

**SCRAMBLING FOR PARENTHOOD? CONFLICTED HOPE,
BIOGENETIC PARENTHOOD, AND EGG FREEZING AMONG
TRANSGENDER AND GENDER DIVERSE INDIVIDUALS TAKING
TESTOSTERONE IN ONTARIO**

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Abstract

Transgender and gender diverse (TGGD) individuals remain out in the cold when it comes to reproductive healthcare in Ontario. While trans-based organizations continue to promote the importance of providing gender-affirming reproductive healthcare¹ to all TGGD individuals before, during, and after HRT (hormone replacement therapy), many TGGD individuals remain unaware of their fertility options. Using a 31-question survey, in-depth, semi-structured interviews, and a research journal, this thesis explores fertility preservation among 21 TGGD survey respondents and nine TGGD interview participants living in Ontario who are or have used testosterone (HRT). This thesis uses queer theory and is based on themes of biogenetic parenthood, egg freezing, and conflicted hope to demonstrate how TGGD individuals in ON live out queer kinship by delegitimizing the importance of biogenetic connection. Rather, TGGD participants in this thesis turn to family formation such as adoption, fostering, and mentorship for complex reasons. Even those who have used biogenetic forms of reproduction such as egg freezing and pregnancy to form their families deprioritize biogenetic parenthood but still have some concerns regarding age-related infertility. Regardless of the pathway to parenthood and family formation taken by participants, concerns regarding transphobia, financial cost, disability, and gender dysphoria remain.

¹ Gender-affirming health care can mean providing healthcare “designed to support and affirm an individual’s gender identity” (World Health Organization, 2024, n.p). Providing gender-affirming services can include “various procedures such as hormone therapy, genital reconstruction, breast reconstruction, facial plastic surgery, speech therapy, urologic and psychiatric services and primary care” to TGGD individuals (Johns Hopkins University, 2023, n.p).

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Introduction: Let's Crack Into It

“When I was younger, I found there was huge importance that I placed on becoming a mother when I identified as cisgender and heterosexual. I had been in a long-term relationship and was engaged to be married to a cisgender, heterosexual man at that point. I felt like having children was a part of the package of being married and in a long-term relationship.”²

Beginning as early as 2014, companies like Meta (formerly Facebook) (Fox, 2014), Amazon (Berman, 2014; Chapin, 2022), and Apple (Weller, 2017) began offering oocyte cryopreservation, more commonly known as egg freezing, to their cisgender,³ heterosexual female employees as a part of their healthcare coverage (Alteri et al., 2019). Now, in 2024, even medical university faculty members working at campuses like John Hopkins University, may be provided with egg freezing coverage (Spiegel, 2023). I had an unusual fascination with the practice of egg freezing as a method of “egg insurance” (Goold & Savulescu, 2008) that promises to “freezing time” (Meyes & Martin, 2021), “rewinding the biological clock” (Inhorn, 2017). At this point, the American Society for Reproductive Medicine had removed the experimental label from egg freezing for those who had a risk of fertility loss due to medical reasons. However, egg freezing for non-medical reasons such as age-related fertility loss continued to be discouraged due to lack of data (Bhatia & Campo-Engelstein, 2018).

Nevertheless, Meta and Google (Datta, 2017) were offering egg freezing to help women advance their careers and education by delaying motherhood. I found it intriguing that egg freezing was promoted and advertised to women as a technology that would give them everything they supposedly dreamed about: a career, a family, and a loving husband. Of course, this picture is not accessible to many. As publicity and popularity concerning egg freezing grew

² Research journal excerpt, 11/21/2021.

³ “Cisgender individuals’ gender identity aligns with their sex assigned at birth” (Maxwell et al., 2017, p.1031).

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(Barbey, 2017), polarizing ethical views began to emerge about the technology (Weber-Guskar, 2018). Was egg freezing pro-feminist (Bhatia & Campo-Engelstein, 2018), or did it alienate women (Robertson, 2014)? For Weber-Guskar, when it comes to egg freezing “there are no strictly binding ethical rules as there are moral ones” (2018, p.1). While egg freezing provides “opportunities for women to widen their range of reproductive choices” there seems to be “the [same] traditional forms of medical paternalism [that] can be reinforced by gendered paternalism” (Sándor et al., 2018, p.311). Criticisms of egg freezing held that the technology was marketed mainly to white women (Harwood, 2017) and that it excluded Black Women,⁴ Indigenous Women, Women of Colour,⁵ and transgender and gender diverse individuals (TGGD).⁶ I became highly skeptical of the companies providing this coverage to their

⁴ The term Black is used in this thesis as a political significant term to describe individuals who self-identify under the umbrella category of Black. While the term Black itself is debated, especially in the United States, many adult individuals stress the importance of being Black to their identities and the way they see themselves (D, 2021). The term Black as a form of self-identity has been used by many individuals as a political and socially significant identity. However, it can also be used to “lump” together certain ethnic minorities (Eligon, 2020). This thesis used the same race based demographic categories as the 2019 Trans PULSE survey to ensure that all TGGD individuals would be able to identify based on personal identity and cultural heritage. This thesis did not have any respondents or participants who self-identified as Black, including anyone with African or Caribbean heritage.

⁵ Given the importance of a decolonizing methodology, this thesis capitalizes the terms Black, Indigenous, and Women of Colour. The term white is not capitalized unless it begins a sentence or is capitalized by a TGGD participant in this thesis. While the capitalization of terms for racial/ethnic communities is not always accepted (Nguyễn & Pendleton, 2020), it is important to do so as an acknowledgement of the ways in which white supremacy continues to thrive. I use capitalization as an “act of recognition” and as a means of respecting BIPOC identities, histories, and futures (Coleman, 2020, n.p).

⁶ TGGD individuals are part of the 2SLGBTQIA+ community. This community includes (but is not limited to): Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, Intersex, asexual, plus individuals. Specifically, TGGD individuals are defined in this thesis as any individual who does not identify with the sex they were assigned at birth and identifies under the umbrella terms of transgender or gender diverse including, but not limited to individuals who identify as: genderqueer, agender, demigender, non-binary, gender non-conforming, transgender men, and/or trans men. The term transgender and gender diverse was chosen over other potential

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employees. I wondered who was offered this coverage and the legal, ethical, and bioethical implications. Although the direction of my thesis shifted, I remain highly interested in the same systems of power and privilege surrounding egg freezing.

My thesis has developed and transformed alongside my personal and professional growth. I began my own social transition⁷ in 2017, over one year after beginning my Ph.D. program. I had been questioning my gender during my first year of doctoral studies and was identifying as a “trans guy” by December of the following year. I was hesitant, and wanted to ensure I was making the right choice for myself. Once I had chosen the name Elgin one quiet Thursday night in my bathtub, I knew I was ready to move forward. Armed with my new and more authentic identity and name, I began my medical transition⁸ at the Centretown Community Health Center, located in Ottawa, Ontario. My first consultation took place in January 2018 and was followed by beginning testosterone injections in June. The Centretown Community Health Center was not only gender-affirming, but it also employed trans-identifying healthcare professionals. My initial meeting was an intake appointment with a social worker. I was asked about my knowledge of the short and long-term impacts of testosterone, and how I pictured my medical transition, including what made me nervous, and what made me most excited. At that

terms such as trans* to describe this collective. While trans* seeks to be more inclusive (Halberstam, 2005), this thesis prioritizes the voices of non-binary identifying individuals.

⁷ A social transition consists of the “parts of transitioning that are not specifically medical” which can include “coming out” to family and friends as transgender, using new pronouns, changing one’s appearance through styling and clothing, changing one’s name, and using different gendered spaces such as restrooms (Rainbow Health Ontario, 2022, n.p).

⁸ A medical transition for many includes “the use of cross-gender hormone therapy [HRT] to induce the secondary sex characteristics of the affirmed gender while suppressing those of the natal sex” (Radix, 2016, p.351). A medical transition can include but is not limited to surgery, hormone therapy, body hair removal, speech therapy, and/or fertility preservation measures (UCSF Gender Affirming Health Program, 2024, n.p).

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point, I was asked if I was aware of my fertility options. I laughed and told the social worker that I was doing my thesis on egg freezing. I found it interesting and encouraging that egg freezing was discussed so early in the process as I had not even begun to take hormones yet. This conversation has stuck with me ever since.

Once approved to begin testosterone, I met with one of the doctors at the Centretown Community Health Center. I was pleased by how considerate the medical professionals at the clinic were to me. At my first appointment with my new doctor, I was asked again: had I thought about my fertility options? Many TGGD individuals discuss this topic with their healthcare professional based on the effects of testosterone use. However, I was also in my late twenties, with the “fertility cliff” ahead (Waldby, 2015; Gruben, 2016). Age-related infertility is a motivation for some individuals to freeze their eggs, and I was a great age for egg freezing. Once more I laughed, and replied that since I was studying egg freezing, I was well informed. Months later, I was released from the care of the Centretown Community Health Center and provided with a family doctor at the University of Ottawa's health clinic. Again, I was asked by my new doctor whether I understood the impact testosterone might have on my fertility. At this point, I had been on testosterone for several months. I wondered why I was asked repeatedly about my fertility. Perhaps it was my charming, good looks, my assumed intelligence as a Ph.D. student, or just gender-affirming medical care for trans patients?⁹ Was it usual for patients like me to be asked about their fertility and knowledge of fertility options at different stages of their medical transition? I could not shake my curiosity.

⁹ In this case, affirming medical treatment can be defined as “a combination of interventions designed to support transgender and nonbinary people, including delivering and addressing their primary health care needs” (Health Quality Ontario, 2024, n.p).

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These experiences led me to move beyond my interest in corporate egg freezing, and to focus on the prospect of biogenetic parenthood among TGGD individuals taking testosterone. In ON, taking testosterone is commonly known as hormone replacement therapy (HRT).¹⁰ To begin HRT, TGGD individuals in Ontario often go through their healthcare professional or a clinic. While a formal gender dysphoria¹¹ diagnosis is no longer required to access HRT in Ontario, it is recommended that all healthcare professionals speak to the TGGD individual about their desires for transitioning and their hormone-related goals (Shelburne Health, 2023). The purpose of beginning HRT for TGGD individuals is commonly to provide an individual who is assigned female at birth¹² (and possibly including Intersex identifying-individuals) with more testosterone to bring out physically masculine characteristics such as body hair, facial hair, a deeper voice, changes in body weight distribution, face shape, and possibly, ceasing menstruation. For some, HRT can be used on a long-term or short-term basis. For these TGGD individuals, HRT can be taken via injection, applied onto the skin using a gel, or worn on the skin as a patch (UCSF

¹⁰ HRT is used throughout this thesis to refer to any TGGD individual who is using testosterone for gender affirmation in the case of female-to-male medical transition. Having engaged with HRT in the past, present, or planning on pursuing HRT in the future were part of the eligibility criteria for this thesis. While many TGGD individuals who participate in this thesis are currently using HRT, many are no longer using HRT. Doses for HRT can vary and are based on the individual's hormone levels and desired results.

¹¹ Gender dysphoria is “a sense of unhappiness over the incongruence between how one subjectivity understands one's experience of gender and how one's gender is perceived by others” (Stryker, 2017, p.17). Dysphoria is the opposite of euphoria and is the “distress caused by gender incongruence” (Feigerlová et al., 2019, p.19). This research is careful to consider how the term or experience can reinforce “concepts such as “true transsexualism” and “gender dysphoria” are part and parcel of the conceptual universe of transsexuality and contribute to delineate the “disembodied” model of trans* existences” (Radi, 2019, p. 51).

¹² Assigned female at birth is one of two classifications provided to human children upon their birth. Based on the appearance of an infant's body, a sex will be assigned to them (Stryker, 2017). An infant is assigned a sex at birth based on their perceived external genitalia (Clarke, 2022). Assigned female at birth individuals have been assigned female based on their genitalia being classified as female. Sex assigned at birth is not determined by the individual but by the medical staff present at the time of birth (Stryker, 2017).

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Transgender Care, 2020). Many TGGD individuals may desire certain attributes that come with initial testosterone use such as an increase in body hair and the deepening of their voice. These individuals may, however, end testosterone use after a selected amount of time to avoid more prominent masculine features to continue to be prevalent. For instance, a TGGD individual may want to lower their voice but not wish to have extensive body hair. They may choose to go on testosterone for a shorter period to avoid the long-term implications of a large increase in body hair (Dunbar et al., 2022). Some effects of testosterone are irreversible, while others are maintained only through continuous testosterone use. HRT can have adverse effects for some including weight gain, acne, oily skin, male-pattern baldness, an increased risk of high blood pressure, higher cholesterol, and mood swings. Many of these symptoms can decrease over time (Shelburne Health, 2023), however, some long-term side effects of HRT remain highly debatable, including the impact that prolonged HRT¹³ use has on fertility. For this reason alone, all TGGD individuals beginning HRT should be advised about their fertility preservation options, including egg freezing.

The scholarly literature on egg freezing in general is vast but concentrates on cisgender, heterosexual women seeking to preserve their fertility after age 35. Current topics in reproduction and fertility preservation among TGGD individuals taking testosterone explore:

The scholarly literature on egg freezing in general is vast but concentrates on cisgender, heterosexual women seeking to preserve their fertility after age 35. Current topics in reproduction and fertility preservation among TGGD individuals taking testosterone explore:

¹³ This thesis defines prolonged HRT use, meaning prolonged testosterone use, as twelve months or more in duration.

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Fertility choices and options for adolescent and young adults,¹⁴ fertility choices and options for adults,¹⁵ treatment by healthcare professionals,¹⁶ contraception,¹⁷ abortion (Moseson et al., 2021), family planning and prepregnancy counselling,¹⁸ fertility options,¹⁹ desires and experiences of pregnancy, delivery and birth,²⁰ parenting and reproductive desires,²¹ fertility preservation,²² reproductive technology use,²³ postpartum,²⁴ hysterectomy²⁵ and, pregnancy loss (Riggs et al., 2020).

¹⁴ See Knudson & De Sutter, 2017; deNormand, 2017; Nahata et al., 2018; Chen & Simons, 2018; Campo-Engestein et al., 2019; Chen et al., 2019; Chiniara et al., 2019; Hodax et al., 2020; Persky et al., 2020; Insogna & Ginsberg, 2019; Insogna et al., 2020; Segev-Becker et al., 2020; Lai et al., 2021; Quain et al., 2021; Robinson et al., 2023.

¹⁵ See De Roo et al., 2016; Mattawanon et al., 2018; Moravek et al., 2018; Armund et al., 2017; Blakemore et al., 2019; Neblett & Hipp, 2019; Swartz & Moravek, 2021; Powers et al., 2024.

¹⁶ See Riggs et al., 2014; Bartholomaeus & Riggs, 2019; Armund et al., 2020.

¹⁷ See Elaut, 2014; Elaut et al., 2016; Boudreau & Mukerjee, 2019; Fix et al., 2020; Gomez et al., 2020; Krempasky et al., 2020; Mancini et al., 2021; Okano et al., 2022; Agénor et al., 2023.

¹⁸ See Light et al., 2018; Stark et al., 2019; Martinez et al., 2020; MacLean, 2021; Robinson et al., 2023.

¹⁹ see De Roo et al., 2016; De Sutter, 2016; Mitu, 2016; Olson & DePalma, 2024.

²⁰ See Margaria, 2021; Kukura, 2022; Perini, 2022; Falck et al., 2024.

²¹ See Verlinden, 2012; Light et al., 2014; Obedin-Maliver & Makadon, 2016; Selix & Rowniak, 2016; Hoffling et al., 2017; Maxwell et al., 2017; Toze, 2018; Charter et al., 2018; Payne & Erbenius, 2018; Walks, 2018b; Hafford-Letchfield et al., 2019; Besse et al., 2020; Charlton et al., 2020; Light et al., 2020; Radi, 2019; Carpenter & Niesen, 2021; Dietz, 2021; Drouillard, 2021; Kirczenow MacDonald et al., 2021; MacLean, 2021; Taylor et al., 2021; Kukura, 2022; Pfeffer et al., 2023; Jacobsen, 2022; Brandt, 2023; Charter et al., 2023; Patel & Sweeney, 2023; van Amesfoort et al., 2023; Riggs et al., 2023; Sørli, 2023; Falck et al., 2024; Moayed et al., 2024; Olson & DePalma, 2024; Thomas et al., 2024.

²² see Millar et al., 2015; Jones et al., 2016; Mattawanon et al., 2018; Adeleye et al., 2019; Riggs, 2019; Ainsworth et al., 2020; Riggs & Bartholomaeus, 2020; Rodriguez-Wallberg, 2020; Choi & Kim, 2022; Giacomozzi et al., 2022; Ker & Shaw, 2022; Persky et al., 2022; D'Amato et al., 2023; Dubin, 2023; Nadgauda & Butts, 2024; White et al., 2024.

²³ See Ross et al., 2014; Marvel et al., 2016; Johnson & Finlayson, 2016; Jones et al., 2016; Moravek, 2019; Cheng et al., 2019; Leung et al., 2019; von Doussa et al., 2015; James-Abra et al., 2015; Defreyne et al., 2019; Kyweluk et al., 2019; Sterling & Garcia, 2020; Rogers et al., 2021; Kerr et al., 2021; Kerr & Shaw, 2024.

²⁴ See MacLean, 2021; Perini, 2022; Olson & DePalma, 2024.

²⁵ See Rachlin et al., 2010; Obedin-Maliver et al., 2017; Louie & Moulder, 2018; Toze, 2018; Reilly et al., 2019; Cao et al., 2021; Carbonnel et al., 2021; Becker, 2023a; Becker, 2023b.

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Despite the increase in international scholarship, Canada falls behind. To date, Canadian scholarship addressing egg freezing in TGGD individuals is extremely limited. Earlier studies addressing egg freezing among TGGD individuals in Ontario include Millar et al. (2015), featuring three transgender men, and Jones et al. (2016), providing data on 11 transgender individuals whose gender identities are unknown. Both studies had small sample sizes and excluded the experiences of non-binary and gender diverse identifying²⁶ transgender individuals. According to a 2021 Statistics Canada study, Canada has over 59,460 individuals over the age of 15 who self-identify as transgender and 41,355 individuals over the age of 15 who self-identify as gender diverse (Statistics Canada, 2022). According to the same study, Toronto is home to 15.3 percent of TGGD identifying Canadians, and 5.6 percent live in Ottawa-Gatineau. Even with the large numbers of TGGD identifying individuals in Ontario, no research to date addresses egg freezing among TGGD individuals includes their lived experiences. Finally, this thesis took place during the unprecedented COVID-19. COVID-19 and subsequent lockdown acted as barriers to reproductive care and egg freezing that will be explored throughout this thesis. This thesis seeks to fill the gap in scholarship by using demographic information, including gender identity, as well as primary source qualitative data addressing egg freezing among TGGD individuals in Ontario. It turns to secondary source egg freezing scholarly literature, and queer theory to explore the complexities of reproduction and egg freezing among

²⁶ Someone who identifies under the umbrella term of gender diverse may identify as non-binary, gender non-conforming, agender, demigender, transmasculine, etc. These individuals may not identify as transgender men but still take HRT for similar results.

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TGGD individuals in Ontario, employing two key theoretical terms, “biogenetic parenthood” and “conflicted hope.”

The Chicken and the Egg

Biogenetic parenthood is achieved through “genetic thinking,” whereby biological belonging, identity, and kinship (Mamo, 2007) are reified through genetic connection between both parents, or at least one parent, to the child (Nordqvist, 2017). International scholarship addressing egg freezing among TGGD individuals demonstrates that they freeze their eggs to ensure a biogenetic connection between themselves and their offspring (Birenbaum-Carmeli et al., 2021). Research addressing desires for biogenetic parenthood among TGGD individuals has been explored in Australia (von Doussa et al., 2015; Riggs et al., 2014; Riggs & Bartholomaeus, 2018), Belgium (Wierckx et al., 2011), Canada (Millar et al., 2015; Jones et al., 2016), Israel (Segev-Becker et al., 2020; Birenbaum-Carmeli et al., 2021), Greece (Voultsos et al., 2021), Sweden (Payne & Erbenius, 2018), and the United States (De Sutter et al., 2016; Tornello & Bos, 2017; Chen & Simmons., 2018; Strang et al., 2018; Birenbaum-Carmeli et al., 2021). Biogenetic parenthood has been shown to be a key motivator for egg freezing regardless of gender (Inhorn et al., 2019). Among cisgender, heterosexual women, feminist scholars continue to question if egg freezing can provide “conflicted hope” (Mayes et al., 2017), “false hope” (Harwood, 2009; Martin, 2017), and “frozen hope” (Quinn et al., 2010) by employing “contestable forms of wishful medicine” (Petropanagos, 2010). Many remain deeply upset when their “egg insurance” (Birenbaum-Carmeli et al., 2021) fails to result in the birth of a healthy child (Mertes & Penning, 2011; Inhorn et al., 2018; Kılıç & Göçmen, 2018). Many individuals who freeze their eggs lack the information needed to make truly informed decisions (Harwood,

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2015; Paller, 2015; Jackson, 2018; Bhatia, 2022; Peate et al., 2022), which can lead to conflicted hope. I argue that conflicted hope arises from the lack of informed consent provided to those seeking to freeze their eggs, including the associated medical risks, high financial cost, and low success rates. Conflicted hope has unique implications for TGGD individuals considering egg freezing. Just as heterosexual, cisgender women seek to freeze their eggs to achieve biogenetic parenthood, TGGD individuals have also used egg freezing for this purpose (Birenbaum-Carmeli et al., 2021). At the same time, TGGD individuals experience particular barriers to egg freezing that their cisgender counterparts do not. Regardless of gender, hope becomes conflicted for all those seeking to freeze their eggs based on the extensive medical risks, high financial cost, and varying success rates. For TGGD individuals seeking to freeze their eggs, barriers can include: a lack of information about fertility options (von Doussa et al., 2015; Jones 2016, Mitu, 2016; Moravek et al., 2018; Cheng et al., 2019); invasiveness of the procedure²⁷ (Cheng et al., 2019); having to cease HRT or delay HRT (Bartholomeaeus & Riggs, 2019; Charter et al., 2019; Defreyne et al., 2019); financial difficulties (Millar et al., 2015; Jones, 2016; Mattawanon et al., 2018; Bartholomeaeus & Riggs, 2019; Cheng et al., 2019; Defreyne et al., 2019); transphobia, including misgendering in the clinic setting (Charter et al., 2018); and being dehumanized in healthcare settings, including being called “it” (Riggs et al., 2014). The use of conflicted hope as a critical theoretical concept can provide original contributions to the field of trans reproduction and feminist scholarship.

