided to put up with it'. The description of Beatie's choice to be pregnant as a pragmatic one made at least in part because his wife could not be pregnant, further adds to the sense of 'normality', as it alludes to dominant cultural assumptions that the desire to have children is more or less universal and that, in the wake of the biomedicalisation of reproduction, there is a range of ways to fulfil this desire.

Cecilia also emphasises the importance of personal meetings more generally as crucial for the process of normalising transgender fertility treatment. She acknowledges the difficulty for a cis-person to empathise with a transperson's feelings in relation to their body and explains that it may be different for those professionals who work with transgender patients in their everyday work life: 'we learn to understand this through our patients', she says. She continues to explain that 'this thing about pregnancy was extremely difficult to envision [to many]; it is not out of spite [that they are/were skeptical], but it makes an enormous difference if one has met [transgender] people [or not], for the personal sense of it'. She also describes this year, 2011, as not only the year when the issue of sterilisation in gender affirmation care began to be seriously debated in public, but also the time that she and some of her colleagues began working more actively for a law change, in parallel and sometimes in collaboration with RFSL who offered their expertise on LGBTQ reproduction.

New routines: Integrating fertility treatment into transgender care

In the clinical context, much of the initial work of 'translating' the 'new normal' of transgender reproduction to concrete routines and habits cohered around dealing with the organisational and policy structures of the hospital. The dilemma the clinicians faced before the law change was that technologies for fertility preservation were available in the fertility unit, but the legal restrictions meant that they could not formally refer their patients there – although they could inform them of its existence and services. In a sense, we can say that this phase consisted of a form of tactical and informal routinisation. As a result, some patients managed to freeze their gametes before the new law was instigated. 'Beatriz' (midwife at the fertility clinic) reveals that there was one man who just before she was employed there managed to conceive using his own frozen eggs. 'And that was before the law change actually', she adds. When asked further about the period before the law change, 'Beatriz' explains that transwomen had frozen their gametes in the clinic before: 'Yes, I know that, they have had access to the sperm lab for a long time.'

But it was only after the sterilisation requirement was actually abolished in 2013 that the work of constructing a new care chain to fully integrate fertility preservation into transgender affirmation treatment could begin – and this was by no means a straightforward process. It involved, among other things, negotiations with the fertility clinic including knowledge exchange between the different units concerning the medical and psychosocial needs of this specific patient group. ‘Orvar’ describes how at this time, transgender fertility patients were still an unknown patient group in Swedish fertility care: ‘for them, this was like turning a whole lot of conceptions upside down and that was very important, to give them the chance to understand this patient group’. He describes the importance of education for staff, because ‘if one has not had a chance think through and be confronted with [new, non-normative] ways of thinking, they can be experienced as provocative, or very odd’. Much of this work was conducted in cooperation with RFSL, members of which participated in meetings with staff and leadership of the fertility clinic to inform them about the specific situation and needs of transgender patients, and assisted with practical advice (including how to design forms that were neither hetero- nor cis-normative). As the work progressed, an increasing number of people became involved, among them representatives from RFSL who according to Cecilia ‘did a massive job!’. The patients, she says ‘did a real pioneering work by explaining [to other medical professionals], without being frustrated, [...] And now I think it’s running very smoothly’.

In addition to the purely medical aspects, this work involved a large number of psychosocial and cultural issues of everyday hospital life and organisation. Examples of this include staff learning to avoid expressions that could be perceived as what Riggs (2013) refers to as ‘mundane transphobia’ by learning new habits of using the right pronouns, changing the colour and design of forms to be filled in by patients, and posters and images of gametes and reproductive organs. Cecilia remembers for example that ‘it turned out that the fertility units’ papers [forms] were extremely heteronormative and binary, [...] that they were pink [for egg-freezing]’, but also that the staff at the fertility unit had no to little experience of transgender patients and their needs.