²⁷ While the procedure is uncomfortable for many who freeze their eggs, for TGGD individuals’ experiences can invoke emotional distress related to feelings regarding their bodies. Invasive procedures where their bodies must be examined, especially in such an intimate manner, can be truly distressing.

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Thesis Components

This thesis is among the first qualitative research studies to address TGGD individuals taking or having taken HRT in Ontario that is conducted by a self-identifying transgender researcher. Its objectives are:

- 1) To determine if TGGD individuals who are taking or have taken HRT, and live in Ontario, Canada, are engaging in fertility preservation practices, and particularly, in egg freezing.
- 2) To explore why or why not TGGD individuals who are taking or have taken HRT are choosing biogenetic parenthood as a form of family formation.
- 3) To determine which, if any, economic, cultural, ethical, and social barriers TGGD individuals taking or have taken HRT may face in attaining biogenetic parenthood inside and outside the medical setting.

It is guided by the following research questions:

- 1) How is egg freezing linked to biogenetic parenthood for TGGD individuals in Ontario who are taking or have taken HRT? (Objectives 1 and 2)
- 2) How might an intersectional framework address how conflicted hope be experienced by TGGD individuals taking or who have taken HRT? (Objective 3); and
- 3) How might the medical system in Ontario help or hinder TGGD individuals taking or having taken HRT seeking biogenetic parenthood? (Objectives 1-3).

I used three primary data collection methods alongside secondary source scholarship. This methodology consisted of a 31-question survey, 45-60 minute long in-depth, semi-structured interviews, and the use of autoethnography via a research journal I kept throughout this research process. Secondary source scholarship addressing egg freezing among TGGD individuals was utilized to provide a comprehensive background, literature review, and current

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global data. Primary data collection took place between November 2021 and June 2022, much of it during COVID-19. Recruitment for the survey and in-depth, semi-structured interviews was conducted via the social media platform Meta, targeting three specific groups: *Canadian Trans Men*, *Trans ON FTM or MTF*, and *FTM Canada*. These groups were chosen based on their large geographic range and limited age restrictions. All participants completed a SurveyPlanet survey using a link in the social media post and were asked, if interested, to provide their email contact information at the end of the survey if they chose to participate in the follow up, in-depth, semi-structured interview process.

Data collection resulted in 21 viable²⁸ surveys and nine in-depth, semi structured interviews. TGGD survey participants were aged 19-38. Each TGGD survey participant's responses were input into a Microsoft Excel document for later quantitative and qualitative analysis. Data analysis software was not used because of the low number of responses resulting in fewer data sets (explored in Chapter 3). All in-depth, semi-structured interviews were transcribed verbatim using Otter.ai. Once completed, interviews were transcribed and provided to TGGD interview participants so they could change and clarify their transcript content prior to acceptance and finalization. In-depth, semi-structured interviews were conducted between December 2021 and May 2022. Following each interview, I engaged in a 30-minute-long writing reflection in my research journal to capture my thoughts and feelings throughout the research process. All data analysis from surveys and interviews were completed using thematic analysis. Excerpts from my research journal can be found at the beginning of each chapter and are identified by their italicization. Participant contributions will be used throughout the thesis to

²⁸ Viable responses were based on the eligibility criteria. Individuals who were removed from the data set transitioned medically in Ontario.

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highlight the ways that participants in this thesis desire, experience, and move forward with biogenetic parenthood.

Once a participant had determined they wished to participate in the interview process, their survey data was identified and extracted from SurveyPlanet. Section One of the survey collected quantitative survey data. The data included the participant's self-identification as living with a disability and/or neurodivergent, age, race or ethnicity, and gender identity. This data was used to provide a snapshot of the participant prior to their interview (see Chapter 3 & Chapter 4). Sections Two, Three, Four, Five, and Six collected qualitative research data from the participant's survey and were used to determine potential themes and influence interview guides (See Appendix H). I constructed interview guides with the intention of exploring biogenetic parenthood, egg freezing, and conflicted hope.

The three sets of qualitative research data from the survey responses, interview transcripts, and my research journal were analyzed using thematic analysis and explored using queer theory. Thematic analysis is one of the common methods used for identifying themes in quantitative data sets (Mishra & Dey, 2022). Thematic analysis has been used by other scholars exploring TGGD topics including reproduction, fertility, and kinship (Charter et al., 2018; Gerritse et al., 2018; Wingo et al., 2018; Armuand et al., 2020; Besse et al., 2020; Gomez et al., 2020; Mendieta & Vidal-Ortiz, 2020; Riggs & Bartholomaeus, 2020; Riggs et al., 2020; Tasker & Gato, 2020; Asklöv et al., 2021; Fischer, 2021; Lai et al., 2021; Agénor et al., 2022; Ker & Shaw, 2024). Thematic analysis was chosen as the research methodology for this thesis because it is a versatile, flexible, and adaptive method to determine themes including patterns and commonalities in data sets across various type of disciplines (Vaismoradi et al., 2016). Thematic analysis is commonly used in qualitative research as “a method for identifying, analysing and

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reporting patterns (themes) within data” (Braun & Clarke, 2006, p.79). A theme in this thesis is defined as the “perceptions, experiences, feelings, values and emotions residing in the minds of participants/respondents of [the] research [project]” that must be extracted by the researcher using probing questions (Mishra & Dey, 2022, p.187). I constructed in-depth interview guides with the intention of exploring the themes of biogenetic parenthood, conflicted hope, barriers to reproduction, and TGGD identity.

Queer theory was determined as an adequate theoretical tool for investigating systems of heteropatriarchy²⁹ through the lens of deconstruction and otherness (Hames-García, 2020). This thesis explores the deep-rooted and complex connections between heteronormative³⁰ standards of white, middle-class, cisgender, heterosexual family formation and desires for biogenetic parenthood among TGGD individuals. Queer theory carefully examines the recirculation of heteropatriarchal systems, critiquing white, middle-class, cisgender, heterosexual families’ prioritization of biogenetic ties. Queer theory also highlights the mechanisms through which reproductive gatekeeping and restricted access manifest for 2SLGBTQQIA+ individuals. For many TGGD individuals, family formation does not include sexual intercourse as a means of biogenetic reproduction.³¹ Rather many TGGD individuals utilize non-biogenetic means of

²⁹ Heteropatriarchy “refers to the social, political, and economic system in which heterosexual men are the dominant group in a society or culture. The concept is made up of two parts: hetero, described as an inherent attraction to the opposite sex, and patriarchy, defined as systematic domination of men across a myriad of social institutions” (Kelly & Arce-Trigatti, 2022, p. 256).

³⁰ Heteronormativity is a term coined by Michael Warner in 1991, “to describe a pervasive discursive framework that is deeply embedded in social institutions and that perpetuates homophobia... through its presumption of heterosexuality as normal and natural, heteronormativity privileges heterosexuality in all its forms, including identities (i.e., heterosexual people) and arrangements (e.g., traditional family structures and romantic relationships)” (Stanley, 2022, p.250).

³¹ TGGD individuals and their partner(s) may be able to reproduce biogenetically through sexual intercourse. These individuals may or may not identify as heterosexual, therefore this thesis does not use the term “heterosexual” when referring to sexual intercourse. To assume all

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family formation that commonly rejects the reinforcement of biogenetic legacy. For this reason, queer theory offers an ideal instrument to consider the strength of white, middle-class, cisgender, heteronormative biogenetic ties and the resistance seen through diverse forms of 2SLGBTQIA+ family formation. Using reproductive technologies such as egg freezing can provide a means of reinforcing the white, cisgender, heteronormative status quo while simultaneously offering biogenetic parenthood that is considered naturally desirable among many, with some TGGD individuals being no exception. Queer theory provides space for the examination of alternative forms of family formation and prioritizes the lived realities of 2SLGBTQIA+ individuals seeking parenthood. Therefore, queer theory provides a solid framework for this thesis to examine how non-heterosexual forms of family formation occur, emphasizing the vitality of queer and queering reproduction and parenthood.

Another careful consideration of this thesis includes the use of language. Feminist scholars continually demonstrate the power of language. While language shifts over time (Stryker, 2017), especially pertaining to the ways that individuals self-identify, this thesis will use terms I have chosen based on the thesis and participants, as follows:

TGGD Individuals: This term was chosen as opposed to trans* or transgender alone. While many scholars emphasize the diversity and inclusion of trans*, this thesis sought to list explicitly both transgender and gender diverse identities. While some may identify under the umbrella term of transgender, or trans, others will not. Transgender or trans is broadly defined by this thesis as a means of self-identification for those who do not identify with the gender and sex assigned to

cisgender individuals who engage in penetrative sexual intercourse are heterosexual is exclusionary to many 2SLGBTQIA+ individuals.

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them at birth. Throughout this thesis, terms such as female-to-male (FtM or FTM), trans man/men, or assigned female at birth (AFAB) were used because they were the specific terms used in secondary source data by the researcher or research team. Literature in Canada can neglect the lived experiences of non-binary identifying TGGD individuals. Not only do non-binary identities such as genderqueer, demigender, agender, non-binary, and/or gender diverse identifying individuals receive less recognition, but their lived experiences are commonly excluded from research about their community. Various gender-based terms are used by the participants in this thesis to self-identify, therefore, whenever possible, I honour their chosen terminologies for their individual gender identities; however, TGGD is used in general to describe the participants, regardless of their chosen terminology.

Individuals who freeze their eggs: This phrase pertains to any individual who has chosen to complete the process of egg freezing. An egg freezer is the term used by scholars in the field of fertility preservation and is the language used by fertility clinics to address those who freeze their eggs. The term, individuals who freeze their eggs, is attributed to all individuals who have frozen their eggs regardless of the reason for freezing or their gender identity. Terms like medical egg freezer and social egg freezer follow the medical distinction made between medical egg freezing (MEF) and social egg freezing (SEF) and are used to distinguish medically between the reasons for freezing one's eggs and the studies, literature, and scholarship on these reasons.

This thesis consists of six chapters, an introduction, and a conclusion. They were all guided by the three foundation anchors of biogenetic parenthood, egg freezing, and conflicted hope. The first chapter, *Murky Waters*, outlines the history of egg freezing and examines the medically imposed distinction between MEF and SEF. This chapter situates TGGD individuals

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in the murkiness of their classification under MEF. It provides the theoretical framework for this thesis, including an elaboration of the three key theoretical terms, biogenetic parenthood, egg freezing, and conflicted hope. Chapter 2: It's Freezing in Ontario outlines the complexities of regulation, funding, and fertility clinics in Ontario. It explores the nuanced difficulties of egg freezing, making it clear that the process does not necessarily result in a successful pregnancy or birth. Chapter 3: Frost Bitten? Examining Survey Results provides survey results from the 21 viable surveys upon which this thesis is based, in addition to demographic information and an overview of trends in the survey data. Chapter 4: Making Chilling Discoveries, Interview Methods, Participant Profiles, and Setting the Stage delves into the methodological tools used in this thesis including nine in-depth, follow up, semi-structured interviews, and my research journal. This chapter provides TGGD interview participant profiles and explores the use of an intersectional, trans*-epistemological, and ongoing consent framework. Chapter 5: Freezing Time in a Frozen World? Interview Data Results examines the themes of biogenetic parenthood, egg freezing, and conflicted hope based on the in-depth, semi-structured interviews with nine TGGD interview participants. This chapter explores how despite a lack of desire for biogenetic parenthood among TGGD interview participants, some TGGD interview participants desired to become pregnant in the future; one had frozen his eggs, and one had already become a parent through pregnancy. Other forms of family formation desired by TGGD interview participants included adoption, fostering, and mentorship. The final chapter, Chapter 6: Passing the Torch and Queer(ing) Parenthood investigates the past, present, and future of 2SLGBTQQIA+ parenthood. It delineates some of the complications TGGD individuals who wish to become parents face and explains how conflicted hope can apply not only to egg freezing but to all forms of family formation among TGGD individuals. It highlights that despite barriers to pregnancy

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and adoption, TGGD individuals continue to engage in queer and queering means of family formation. Finally, *Conclusion: The Bittersweet End* revisits the chapters and their themes. It provides some recommendations for future research and ways of continuing gender-affirming reproductive care.

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Chapter One: Murky Waters

“The more I dive into the waters of regulation in Canada, the more I realize how little regulation there is. There is no one to go to when things go wrong, no one to report to when clinics need to do better, and no feeling of security for TGGD individuals using fertility clinics. How are people expected to work with a system they can hardly understand?”³²

According to Statistics Canada (2022), in 2018 approximately 75,000 self-identifying TGGD individuals were living in Canada. A national 2020 Trans PULSE Canada demographic survey showed that of the 2873 individuals who participated, 1,012 were TGGD individuals residing in Ontario (n.p). In 2021, Statistics Canada released its first set of quantitative data, finding that of the 100,815 TGGD individuals living in Canada, 39,450 resided in Ontario (Statistics Canada, 2022, n.p). Statistics Canada also found that Generation Z, or Gen Z, those born between 1997 and 2006, were three to seven times more likely than previous generations to identify as transgender or gender-diverse (Statistics Canada, 2021f, n.p). Of all Generation Z surveyed, 0.79 percent identify as TGGD, whereas Millennials (those born between 1981 and 1996) were at 0.51 percent, Generation X (those born 1966 to 1980) at 0.19 percent, Boomers (those born 1946 to 1965) at 0.15 percent, and the Greatest Generation (those born between 1945 or before) at 0.12 percent (Statistics Canada, 2015, n.p). Despite the increasing visibility of TGGD individuals, there remain significant gaps in the literature regarding their health, well-being, and family formation.

Ontario is a central hub for many TGGD individuals, making it a prime location for this thesis. It is home to gender-affirming medical and social services such as: Rainbow Health Ontario, Trans Wellness Ontario, Rainbow Railroad, The 519, and The 613. They provide the TGGD community with much needed resources and support. Resources for the TGGD

³² Research journal excerpt, 04/06/2022.

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community continue to grow, and so does the need for inclusivity, adaptability, and research on the specific and unique needs that speak to the diversity of the 2SLGBTQQIA+ community. The Government of Ontario has become more aware of the needs of TGGD individuals. The province has been working to remove transphobic policies and create more accessible avenues for legal name and gender changes for TGGD individuals. Moreover, the province has sought to reduce economic barriers based on the under employment and common low-income status of community members. When it comes to family planning, one way the government is addressing economic disparities is by classifying those TGGD individuals seeking to freeze their eggs as medical egg freezers. This designation provides some coverage through Ontario's Health Insurance Plan (OHIP). At the same time, OHIP does not cover all the expenses of egg freezing (explored in Chapter 2). This chapter will explore the history and process of egg freezing, the medically imposed distinction between MEF and SEF, and will situate TGGD individuals in terms of these categories. It will situate egg freezing within discourses of biogenetic parenthood and conflicted hope to demonstrate why egg freezing is not all it is cracked up to be. Finally, this chapter asserts how biogenetic parenthood and conflicted hope combine to create the murky waters of egg freezing in Ontario.

Procedure and Types of Freezing

Egg freezing is the process of oocyte cryopreservation, the method of cooling cells or tissue below freezing temperatures to halt their biological functions and aging (Iussig et al., 2019). Since the 1900s, scientists have successfully attempted to freeze reproductive tissue (Oktaý, 2022). During the early 1980s, slow freezing was the most well-established process. However, this method yielded low survival rates, low birth rates, and poor embryo development

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(Basile & Garcia-Velasco, 2016; Inhorn, 2018). Despite these outcomes, the first successful birth of a child using a frozen egg occurred in 1986 (Evans et al., 2014; Inhorn, 2018). Today, success rates for slow freezing have improved by 70 to 80 percent using a technique called vitrification (Iussig et al., 2019). Vitrification or "flash freezing" has become more common since the 2000s following its discovery by Lilia Kuleshova in 1999 (Kuleshova et al., 1999). Vitrification solved the previous dilemma of ice crystal formation during egg freezing, increasing the success of the freezing process and boosting live birth rates (Iussig et al., 2019). Vitrified eggs now maintain similar pregnancy rates to fresh eggs, with a 62.6 percent clinical pregnancy rate and a 52.1 percent live birth rate (Iussig et al., 2019).

In 2012, the experimental label was removed from MEF by the American Society for Reproductive Medicine. It was done explicitly to assist those who were at risk of losing their fertility due to disease or medical treatment. At this point, medical risks to those seeking to freeze their eggs was extensive and included the health risks associated with hormone use (Goold & Savulescu, 2008; Harwood, 2009; Cattapan et al., 2014; Robertson, 2014; Ikemoto, 2015; Roth, 2016; De Roo et al., 2016; Gruben, 2017; Mayes et al., 2017; Weber-Guskar, 2017).

Hormones used to stimulate egg maturation can cause:

- Ovarian Hyperstimulation Syndrome due to over stimulation of the ovaries (OHSS which can cause pain (Petropanagos, 2015; Cha, 2018; Alteri et al., 2019; Jones et al., 2022; Shah, 2023).
- Physical sickness, fluid build up (Shao, 2020; Cha, 2018; Miner et al., 2021), and rarely death (Cha, 2018).
- General medical risks such as possible failure of treatment (Gruben, 2017).
- Headaches, bloating, abdominal pain (Petropanagos et al., 2015; Jafarova, 2023).

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- Mood swings, and fatigue (Jafarova, 2023).
- Potential risk for damage during the extraction process (Bernstein & Wisemann, 2014).
- And many unknown risks (Mohapatra, 2014) including long term risks that remain unstudied (Bernstein & Wisemann, 2014).

The American Society for Reproductive Medicine³³ continued to caution against SEF, such as freezing due to age-related fertility decline (see Bernstein & Wisemann, 2014; Harwood, 2009; Lockwood, 2011; Martin, 2010; Mertes & Penning, 2011; Stoop et al., 2014; Petropanagos et al., 2015; Mensen et al., 2015; Inhorn, 2017; Jones et al., 2018; Göçmen & Kılıç, 2018; Myers & Martin, 2020; Delbaere et al., 2020; van de Wiel, 2020; Wennburg, 2020; Chronopoulou et al., 2021; Varlas et al., 2021). In 2014, the Canadian Fertility & Andrology Society released guidelines outlining that patients need to be aware of the risks, success rates, and potential harms that SEF and the procedure can cause (Petropanagos et al., 2015). The same year, large technology companies, including Meta and Google, flaunted their inclusion of the egg freezing healthcare benefit as promoting workplace gender equality (Barbey, 2017). By 2018, the Society of Obstetricians and Gynaecologists of Canada was asserting the importance of “upfront counselling” for anyone seeking SEF (Dimoff, 2018). The risks of egg freezing are commonly under discussed (Harwood, 2015; Jackson, 2017; Borovecki et al., 2018; Bhatia, 2022; Lahoti et al., 2023). Many individuals who choose to freeze their eggs begin the process with little knowledge regarding the associated medical risks (Mohapatra, 2014; Paller, 2015; Jackson,

While the American Society for Guidelines creates these guidelines for general population use, there are also TGGD population specific guidelines created to ensure adequate healthcare. These include the World Professional Association for Transgender Health (WPATH) guidelines, Sherbourne Health Guidelines, the Ethics Committee of the American Society for Reproductive Medicine, the Endocrine Society Guidelines, the UK National Health Service, and the Guidelines of the World Professional Association of Transgender Health.

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2016; Mayes et al., 2017; Myers & Martin, 2021), demonstrating a lack of informed consent (Martin, 2010; Harwood, 2015; Jackson, 2017; Borovecki et al., 2018; Bhatia, 2022; Cameron & Garcia, 2023; Drost et al., 2023). Despite this aspect, fertility clinics globally began to promote their egg freezing services and establish programs (Inhorn, 2018). Between 2020 and 2022, there has been a 25 percent increase in the number of Canadian employers offering fertility coverage in healthcare benefits. By contrast, only ten percent of adoption and childcare benefits have been added to such packages (Janes, 2023).

MEF and SEF are considered separate from each other. While the procedures of MEF and SEF are identical, the distinction between the two is imposed and entrenched in egg freezing literature and medical discourse (Petropanagos, 2010; Goold & Savulescu, 2008). Despite the reasons for freezing, the risks of the procedure, financial cost, and success rates remain an extensive concern for all individuals choosing to freeze their eggs.

Medical Egg Freezing

The label MEF is applied to:

- Individuals who need to freeze their eggs due to reproductive diseases (Inhorn, 2017).
- Medical conditions (autoimmune disorders, severe endometriosis, BRCA1 and 2, Turner syndrome, and fragile X syndrome) (Inhorn et al., 2018; Pérez-Hernández, 2023).
- Disease-related/iatrogenic premature menopause (Bhatia & Campo-Engelstein, 2018).
- Individuals needing cytotoxic chemotherapy (Inhorn et al., 2018).
- TGGD individuals taking testosterone (Inhorn et al., 2018).

When considering how TGGD individuals taking testosterone are included in this list under MEF, it is critical to reflect on the history of TGGD healthcare. In 1919, German scientist

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Magnus Hirschfeld, known as the father of transgender healthcare, opened the Institut für Sexualwissenschaft (Institute for Sexual Science) in Berlin (Stryker, 2017). Hirschfeld introduced the first center where TGGD individuals could access HRT and gender-affirming surgeries (Folx, 2022b). In England in the 1940s, Michael Dillon was among one of the first English citizens to receive HRT and gender-affirming surgery (Historic England, 2024). It wasn't until the 1960s that TGGD individuals in Canada began to gain more visibility. In 1962, Dianna Boileau began her HRT journey, later undergoing gender-affirming surgery in the 1970s (Ontario Heritage Trust, 2024). Today, TGGD individuals in Canada have much more access to HRT; however, there has been little research about the impacts of HRT on important aspects of TGGD health.

It is critical to note that while there are no age restrictions when it comes to gender-affirming treatment in Ontario (Rainbow Health Ontario, 2023a), Canadian health organizations such as the Endocrine Society do not recommend hormonal intervention for youth under the age of 16 (Quan, 2019). However, TGGD youth can use hormone blockers, or hormone-suppressing agents to “pause or slow sex steroid-related physical changes that continue into young adulthood” until they can begin HRT (Canadian Paediatric Society, 2023, n.p). While the impacts of hormone blockers were not explored in this thesis, the 2024 Cass Review reiterates “no conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility” (Cass, 2024, p.33). Some participants in this thesis began their transitions earlier in life and used hormone blockers as part of their journey. Historically, few studies have explored the impacts of prolonged HRT³⁴ on TGGD individuals taking testosterone. Due to lack of scientific evidence and studies, TGGD individuals

³⁴ See appendix for information about the effects of prolonged testosterone use.

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taking HRT were deemed as infertile. Forms of infertility due to medical intervention are classified under the umbrella of MEF. Since there was no true understanding regarding the impacts of that prolonged use of HRT, it was not known if they could have adverse effects on fertility and egg quality for TGGD individuals. Therefore, infertility was promoted as a life-long side effect.

Like other individuals who freeze eggs for medical reasons, TGGD individuals taking HRT freeze their eggs because of the presumed loss of fertility caused by prolonged testosterone use. In 2019, Extended Fertility, a New York based medical practice, claimed TGGD individuals may want to engage in “egg freezing [that] protects the cryopreserved eggs from any damage as a result of gender-affirming hormone therapy” (n.p). New research could resolve the question of whether infertility is a result of prolonged HRT (Boston IVF, 2023). Studies have shown that while testosterone can have a negative impact on ovaries and eggs during its use, it does not in fact cause infertility (Boston IVF, 2019; Light et al., 2014). In 2014, this was first found by Light et al. (2014) who noted of the 41 transgender men who completed their survey, 80 percent regained their menstrual cycles after ceasing HRT, and 61 percent had been on HRT before achieving pregnancy. In fact, the average time on HRT among these transgender men was 6.8 years, showing great potential for pregnancy, even among those with prolonged HRT exposure. During pregnancy, TGGD participants had experiences of “perinatal complications including hypertension (12%), preterm labor (10%), placental abruption (10%), and anemia (7%)” (Light et al., 2014, p.1124). Authors noted “pregnancy, delivery, and birth outcomes did not differ according to prior testosterone use” yielding similar complications between transgender and cisgender individuals (Light et al., 2011, p. 1124). This sample of transgender men had babies who were just as healthy as babies born to non-testosterone users. At the same time, TGGD

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individuals reported being more likely to deliver by caesarian section by choice to avoid the discomfort of a vaginal birth. TGGD individuals also experience post-partum depression including isolation, and feel they had few post-birth resources (Light et al., 2014)

More recently, Boston IVF (2021) a US based research center, reported prolonged HRT use can “suppress ovulation and alter ovarian histology” (n.p). However, TGGD individuals taking HRT can stop testosterone use and then become pregnant just as easily as their cisgender counterparts (n.p). Boston IVF found that TGGD individuals could cease using HRT and freeze their eggs with comparable success to cisgender, heterosexual women (2021). Over an eight-year period, Boston IVF had 26 transgender male patients, over half of whom were on HRT for longer than four months, engage in egg freezing and/or embryo transfer. Sixteen of the 26 transgender male patients underwent ovarian stimulation and egg freezing, and seven used fresh or frozen embryos for transfers. Results found on average that transgender male patients yielded 19.9 eggs per cycle and all seven embryo transfers resulted in pregnancy and live births. In comparison, a control group of 130 cisgender female patients was used. The cisgender female patients yielded an average of 15.9 eggs per cycle from ovarian stimulation and extraction, showing comparable success rates between both groups, despite the sample. Boston IVF concluded their study claiming, “even long periods of gender-affirming androgen [testosterone] therapy did not appear to have a negative effect on ovarian stimulation outcomes” (2021, n.p). Most recently, a 2022 case study mirrored previous findings. Hassan et al. highlighting that their case study “questions the commonly held belief that transgender male pregnancy is highly difficult in people receiving GAHT [gender-affirming hormone therapy] who have not received fertility preservation” (2022, p.3). Not only are medical research studies outlining the viability of TGGD individuals to become pregnant, but they are also even reporting successful egg freezing in TGGD individuals

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who have already been on HRT (Extended Fertility, 2019). However, egg freezing is recommended before beginning HRT to ensure the best possible egg quality (Tecco, 2023).

Despite these recent findings, TGGD individuals remain classified under MEF. While TGGD individuals can be categorized under MEF for multiple reasons such as reproductive diseases, HRT use alone is not a reason for future infertility. Not all individuals engaging in chemotherapy or HRT experience future infertility, but egg freezing before beginning treatment is the best time to collect the healthiest eggs. For individuals undergoing chemotherapy, MEF can assist in preventing “anticipatory fertility-related regret” by allowing parties to freeze for future use (Inhorn et al., 2017, p.27). Individuals freezing for medical reasons freeze their eggs based on the possible loss of fertility and the unknown future. While medical conditions and treatments vary, the goal of all individuals freezing for medical reasons is prospective biogenetic parenthood. Biomedicalization of fertility, especially egg freezing, continues to create anxiety surrounding all forms of infertility (Myers & Martin, 2020). For those freezing for medical reasons, the emergence of “COVID-19 could be a new indication for fertility preservation for a determined deadline” since time remains an urgent matter (Gerber et al., 2020, p.233). COVID-19 brought an additional layer of urgency for many seeking to freeze their eggs (Murugesu et al., 2022). COVID-19 enters discussions about the distinction between MEF and SEF because of COVID-19 changed a socially based concern about infertility into a medical concern for many users, a point that will be explored in the following chapters.

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Desires for Biogenetic and Egg Freezing Among TGGD Individuals

While TGGD individuals, especially transmen,³⁵ have been found to desire biogenetic parenthood in countries like the US (Tornello & Bos, 2017), only zero to 1.3 percent had engaged in egg freezing technology use before medically transitioning (Bartholomeaeus & Riggs, 2019). Similarly, another 2016 US study found only two of 72 trans male youth participants desired fertility preservation counseling (Nahata et al., 2017). Low utilization of egg freezing among TGGD individuals taking testosterone could be attributed to the process required, including the need for ultrasounds and gender incongruent hormones that can trigger gender dysphoria.³⁶ For those seeking fertility preservation after HRT, stopping testosterone intake can result in the reappearance of menstrual cycles, hip growth, breast tissue fullness, and belly swelling (Armuaud et al., 2017). Estrogen injections required for egg freezing can also restore more pronounced characteristics associated with characteristically feminine appearing bodies,³⁷ causing additional psychological and emotional suffering for some (De Roo et al., 2016). In a 2018 US study, over half of the transmen surveyed stated they had not had their fertility discussed with them (House of Commons, 2019). Other reasons why egg freezing rates could be low include lack of access to information regarding fertility preservation (von Doussa et

³⁵ Language used outside of TGGD is taken verbatim from the language used by source.

³⁶ Gender dysphoria refers to psychological distress associated with the gender assigned at birth (Armuaud et al., 2017). In 2013, “gender identity disorder” became a term used by medical and healthcare professionals under the American Psychology Associations reference guide *Diagnostic and Statistical Manual of Mental Disorders*. Under the *Diagnostic and Statistical Manual of Mental Disorders* gender identity disorder was used to describe an individual who was experiencing “psychological distress caused by discontent with one’s natal sex” (American Psychological Association, 2013). However, the diagnosis of gender identity disorder is no longer used (Jarin et al., 2019) and is now replaced with the term of gender dysphoria.

³⁷ The term feminine is used in this case to describe the characteristics attributed to the impact of naturally occurring estrogen or estrogen use. Characteristics such as hip and breast growth are commonly attributed to assigned female at birth individuals.

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al., 2015; Jones 2016, Mitu, 2016; Moravek et al., 2018; Cheng et al., 2019; Marvel et al., 2017; Ross et al., 2014), a long geographical distance to clinics (Ethics Committee for the Society of Reproductive Medicine, 2015), and overall financial cost of transitioning (Bartholomeaeus & Riggs, 2019). Financial costs of transitioning can include:

- Changing legal name and gender on documentation.
- Gender-affirming clothing.
- HRT necessities (including alcohol pads, bandages, depo-testosterone, needles, and syringes).
- Chest-reducing accessories (binders, chest tape, or sports bras).
- Gender-affirming surgery.
- Lost wages due to time off work.
- Cost of transportation to psychological and/or medical appointments

Simultaneously, unemployment or underemployment among TGGD individuals contribute to their lack of access to the financial capital (Irving, 2017) needed for fertility preservation. For such reasons, MEF becomes even more complex for some, and the quest for biogenetic parenthood weighs heavily. Globally, TGGD individuals struggle to manage the financial cost of egg freezing. Some, like Charlie Scarterfield, a 17-year-old UK citizen, have even resorted to crowdfunding through organizations like GoFundMe to afford fertility preservation (Lo, 2019).

Social Egg Freezing

Despite the reservations conveyed by the American Society for Reproductive Medicine and the Society of Obstetricians and Gynaecologists of Canada, SEF has become increasingly

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popular as a means for cisgender, heterosexual women to combat age-related infertility allowing them to wait for the “right time” to have a family (Baldwin, 2017). The term “social” in SEF has been debated, with some preferring “elective egg freezing,” “non-medical egg freezing,” and “freezing for non-medical reasons” (Alteri et al., 2019, p. 647). Medical professionals researching egg freezing claim that egg freezing for age-related infertility is proactive and could be classified as medical as a means of preventing the adverse effects of reproductive aging (Stoop et al., 2014). SEF is generally presented as a technology for middle-class, white, cisgender, heterosexual, professional women. Scholars have found that egg freezing is “something that’s generally spoken about” (Waldby, 2015, p. 474) as a way to beat the “biological clock” (p. 475). In women, age-related infertility begins at approximately 35 years of age (Gruben, 2017) and progresses quickly, leaving them with a smaller window of time to have a family. While freezing eggs does not avoid the “fertility cliff” (Martin, 2017; Gruben, 2017), using younger eggs provides additional chances of being able to have a biogenetic child when over the age of 35 (Mayes et al., 2017). The average age of first-time birth givers in Canada was 31.6 in 2022 (Statistics Canada, 2023b), which can leave many women anxious about future biogenetic children. In a recent 2024 article, CBC News journalist Bárbara d’Oro explored her own experience of freezing her eggs due to age-related infertility. After freezing her eggs in her home country of Brazil, 40-year-old d’Oro separated from her long-time partner, wondering “should I continue to wait to meet “the one” or decide to pursue my dream of motherhood alone by using a sperm donor?” (d’Oro, 2024, n.p).

Age is used as a weapon, especially against cisgender women, with fertility clinics benefiting from the fear of falling over the fertility cliff and into menopause. Fertility clinic start-ups are using social media platforms such as Instagram, creating “new and invasive ways” to

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advertise fertility clinic services, especially egg freezing to younger and younger women (Mull, 2019, n.p). College campuses across the US have even been targeted as places to find young, intelligent, female egg donors, with advertisers claiming: “it's surprisingly easy to donate eggs while you are a student” (Simply Egg Bank, 2024, n.p). The ultimate goal of younger individuals freezing their eggs is portrayed as ensuring their biogenetic future. Initial assumptions were that women would freeze their own eggs to give themselves additional time (Petropanagos et al., 2015) to further their careers and education before starting a family, therefore "having it all" (Cattapan et al., 2014, p. 238; Baldwin et al., 2014; Baldwin, 2017; Baldwin et al., 2018; Bernstein & Wisemann, 2014; Goold & Savulescu, 2008; Bhatia & Campo-Engelstein, 2018; Carroll & Krolokke, 2017; Harwood, 2017; Mertes & Pennings, 2011; Martin, 2017; Lallemand et al., 2016; Inhorn, 2017; Cobo & Garcia-Velasco, 2016).

Some scholars claim that egg freezing technology may place additional pressure on women (Reis & Reis-Dennis, 2017). With recent increases in coverage for fertility clinic services and low support for childcare needs for Canadian, this is not surprising. Another key concern is that SEF is advertised and promoted as a progressive technology without providing those seeking to freeze their eggs with the information needed to make informed decisions (Barbey, 2017; Mull, 2019; Bayefsky, 2020; van de Wiel, 2020; Görtin & Tiemann, 2021; Polyakov et al., 2023). Moreover, recent studies have found that few women cite career or education as a motivation to freeze their eggs. Gay et al. (2013) found in their online US sample of 337 surveys that 92.1 percent of their sample of young graduate students and professional women would consider SEF. Lallemand et al. (2016) in Denmark and the UK found that 89 percent of the women in their online study would consider egg freezing. However, participants found no identifiable correlation between educational aspirations and egg freezing. Martin (2017) found

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that of 71 childless female US participants between the ages of 25-40, only 25.4 percent of them were motivated by their careers, and only 21.1 percent by education (p.93). Therefore, despite the projection of SEF as a tool for gender equality, women are not using technology for the assumed purpose of career and educational advancement. Recent studies expose other motivations for those wishing to freeze their eggs for social reasons. Partnership was cited as a central motivator in both cases of SEF *and* MEF. A 2021 Canadian study found that of their sample of 224 cisgender women, 89 percent froze their eggs while they were single, fearing age-related infertility and lack of partner (Yee et al., 2021, p. 285). Another 2021 UK study found that of their sample of 191 cisgender women, over 93 percent froze their eggs due to partnership concerns (Murugesu et al., 2021). In 2022, in an online article, a University of Toronto medical student, Maxime Billick, explained how egg freezing empowered her because it “seemed like the best way to relieve some of the anxiety and pressure I felt about having children,” and concluded: “screw the patriarchy. I am doing this” (2022, n.p). Intersecting social, political, and personal contexts must also be considered in women's motivations for egg freezing (Bernstein & Wisemann, 2014). Moreover, SEF literature often leaves the intentions and desires of cisgender, queer-identifying women unexplored. While the distinctions between SEF and MEF are highlighted, even among research participants, the motivations for freezing eggs remain the same, typically, the desire for biogenetic parenthood and family formation.

Biogenetic Parenthood, Egg Freezing, and Skating on Thin Ice

Egg freezing is posed as a solution to the age-old concern of future infertility. While egg freezing has been proposed as a revolutionary “technomedical” solution to age-related infertility (Martin, 2010), egg freezing may not be all it is cracked up to be. Many feminist scholars are

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skeptical of egg freezing; however, some assert the distinction between MEF and SEF remains important. Egg freezing is a technology that “banks” time for those who want to become future biogenetic parents. At the same time, egg freezing, and other reproductive technologies provide an expensive, invasive, and risky way to achieve biogenetic procreation. Egg freezing is presented by the media (Barbey, 2017) and clinics (van de Wiel, 2022) as a proactive solution to infertility, providing the only solution if you want to have biogenetic children. Simultaneously, 2SLGBTQIA+ individuals seeking parenthood are commonly required to use fertility clinics for family formation, regardless of their desire for biogenetic parenthood (Inhorn et al., 2009).

Scholarship in Canada addressing egg freezing among TGGD individuals taking testosterone seems like a neglected field. Currently, only two studies (Millar et al., 2015 & Jones et al., 2016) have explored egg freezing and biogenetic reproduction within TGGD adults. Both studies contain small sample sizes, that withhold important demographic information (such as the age of participants, racial identity, and geographic location) and do not include interviews in their methodology. While this research provides some foundational information regarding the desires of transgender individuals,³⁸ the age range is limited and the demographic information, including gender identity, age, race, and class are missing. Demographic information is required to determine a link between intersecting forms of systematic oppression whereby a researcher can link forms of identity to qualitative data collected. In 2015, Millar et al. published preliminary results addressing reproductive knowledge and beliefs among a “transgendered”³⁹

³⁸ Transgender and not TGGD is used here intentionally since research did not include any gender diverse identifying individuals.

³⁹ It is significant to note that this research study uses the incorrect term of “transgendered” and “people of transgender experience” to describe the transgender population. Given the rapid shift in terminology, even predating this 2015 study, this term transgendered is considered outdated (Steinmetz, 2014) and even offensive because it turns an identity (an adjective) into a verb.

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sample within Toronto, Ontario. Their methodology included a semi-structured survey that was distributed through multiple endocrine, psychiatric and family practice clinics. Despite an intended sample of 200 surveys, authors only published the preliminary results with 11 surveys completed. Results yielded a young sample, aging in range from 19 to 25. The authors found that five out of the 11 participants desired future biogenetic children (45 percent), four of the 11 said their fertility was somewhat important to them (36 percent), and only six of the 11 had fertility options discussed with them in a medical setting (55 percent). Eight of the 11 participants mentioned economic barriers, with the costs of fertility preservation hindering their ability to engage in the process (73 percent). While this research provides some foundational information regarding the desires of transgender individuals, the age range is limited, the demographic information including the gender identity, age, race, class are missing including the gender identities of participants, and the sample size is small. Demographic information is required to determine a link between intersecting forms of systematic oppression whereby a researcher can link forms of identity to qualitative data collected.

The second study conducted in Canada by the research team of Jones et al. (2016), used a retroactive chart review to determine the population of transgender individuals, referred to an undisclosed, university-affiliated fertility clinic within Canada between January 2011 and May 2014. The sample included 11 MtF (male-to-female) individuals and three FtM (female-to-male) individuals⁴⁰ referred for fertility preservation consultation. The FtM participants were older in

Transgender is a gender-based identity that someone is, it is not an action that one takes (Lopez, 2015).

⁴⁰ FtM or FTM, meaning female-to-male, can also be used to describe individuals who are AFAB, but the term can be considered out of date. It assumes all individuals AFAB transition from female to male. AFAB is inclusive to all individuals who do not identify as female despite being assigned the label of female at birth.

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comparison to the Millar et al. (2015) study participants, at 33 (Patient 2), 37 (Patient 1), and 39 years of age (Patient 3). Concerns among the FtM sample regarding fertility preservation included time off their masculinizing hormones (HRT), the financial cost of fertility preservation, their age, and the transabdominal and transvaginal ultrasounds required. Patient 1 was still considering fertility preservation but sought a second opinion from another fertility clinic; Patient 2 postponed surgery to save money for fertility preservation in the future; and Patient 3 decided against fertility preservation at any time. This review offered critical insight into why TGGD individuals rejected fertility preservation. However, the context and demographic information provided were minimal (including only age; gender identity; length of time on HRT; which medical professional referred the individual; if the individual had a primary care physician or other medical professionals) resulting in a failure to account for the intersecting forms of oppression that contribute to the many barriers experienced by TGGD individuals in fertility clinics. This review provides the recommendation of increasing awareness of fertility options in the TGGD population by healthcare professionals such as family physicians, endocrinologists and gynecologists (Jones et al., 2016).

While the intention of egg freezing is providing a solution to reproductive uncertainty, it remains a neoliberal and capitalist technology (Barbey, 2017), promising more than it can commonly deliver. This is especially true during times such as COVID-19. A 2023 UK study found that 82.3 percent of women in the clinic freezing their eggs for social reasons experienced COVID-19 as a barrier and procedures were delayed for COVID-19-related reasons (Murugesu et al., 2023, p. 760). Egg freezing is a technology that monopolizes the historical emphasis on heteronormative and middle-class family formation by promoting its ability to help with the achievement of biogenetic parenthood. While in some cases, the promise for biogenetic

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parenthood is achieved through egg freezing, it is more common that egg freezing can lead to conflicted hope. Conflicted hope is a living emotional state that grows with anticipation and excitement (Mayes et al., 2017). Egg freezing exemplifies conflicted hope as a technology that promises the world with high uncertainty. Terms like “bank” (Cobo et al., 2011), “insurance” (Inhorn et al., 2018), “time” (Baldwin et al., 2018), and “clock” (Harwood, 2018) are used to produce a feeling of urgency in those who are considering the procedure. However, the science behind the biological clock and at what exact age the “fertility cliff” is hit remains uncertain (Waldby, 2018).

For TGGD individuals, the time crunch can mean waiting to begin HRT, freezing their eggs, the potential loss of fertility due to HRT, and the fear of declining fertility with age. COVID-19 brought on additional anxiety to many struggling with infertility with experts commenting, “treatment changes and cancellations are creating a clear crisis for those who badly want to have a child” (Gerber et al., 2020, p. 233). Eggs can become a symbol for hope for many, especially those freezing for medical reasons. They believe it may be their only chance at biogenetic parenthood in the future, but that future grew uncertain because of COVID-19. Loss of fertility provides an additional emotional element for some (Carter et al., 2011), despite recent developments that prolonged HRT does not cause infertility in all users (Light et al., 2014; Boston IVF, 2022).