Important needs to consider in the new routines included the effect that fertility preservation might have on the patient’s gender dysphoria. Both Kenny and ‘Beatriz’ explain that the very procedures involved in fertility preservation may cause distress because they involve reproductive organs and cells that are culturally – and for many emotionally – associated with the gender with which a transperson dis-identifies. Kenny explains that the use of vaginal ultrasound rod therefore can be emotionally difficult for a transman. Therefore, an important part of the treatment process is to explain why using this instrument is necessary to ‘get as close as possible to the ovaries through the vagina’. It is also important that clinicians understand that it can take a long time (even months) for some patients to become emotionally prepared for this procedure, and it is equally important that patients are aware that this is not an obligatory part of gender affirmation care. ‘Beatriz’ explains that fertility preservation may also cause distress for transwomen, who might not be comfortable with the procedure of depositing sperm. Some of the female patients decide against it for this reason.

Lagging routinisation

One pressing problem for this patient group is the long waiting time involved for both gender affirmation care and fertility preservation. In fact, the long waiting times constitute a crucial reason for some patients to decide against fertility preservation. Anna, who works

with issues LGBTQ-families at RFSL emphasises that ‘this is really something that needs to be tackled’ as ‘it can be a *long, long, long* wait in every step of gender affirmation care.’ She expresses a worry that ‘if we continue down this line, in five, ten years, we will have testimonials from people who had wanted [fertility preservation], but that because of the waiting lines have not received it’. Although, as her colleague Veronica says, waiting times is a problem in fertility care more generally, Veronica emphasises the ‘added layer’ of time and waiting lists for transgender patients specifically, because fertility preservation in itself adds another step to the process, and thereby delays gender affirmation treatments that the patient might feel are equally or more urgent.

‘Orvar’ speaks of the long waiting times as a result of a ‘lagging phase’ in healthcare, caused by the proportionally vast increase of patients entering the system in a relatively short period of time. Cecilia also confirms that ANOVA (the transgender care unit) have had an increase of remitted patients of about 30-50% each year: ‘In the year of 1999, 20 persons were remitted [in the Stockholm region] for medical investigations and treatment of gender dysphoria, a number that last year [2016] had increased to as many as 350’ (Dhejne 2017, see also Dhejne et al. 2014). Among young people, the increase after the sterilisation requirement was abolished is even starker, especially after 2013. Remittances to the unit that diagnoses young people under 18 years of age, have increased from only single cases each year to 197 individuals in 2016, with a dramatic increase since 2013 (Frisén, Söder and Rydelius 2017, 1).

‘Orvar’ explains this general increase as probably caused by a combination of factors, including increased visibility of transgender persons and issues in mainstream media, and increased possibilities of finding information and communities online, and most likely better treatments and the abolished sterilisation requirement. He also thinks that one possible explanation of the vast increase in the Stockholm clinic specifically might in part be a result of the high quality and good reputation of the clinic, and the fact that it attracts patients from other parts of the country. According to ‘Orvar’, unfortunately, the increase of patients has not been followed by a proportionate increase in financial resources. This, in turn, has led to what ‘Orvar’ calls a ‘lagging phase’ in transgender care:

It has gone very quickly, the increase. And that healthcare has, what shall I call it, a ‘lagging phase’ before it is possible to swallow new large patient groups. And such an increase is hard to keep up with. It also depends on the fact that our examination and treatment has been pretty attractive [among patients], I think, so that people from other parts of the country also come here. [...] (‘Orvar’)

In order to implement a sustainable working pace, he says, the clinic has had to develop a certain acceptance of waiting times in order to ensure a reasonable working environment for the staff.

It’s difficult to keep up, and you can’t pressure the staff too much either. You can do a little more, but you can’t do enough and then it’s just as well to see that ‘this level we can do, people do not get burnt out and manage to do a good job’. And then unfortunately it is the case that there are waiting lines, but it’s still better than if we would have worn out everyone here within two years. (‘Orvar’)

The lack of adequate increase of funds is felt at the unit for reproductive medicine as well. Both ‘Agneta’ and Kenny points out that it is a problem that they receive ‘new patients but not more funding’. Kenny emphasises that ‘It’s a fact that we don’t have any more doctors, but we have new patients that need resources, so well... we have done as well as we can’.

Crucially, waiting times for transgender patients are further exacerbated not only as a result of an increase in patients in the clinics, but also because the very extra step of fertility preservation takes time in itself. In addition, fertility preservation has consequences for when hormonal treatments can begin – hormonal treatments that are often urgently needed for psychosocial reasons. Cecilia emphasises that ‘[Waiting lists] are long! I don’t know. Sometimes [my colleague] says that it’s two-three months, but it feels like half a year, at least’, and explains that ‘And then they can’t begin hormonal treatment, so there are a lot of people who decides against [fertility preservation]. Although it is possible to begin hormonal treatment and temporarily stop taking then for fertility preservation, Cecilia points out that there are some uncertainties about how this might impact fertility, but adds that ‘But we don’t know how well they do in the freezer either, to be honest.’

Based on the narratives of the medical staff, the necessity that the legal recognition of transgender reproductive rights needs to be followed by adequate increase in resources. And that the long waiting times required to access this care are not only onerous for patients, but also deter some of them from seeking fertility preservation, which they may have desired under better practical circumstances.

From fertility preservation to a reproductive life-cycle perspective

Significantly, the obstacles for transgender individuals to become parents are not confined to available treatments, the quality of care or even psychosocial difficulties. Indeed, current regulations on assisted reproduction as well as family law are both strictly organised around a cis-normative understanding of kinship and family. As a consequence, transgender people who wish to use their gametes in the future might not be able to do so.

For example, a transman who is not partnered with a person who can gestate a child (e.g. a transwoman, or a cis-woman without a functioning uterus) will not be able to reproduce with the help of a surrogate, since surrogacy-related treatments are not legally permitted within the Swedish healthcare system, and gametes cannot be exported to another country. When asked what a transman could do in this situation, gynaecologist ‘Agneta’, who works in the fertility unit, simply responds that ‘Then you would have to store your sperm abroad.’ On the question of whether this is part of her information to the patients, she answer that she does if they ask. In the past, she says, they conveyed more information, but nowadays, ‘most of the time they are already informed, they come here as quite young.’ She explains that the patients are already well informed when they come for fertility preservation: ‘when they come here now, they have gone through their examinations, and then they have the right to this, so it is nothing that we question.’ Their role, she says, is more like ‘an egg-harvesting and sperm-saving unit’, but adds that

Well, we can... sometimes it’s possible to... ask if they have a partner, and of course if you have a transman here that has a [transwoman as partner], then, at least I normally inform them that today, according to the law, you have no possibility to use. Or, I mean with a male partner. That today there is no possibility to use [the sperm]. (‘Agneta’)

The situation described above is only one of many examples of obstacles that this patient group might face when wanting to become genetic parents. And for those who do manage to reproduce, family law continues to complicate the matter.

Lagging legislation

While 'Agneta's' impression is that the patients are well informed, Veronica, who worked with educational issues in RFSL around the years of 2012–2013, discovered that there was an acute lack of information about different ways for non-heterosexual and transgendered people to become parents.

In her quest to address this lack, she received funding for the project *HBTQ-familjer* that lasted between 2014 and 2017. Her colleague Anna, who also participated in the interview, joined the project in its final year and is at the time of the interview back at her job at RFSL national office, where 40% of her time is spent working with family matters. Veronica and Anna talk about how the family project expanded over time, and included a broad range of activities, including meeting places for LGBTQ families and their children, preparatory family courses, theme-days and -evenings, activities during Stockholm Pride, and the development of a website. They also educated professionals, such as midwives and medical doctors, participated in the media and took part in various referral groups. In short, the website expanded to offer resources and information for people outside of the hetero- and or cis-norms to navigate a system that is based on a cis-normative understanding of parental kinship.

It's like you say, the basic analysis is that regulations of fertility care and law, [and] family law, is adjusted after [the] cis-, hetero-, nuclear family, so to speak. Which means that the situation for LGBTQ-people become rather special, and we want to gather all information in one and the same place, [...] practically, legally, and medically, as it turned out. And it has to be fact checked and updated. [...] It's for that target group, LGBTQ-persons, who are or want to become parents, with an emphasis on want to, really...