For many considering freezing their eggs, the shiny picture of a career, partnership, and children is truly appealing. However, the hope created by egg freezing can quickly become conflicted since egg freezing is a technology that cannot guarantee a successful pregnancy or live birth. Based on the medical risks, success rates, and cost of egg freezing, individuals who pursue medical or social egg freezing can quickly be left with shattered dreams. For individuals freezing

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their eggs for medical or social reasons, these risks, costs, and rates are identical, however individuals freezing for medical reasons, especially those about to undergo cancer treatments experience risk in different ways since the medical risks may appear less threatening based on their current diagnosis (Goold & Savulescu, 2008; Stoop et al., 2014). However, for many, egg freezing is a matter of biomedicalization (Myers & Martin, 2021). Biomedicalization is the process of reframing non-medical issues to “become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad, 1992, p. 209). In doing this, “biomedical concepts became structured around the polarity of the normal and the pathological” (Spurlin, 2019, p. 8). Egg freezing is a medical means through which often non-medical concerns can be addressed including age-related infertility, and the potential for HRT related infertility. For Baldwin et al., “reproductive ageing is perceived and represented, not as a natural inevitability but as a pathological liability in need of monitoring and management” (2018, p. 268) that becomes the responsibility of the individual freezing their eggs. Similarly, in this thesis, TGGD individuals living in ON, age-related infertility was cited as a concern among two TGGD interview participants. Conflicted hope is what occurs when egg freezing fails unexpectedly. Hope becomes conflicted and “cruel optimism” imposed when considering the risks associated with the practice of egg freezing itself. Scholars question how reproductive autonomy and informed consent can be given by individuals who are not provided with information about extensive medical risks or low success rates (Gruben, 2017; Bartholomeaeus & Riggs, 2019; Bernstein & Wisemann, 2014; Harwood, 2009; Weber-Guskar, 2017).

Conflicted hope is a living emotional state that grows with anticipation and excitement. It can manifest when egg freezing is framed by media messages and fertility clinic settings as progressive, (Barbey, 2017) while “cultivating anxiety in potential customers or by linking egg

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freezing to desirable personal traits” (Barbey, 2017, p. 196). Neoliberal forms of individual responsibility for reproduction including the anticipation of future regret (Greenwood et al., 2018) shapes the fears of individuals who freeze their eggs. Egg freezing is promoted as reproductive liberty telling women their best chance at future pregnancy and biogenetic parenthood (Carroll & Kroløkke, 2017) is technology use. At the same time, neoliberalism places blame on those who are not proactive against age-related infertility (Baldwin, 2018). While many TGGD individuals commonly prioritize their medical transition over reproduction (Perksy et al., 2020), their cisgender counterparts have less to consider. Harwood (2009) cautions that cisgender, heterosexual women can “act out of desperation and relative ignorance” (p.45). Many women can feel “fertility pressure clouded” in terms of their hopes and desires for a future family, reducing their ability to make decisions based in informed consent (Richards, 2013, p.56). Conflicted hope can leave those who freeze their eggs regretting their decision to freeze, especially when the technology fails them (Jones et al., 2020).

To Mayes et al., (2017) egg freezing must be contextualized against the increasing anxiety regarding health, the supposed empowering nature of reproductive technologies, and the way biological citizenship is shaped through reproductive technology use. For these authors, egg freezing encompasses forms of cruel optimism by promising individuals who freeze their eggs “the good life” even though the technology becomes an obstacle for the flourishing of the individual (Mayes et al., 2017, p. 54). Egg freezing and the quest for biogenetic procreation are not innately “cruel”, however, hope for biogenetic parenthood is overshadowed by low success rates, high medical risks, and astounding financial cost (Mayes et al., 2017). Egg freezing offers the good life, with users envisioning middle-class nuclear family joy, but the technology is often unable to fulfil these aspirations. Given the associated medical risks, egg freezing, when

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undertaken specifically for social reasons, allows the users of this technology to raise their hopes with false and misleading information. This chapter will now elaborate on the importance of situating egg freezing practices alongside medical risks, financial cost, and success rates to demonstrate how technology use provides falsified hope or cruel optimism.

Risks of Egg Freezing

Egg freezing comes with extensive medical (Goold & Savulescu, 2008; Harwood, 2009; Cattapan et al., 2014; Robertson, 2014; Ikemoto, 2015; De Roo et al., 2016; Roth, 2016; Gruben, 2017; Mayes et al., 2017; Weber-Guskar, 2017), emotional (Inhorn, 2018), psychological, and physical risks (Gruben, 2017). Physical risks associated with hormone use include Ovarian Hyperstimulation Syndrome (OHSS) which can cause pain, physical sickness, fluid build up and rarely death. On the other hand, general medical risks such as possible failure of treatment (Gruben, 2017), headaches, bloating, abdominal pain (Cattapan et al., 2014), potential risk for damage during the extraction process (Bernstein & Wisemann, 2014), risk of reintroducing cancerous cells through reimplantation of an oocyte (among cancer patients) (Petropanagos, 2010) and many unknown risks (Mohapatra, 2013) including long term risks that remain unstudied (Bernstein & Wisemann, 2014).

A 2020 UK study by Baldwin & Culley concluded that women were told some of the potential risks of egg freezing, however, many women conducted additional research online for their own purposes. For participants, egg freezing was considered as “half an In Vitro Fertilization cycle and therefore lower in risk or bearing the same risk as those undergoing In-Vitro Fertilization, which they believed to be routine and safe” (Baldwin & Culley, 2020, p. 188). In-Vitro Fertilization is the process of extracting mature eggs from an individual’s ovary,

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fertilizing the extracted eggs in a lab using sperm from a partner or donor, and then implanting the fertilized egg into a parent or surrogate (Mount Sinai Fertility Clinic, 2021). At the same time, authors had many participants who experienced intense bloating to such levels that it was mistaken for pregnancy (Baldwin & Culley, 2020). As explored, individuals who freeze their eggs for medical reasons may frame the medical risks of egg freezing from a different perspective than their social freezing counterparts, as some experience medical risks associated with illness or medical interventions (Inhorn, 2018). Individuals who freeze their eggs often associate the risk of future infertility as greater than the medical risks associated with hormone use, follicle stimulation and extraction. The complex dynamics of risk and hope causes scholars to question how risk is portrayed to egg freezing patients and whether informed consent and reproductive autonomy can be explicitly expressed when risks are not properly relayed to technology users (Gruben, 2017; Bartholomeaeus & Riggs, 2019; Bernstein & Wisemann, 2014; Harwood, 2009; Weber-Guskar, 2017).

Older individuals above 35, who freeze their eggs and later use In-Vitro Fertilization to become pregnant face risks additional to the egg extraction process. The medical risks associated with gestating a fetus over age 35 poses challenges that individuals freezing their eggs have to face. Risks can be exacerbated when clients wish to save money and ensure successful implantation by embedding multiple embryos in a single procedure, contributing to the number of multiple births from In-Vitro Fertilization use (Darr, 2017, p.75). The total national multiple birth rate within US fertility clinics rose from 24 percent in 1971, to 54 percent in 2011, raising the chance of multiple births of those over 30 by 125 percent (Sunderam et al., 2017). The advanced age of pregnant individuals increases the likelihood of medical complications. All pregnancies by individuals over the age of 35 are deemed as high risk (Bernstein & Wisemann,

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2014) with increasing risks such as placenta abruption, emergency caesarian sections, gestational diabetes, pre-eclampsia, chronic hypertension and post-partum hemorrhaging (Baldwin, 2017), miscarriage, ectopic pregnancy, placental complications and intrauterine growth restriction (Cattapan et al., 2014). The social risk of advanced age includes the risk of orphaning children at a younger age and the possible dependence of a parent on their child due to illness or disease (Goold & Savulescu, 2008). One TGGD individual in this thesis worried about the hardship for older parents with young children, fearing they would not have the energy for older parenthood. Scholars consider medical and social factors when weighing the autonomy of individuals freezing their eggs in contrast to how hope is constructed. With such scrambled messages, individuals freezing their eggs may not understand the true risks associated with freezing their reproductive tissue.

For many, the medical and social risks of parenthood are outweighed by the hopes and aspirations of future parenthood. Egg freezing provides false or conflicted hope to many users through the promotion of the technology as miraculous, when in fact, little evidence has been found to support its popularity. Baldwin and Culley's 2018 UK study found that some women knew egg freezing was "not 100% safe...not 100% certain," yet they chose to freeze their eggs, regardless (p. 2). Cisgender female participants believed egg freezing placed them, as one respondent stated, "in a better position that I could possibly have been before" (Baldwin & Culley, 2020, p. 2). Greenwood et al. (2018) found that women were generally pleased with the amount of information provided, with 80 percent feeling the information they received was adequate, but with 14 percent disagreeing and six percent remaining neutral. Nevertheless, success rates are sporadic, misleading, and variable, depending on the clinic conducting the procedure (Bhatia & Campo-Engelstein, 2018; Gruben, 2017; Mertes & Penning, 2011).

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Success Rates

Clinics allow limited reporting regarding their egg freezing success rates (Baldwin & Culley, 2020) with poor quality of information provided in the US (Avraham et al., 2014), or even biased information through fertility clinic advertising (Barbey, 2017). Information provided to individuals regarding the medical risks and success rates lacks consistency. Egg freezing literature has claimed that the younger the individual freezing their eggs, the higher the quality of the eggs and therefore, the higher the chance of a successful pregnancy. Pregnancy rates using frozen eggs plummet from 85 percent to 20 percent when the eggs are frozen after the age of 36 (Cobo et al., 2016). Stoop et al. (2014) found that the overall survival rate of eggs through vitrification was 85 percent per egg with a delivery rate of 28 percent per embryo transfer. Within recent data, eggs that had been frozen using vitrification resulted in 8.2 percent live births in women under 36 (12.1 oocytes required per live birth) and 3.3 percent in women 36 to 39 years of age (29.6 oocytes required per live birth) (Bracewell-Milnes et al., 2018).

In the UK, women who froze their eggs at age 35 found that In-Vitro Fertilization success rates were closer to 38 percent, while in their 40s it was closer to two percent (Jackson, 2016). Current statistics find a mass decline in the success rates of In-Vitro Fertilization procedures, beginning with a vast decline in 2016, low rates not seen since 1998 (Inhorn et al., 2019). Gruben (2017) claims that the lack of standard protocols among clinics in Canada causes differentiated numbers. Prior to Greuben's work, medical literature reported 2,000 births from frozen eggs. Rates vary greatly depending on the age at which an individual froze their eggs. For this reason, egg freezing has been promoted widely to younger women, but most individuals freezing their eggs are in their 30s to 40s (Baldwin & Culley, 2020; Baldwin, 2018; Browne, 2018; Mayes et al., 2017; Greenwood et al., 2018; Inhorn et al., 2018).

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Financial Cost

Finally, the cost associated with egg freezing is substantial and inaccessible for many individuals. While individuals freezing their eggs for medical reasons have partial coverage through OHIP in Ontario, success rates make it very unlikely that a child will be born from the covered procedures. Within Canada between 2016 to 2017, Gruben (2017) put the average cost of an egg freezing cycle can range from \$3,500 to \$5,850 CAD, fertility drugs at cost upwards of \$3,500 CAD, including storage costs at \$250/year CAD and finally the cost of In-Vitro Fertilization at \$3,000-\$4,000 CAD. Therefore, “for a woman who freezes her eggs when she is 30 and uses them to conceive one child when she is 40,” the cost would be nearly \$36,500 CAD (Gruben, 2017, p.756). Currently, the Ottawa Fertility Centre charges \$9,000 for one egg freezing cycle, and \$7,500-\$9,000 per cycle of In-Vitro Fertilization (2021, n.p). While the Government of Ontario provides funding for one round of In-Vitro Fertilization, the cost of freezing remains high (Elliot, 2017). This means for individuals seeking to freeze their eggs and engage in In-Vitro Fertilization in the future, their chances of parenthood are slim, and the cost could add up to be monumental. In the US, women have been told they can use different strategies for affording egg freezing, “including financing, using money from your flexible spending account (FSA) or health savings account (HSA), [and] crowdfunding” (Spiegel, 2024, n.p). For some, additional medical expenses, including costs of transitioning and gender-affirming surgeries, all contribute to the affordability of the required reproductive technologies (Bartholomeaeus & Riggs, 2019). So too do the invisible costs of lost wages, transportation to the clinic, and a lack of insurance coverage (Inhorn et al., 2018). For this reason, only those individuals with economic capital can engage in fertility preservation through egg freezing.

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Freezing During COVID-19

Canada saw its first presumed case of COVID-19 on January 25, 2020, and went into lockdown. By March 23, all non-essential business were to be closed (Nielsen, 2020). Although Canadian, American, and European fertility societies agreed that “fertility care is considered essential” (Baratz in Taylor, 2021, n.p), fertility clinics were forced to postpone non-essential procedures. COVID-19 protocols created conflicted hope with many concerned about the delay in treatment, and ongoing reproductive aging (Botelho et al., 2022). A 2022 US study found there was “sense of urgency due to the delay in fertility procedures” among participants because of COVID-19 (DSousa et al., 2022, n.p.).

Despite the “emphasis on family wellbeing” during COVID-19 (Prime et al., 2021, p.631), fertility rates declined over COVID-19 for assigned-female-at-birth individuals (Fostik & Gailbraith, 2021) and potentially caused fertility issues with assigned-male-at-birth individuals who contracted COVID-19 (Lee et al., 2021). COVID-19 exacerbated anxieties. The desperation led some participants to underestimate the risks of COVID-19, prioritizing achieving a pregnancy over potential harm to maternal and fetal health (Dsouza et al., 2022, n.p). Despite the heightened desire for fertility clinic services during COVID-19, COVID-19 lockdowns meant fewer personnel to monitor storage equipment in fertility clinics (Hickman et al., 2020), procedures suspended (Rippon, 2020), and difficulty accessing services (Gemmell et al., 2020). Nevertheless, many continued to seek out reproductive technologies and fertility clinic services. Despite COVID-19 lockdowns, in countries such as the UK, 83 percent of private clinics were granted permission to open in comparison to 34 percent of National Health Service (Human Fertilisation and Embryology Authority, 2024, n.p) bringing into question the importance of money over COVID lockdown procedures.

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Conclusion

While distinctions between MEF and SEF are made based on the intended use of the technology, all individuals freezing their eggs long for future biogenetic parenthood. Based on the medical risks, weak success rates, and high costs, egg freezing in either case leads to high expectations with minimal results. While some individuals understand the risks they are undertaking, others remain in a state of cruel optimism (Mayes et al., 2017), assuming that the technology will provide them with the time needed to find their “Mr. Right”. Those who are unable to find the right male partner in time, frame themselves within discourses of failure, with single motherhood as the final, undesired option (Baldwin, 2017). Therefore, both medical egg freezing, and social egg freezing contribute to conflicted hope, with the promotion of technology as the perfect way to ensure a fairy tale ending.

Although the right to biogenetic parenthood should be available to all, the distinction between MEF and SEF, as explored in this chapter, is murky at best. MEF is based on concept of “medical necessity” which is defined as an “intervention considered important enough to merit public funding” for the practice (Cattapan, 2020, p. 62). However, some feminist scholars have argued that age-related infertility is “proactive freezing” (Wennberg, 2020, p. 95), calling SEF “age banking” (Stoop et al., 2014, p. 548). Others wish to treat all egg freezing as “preventive medicine” since users freeze to prevent future infertility due to “both disease and age-related fertility decline” (Shkedi-Rafid & Hashiloni-Dolev, 2011, p. 291). Regardless of the reasons for egg freezing, conflicted hope is a result of both MEF and SEF users.

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Chapter 2: It's Freezing in Ontario

“After speaking with Milo, and hearing about the concerns he has about reproductive technology coverage outside of Ontario, the more I realize how complex and inconsistent the country is. How frustrating to have to think about what to do before moving to another province. Should we use our eggs before we move? The new province won't cover the same fertility expenses, what do we do?”⁴¹

In Canada, medical healthcare coverage is provincially or territorially controlled. Some costs of egg freezing are partially covered or returned via tax credits in provinces like Ontario (OHIP), Manitoba (Manitoba Tax Credit), Prince Edward Island (Fertility Treatment Program), New Brunswick (Infertility Treatment - Special Assistance Fund) and in Quebec where no coverage is provided for TGGD individuals. However, to date, no provincial or territorial coverage is provided in Alberta, Saskatchewan, the Northwest Territories, Nunavut, or Yukon.⁴² Coverage in Ontario shifted in 2015 to include TGGD individuals as they are classified under MEF.

Coverage under OHIP for MEF include:

- Up to two attempts at cycle monitoring.
- One attempt at egg retrieval.
- Freezing of one batch/sample of eggs or sperm (not including storage fees).
- Sperm collection or, if required, one attempt at surgical sperm retrieval using certain technique.
- One round of In-Vitro Fertilization.⁴³

What remains an additional cost not covered under OHIP includes the cost of hormones, transportation, time off work, accommodation, and storage fees are currently not covered. While

⁴¹ Research journal excerpt, 04/04/2022.

⁴² Currently, there are no fertility clinics in the Northwest Territories, Nunavut, or Yukon.

⁴³ Information can be found at <http://www.ontariofertility.ca/>

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individuals freezing their eggs for medical reasons in Ontario can receive financial coverage and some relief through OHIP, they may be unaware of the overall costs associated with egg freezing and subsequent In-Vitro Fertilization procedures (Elliot, 2018). Unlike privately funded treatments in Canada, publicly funded treatments, like through OHIP coverage, must adhere to strict guidelines, including the number of embryos used in an In-Vitro Fertilization cycle. After the first cycle of In-Vitro Fertilization, costs can skyrocket (Inhorn et al., 2019), adding additional financial pressure, especially when the cycles do not result in a live birth. Those seeking to freeze their eggs must pay out of pocket for other services if they wish to continue. Therefore, biogenetic parenthood using reproductive technologies could come at a hefty cost. As seen when considering how hope can be conflicted by the financial inaccessibility of egg freezing for all, TGGD individuals can freeze only one batch of eggs believing that they have a high chance of a live birth. TGGD individuals remain in the precarious position of lacking access to information about their fertility options (De Roo et al., 2016) un/under employment (Irving, 2017) leading to fewer opportunities for family formation, and a lack of options for biogenetic parenthood other than reproductive technology use.

According to a Zion Research study, in 2021 the global worth of the fertility industry was over \$26 million (2022). Individuals seeking to freeze their eggs require access to a fertility clinic. Fertility clinics, which play a significant part of the industry, can be located in hospitals and other healthcare establishments; however, some exist independently. In Canada and around the globe fertility clinic provides services to couples struggling with infertility, promising to create smiling babies and happy families. In Ontario, a fertility clinic is a medical setting, regulated based on physical location, where individuals and couples can turn to scientific and medical methods to have biogenetic children. Fertility clinics offer services ranging from low-

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tech procedures including artificial insemination, donor insemination, and intrauterine insemination to more complex and high-tech procedures such as In-Vitro Fertilization, egg freezing, and surrogacy. In 2023, fertility clinic services led to approximately two percent of live births in Ontario (Dimanlig-Cruz et al., 2023). This chapter explores the complexities of fertility clinics in Ontario while investigating overarching global concerns regarding fertility clinic services. This chapter also seeks to illustrate the complex and conflicted nature of fertility clinics and medical coverage in Ontario, exploring the ways in which services such as egg freezing are troublesome for TGGD individuals seeking to use them.

The first instance of reproductive technology use resulting in pregnancy was by Scottish surgeon John Hunter who successfully facilitated the first success case of human artificial insemination in 1790 (Ombelet & Van Robays, 2015). Centuries later, fertility clinics emerged as a resource for cisgender, heterosexual women hoping to achieve biogenetic parenthood. Canada's first fertility clinic was founded in 1980 by Dr. Jacques Rioux and Raymond Lambert and was located in the University of Laval Hospital in Laval, Quebec (Yuzpe, 2019). In Ontario, the LIFE Program began in 1982 at the Toronto East General Hospital (IVF Canada, n.d., n.p). By 2013, Canada had 30 fertility clinics (Canadian Fertility & Andrology Society, 2016, n.p). In 2022, there were over 50 fertility government funded clinics in Ontario (Ontario Ministry of Health, 2015), and by 2023, there were over 35 fertility clinics providing IVF services alone (Aziz, 2023, n.p). Of fertility clinics in Ontario, 19 have fertility preservation services that include egg freezing.

Unfortunately, only 11 fertility clinics promote fertility services to 2SLGBTQIA+ individuals on their websites, and only five currently advertise the active inclusion of TGGD individuals (See Table 1). I associate active inclusion with the use of the transgender flag or

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direct mention of TGGD individuals, their families, or the use of transgender or non-binary specific terms and language on the clinics' websites. The small number of actively inclusive clinics potentially shatters the dreams of biogenetic parenthood for many TGGD individuals, while adding barriers to egg freezing.

Table 1: Government Funded Fertility Clinics in Ontario That Provide Egg Freezing

City	Clinic Name	Address	Services Provided	2SLGBTQIA+ friendly?
Burlington	ONE Fertility Burlington	3210 Harvester Road Burlington, ON L7N 3T1 Telephone: 905-634-4440 www.onefertility.com	AI /IUI/ IVF/FP ⁴⁴	· States they are LGBTQIA2S+ friendly. However, it uses the term "transgendered" which is out of date and transphobic. I emailed them December 4, 2022, about their language on the website with no response. As of August 8, 2024 this error has been remedied.
Kitchener-Waterloo	ONE Fertility Kitchener-Waterloo	4271 King Street East Suite 200 Kitchener-Waterloo, ON N2P 2X7 Telephone: 519-650-0011 www.onefertilitykitchenerwaterloo.com	AI/IUI/IVF/FP Embryo freezing not egg freezing	· No indication they are 2SLGBTQIA+ friendly.
London	London Health Sciences Centre (LHSC) - The Fertility Clinic	Victoria Hospital 800 Commissioners Road, East London, ON N6A 5W9 Telephone: 519-663-2966 www.lhsc.on.ca	AI/IUI/IVF/FP	· No indication they are 2SLGBTQIA+ friendly.
Markham	Markham Fertility Centre	379 Church Street 5th floor Markham, ON L6B 0T1 Telephone: 905-472-7128 markhamfertility.com	AI/IUI/IVF/FP	· Mention LGBTQ family planning, but no reference to TGGD individuals specifically.