The rationale behind the website is to gather all information about not only possibilities and rights, but also obstacles, possible solutions and instances that may not yet have a solution. While RFSL does work politically on removing obstacles for this group, Veronica argues that the website seek to respond to the concrete questions: 'Which possibilities are there? How can you do it? Which rights do you have, and which ones are lacking?' She states that 'It can be a nuisance that some rights are lacking, but you need to know!'

Legal regulations are central to both the website and the internal discussions held within the project. Veronica says that many people they speak to feel that they are 'tricking the legal system', either because they end up in a situation that they either planned for, 'or [a situation] that only occurs because the system looks like it does, and, yes, [these situations] can be very peculiar'. Anna continues:

Yes, exactly! We talk a lot about legal security, and the legal security of children. And that there can't be so much security if it is not possible to predict what will happen to the child. If the system is so complicated – which [Swedish] family law is – so that one... Yes, one will be able to make a choice, or to know at least, so that one can make some kind of informed decision.

For transgender people who have changed their legal sex, the legal consequences for the child are often unpredictable. One issue is whether the child will have one or more legal parents from birth, another how parental status is confirmed.

On the website, a special section is dedicated to the current family law and its consequences for transgender parents. It initially states that 'In the current situation, it is not obvious how family law shall be interpreted when it comes to determine parental status for

persons who have changed their legal sex,' and explains that family law has not been updated after the law on sterilisation was abolished. It points out that although the right to parental designation is not yet mentioned in family law, a court has set a precedence that a person who has changed their legal sex does have the right to receive a parental status that is compatible with their legal sex. That is, a person who is legally recognised as a man has the right to be registered as the father, and a person who is legally recognised as a woman has the right to be legally registered as the mother (regardless of the gametes contributed to the conception of the child). It also confirms that a person who gives birth to a child is always considered its legal parent. Swedish law applies the principle of *mater semper certa est* – which applies equally for any pregnant person. Because of this, the issues of legal parental status for trans persons mainly concern people who are or wish to become parents but have not been or will not be pregnant.

Based on a range of different scenarios that vary depending on the gendered couple constellations (e.g. same- or different sex relationships, contributions of gametes or gestation), the website pedagogically guides the reader through the complex legal consequences in each case: (i) 'Legal woman married to or co-habiting with a legal man'; (ii) 'Legal woman married to or co-habiting with a legal woman'; (iii) 'Legal man married to or cohabiting with legal man'; (iv) 'Person who contributes with sperm', and; (v) 'Person who neither carried the child nor contributed with sperm'. Based on the number and severity of legal complications that may arise in the different constellations, it is quite clear that although both family and marriage law are no longer explicitly heteronormative, they remain fundamentally cis-normative in the way that gestation and eggs are seen as intrinsically tied to women, while the assumption is that only men can contribute sperm.

There is also a lack of knowledge about regulations in the healthcare system. Anna states that:

There are probably quite a few people who have an idea about the regulations, but don't necessarily know where to find [the information], black on white. There are several people from this group that have turned to us and said that 'I know that it is supposed to work like this, but where can I find [the information] black on white so that I can put it under somebody's nose?' And that has been really difficult to find. And really, [the information that] exists is [to be found] in the [materials] on gender affirmation care or [materials] on gender dysphoria. And often one looks for it in the guidelines for assisted conception, where it is not mentioned at all, even though there are newly formulated guidelines about parts of the assisted conception aspect, of it, where the rules are not at all that explicit. So that's very problematic.

Anna and Veronica point out that even when recent legislations in the field of assisted reproduction were created, these were still formulated in a cis-normative manner. When single people gained access to treatment with donated sperm in 2015, for example, it was explicitly formulated for single *women*, meaning that e.g. a transman seeking treatment with donated sperm would not fit into the available description.

These problems are also acknowledged by the report *Transpeople in Sweden* (2017), which like Anna and Veronica argue that the main problem of current legislation (also recent ones) on assisted reproduction and parental status is that it presupposes a connection between sex-cells and legal gender. Retroactively, it can be argued that previous law changes that have been made to include same-sex parents and single women constitute a set of lost opportunities to adjust the law in accordance with the range of possible parental kinship positions that have been made possible by existing biomedical advances in fertility medicine. For instance, while

existing legislation does include the gender neutral position of 'parent', this has only been included as a possibility for lesbian couples; the fact that a child can now have a 'mother' and a 'parent' – but not a 'father' and a 'parent' will not least cause problems when a person changes their legal sex after having had a child. This, in turn, has major consequences for these parents to exercise parental duties that require a legally recognised parental status.