⁴⁴ Artificial insemination (AI); Intrauterine Insemination of Sperm (IUI); In-Vitro Fertilization (IVF); and Fertility preservation, including egg and embryo freezing (FP).

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Mississauga	ASTRA Fertility-Mississauga	4303 Village Centre Court, Mississauga, ON L4Z 1S2 Telephone: 905-949-6999 www.astrafertility.com	AI/IUI/IVF/FP	· No indication they are 2SLGBTQIA+ friendly.
Mississauga	NewLife Fertility Centre	4250 Sherwoodtowne Boulevard, Mississauga, ON L4Z 2G6 Telephone: 905-896-7100 newlifefertility.com	AI/IUI/IVF/FP	· Have 2SLGBTQIA+ page and TGGD specific resources.
Mississauga	The Reproductive Care Centre (RCC)	2180 Meadowvale Boulevard, Mississauga, ON L5N 5S3 Telephone: 905-816-9822 www.rccfertility.com	AI/IUI/IVF/FP	· List Fertility options for 2SLGBTQIA+ families but do not mention TGGD individuals.
Ottawa	Ottawa Fertility Centre	955 Green Valley Crescent, Suite 200 Ottawa, ON K2C 3V4 Telephone: 613-686-3378 1-855-596-6755 www.conceive.ca	AI/IUI/IVF/FP	· I have done focus groups for this clinic; they are pushing for an inclusive website but currently there is no indication they are 2SLGBTQIA+ friendly.
Richmond Hill	Nahal Fertility Program	30 Wertheime Court Suite 22 Richmond Hill, ON L4B 1B9 Telephone: 905-482-3389 nahalfertility.com	AI/IUI/IVF/FP	· No indication they are 2SLGBTQIA+ friendly.
Scarborough	IVF Canada & The Life Program	2347 Kennedy Road Suite 304 Scarborough, ON M1T 3T8 Telephone: 416-754-1010 www.ivfcanada.com	AI/IUI/IVF/FP	· No indication they are 2SLGBTQIA+ friendly.
Toronto	Anova Fertility & Reproductive Health	25 Sheppard Ave. West Suites 650 & 690 Toronto, ON M2N 6S6 Telephone: 416-225-4440 www.anovafertility.com	AI/IUI/IVF/FP	· Has 2SLGBTQIA+ friendly material.
Toronto	TRIO Fertility	655 Bay Street, 11th and 18th floor Toronto, ON M5G 2K4 Telephone: 416-506-0804 or 416-972-0110 1-866-543-3046 or 1-800-520-0110 triofertility.com/	AI/IUI/IVF/FP	· Provides 2SLGBTQIA+ “Family Building” (clinics term).
Toronto	Mount Sinai Fertility	250 Dundas Street West, 7th Floor Toronto, ON M5T 2Z5 Telephone: 416-586-4748 mountsinafertility.com	AI/IUI/IVF/FP	· 2SLGBTQIA+ specific resources and web pages. · I am part of their LGBTQ+ advisory board.
Toronto	CReATe	790 Bay Street Suite 1100 Toronto, ON M5G 1N8	AI/IUI/IVF/FP Oncofertility and	· No indication they are

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		Telephone: 416-323-7727 www.createivf.com	elective egg freezing options	2SLGBTQQA+ friendly.
Toronto	Hannam Fertility Centre	160 Bloor Street East Suite 1500 Toronto, ON M4W 3R2 Telephone: 416-595-1521 hannamfertility.com	AI/TUI/IVF/FP	· No indication they are 2SLGBTQQA+ friendly.
Vaughan	Generation Fertility, Vaughan	955 Major Mackenzie Drive West Suite 400 Vaughan, ON L6A 4P9 Telephone: 289-357-0100 www.generationfertility.ca	AI/TUI/IVF/FP	· 2SLGBTQQA+ friendly and mentions TGGD individuals.
Windsor	Victory Reproductive Care	8100 Twin Oaks Drive Windsor, ON N8N 5C2 Telephone: 519-944-6400 www.drivictory.com	AI/TUI/IVF/FP Just embryo transfer	· Mentions LGBTQ+ family and transgender patients.
Waterloo	KARMA Kitchener Area Reproductive Medicine Associates	435 The Boardwalk, Suite 508 Waterloo, ON N2T 0C2 Telephone: 519-570-0090 www.karmaobgyn.com	AI/TUI/IVF/FP	· 2SLGBTQQA+ friendly and has trans flag.

Current attempts to provide gender-affirming care for TGGD individuals involve the Ottawa Fertility Centre,⁴⁵ which hosted focus groups in 2022 to improve reproductive equality for their patients, and Mount Sinai Fertility Clinic, that continues to host quarterly meetings with their 2SLGBTQQA+ Advisory Board.⁴⁶ On its website, ONE Fertility remains inclusive. However, the language was outdated, referring to TGGD individuals only as “transgendered.”⁴⁷ This concern has since been remedied. Mount Sinai remains one of the most popular fertility clinics among TGGD individuals seeking to freeze their eggs.

In 2022, Ontario opened its newest fertility clinic, EVOLVE. EVOLVE is the first fertility clinic in Canada dedicated specifically to egg freezing (EVOLVE Egg Freezing, 2024). EVOLVE mentions career, education, partnership, COVID-19, and medical reasons, including

⁴⁵ I have hosted three focus groups for the Ottawa Fertility Centre specifically pertaining to inclusive, services, and needs of 2SLGBTQQA+ patients.

⁴⁶ I have been an active member of the 2SLGBTQQA+ Advisory Board since June 2021.

⁴⁷ I reached out to ONE Fertility in December 2022 with no response to this concern.

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transitioning to be reasons to freeze one's eggs (2024). In Ontario and across Canada, healthcare professionals are not required to discuss fertility preservation with their patients prior to beginning HRT. However, it is now considered an ethical and informed practice that is becoming more commonplace and is recommended by *The Standards of Care for Transgender and Gender Diverse People* (Version 8)⁴⁸ and *The Cass Report* (2024).⁴⁹

Framing Hope in Fertility Clinics

As explored in Chapter 1, those seeking to freeze their eggs can experience conflicted hope through extensive medical risks, confusing success rates, and high financial costs. However, conflicted hope can also become a factor for those seeking other fertility clinic services for different reasons. For reasons explored in this chapter, risk, cost, success rates, and often COVID-19 remain extensive considerations. Risk can be physical, emotional, or psychological in nature, with many who freeze their eggs unaware of the potential risks that accompany the procedure of egg freezing. This lack of awareness is deeply tied to regulation since fertility clinics remain independent. However, depending on the physical location of the fertility clinic, standards will differ. For instance, those fertility clinics located in hospitals will

⁴⁸ The *Standards of Care* were originally developed in 1979 by the World Professional Association for Transgender Health. The *Standards of Care* are evidence-based guidelines to promote gender-affirming treatment by healthcare professionals. Currently, the *Standards of Care* is on its 8th edition with the 7th edition published back in 2012 (World Professional Association for Transgender Health, 2024).

⁴⁹ *The Cass Report* is an independent review of 103 scientific papers conducted by Dr. Hilary Cass, former president of the Royal College of Paediatrics in the U.K (McIntosh & Koseda, 2022). *The Cass Report* has been critiqued by some for including low quality studies and research in the review and the lack of evidence to base some claims (Bell, 2024). At the same time, little research regarding TGGD individuals continues to be done, leading to smaller research projects to reference. The review provides information that reiterates the need to believe transgender children in a time when politics continue to question the legitimacy of transgender identity in youth.

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also be required to follow the parameters of the *Public Hospitals Act*, while those located outside of a hospital will not be required to follow these parameters. This can make the regulation of fertility clinics jarring for patients and healthcare professionals. Finally, financial cost is another foundational barrier experienced by TGGD individuals despite the partial financial coverage they may received through OHIP. Financial cost can become even more extensive with success rates that can be confusing for those seeking out fertility clinic services. Success rates also remain closely linked to the regulation of fertility clinics as there is no required reporting system or universal way to provide comparable statistics.

These variables can allow hope to thrive when TGGD individuals have limited access to information or are unable to become more educated regarding fertility clinic procedures (Meyes et al., 2017). As explored in Chapter 1, all those seeking to freeze their eggs can experience conflicted hope because of the accompanying extensive medical risks (Petropanagos, 2010; Bernstein & Wisemann, 2014; Cattapan et al., 2014; Gruben, 2017), confusing success rates (Bhatia & Campo-Engelstein, 2018; Gruben, 2017; Mertes & Penning, 2011), and high financial costs (Gruben, 2017; Barbey, 2017; Mayes et al., 2017; Inhorn et al., 2018). Conflicted hope is the hope that comes from the realization that there are more barriers to biogenetic parenthood than expected (Mayes et al., 2017). Conflicted hope may also become a factor when TGGD individuals freeze their eggs only to find that they require additional procedures or fertility clinics services such as requiring a sperm donor for egg fertilization (De Roo et al., 2016; Mattawan et al., 2018), In-Vitro Fertilization for pregnancy, and/or surrogacy assistance to achieve a live birth (De Roo et al., 2016; Auer et al., 2018; Stark et al., 2019). Many 2SLGBTQIA+ individuals may require multiple different fertility clinic services or procedures depending on their desires for biogenetic parenthood and pregnancy. 2SLGBTQIA+

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individuals will seek out specific fertility clinics in Ontario (Epstein, 2014a; Tornello & Bros, 2017) who have demonstrated allyship. This is especially true for TGGD individuals in Ontario who already receive inadequate reproductive healthcare and report experiencing discrimination in fertility clinic settings. Ultimately, 2SLGBTQQIA+ individuals may find themselves struggling against heteronormative policies, restrictions, and regulations that make biogenetic parenthood more extensive and expensive than anticipated.

Since most fertility clinics remain separate, their policies, allyship, and services may also reflect this. For instance, EVOLVE only provides egg freezing services, while other fertility clinics may not provide egg freezing, or In-Vitro Fertilization. Regardless, all fertility clinics sell more than fertility services (Barbey, 2017; van de Wiel et al., 2020). Many fertility clinics use the hope of a successful pregnancy and live birth as a strong emotional motivator to engage their services (Barbey, 2017; Takhar & Pemberton, 2019). Some fertility clinics will use the words “hope,” (Inhorn et al., 2022) “choice,” or “empowerment” in their marketing (Takhar & Pemberton, 2019, p. 314). Without regulatory guidance for advertising, consumers can become quickly misled. In 2021, the American Society for Assisted Reproductive Technology provided guidelines for all associated fertility clinics to ensure success rates are up to date, and include disclaimer statements (Sauerbrun-Cutler et al., 2021). However, even with such guidelines, affiliated fertility clinic websites came up short by “simplifying” success rates with only 10.5 percent of clinics adhering to the necessary guidelines (Sauerbrun-Cutler et al., 2021). Canadian fertility clinics act in similar ways, using the allure of hope to promote fertility services. For instance, Future Fertility, a Toronto-based fertility clinic, has the “Power of Hope Fertility Centres” and promotes the “Power of Hope Program” for those who have been diagnosed with

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cancer (Murray, 2010). Hope not only becomes a feeling attached to egg freezing and other forms of reproductive technology use but also sells a specific dream to users.

Clinics in Canada and the US reinforce the norms of biogenetic parenthood through showcasing images of the perfect babies. This includes images of baby slippers over pregnant bellies,⁵⁰ hands on pregnant bellies,⁵¹ happy white, middle-class families walking in the sunlight,⁵² toddlers with teddy bears, and indicating the possibility of a future pregnancy i.e. a positive pregnancy test with a smiling heterosexual couple (Hawkins, 2012; Speier, 2016; Takhar & Pemberton, 2019). Between 2005 to 2012, Hawkins coded 372 fertility clinics advertisements in the US and found 97.28 percent of websites contain pictures of white individuals and 62.93 percent had only pictures portraying white babies (2013, p.1148). Today, advertisements for fertility clinics and services continue to impact the choices consumers make which may provide them with hope that may not be attainable (Barbey, 2017). Fertility clinics are even advertising add-on services (van de Wiel et al., 2020). For consumers, the ultimate hope may be that frozen eggs will never be required for family formation (Inhorn, 2018) but freezing can provide a safety net, just in case. Using frozen eggs can feel like failure to some that are unable to acquire a partner (Lockwood & Johnson, 2015), an education, and a career before the fertility clock runs out (Goold & Savulescu, 2009; Bernstein & Wiesemann, 2014; Baldwin, 2018).

For those cisgender, heterosexual women who are freezing eggs for medical reasons, hope can mean that the unspeakable has occurred and they suffer from the anticipated infertility they feared. For other individuals freezing for medical reasons such as TGGD individuals, “hope

⁵⁰ HOPE Fertility & Reproductive Medicine Centre at <https://fertilefuture.ca/programs/power-of-hope/>

⁵¹ New Life Fertility at <https://newlifefertility.com/>

⁵² HOPE Fertility & Reproductive Medicine Centre at <https://fertilefuture.ca/programs/power-of-hope/>

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is a complex emotion” (Martin, 2008, p. 55) that can manifest for many reasons (Tasker & Gato, 2022). Hope acts as the preliminary emotion to conflicted hope. Hope is the fuel that drives desires and motivations with conflicted hope coming as the reality of unexpected barriers or the realization of initial hopes of biogenetic parenthood as unobtainable (Mayes et al., 2017). Hope is easily shattered for TGGD individuals who must navigate complex barriers to biogenetic parenthood, including navigating pre-existing structures that condemn their own versions of family formation (Boucai, 2016; Costa & Tasker., 2018; Goldberg & Allen, 2022). After transitioning, TGGD individuals commonly feel a refreshed vibrance about future parenting in their authentic gender with some finding the potential for fatherhood (Charter et al., 2018) or gender-neutral parenting exciting (Tornello et al., 2019). Biogenetic parenthood remains highly desirable, which can make the inability for TGGD individuals to achieve biogenetic parenthood even more complicated, with some experiencing extensive barriers to family formation. Anti-trans rhetoric remains one of these barriers.

Anti-trans rhetoric continues to hamper the human rights of TGGD individuals in Canada. Far right and conservative politics question the emotional and psychological safety of children who have TGGD parents (Stotzer et al., 2014) and even question the morality of TGGD individuals themselves (Monroe & Plant, 2019), making access to biogenetic parenthood more tedious. Despite the instance of anti-trans hate, TGGD individuals make successful parents (Murphy, 2010; Sterling & Garcia, 2020) who have meaningful relationships with their children (Stotzer et al., 2014). Transphobia⁵³ is commonly based on the ways that TGGD individuals do

⁵³ For Bettcher, “while it is clear transphobia exists, however, it is far from evident what transphobia is” (2014, p.249). Transphobia related to “the irrational fear of, aversion to, or discrimination against people whose gendered identities, appearances, or behaviours deviate from social norms” (Serano, 2007, p.12). Transphobia ultimately “addresses fear of trans-identified individuals instead of capturing the critically central and evidently flawed assumptions

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not fit into white, heterosexual, middle-class notions of family formation (Pfeffer, 2017; Briggs et al., 2020; Davis, 2021). Rather, TGGD individuals come to expect familial rejection from their own biogenetic families (Rood et al., 2016). TGGD individuals must often face the realities of having to deal with heteronormative and cisnormative⁵⁴ structures (Dierckx et al., 2017) of personhood and parenthood (Pfeffer, 2017). Davis notes that “trans reproduction is often met with reproach when compared with the norm of the cisgender, heterosexual, nuclear family” (2021, p. 179). This is because TGGD individuals are unable to achieve the “gold-standard of nuclear family” which includes marriage, a cisgender, heterosexual identity, and biogenetic parenthood (Bower-Brown, 2022, p. 223).

Conflicted hope can manifest when seeking out fertility clinic services for TGGD individuals who may be seeking the comforts awarded to those who engage in a white, middle-class, heteronormative lifestyles (Mayes et al., 2017). Fertility clinics can foster this feeling of hope (Sousa-Leite et al., 2022), however, TGGD individuals seeking to freeze their eggs have limited options based on the small number of gender-affirming and 2SLGBTQQIA+ inclusive fertility clinics. In 2017, Wu et al. found that in fertility clinic websites associated with the Society for Assisted Reproductive Technology in the US, only 32 percent of them included

that underlie the pervasive cultural system of prejudice and discrimination directed toward the transgender community” (Lennon & Mistler, 2014, p.63). Transphobia is not just about the intention of what is said or done but about “communicating othering messages” that reinforce “that individuals perceive difference” (Nordmarken, 2014, p. 131). Transphobia in healthcare can range from transphobia language in healthcare cost reimbursement (Eisfeld, 2014), the refusal to acknowledge the gender identity of a person, disregarding pronouns (Guss et al., 2017), verbal abuse (Kosenko et al., 2013), using previous name (i.e. deadnaming), misgendering (Hinrichs et al., 2018), and outright denial of care (Pitts et al., 2009; Hudson, 2018; Kattari et al., 2020).

⁵⁴ Cisnormativity is a term coined by Bauer et al (2009). Cisnormativity refers to the system that “highlights the privileging of a non-trans norm” (Pyne, 2011, p.129) where the ideal is “that everyone has a sexed body that matches their gender identity, limited to only binary options between male and female” (Jacobsen, 2022, p.5).

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topics relevant to TGGD individuals. As explored, Ontario also has limited choices for TGGD individuals considering fertility clinic services. The fertility clinics available to TGGD individuals may not understand the importance of gender-affirming care. Or, even when TGGD individuals use a fertility clinic that is known to be gender-affirming, they could still end up experiencing transphobia and cissexism⁵⁵ in the clinic setting (Finlayson et al., 2016).

Some TGGD individuals may find that mirroring heteronormative relationships awards them the acceptance they seek from their own families and society generally (Fielding, 2021). While some 2SLGBTQIA+ individuals hope that they will have a spot, “a place at the table,” (Ahmed, 2010), they struggle to achieve the same level of acceptance as their cisgender, heterosexual counterparts. Queer and trans rights come at a cost (Ahmed, 2010, p. 106), and for TGGD individuals, the cost could be the ongoing lack of acknowledgement from their families (von Doussa et al., 2017). This is where conflicted hope manifests itself for TGGD individuals who freeze their eggs to achieve biogenetic parenthood but end up reinforcing heteronormativity.

Cracks in Fertility Clinic Regulation

While those seeking fertility clinic services must deal with conflicted hope (Myers et al., 2018), behind the scenes there is even more at work. The lack of regulation of fertility clinics can also be a barrier to TGGD individuals who desire biogenetic parenthood. There remains minimal and confusing regulation (Snow, 2018; Epstein, 2018) of fertility clinics in Canada (Mykitiuk & Wallrap, 2002; Cattapan & Baylis, 2015; Ishii & Hibino, 2018). This can mean that there are few regulations in place to protect individuals seeking out fertility clinic services (The Ethics

⁵⁵ Cissexism “is the belief that transsexual’s 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 ad physical sexes as being aligned)” (Serano, 2007, p. 12).

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Committee of the American Society for Reproductive Medicine, 2013). Currently, there is little federal and provincial regulation, leading to inconsistencies in access to fertility clinic services (Baylis & McInnes, 2007; Pfeffer, 2011; Krahn & Baylis, 2016; Couture et al., 2019) and wait times for procedures (Moore & Arthur, 2019) can take at least one year (Assal et al., 2019). This can cause distress, especially to those waiting to begin HRT or waiting to begin medical treatments.

Regardless of sex, gender, or procedure, fertility clinic access is mandated under Canada's federal *Assisted Human Reproduction Act* (2004), however, the enforcement of regulations is sparse. The *Act* monitors "aspects of medical practices related to assisted human reproduction" (Advisory Process for Infertility Services, 2015, p.14). However, cracks continue to form in the regulation of fertility clinic and fertility clinic services. Key elements of the federally mandated *Act* include:

- The illegality of providing financial compensation for egg donation, sperm donation, or surrogacy services.
- All reproductive research must be for the betterment of human health, protection, and promotion.
- The wellbeing of children born from reproductive technology use must be ensured.
- Human diversity and integrity of human genomes must be valued.
- The protection of women in reproductive technology use.

However, the *Act* itself provides a limited framework to regulate fertility clinics. The regulatory system is almost impossible to monitor on a federal level due to a 2010 Supreme Court ruling that gave provinces or territory jurisdiction over their own fertility clinics (Advisory Process for Infertility Services, 2015). The ruling meant that each province or territory regulates

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its own fertility clinics and financial coverage for services, leading to a lack of uniformity across the country (Tam, 2021). One of the ways that lack of regulation can be seen is through the voluntary nature of reporting. The *Canadian Assisted Reproductive Technologies Register*, a national database that collects information about patients and services, does not require fertility clinics to provide annual reports on their services, rates, and fees, (Velez et al., 2019; Tam, 2021), leading to missing information (Cantor et al., 2023). In 2002, when fertility clinics were newer to Canada, 95 percent of Canadian fertility clinics voluntarily registered (Gunby & Salim, 2006), and by 2007 all 26 fertility clinics were registered (Gunby et al., 2011). In a 2020, the *Canadian Assisted Reproductive Technologies Register* was asked to investigate the validity of data provided to them because only six Canadian fertility clinics participated in annual reporting, showing a lack of dedication to reporting by many provinces (Bascal et al., 2020, p. 1).

Limited regulation intersects with more than just the guidelines provided to fertility clinics in each province; it also influences the funding. The financial cost for egg freezing and other fertility services can be expensive. Provincial funding through programs such as OHIP's fertility program provide partial coverage to TGGD individuals who are already experiencing barriers due to financial inaccessibility (Snow, 2018). However, two-tiered provincial funding systems separate public from private, meaning that individuals paying out of pocket will ensure that procedures occur more quickly and can avoid some of the regulations that come with accepting provincial funding through OHIP.

The 1984 *Canada Health Act* sought to provide equitable healthcare for all in Canada (Wilson & Rosenberg, 2004). However, the provinces, including Ontario, continue to push for privatized funding (Eppel, 2023). In 2017, the Ontario Health Coalition found that patients in 88 fertility clinics across six different provinces were subject to "extra user-fees and selling

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medically necessary services” (Mehra, 2017, p. 5). A two-tiered provincial system in Ontario impacts wait times for services (Dadiya, 2022) which can be especially precarious for TGGD individuals seeking fertility clinic services. TGGD individuals commonly prioritize beginning HRT before biogenetic parenthood (Defreyne et al., 2019), meaning that wait times could contribute to delays in fertility treatments. Moreover, TGGD individuals who accept provincial funding for procedures could end up waiting for longer periods despite the dire need for them to begin HRT to affirm their gender and ease feelings of dysphoria (Lane et al., 2021).

Moreover, two-tiered provincial systems disadvantage TGGD individuals considering egg freezing in additional ways. TGGD individuals experience higher rates of unemployment (Irving, 2017; Statistics Canada, 2022; House of Commons, 2019), which makes it financially difficult to pay out of pocket for fertility clinic services. TGGD individuals are already more susceptible to experiencing poverty, and a lack of resources, and being unhoused (Marvel et al., 2016). There is overwhelming evidence that suggests that TGGD individuals are living in lower income communities (Devor Knowledge Services, 2020) and have higher rates of poverty than their cisgender counterparts (Marvel et al., 2016). In Canada in 2018, 40.5 percent of 2SLGBTQIA+ individuals made less than \$20,000 compared to 26.2 percent of their cisgender and heterosexual counterparts (Statistics Canada, 2023c). In 2019, another study also found that of 2,000 TGGD individual surveyed, 50 percent live in low-income neighbourhoods compared to 37 percent of their cisgender counterparts (Statistics Canada, 2022). Due to low-incomes, underemployment, and unemployment, TGGD individuals in Ontario are disadvantaged by a two-tiered provincial system that deprioritizes their transition needs and desires for biogenetic parenthood. Despite the urgent need for TGGD individuals to have access to this funding through OHIP, the funding process is decidedly complex.

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Funding to Freeze

As previously explored, OHIP provides only some coverage for MEF, and no coverage for SEF. While some fertility clinics in Ontario accept OHIP funding and take on patients who use it, other clinics are privately owned and monitored. Some costs of egg freezing are covered or returned via tax credits in provinces (See Table C). Partial coverage in Ontario (as seen in Table 2 below) shifted in 2015 to include TGGD individuals who wanted to freeze their egg under the MEF coverage. This resulted in more TGGD individuals seeking information about egg freezing. OHIP coverage creates the perception that MEF costs and procedures may be manageable for TGGD individuals. At the same time, partial coverage under OHIP (Table 2, see below) can be limiting (Dadiya, 2022). MEF includes only a limited amount of coverage, including one time coverage for ovulation cycle monitoring, egg retrieval, egg freezing, and In-Vitro Fertilization. In 2016, OHIP was amended to remove In-Vitro Fertilization and Intrauterine insemination from its list of insured coverages (Dadiya, 2022). The hope of financial feasibility of egg freezing becomes quickly embroiled in costs for hormones, transportation, missed time from work, accommodation, and storage fees that are not covered by OHIP. While individuals seeking MEF in Ontario can receive financial coverage and relief through OHIP, some are still unaware of the overall costs associated with egg freezing and subsequent procedures (Elliot, 2017).

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Table 2: Resource Table for Coverage through for Oocyte Cryopreservation⁵⁶

Covered under OHIP		Not covered under OHIP
Up to two attempts at cycle monitoring		Preservation of additional batches/samples of eggs or sperm (\$8,000/cycle)
One attempt at egg retrieval		Medications (costs can range from \$3,000-\$5,000)
Freezing of one batch/sample of eggs or sperm with no time restriction (however individuals freezing their eggs pay storage fees)		Storage fees (\$300-500 per year)
Sperm collection or, if required, one attempt at surgical sperm retrieval using certain techniques		Sperm donor (if required)
One round of In-Vitro Fertilization		Additional rounds of In-Vitro Fertilization (if required) \$8000-\$10,000/cycle
		Lost wages due to missed work
		Transportation costs (depending on geographic location)
		Surrogate (if required)

Conflicted hope emerges for many TGGD individuals seeking to freeze their eggs because unforeseen costs add up quickly. Even for those living in Canadian cities with fertility clinics, the costs of hormones to stimulate egg production range from \$2,000 to \$3,000 (Kallen, 2022, n.p) and the absence from work can be a financial burden (Inhorn et al., 2019). Once the egg retrieval procedure is completed and hormones are no longer required, the cost for egg

⁵⁶ Information can be found at <http://www.ontariofertility.ca/>

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storage can be up to \$800 annually.⁵⁷ TGGD individuals living in the US noted potential additional future costs associated with egg freezing such as possible surrogacy use, legal costs, and costs of purchasing sperm (Sterling & Garcia, 2022). Regardless of their intention to freeze or use fertility clinic services, many participants in this thesis noted that the quest for biogenetic parenthood was financially unmanageable despite OHIP coverage.

While funding for egg freezing is promoted by some scholars as a way of providing reproductive justice, many also claim that funding for fertility clinic services through OHIP also provides much needed regulation (Cattapan, 2020). Regulation and funding go hand in hand because funding acts as a form of regulation by limiting procedures that are considered unethical or that can cause harm (Cattapan, 2020). One of the foundational concerns regarding reproductive technology use is the occurrence of multiple live births through In-Vitro Fertilization (Templeton & Morris, 1998). Due to the expense of In-Vitro Fertilization, fertility clinics implant numerous embryos at the same time into the uterus of individuals seeking to become pregnant (Thompson, 2016). This practice is meant to heighten the chance of at least one live birth. As a result, twins, triplets, and even larger number of babies could be born depending on number of embryos implanted. In 2013, 30 percent of those who became pregnant through In-Vitro Fertilization had multiple births (Born Ontario, 2022). However, the years 2013 to 2017 saw a decrease of 9.7 percent in multiple births (Canadian Fertility and Andrology Society, 2019, n.p). The reason for this is that multiple births caused by reproductive technology use can increase the risks of the pregnancy and the number of children born.⁵⁸ A significant shift occurred in 2015 in Ontario when In-Vitro Fertilization became provincially funded.

⁵⁷ Ranges based on the Canadian clinic.

⁵⁸ Complications associated with multiple births include “premature labor, premature delivery, pregnancy-induced hypertension, toxemia, gestational diabetes, and vaginal-uterine hemorrhage”

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In Ontario, public funding differs from privately funded procedures because there are stricter regulations for those who use public funding through OHIP. One of the positive aspects of public funding is the regulation of the number of embryos that can be implanted in each In-Vitro Fertilization cycle, thereby reducing multiple live births. There are pros and cons to the privatization of fertility clinics (See Table 3), but the negative aspects are considerable. They include a lack of accountability regarding ethical practices, concerns about focusing on profits over patients (Gruben, 2020), fewer legal and professional penalties for malpractice including loss of license, legal fees and charges, and a lack of information available regarding practitioners and malpractice. The latter issue is exemplified by cases in which fertility doctors have used their own sperm to inseminate patients without their consent, including in Ontario (Zhang, 2019). Fertility doctors such as Norma Baldwin (Pfeffer, 2021), who was discovered to be using his own sperm to inseminate female patients, resulting in over 100 biogenetic offspring (Pfeffer, 2021).

Table 3: Pros and Cons of Privatization of Fertility Clinics

Pros of Privatization of Fertility Clinics	Cons of Privatization of Fertility Clinics
· Demonstrates a strong professional responsibility. · Health care professionals have the knowledge to know how to ensure professionalism based on expertise. · avoids politicization of medical standards 4) · Able to settle professional concerns within the profession (Gruben, 2020) · “Can create a more flexible, adaptable, and financially efficient governance structure compared with outright state regulation, as administrative costs are often internalized by	· Concerns that medical professionals will not meet the required criteria to regulate themselves. · No compensation for patient complaints, complaints will not be known widely, patients may be unable to know the process to set forth a complaint. · Penalties for malpractice are considered insufficient. · Lack of public access to information on professionals · Policy changes can be slower with colleges.

to the birther and “offspring include death, low birth weight, [and] deformational plagiocephaly” to the offspring (Elster, 2000, p.617). Socially, children who are members of multiple births including sextuplets can struggle with socializing during youth (Elster, 2000).

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self-regulating professions” (Snow, 2018, p.123).	· Concerns about protecting own members over patients (Gruben, 2020) · “Canadian Assisted Reproductive Technologies Register⁵⁹ has not assuaged critics of self-regulation in Canada because such re-porting remains entirely voluntary and is not subject to government oversight, and the register does not identify individual clinics” (Snow, 2018, p. 123). · Can be considered motivated by profit (Snow, 2018)
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TGGD individuals are disadvantaged regarding access to information about reproductive technologies generally (Bartholomeaeus & Riggs, 2019; Schwartz & Moravek, 2021), and when TGGD individuals have issues with a fertility doctor or fertility clinic, the reporting process can be difficult to navigate. This is because fertility clinics are provincially regulated, physical locations of a fertility clinic change the regulation, and private versus public funding. Clinics that are located on their own have fewer regulatory bodies to consider but fertility clinics established in or attached to hospitals, are required to adhere to additional guidelines laid out under the *Public Hospitals Act* since they are operating in a hospital setting. These guidelines can mean requiring active reporting, increasing the information available regarding misconduct and limiting the number of embryos implanted. On the one hand, individuals using provincial funding through OHIP for egg freezing and later, In-Vitro Fertilization, will have a statistically much lower chance of achieving pregnancy and having a live birth since fewer embryos are allowed to be implanted. On the other hand, it is a positive development because fewer embryos reduce pregnancy health risks and the cost of having multiple children at once (Cattapan, 2020).

⁵⁹ The registry “CARTR Plus is Canada's national register for collecting extensive information on IVF and corresponding pregnancy outcomes, and it has yet to be validated” (Basal et al., 2020, p.1).

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Regulation also influences the ability of those using fertility clinics and services to have transparency in reporting and knowing about malpractice issues of specific fertility clinics and fertility specialists. OHIP coverage for all In-Vitro Fertilization procedures, not just the first one, would mean the protection of all patients and would help alleviate any TGGD individuals' fears of experiencing transphobia and cissexism in the fertility clinic. Conflicted hope appears differently for TGGD individuals seeking to freeze their eggs, not only because they commonly use provincial funding, but also because of the quality of care they may or may not receive in fertility clinics.

Frozen Eggs Seeking Frozen Sperm

The process of egg freezing in TGGD individuals can be quick if it takes place before beginning HRT or it could take a few months longer for those who must cease HRT before egg freezing. Egg freezing includes stimulating the ovaries to mature the eggs, monitoring the egg maturation process, and extracting the eggs when they are ready (Nasab et al., 2020). However, the process does not end there. Once frozen, eggs can remain in the care of fertility clinics until they are ready to be used, donated to the fertility clinic for research, or destroyed (Chin et al., 2022). Fertility clinics continue to use the more modern method of vitrification, or flash freezing. The next step for all individuals freezing their eggs is In-Vitro Fertilization. While vitrified eggs have a high chance of surviving the thawing and fertilization process, In-Vitro Fertilization rates are much lower, with individuals who freeze their eggs requiring up to six cycles or more to achieve biogenetic parenthood (Smith et al., 2015, n.p.). According to the Canadian Fertility & Andrology Society, statistics in 2016 showed that one healthy child is born after “16% of cycles started, 18% of cycles having egg retrieval, and 19% of cycles having embryo transfer” (2016,

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n.p). Many TGGD individuals and their partners are unable to afford or navigate the expense of five additional cycles of In-Vitro Fertilization at a cost of \$8000-\$10,000 at the Ottawa Fertility Centre per cycle (2023, n.p). This means that some individuals may find the pursuit of biogenetic parenthood financially impossible after multiple rounds of In-Vitro Fertilization fail.

For many 2SLGBTQQIA+ individuals seeking sperm donors, conflicted hope arises in multiple ways. In Canada, sperm donation is altruistic, meaning those donating their sperm cannot be financially compensated for donating. In 2011, Canada was in dire need of sperm donors with a pool of only 35 donors (Groen, 2011), and one sperm bank available (Mohapatra, 2020). Still, in 2017, only 63 sperm donors passed Canadian screening criteria, meaning less than one percent of people who could donate sperms actually donated (O'Reily et al., 2017). There is currently little information regarding the number of sperm donors donating to sperm banks in Canada and how many donor samples there are to choose from. Canada imports 90 percent of all sperm from the United States (Mohapatra, 2020).

Sperm donation and egg freezing are inextricably connected to each other because some TGGD individuals will require sperm for the future fertilization of their eggs (Murphy, 2012; T'Sjoen et al., 2013; De Roo et al., 2016; Mattawanon, 2018). However, the connection between sperm donation and egg freezing is more nuanced. For those seeking sperm, there are two options, known sperm donation and anonymous sperm donation. Sperm donation is the process where an individual who can produce sperm provides a sperm specimen with the intention that it will be used to result in pregnancy in another individual. Some may choose to use sperm donors from sperm banks, but sperm can cost between \$750 and \$1200 CAD per vial of sperm (Ottawa Fertility Centre, 2024, n.p). Advantages to parent(s) of using an unknown donor are that potential

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conflicts over parental rights are avoided (Fatovic, 2020). At the same time, with modern DNA technology, anonymous donation is becoming more and more of a myth (Mohapatra, 2020).

TGGD individuals may opt against using a sperm bank based on their acceptance of TGGD parents (Hoffkling et al., 2017), financial costs, more complicated technology procedures employed, and requirements for importing sperm, in addition to the fact that their future child may have no option but to know the donor's identity (Motluk, 2020). Lack of access to sperm in Canada (Chong et al., 2010), fears that a sperm donation will not lead to the birth of a child, and the cost of purchasing sperm remain key contributors to conflicted hope when seeking sperm. These considerations are in place for not only TGGD individuals but also for any 2SLGBTQIA+ individual or couple considering sperm donation (Marvel et al., 2016).

The second type of option for sperm donation is using a donor that is known to the individual or couple. An increasing number of 2SLGBTQIA+ individuals are using known sperm donors for the purposes of family formation (Klein et, 2022). Many 2SLGBTQIA+ individuals and couples ask their gay, bisexual, or pansexual friends to provide sperm samples (Mamo, 2007). Benefits of using a known sperm donor include reducing the trouble of ordering, shipping, and any regulation of frozen sperm by using fresh sperm from a local, reliable, source (Epstein, 2014), the possibility that the future child will have a relationship with the sperm donor, lower financial costs (Beeson et al., 2011), and the promotion of alternative forms of parenthood. While more 2SLGBTQIA+ individuals and couples are using known sperm donors, this trend has been a historical necessity for many 2SLGBTQIA+ families due to the historical exclusion of non-heterosexual families from the fertility clinic, the lack of legal rights of 2SLGBTQIA+ families, and the close and unique kinship structures that exist within the

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community (to be explored in Chapter 6) (Riggs, 2008; Epstein, 2014; Gibson, 2014; Nordqvist, 2017; Koh et al., 2020).

While using a known sperm donor is idealized for cisgender, heterosexual women who commonly use their male partner's sperm for insemination, 2SLGBTQQIA+ individuals do not usually have this option (Darwin & Greenfield, 2019). When using a fertility clinic to get access to sperm, clinics must adhere to the *Safety of Sperm and Ova Regulations* (2019). These regulations were established in 1996 under the *Food and Drug Act* to manage the distribution of sperm and eggs in Canada (Epstein, 2014). The purpose was to "minimize the potential health risks to individuals in Canada who use donor sperm or ova for [assisted human reproduction] to help them build their families" (Health Canada, 2021, n.p). At the same time, the regulations favor heterosexual couples. All sperm donated in Canada is required by the *Safety of Sperm and Ova Regulations* to be frozen and quarantined for a minimum of six-months to ensure its safety (Health Canada, 2021). While this long period is not ideal, many individuals must endure the longer-than-anticipated wait time to begin their families. Those who are sexually active with their donors, can, of course, waive this period (Epstein, 2014). This means that cisgender, heterosexual women can use their husband's sperm without needing to freeze and quarantine it.

When donor sperm is needed by a cisgender heterosexual couple, fertility clinics and sperm banks may project that conception by donor sperm does not feel natural or easy for them, and particularly for the woman's male partner (Feingold, 2008, n.p). It requires that a known donor go through extensive testing or be a sexual partner to the individual seeking pregnancy. Using a known donor is an advantage to fertility clinic based on the sperm available. While the *Safety of Sperm and Ova Regulations* may seek to reduce the possible spread of sexually transmitted infections and blood-borne diseases, it restricts men who have sex with men from

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donating sperm and continues to pathologize their bodies. Men who have sex with men have been ineligible to donate due to queerphobic policies that continue to associate men who have sex with men with the HIV/AIDS crisis (Cameron et al., 2010; Epstein, 2014; O'Reilly et al., 2017). However, as of May 8, 2024, Health Canada permits men who have sex with men to donate sperm (Sciorio, 2024; Zafar, 2024). This new opportunity may help increase the small number of sperm donors in Canada. While other services, such as Canadian Blood Services, are beginning to lift the ban on men who have sex with men, the categorization of donors remains highly stratified.

Many 2SLGBTQIA+ individuals look for certain physical traits and even personality traits to be biogenetically passed on from the sperm donor to a child. While Zwir et al., (2020) found that over 700 genes can be passed on biogenetically, environment and individuality play critical roles in the development of an individual's personality (Koenig, 2020). This quest for certain traits to be expressed in their future children may remain unfulfilled for TGGD individuals, especially when they are engaging in donor-matching practices. Donor-matching refers to choosing a sperm donor based on specific physical and personality characteristics that mirror the non-biogenetic parent (Nordqvist, 2012; Łukasiewicz & Allan, 2022). Both anonymous and known sperm donors embody the potential for conflicted hope in donor-matching. For instance, if a TGGD individual chooses to freeze their eggs, they may choose a sperm donor who has some of the characteristics of their partner, including race, eye colour, hair colour, or height. While this is connected to personal preference, Aharoni et al., (2022) found that those recipients using sperm donors wanted a "healthy child" as a key priority but were "also trying to assemble the perfect looking child" (p. 148).

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While a sperm donor may have particularly desirable traits, children can not be biogenetically engineered to fit the aspirations of parents. Conflicted hope can emerge when those traits prove to be recessive and fail to materialize in the child. This can cause additional tension when a non-biogenetically related parent seeks to strengthen their likeness to the child through physical resemblance. Nordqvist found that the lack of resemblance between non-genetic parents and children was emotionally charged especially among 2SLGBTQQIA+ families (2017). Family resemblance is commonly not achieved for some parents and their hopes of stronger senses of belonging are shattered. While 2SLGBTQQIA+ families are considered subversive in many ways (Halberstam, 2005), attempts at this kind of biogenetic engineering can reinforce heteronormativity and projections of what it means to be a good parent that may not be achievable for some TGGD individuals (Nordqvist, 2017).

Frozen Eggs Seeking Warm Womb

Even when a suitable sperm donor is found, many TGGD individuals do not want to gestate their future offspring. Rather, some may use a partner or a surrogate to carry their baby to term using their fertilized eggs. The term baby is used here instead of fetus intentionally to demonstrate the promises fertility clinics make and the specific language they use to promote their services. Using baby over fetus acts as a way of moralizing and humanizing future offspring. In Canada, surrogacy use increased (Armour, 2012), growing even more popular among queer-identifying men (Fantus, 2021). Between 2001 and 2012, over 800 babies were conceived using In-Vitro Fertilization. The number of babies born through In-Vitro Fertilization increased by 92 percent between 2011 and 2016 (White, 2016). Currently, there are two different types of surrogacies, “traditional surrogacy” and “gestational surrogacy”. Traditional surrogacy

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occurs when a surrogate's egg and womb are used to become pregnant and give birth. This process requires the surrogate be inseminated with the sperm of a biogenetic parent or a sperm donor. For a gestational surrogate, only the womb is used. A fertilized egg is implanted using the intended parents' egg and sperm belonging to the partner or donor (Deonandan, 2020). A surrogate is an individual who gestates and gives birth to a baby they typically do not intend to parent. A surrogate provides the service of growing a child for another individual or couple with the intention of being financially compensated for their time. Worldwide, this service falls disproportionately on Women of Colour, commonly living in Global South nations (Speier, 2016).

Between 2001 and 2014, Canada saw the birth of over 1100 babies through gestational surrogacy (White, 2017, p. 1046). Surrogacy can take place both nationally and internationally for those living in Ontario and seeking surrogacy services. TGGD individuals seeking surrogacy services may find that turning a frozen egg into a live birth is more complex than initially presented. Not only can it be difficult to find a surrogate in Canada due to the country's laws and regulations, but for those 2SLGBTQQIA+ individuals who go outside Canada for surrogacy services, they may struggle with discriminatory laws, the financial cost of surrogacy, and the "genetic distancing" (Deonandan, 2020, p.269) that is inevitable for many individuals and partners.