From anticipating infertility to reconceptualising parenthood: Concluding reflections

As stated earlier, the biomedicalisation of reproduction has made possible a whole new set of possible ways for humans to reproduce – one of which is the possibility to preserve fertility for the future. This development has been co-constitutive of new claims to reproductive rights, also among groups who were previously seen as 'inherently infertile'. In the last few decades, transgender patients have been reconceptualised from being seen precisely as non-reproducing subjects to becoming a new patient group with reproductive rights. As this paper shows, however, reproductive rights and access to fertility treatments are worth far less that they ought to be unless they are followed by provisions not just to become a parent, but also to have their specific psychosocial and medical needs met and to practice parenthood in a legally safe way.

As our study demonstrates, the process of reconceptualising parenthood so as to include transgender people has not been a straightforward process. Indeed, the initial work to de-naturalise sterilisation and work for a new law was subsequently followed by a long process of re-naturalising transgender patients as (potential) fertility patients and (potential) future parents. While the interviewed medical staff all expressed positive attitudes about welcoming transgender patients in the fertility clinic, it is clear that they had to find strategies of un-learning cis-normative ways of talking and thinking about reproduction and parenthood as well as creating new routines and habits to implement this new perspective. Crucially, the medical staff and transgender advocates acknowledged a number of remaining obstacles to implementing these new reproductive rights in practice. Such identified obstacles include inadequate funding to meet an increased number of patients as well as cis-normative legislations that either prevent patients to use their frozen gametes and/or create an unsafe legal situation for their children.

Based on these insights, we call for a renewed political debate about financial resources for transgender healthcare (including fertility treatments) as well as a thorough reworking of legislation of assisted reproduction and family law. In line with the governmental investigation (SOU 2017:92), this paper argues that many of the problems can be avoided if legislation is formulated around 'reproductive function' rather than legal sex in order to better mirror existing biomedical advances. This would not only decrease discrimination and difficulties of transgender individuals who are also parents, but it would also increase the legal security of children born as a result of transgender reproductive rights. Moreover, sex education and family planning practices need to be revised along the same lines to become more inclusive: as an increasing number of young people identify as trans- and non-binary, it is crucial also for this group to receive adequate and realistic information about the possibilities for and obstacles to forming a family in the future – and for the cis-gendered majority to gain a better understanding of the multiple modalities of gendered parental positions, so as to prevent discrimination of transgender parents and their children.

Notes

1. In public debates the now obsolete law is often recognised as belonging to Sweden's dark history of coerced sterilisations (for a more detailed account, see Author 2013). A proposal for a new legislation concerning monetary compensation to transgender individuals who have been sterilised was handed over to The Council on Legislation (Lagrådet) on 9 November 2017 (Lagrådsremiss 2017).
2. One interviewee has been interviewed twice, and one interview was conducted with two interviewees together.
3. The organisation was formed in 1950, and gathers 7000 members. It is a national organisation with 38 local branches across the country.
4. Thomas Beatie, a transman from Oregon, USA, first received international media attention for his pregnancy in April 2008. Although Beatie is sometimes referred to as the 'first pregnant man in the world', Currah notes that even at this time it was 'not unheard of in the transgender community' (Currah 2008).
5. The Swedish situation for people undergoing gender affirmation treatment has also been investigated thoroughly by Signe Bremer, who analysed personal narratives of going through gender affirmation treatments before the aforementioned law change (2011). Studies on the experiences of Swedish transgender fertility care and parenting experiences are, still few and far between, which at least in part can be explained by the fact that the law changed only recently.

Ethical approval

The study was conducted in line with the principles of the CODEX website (Vetenskapsrådet) and the authors conformed to the full ethical principles of qualitative research. All interviewees have been given the opportunity to read and approve the accuracy of their quotes before final publication, as agreed at the time of the interview.

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