In Canada, just like with sperm donation, the *Assisted Human Reproduction Act* rejects financial compensation for surrogacy services, meaning that all surrogacies must be altruistic. Altruism "implies that the arrangement is selflessly and generously gifted" (Lee et al., 2021, p.2). Altruistic surrogacy is practiced in Canada, the UK, and Denmark (to name a few countries) (Lee et al., 2021). In contrast, "commercial surrogacy" is the term used to identify the practice of

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financially compensating individuals for their reproductive labour and services (Daar, 2017), and is available in a few countries like the US, Ukraine, and Georgia (Lee et al., 2021). Some countries, such as Germany, Italy, and Spain, have banned surrogacy services altogether (Lee et al., 2021). Especially in instances of paid surrogacy, feminist scholars raise concerns that women are exploited for their reproductive capacity (Roberts, 1999; Twine, 2015; Jadvá, 2016), especially when they are financially vulnerable (Deonandan, 2015). Feminist critiques have referred to surrogacy and egg donation as "alienated labour" (van Nieerk & van Zyl, 1995, p.347) and are concerned for the reproductive justice and wellbeing of women (Stuvøy, 2018; Lee, 2021) claiming that some women can become "spare parts" (Gruben, 2017), that surrogate women are selling their babies (Kornegay, 1990), and that surrogacy promotes genetic essentialism (Deomampo, 2016).

Not only has surrogacy become highly debated in Canada but other fertility clinic services have also been questioned regarding informed consent, economic coercion, and freedom of choice (Deonandan et al., 2012). This is especially apparent in the case of international donation and surrogacy where couples may go to Ukraine for a less expensive (Speier, 2016), white egg donor, and then India for a cost-efficient gestational surrogate (Bandelli, 2021). Particularly vulnerable Women of Colour in the Global South can be used as egg factories and incubators to produce white babies for white, heterosexual, middle-class couples in the Global North.

Finding an altruistic surrogate in Canada can be challenging, causing some to seek services in foreign countries. Deonandan notes that legal restrictions alongside lower costs, availability, and "the opportunity to bypass either a service waitlist or a domestic legal impediment to service" remain critical motivators in the desire to seek fertility clinic services

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outside Canada (2015, p. 112). Those seeking surrogacy services in the US find them to be extremely costly, reaching \$110,000 to \$170,000 USD per family (The Fertility Center of Las Vegas, 2024, n.p). Internationally, costs are less expensive at \$7000 USD in Ukraine (Surrogacy Ukraine, 2023, n.p), and \$10,000 to \$12,000 USD in Georgia (Impact Ethics, 2021, n.p). For those seeking a surrogate, fees and financial restrictions may be the first barrier. If they cannot find a surrogate in Canada, 2SLGBTQQIA+ couples may be forced to look elsewhere for surrogacy services. Seeking international services is made more precarious with many countries refusing to provide fertility services to 2SLGBTQQIA+ families, including Ukraine⁶⁰ (Speier, 2016). Moreover, some countries make it difficult for TGGD individuals to access fertility clinic services (Ethics Committee of the American Society for Reproductive Medicine, 2015) and others banning the access of 2SLGBTQQIA+ individuals from fertility clinics altogether (Lee et al., 2013). For this reason, TGGD individuals may be unable to find the resources to turn frozen eggs into a live birth.

In Canada, the process remains expensive despite the altruistic requirements (Deckha, 2015). Another critical consideration is related to egg freezing and the need for surrogates. It includes questioning the connection between surrogates and unborn babies (Danna, 2015). As explored, biogenetic parenthood is the genetic connection between a parent and child (Nordqvist, 2017). Biogenetic parenthood reinforces heteronormative family values by mirroring and simulating the biogenetic parenthood of both parents through donor matching practices and selecting specific donors. A biological tie is created when introducing a gestational surrogate who has no biogenetic connection with the baby but who shares their body, nutrients, and fluids

⁶⁰ Egg donor and surrogacy services in the Ukraine become increasingly precarious with many women missing out on much needed income due to the ongoing violence perpetrated by Russia (Kismödi & Pitchfork, 2022).

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during pregnancy. Deonandan noted that gestational surrogates differ in that they are not biogenetically related to the offspring they are carrying, creating “genetic distance” (Deonandan, 2020, p.269). Genetic distance might weaken the strength of the biogenetic connection, which recirculates ideals of belonging, familiar likeness, and kinship. Biogenetic parenthood through egg freezing and surrogacy may be sites of discomfort for TGGD individuals since they commonly cannot achieve biogenetic relations among all family members. The 2SLGBTQQA+ family formation will commonly include some form of genetic distance when one parent is biogenetically more connected to the baby than is another.

Conclusion

Egg freezing differs from other forms of fertility clinic services as it is most often used to preserve egg quality regardless of age-related infertility or infertility due to medical reasons. For many individuals seeking to freeze their eggs, the intention is to become pregnant later with the frozen eggs; however, for TGGD individuals freezing their eggs, pregnancy is sometimes not in the cards. Fertility clinics are critical sites of conflicted hope for all users. Conflicted hope permeates fertility clinics in terms of partnership, biogenetic parenthood, career, and education (Mayes et al., 2017). Conflicted hope for all users includes the complicated nature of inconsistent success rates between clinics, the unanticipated expenses, and the risks associated with egg freezing specifically. However, TGGD individuals seeking to freeze may also experience queer and trans-exclusionary practices. These can remind 2SLGBTQQA+ individuals seeking reproductive technologies that their hope of a biogenetic child is hampered by their gender and/or sexuality. They may also lack the information required regarding the potential risks and procedures required to turn a frozen egg into a live birth. Canada’s overarching legal framework

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remains very limited in its ability to regulate fertility clinics. All in all, surrogacy and sperm donation remain altruistic but the costs for those seeking these services are an obstacle. TGGD individuals experience conflicted hope when trying to form a family using several fertility services but can be unaware of the long road ahead of them, uncertain success of procedures, and unanticipated financial costs.

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Chapter 3: Frost Bitten? Examining Survey Results

“Looking back over the recruitment process and the number of responses I got over time made me realize how difficult it is, even for community members, to have a solid sample size. I was thrilled with the results from the surveys. Trends in the quantitative data have shown interesting relationships.”⁶¹

This chapter examines survey development and analyzes quantitative data. A total of 21 viable surveys were completed between November 21, 2021, and June 1, 2022. This chapter outlines the importance of choosing the province of Ontario and explains the recruitment processing using the social media platform Meta. It provides the eligibility requirements for participants and determines the logics behind the eligibility criteria. Finally, this chapter provides quantitative data on survey participants demonstrating how the survey sample statistically relates to the larger population of Ontario and showing how representative this survey sample is. All data collection was done in the province of Ontario. Ontario was decided for the scope of this thesis for several reasons. The province of Ontario has been shown by Statistics Canada (2022) to have a large concentration of TGGD identifying individuals; it is the only province that provides partial coverage for egg freezing for TGGD who are eligible under OHIP as provincial residents; it is geographically large; and I transitioned in the province and know the healthcare system well.

Recruitment

Recruitment for this thesis took place between November 8, 2021, and June 1, 2022. Recruitment had two phases using the social media platform Meta. Meta groups were chosen based on criteria outlined in this chapter. Using a QR Code and link in the recruitment poster,

⁶¹ Research journal excerpt, 03/15/2022.

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TGGD individuals were able to complete a 31-question online survey via SurveyPlanet. At the end of the survey, the final question asked participants if they wished to take part in a 45-60-minute, in-depth, semi-structured interview. If interested, they were asked to provide their email address. A total of 23 participants completed the survey during recruitment, however, only 21 data sets were eligible (explored in Chapter 2).

To access social groups on Meta, an account was required. My personal Meta account was used for the recruitment process. I was already a group member of all Meta groups used for recruitment before the recruitment process began. Meta groups are online spaces commonly used to discuss health-related topics such as reproduction for TGGD individuals. While I was not a frequent contributor, rapport had been developed in most groups. Transparency was necessary in the recruitment efforts as each Meta group had varying rules regarding recruitment on its Meta page. Some required only written permission from a group moderator to post any content to the group page, while others required that a form be completed based on the group's size and geographic scope. A post and poster were used for recruitment (see Appendix A). This post included information about my thesis, an outline of my requests, and any Meta group specific information required. With permission of the group moderators, on November 11, 2021, recruitment began with two Meta groups, *Canadian Trans Men* and *Trans ON FTM or MTF*. The third and largest group, *FTM Canada*, did not respond to my email request asking to post recruitment material in November. When I contacted *FTM Canada* the second time in December, I used the Meta messaging system to approach a different moderator who provided approval. These recruitment posts were reposted periodically to ensure more viewers would have the opportunity to see.

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By March 2021 recruitment remained low. This could have been based partially on COVID-19, with many fatigued from online and virtual correspondence. It could also have been due to lack of viewership in the groups, or due to the recruitment materials themselves. For this reason, with my supervisor's permission, I revised the recruitment poster due to increase participation. The changes to the recruitment poster included adjusting the poster's aesthetics, featuring the trans flag colours of baby blue and baby pink, and adding a QR code that linked the individual directly to the survey. Due to guidance from Ethics, the wording on the posters was not impactfully changed. Following these changes, the new recruitment material was reposted in the three Meta groups referred to above. At this point, I decided that more Meta groups for 2SLGBTQIA+ individuals were required for recruitment. Using the same post, I contacted Meta groups in which I was already a member (See chart below for details). Recruitment continued until June 1, 2022; and after this point all Meta posts were removed from all groups (See Appendix A).

Meta was chosen as the social media platform best suited for recruitment for this thesis based on my own experience and rapport in various trans-related and 2SLGBTQIA+ groups. As earlier stated, the first three groups used in the recruitment process were *FTM Canada*, *Canadian Trans Men*, and *Trans ON FTM or MTF*. These groups were selected based on the size and scope of their membership. These groups also contained previous posts and discussions by group members asking questions about reproduction, fertility, hormones, and fertility clinic use. These posts demonstrated an interest among some TGGD group members about COVID-19 protocols, and the risks, costs, and success rates of fertility clinic services.

The second round of recruitment took place in December 2021 and involved 2SLGBTQIA+ Ontario-based Meta groups including *Trans and Gender Diverse Muskoka*,

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Muskoka Pride, Waterloo Regional Transgender Group, Orleans Pride, and Canada-wide groups International Transgender Health, Trans Support FTM, and FTM Brotherhood Trans Ph.D. Network, LGBTQIA+ of Canada. These groups were chosen for the second wave of recruitment based on my inclusion in the Meta groups prior to the beginning of the recruitment process. Permission to post the recruitment poster differed based on each group's regulations, rules, and codes of conduct, with some groups requiring permission from an administrator and others allowing a post to be put forth before being approved or removed.

Table 4: Meta Groups and Recruitment

Group Name	Date Posted (Posted= date was posted to Meta Group, V1= first version of recruitment poster, V2= second version of recruitment poster)
<i>FTM Canada</i>	First posted December 2 (received approval) posted (v1) Reposted April 12 (v2)
<i>Canadian Trans Men</i>	First posted November 8 (v1) Repost December (v1) Repost March 15 (v2)
<i>Trans ON FTM or MTF</i>	First posted November 8 (v1) Repost December 8 (v1) Repost March 15 (v2)
<i>Trans and Gender Variant Muskoka Group</i>	First posted December 29 (v1) Reposted April 12, 2022 (v2)
<i>Muskoka Pride</i>	First posted December 29, 2021 (v1) Repost April 12, 2022 (v2)
<i>Trans PHD Network</i>	Post December 20, 2021 (v1)
<i>LGBTQIA+ of Canada</i>	First posted December 20, 2021 (v1) Repost March 15 (v2)
<i>Waterloo Regional Transgender Group</i>	First posted December 20 (v1) Repost March 15 (v2)
<i>International Transgender Health</i>	First posted Feb 8 (v1)

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<i>Trans Support FTM</i>	First posted Feb 8 (v1)
<i>Orleans Pride</i>	First posted March 15 (v2)
<i>FTM Brotherhood</i>	First posted March 15 (v2)
<i>Waterloo Regional Transgender Group</i>	Posted on behalf of researcher
<i>International Transgender Health</i>	Requested and remains unposted March 15 (v2)

Sample Criteria

I wanted to ensure that all research participants recruited had experience with trans health care in Ontario. Therefore, participants in my thesis sample had to:

- Be comfortable completing the survey and interview in English.
- Self-identify as transgender or gender diverse individuals.
- Be between the ages of 18-35.
- Have transitioned between 2000-2020 in Ontario or be in the process of medically transitioning, plan on medically transitioning, or have medically transitioned under OHIP.

All participants were asked to complete the survey and interviews in English. Since I am unable to speak French, this was the only language option. Self-identification and identity politics were heavily implicated in this thesis sample. Participants were able to self-identify as transgender and/or non-binary, which could include, but is not limited to, folks who also self-identify as genderqueer, non-binary, gender non-conforming, agender, demi-gender, gender fluid, Two-Spirit, and/or Intersex. The age range for this thesis was 18 to 35 years of age. However, three participants were aged 35-40 and were included despite their age. They were included in the thesis sample due to the low number of participants and to provide a wider age

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range. The age range of all the participants was, therefore, 18 to 38. While reproductive desires among TGGD individuals aged 18 to 25 have been studied (Nahata et al., 2018; Chen et al., 2019; Chiniara et al., 2019), the age of 18 was determined as a suitable minimum age. In Canada, 18 is the age of majority and allows TGGD individuals to contribute to research without the permission of parents or guardians. Currently in ON, those aged 18 to 25 are included in additional OHIP coverage as adolescents, and/or are still allowed access to benefits under parent/guardian benefit plans if a student. This information is significant since financial decision-making is a component of fertility preservation. Finally, TGGD individuals under the age of 18 are more likely to have undergone ovarian tissue cryopreservation⁶² if they had frozen reproductive tissue. The age of 35 was determined as the cut-off age of this sample based on the reproductive age limitations and the infrequency of new parenthood among individuals over this age. This age restriction was extended when three TGGD individuals over 35 wished to participate. In hindsight, the average age of those freezing their eggs is 35 (EVOLVE Egg Freeze, 2024) and the oldest age eligible for OHIP funding for MEF is 43 (Trio Fertility, 2024). A higher age range could have included more participants, potentially.

Finally, all participants in this thesis, regardless of gender identity, must have begun, plan to begin, or have medically transition(ed) under OHIP. Three individuals who participated in the thesis were not taking HRT at the time of the project for varying reasons but fit the criteria since they had medically transitioned in Ontario during the required period. Testosterone use in terms of transitioning can differ for many TGGD individuals over time based on their changing gender expression, desires, and medical needs. A medical transition is “the process of seeking and

⁶² This is “an experimental procedure in which prepubertal ovarian tissue is harvested and preserved, is offered to women with cancer” (Johnson & Finlayson, 2016, p. 42).

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receiving various medical interventions including but not limited to hormone therapy (including anti-androgens for transfeminine individuals), transition-related surgeries and other related surgeries (including hair transplants), and hair removal (e.g., electrolysis)” (Sherbourne Health, 2023, p. 116). John Hopkins Medicine includes “hormones,” “surgery,” and “mental health” in their definition of a medical transition (2024).

I was previously acquainted with three of the participants and socially close to two of them. I reached out personally to one of these three participants to take part in my thesis because he had already frozen his eggs. The only information about these individuals, their lived experiences, and desires for parenthood included in the thesis was the data provided in their surveys and interviews. Any previous personal conversations I had with a participant, were disregarded and not included as data. The only information about participants recorded is what was actively disclosed during the research process.

Despite the information on the recruitment poster and requirements of this thesis, three participants were over 35. I included them in my sample based on the low number of participants and because they were all within the reproductive age. All those who requested to be interviewed and responded to follow up emails were included in the final interview data set.

Survey Format

I created an online survey via SurveyPlanet consisting of 31 questions. This survey gathered demographic data, provided a space for participants to volunteer for the interview process, and determined their eligibility as TGGD survey participants (Appendix B). This survey was reviewed prior to recruitment by two non-participant TGGD-identifying individuals I know who are also doctoral graduate students at two external universities. Both these individuals use

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HRT currently but were ineligible to participate because they transitioned outside Ontario.

Although these individuals were not included in the research sample, they reviewed the survey to help me ensure inclusivity and accessibility.

The survey began by requiring consent from the participant. Two survey questions were used to determine eligibility for participation in this thesis. Eligibility required that a participant answer “yes” to Q1 providing consent, and “yes” to Q4: “Have you begun or are planning to begin your medical transition using HRT in Ontario between 2000-2020?” Two participants’ surveys were ineligible based on this criterion. One participant answered “yes” to providing consent but “unsure” to Q4. The second participant answered “yes” to Q1 but “no” to Q4. I reached out via email to both participants for clarification. The first participant transitioned in the US and was therefore ineligible. The second participant had transitioned medically in another province.

This thesis sought to fill needed gaps in demographic information including gender, race/ethnicity, disability, and class. Therefore, demographic questions were vital. Demographic questions for the survey were very strongly influenced by the 2019 Trans PULSE Canada survey.⁶³ In my survey, 21 questions were demographic based. Questions Q2 through Q23 gathered information about age, sexual orientation, gender identity, pronouns, relationship status, race, ethnicity, spiritual practice/religion, language, nationality, socio-economic class, educational attainment, employment status, (dis)ability, and geographic location when they transitioned. Participants could also provide their postal code, and their current legal status in

⁶³ This survey included 2,873 trans and non-binary individuals over the age of 14 who were living in Canada and spoke French or English (2019). This survey was foundation as one of the first TGGD based surveys to explore the health and well-being of TGGD individuals living in Canada.

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Canada (i.e., citizen, refugee, student, among others) should they choose. These answers provided a foundation for determining quantitative data trends and a socio-demographic context. The survey questions Q24, Q25, and Q26 addressed Objective 1 of my thesis: To determine if TGGD individuals who are taking or have taken HRT, and live in Ontario, Canada, are engaging in fertility preservation practices, and particularly, in egg freezing (See survey sample Table 4). Q24 “Have you or a medical professional ever taken steps to preserve your fertility in any way between 2000-2020?” and Q25 “Have you ever engaged in oocyte cryopreservation freezing of your eggs? If so, when? Where?” specifically addressed Objective 1 as well as Objective 2: To explore why TGGD individuals who are taking or have taken HRT are choosing biogenetic parenthood as a form of family formation.

Q24 and Q25 were close-ended and allowed for three possible responses “yes,” “no,” or “unsure.” Q26 “Have you experienced any barriers to freezing your eggs? If so, what were they?” addressed Objective 3: To determine which, if any, economic, cultural, ethical, and social barriers TGGD individuals taking or have taken testosterone may face in attaining biogenetic parenthood inside and outside the medical setting.

Q26 was an essay-style question that allowed participants to write their responses freely. Q27 and Q28 asked about the participants' interest in trans-related social media groups on the Meta platform. These questions determined if participants were using social media platforms such as Meta to collect information about fertility preservation and, more specifically, egg freezing. Q29 and Q30 concluded by asking participants if they had any questions, whether there were questions they wished the survey had included, and if there was anything more the participant wished to share about themselves. Q31 was the final question, asking if the

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participants were interested in being contacted to participate in a 45–60-minute follow up in-depth interview online to dive deeper into their survey answers.

Survey Participant Demographic Data

Survey data was manually input into a Microsoft Excel spreadsheet to organize demographic information for each participant. A total of 23 surveys were completed with 21 of them eligible for this thesis sample. Once a participant began the online survey, SurveyPlanet automatically assigned a number. This participant number was chronological and based on the number of participants who had completed the survey before them. For instance, the first to complete the survey was assigned #1, the second to #2, and so on. All data sets retained a participant number even if ineligible. All surveys once started by a participant were completed. Participants who volunteered for follow up interviews provided their name or a pseudonym, those who only participated in the survey are identifiable based on their P#.

The survey data set provided quantitative data that demonstrated trends in the demographics of participants. Based on the 21-viable survey data sets, the following trends emerged.

Trends in Survey Data

The completed surveys were reviewed, and common over-arching trends were identified. A trend is defined as a “statistically significant event” in quantitative research where there is “high statistical significance” (Bryhn & Dimberg, 2011, p. e19241.) attributed to one or more data sets. High statistical significance is noted as data set(s) that show a strong statistical likelihood or probability. For instance, in 2021, Statistics Canada notes there were 100,815

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TGGD individuals over the age of 15 in the country, with 38,450 TGGD individuals living in Ontario (2022). These figures mean that over 38% of Canada's TGGD identifying population lives in one province. A trend in this thesis is the occurrences of a statistically significant event in data where one or more categories are more common than others. Survey data is also compared to the same statistical data pertaining to the province of Ontario to determine if the survey data are reflective of the general population of Ontario. I will show how TGGD individuals living in Ontario compare statistically to others who do not identify as TGGD.

Table 5 below illustrates the name/pseudonym used by the participant, demographic information, their desires for parenthood, whether they froze their eggs, and the barriers to freezing are outlined. Table 5 provides demographic information regarding the nine TGGD individuals interviewed. Participants who participated in the survey but were not interviewed were included in the chart below with no additional notes. Two participants, Participant 6 and Participant 9 have additional notes based on their lengthy and in-depth responses to the open-ended questions in the survey.

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Table 5: Survey Demographic Information

Participant #	Name	Gender Identity (in participants words)	Age	Racial/ethnic identity (participant's words)	Living with disability?	Currently partnered?	Sexual orientation	Previous annual income in \$ (for 2019)	Currently a parent?	Desires parenthood?	Froze Eggs? Barriers?
1	Andy He/him	Trans man	23	Métis	Yes	Yes	Bisexual	0-8000	No	Adopt/Foster	No COVID-19
- Began at CHEO at 16 or 17; Began hormone blocker- Lupron December of 2016; November 2017 started HRT; top surgery⁶⁴ July 2018. - Called the Ottawa Fertility Centre to discuss egg freezing during COVID-19 and was placed on a waiting list. Andy was not called back. - Sister who is supportive. - Wanted to learn more about egg freezing and fertility options. - Partner is 23 and an assigned female at birth non-binary person (they/them). - Partner does not want biogenetic children because they do not want to pass on their health problems. Not interested in carrying. - Both Andy and partner are open to adoption. - Feels like his parents would disregard his gender identity if he chose to become pregnant and give birth.											
2	Seth He/him	Trans man	32	White	On the spectrum ⁶⁵	Yes	Pansexual	40,000- 65,000	Yes	Parent	No: Option not presented Cost
- Came out as transgender in August 2019 and began medically transitioning December 2020. - Had no knowledge about fertility options, however, was provided with literature and was uninterested in reading it at the time. - Seth has one biogenetic child and an adopted child. - Became pregnant unexpectedly with first child. - Coparents with his current partner; biogenetic father of first child is in his life; second child was known adoption. - Seth's children were 6 and 13 at the time of our interview - Seth is partnered and non-monogamous											
3	NA He/him/the y	Genderqueer /trans	36- 40	White with some Indigeno us (Cree) heritage	Yes	No	Omnisexual/queer	65,000- 80,000	No	NA (not applicable)	No Cost
4	NA They/he	Nonbinary/T ransmasculin e	< 25	White	No	Yes	Queer	8,000- 15,000	No	NA	No, Wait time delaying T, invasiveness of procedure, Cost Storage

⁶⁴ Top surgery is the terminology used by TGGD individuals to describe a “surgery that removes or augments breast tissue and reshapes the nipples and chest to create a more masculine or feminine appearance” (Laing, 2024, n.p.).

⁶⁵ TGGD participant self-identified using this language.

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5	NA He/him/the y/them	transgender man, demigender man, agender, male	< 25	White	Yes	Yes	Demisexual/ pansexual	0-8000	No	NA	Did not try
6	NA He/him	Male (shifting), “gender tired”	31- 35	White with complex heritage	Yes	Yes	Gay/ Queer	40,000- 65,000	No	NA	No Hysterectomy Cost Time (2011) Surgery required for gender marker change
- Had a hysterectomy and bilateral salpingo-oophorectomy in Ottawa in 2011, a little over a year into my medical transition. - Family history of reproductive problems. “I never experienced desire to be pregnant or use my genetic material to conceive”.											
7	NA They/iel	Nonbinary transmasculi ne	< 25	White and Metis Algonqui n	No	Yes	Queer	15,000- 25,000	No	NA	No
8	NA He/him	Male	25- 30	Caucasia n	Yes	Yes	Straight	40,000- 65,000	No	NA	DID NOT ANSWER
9	NA He/him	Trans Masculine	36- 40	Mixed race Canadian	DID NOT ANSWE R	Yes	Asexual	15,000- 25,000	Yes	NA	DID NOT ANSWER
- Three children prior to transitioning and four following transition. - Total of seven children, including twins. Age of children was 19, 17, 14, 11, 11, 5, 2											
10	NA He/him	Trans man	< 25	White	No	No	Queer	15,000- 25,000	No	NA	DID NOT ANSWER
11	NA He/him	Transgender FTM, non- binary	25- 30	Caucasia n	Yes	No	Queer	8000- 15000	No	NA	When I initially inquired about the process prior to starting hormones, I was told about the extensive costs that are uninsured by OHIP. This cost, which would be on- going (for storage of the eggs) is the only barrier

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											for me albeit it is a major one.
12 INELIGIBLE											
13	MK They/them	Non-binary at time of interview, trans man now	38	Jewish and White	non- verbal learning disability	Yes	Bisexual	8000- 15000	No	Yes	DID NOT ANSWER
- Met ex-husband in 2013 and did not want children at that point, husband wanted children. Got divorced from husband. - Transition began at the end of 2018; Started HRT December 21, 2020; Ended HRT use in March 2021 due to anxiety regarding the ways that HRT was reacting with their body. - Had previously wanted children through their 20's but had later discussed with doctor getting their tubes tied following an abortion in 2021. - Began medical transition through Kitchener Downtown Community Health Center. - MK's journey continues since his interview, and he may not identify under these terms any longer.											
14	NA He/him	Man	<25	White	Yes	No	Queer	15,000- 25,000	No	NA	No
15	Logan He/him	Transgender man or genderqueer transmasculi ne	23	White	On the spectrum		Bi-romantic Asexual	0-8000	No	Adopt/ foster	Cost Lack of interest
- Began social transition in 2018; Started HRT in 2020. - Had family doctor discuss fertility with him in 2018 but he was not interested in egg freezing or fertility preservation. - Feels like he has contradictory feelings ie. bottom dysphoria but also desire for future pregnancy. - Felt even if he did not freeze his eggs there were options in the future. - Wants children but mentioned concerns about being sensorially over stimulated by children.⁶⁶ - Had short 2-week experience in foster care system – spend time living with grandparents- and then discussed how mom had numerous relationships during his time living with her. - Logan is Single and poly or non-monogamous/Other											
16	NA He/they	male- adjacent nonbinary	<25	White	Yes	No	Gay	8,000- 15,000	NA	NA	DID NOT ANSWER
17	Charlie They/them	Non-binary	21	White	Yes	No	Queer	0-8000	NA	Adopt/ foster	Lack of interest Not presented Cost
- Transition began at 16 with Lupron and began testosterone at 18. Remains on both for fear of their menstrual cycle returning. Has had top surgery after beginning HRT and is waiting on funding for a hysterectomy. - Did not have a positive experience with CHEO and aged out of their care. Began hormone blockers when they were placed in the care of an endocrinologist. - They are adamantly against biogenetic children because they feel their body isn't make for it.											

⁶⁶ Many individuals who are neurodivergent may experience sensory over stimulation. This occurs when the sensory input for them becomes too great (National Autistic Society, 2024). Since individuals who are neurodivergent can experience over stimulation from sight, sound, smell, or touch, it can be more difficult to navigate raising children. For instance, children playing, the sound of loud toys, or the flashing lights of children's shows might all cause over stimulation.

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- Worried about passing on addiction issues. - Interested in fostering or adoption in the future. - Parents were workaholics. - Has strong relationship with their sisters and her children. - At first when discussed adoption mother was against but she has a friend who is fostering and now understands better											
18	Olive They/he	Non-binary transmasculine	25	White	Yes	Yes	Queer	8000-15,000	NA	Yes	Cost
- Used ARC in Guelph for transition at 16 and had top surgery and began HRT in 2016. - Ceased HRT in 2018-2019 because they found they feel their alcohol dependency and did not feel like testosterone was feeling right for them anymore since they had all the results he was looking for. - Wanted hysterectomy but was discouraged when they were told they would need to be on hormones to avoid going into early menopause. No longer wants a hysterectomy at this point. - Getting married in fall of 2020. - Interested in becoming pregnant and giving birth to one of their children; partner would give birth to other. - Has been looking through sperm donor clinics and known donor friends with cisgender, female partner. - Knew egg freezing was expensive and decided they did not want to do it when young. - Olive is engaged and monogamous.											
19	Salem He/him/the y/them ⁶⁷	queer, transgender, demigender- male, agender	23	White	Yes	Yes	Demisexual pan-romantic	0-8000	NA	Adopt/ foster	DID NOT ANSWER
- Transition began HRT in Feb 2017 at 17 years old; is waiting on funding for top surgery. - Does not believe doctor mentioned anything about future parenthood or fertility but mentioned testosterone was not a contraceptive. - Briefly looked up information on fertility preservation but was not discussed with him during beginning of HRT. They wished they had been told at their initial appointment as a part of gender affirming care. Their doctor is older and while they said he is great; he is not as up to date. - Dad was supportive but mother struggled with their trans identity. However, mother drove him to his appointments when he was younger. - Did not want biogenetic children once he they realized what was involved in the process at age of six or so. - Wants to foster trans teens. - Partner does not biogenetic children either – partner is a cisgender woman who has a Christian background. - Mother passed in 2020 from cancer and tried to increase her support at the end of her life. - Has one brother – he is not sure stance, but he uses name and pronouns. - Would have liked to know at first appointment with doctor about HRT to know about FP- considers this discussion apart of gender-affirming care.											
20	Milo He/him	Trans man	29	White	No	Yes	Gay	40,000-65,000	NA	Wants 2	Traveling to freeze eggs was a barrier
- Transitioned in 20s through a doctor. At the time found there were no resources and found out what to do through a Facebook group. - Had top surgery prior to OHIP funding- had financial help from his parents to pay however, they have not always been the most supportive of his transition or being transgender. - Milo is a nurse and learned as a nursing student that he could freeze his eggs even though he was already on HRT - Felt being a nurse meant he had a very different experience as he was able to. - Milo did not define himself in terms of freezing for medical reasons.											

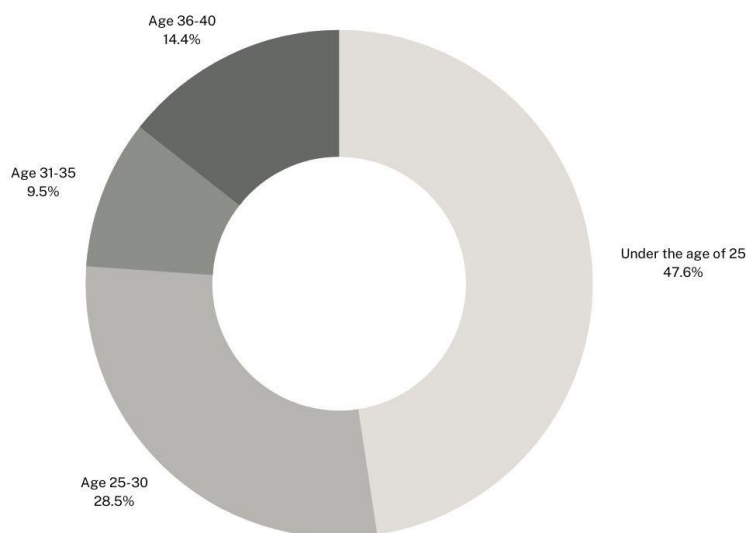
⁶⁷ Note that Salem and Ollie use double pronouns of him/him and they/them. Salem is comfortable with he/him pronouns being used predominantly, and Ollie is comfortable with they/them pronouns being used. The acknowledgement of people who use multiple pronouns is critical to the understanding of the fluidity of many people's gender and expressions.

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- Milo froze 11 viable eggs with Mount Sinai Fertility clinic at the age of 25 or 26.
- Knew egg quality and supply would begin declining at about 30 and worried about age-related infertility.
- Biogenetic parenthood was not important to Milo but his husband was more interested.
- Decided to freeze eggs instead of embryos due to COVID-19, cost, and inconvenience of his husband also having to be present to give semen sample.
- Mentioned worried about passing on mental health concerns to future child(ren).
- Milo is married and monogamous.

21	Ollie They/them /he	Genderqueer	25	White	On the spectrum	Part nere d	Queer	8,000- 15,000	NA	Adopt/ foster	N/A
• Began transition in 2016 and began HRT February 2017, top surgery in May 2019, November 2021 had hysterectomy (kept ovaries), stopped HRT in February 2022. • Mom was supported when they came out, they went to therapy and told their dad who took time to understand and come around. • Fertility and fertility options were not discussed by doctors, but gynecologist offered clinic referral. • Uses medical services at University of Waterloo and then at Carleton University. • They are an only child. • Have an older father and mother who had fertility problems. • When they were young, they wanted a large nuclear family with four children however no longer interested in the institution of marriage. • Having biogenetic children is not a priority but interested in adoption and/or having a space home space for trans youth. • Currently acts as a trans mentor for Children's Aid Society. • Parents had fertility problems so had some ideas what that looked like. • Parents are supportive. • Not interested in pregnancy at time of medical transition. • Prioritizes T4T relationships.											
22: INELIGIBLE: Did not transition in ON											
23	NA He/him	Trans man, non-binary	25- 30	Latinx	Yes	Yes	Pansexual	25,000- 40,000	NA	NA	SKIPPED

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Demographic Data from Survey**Chart 1: Age Demographics of Survey Sample**

One key trend was the relatively young age of the thesis sample with 47.6⁶⁸ percent of the participants under the age of 25, 28.5 percent between 25-30 years of age, 9.5 percent aged 31-35, and 14.4 percent aged 36-40. In previous egg freezing literature in Canada, Millar et al., (2015) excluded the sample age and Jones et al., (2016) contained three trans men ages 33, 37, and 39. A

relatively young thesis sample can be attributed to a few different things.

In 2021, Statistics Canada found that gender diversity was highest among individuals aged 20 to 24 (2022, np). TGGD individuals, who are considered part of Generation Z, were born between 1997 and 2006 (Statistics Canada, 2022). At the time of the survey recruitment in 2020-2021, Generation Z would have been under the age of 23 and Millennials would be aged 24 to 39. Therefore, many survey participants belonged to Generation Z, or were late Millennials. With increased visibility for TGGD individuals across Canada, many individuals are coming out younger and are beginning HRT at younger ages (CBC, 2016). This means that TGGD individuals may be learning about fertility options earlier in their transition before they even

⁶⁸ All quantitative statistics are rounded to the nearest 0.01 number. For instance, a statistic of 11.111 would be rounded to 11.1 or a statistic of 11.19 would be rounded up to 11.2.

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begin hormone blockers.⁶⁹ TGGD individuals may also be told about potential side effects of testosterone when beginning HRT.

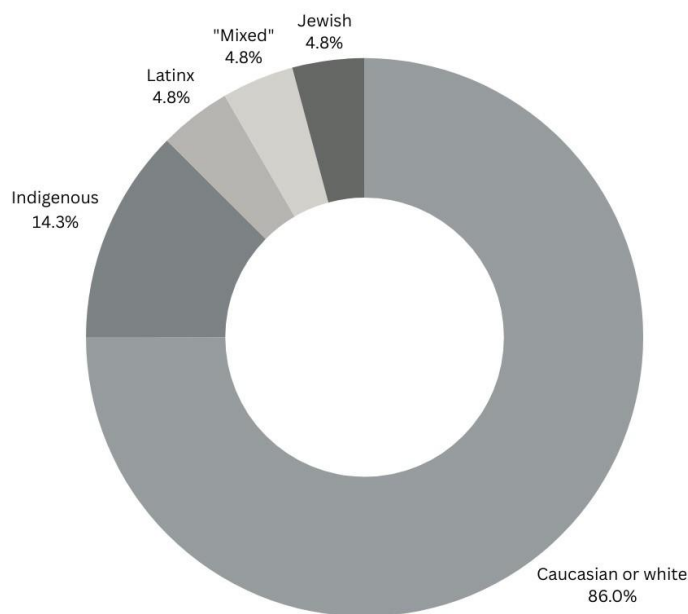
The relative youth of the participants could also be due to younger generations' increased use of technology to network and communicate with each other (Wilson et al., 2010). In 2018, Schimmel-Bristow & Aherns found that nine in ten individuals aged 15 to 34 were regular social media users (2018). In their recent study, the Centre for Addiction and Mental Health found 86 percent of students in Ontario view social media sites daily, with 16 percent spending five or more hours a day on social media (2020, p. 4). By 2020, the social media application Meta was used by 80 percent of Canadians who accessed online social media platforms (Mai & Gruz, 2022). By 2022, 26.6 percent of all Meta users were aged 25 to 34 years of age (Dixon, 2022, n.p.). Meta was the social media platform I used for recruitment between November 2021 and June 2022, which could help explain why there are many younger participants in my thesis sample. Moreover, younger individuals used technology more during COVID-19 (Salzano et al., 2021) with 2SLGBTQIA+ individuals experiencing increased social isolation overall, regardless of social media use (Di Blasi et al., 2020).

⁶⁹ Puberty blockers, also known as GnRH analogues, are used to “stop the body from making sex hormones. That includes testosterone and estrogen” (Mayo Clinic, 2023, n.p). Hormone blockers can be used on young TGGD individuals who are/will experience gender dysphoria if their bodies undergo puberty for their sex-assigned-at-birth. Despite the representation of hormone blockers as harmful to youth, “GnRH analogues don't cause permanent physical changes” but can reduce the experiences of gender noncongruence for TGGD youth before they are able to start HRT at an appropriate age (Mayo Clinic, 2023, n.p; the Cass Review, 2024).

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Chart 2: Racial and Ethnic Identities of Survey Sample

A large majority of participants self-identified as white or Caucasian.⁷⁰ Of the research sample, 86 percent of participants self-identified as white, 14.3 percent as Indigenous, including



Metis, Cree, and Algonquin heritage, 4.8 percent identified as Jewish, 4.8 percent identified as Latinx, and 4.8 percent identified as “mixed”⁷¹ heritage. Individuals were able to identify using their own terms and were not required to identify in one category alone.

Therefore, percentages will not equal 100 percent. This survey sample was predominantly white or Caucasian identifying. Predominantly white participants in reproductive research contribute to the ongoing recentering of whiteness in reproduction and reproductive research and, due to differences in provincial jurisdiction and non-mandatory reporting, the number of BIPOC individuals seeking egg freezing and other clinical services in Canada may not be accurate in any case. In general, race is “too rarely” explored in reproductive research (Valdeza & Deomampo, 2019, p. 551), and “whiteness” and reproductive technology use remains centralized (Harwood, 2018). Even feminist movements have lacked an intersectional approach by neglecting the racial

⁷⁰ TGGD participants were asked to self-identify using their own words. Some individuals used different terms for similar racial groups such as white” and “Caucasian”.

⁷¹ TGGD participants self-identified as “mixed”.

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bias of reproductive healthcare (Oluo, 2018). Reproductive politics “inevitably involves racial politics” (Roberts, 1997, p. 7) wherein, white, cisgender, heterosexual bodies are the most researched (Harwood, 2018). Reproductive technologies have been critiqued as technologies used to help infertile white families (Roberts, 1999), but there are also historical factors that play into how birth control methods and reproductive technologies are seen by various communities. BIPOC individuals have experienced and continue to experience forced and coerced sterilization, forced and coerced temporary sterilization, and the experimental use of birth control against them which can be contributing factors in skepticism towards reproductive technology use (Mittra, 2007; Dyck, 2013; Stote, 2015).

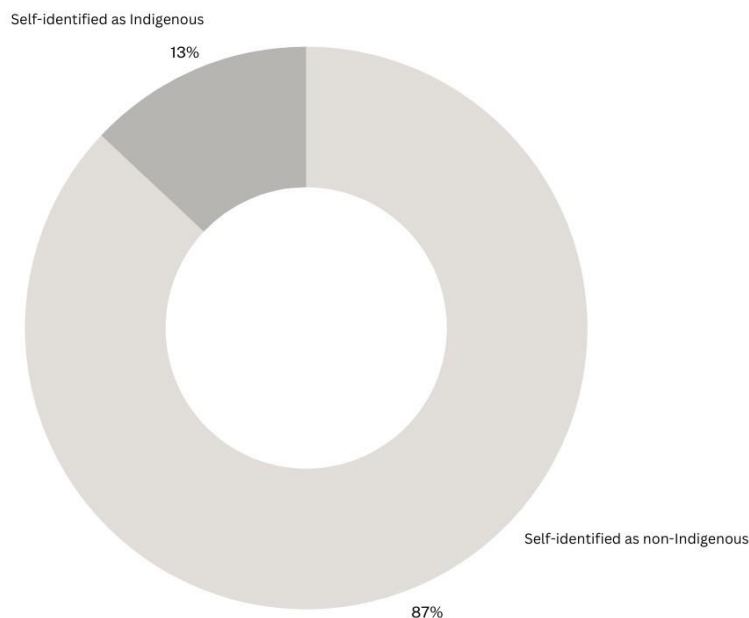
For Marvel (2021), egg freezing and banking “relies explicitly upon the racial commodification of gamete markets which classify and sell genetic material based on race” (p. 191). Egg freezing has been highly scrutinized as a technology targeted towards white women (Allen, 2016) with limited availability to Black, Indigenous, and Women of Colour (Roberts, 2015). Just as egg freezing reinforces ideals regarding normalized middle-class ideals such as marriage, children, and home ownership (Riggs & Bartholomaeus, 2019), it also idealizes whiteness (Harwood, 2017). For Roberts (1999), in the US, “high-tech means of procreation” support “racial inequalities by enhancing the power of privileged whites and contributing to the devaluations of Blacks” (p. 283), while white, middle-class individuals who freeze their eggs are seeking biogenetic parenthood, repressive and discriminatory laws and policy can restrict the reproductive liberties of others (Roberts, 2015). In Canada, continued and historical legacies of sterilization against Indigenous Peoples and other racial minorities continue (Stote, 2015). Poor access to healthcare and reproductive care remains high among BIPOC individuals in Canada, elevated by TGGD identity. While studies have shown that Black Americans experience 50

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percent higher infertility rate than their white counterparts (Roberts, 1999, p. 252), the majority of those seeking fertility clinic services are white (Daar, 2017).

In the US, when contemplating using the modern reproductive technology of egg freezing, Reniqua Allen, a feminist scholar and journalist claimed: “Black women aren’t given the luxury of having their non-traditional choices appear to be new and radical. When we make “unconventional” decisions around reproduction, we’re stigmatized” (2016, n.p). The concept of degeneracy is projected on racialized women with only white, middle-class, educated individuals seen as being worthy of access to reproductive technologies. As I indicated earlier, Women of Colour are commonly used internationally as gestational surrogates but never as egg donors that contribute genetic material. Systems of white supremacy articulate Black women’s capacity in the US to care for white children while degrading their ability to raise their own, as argued by Roberts (1999). The axis of controlling images of African American women (Collins, 1990), paired with the emphasis on white genetic legacy to white parents (Roberts, 1999) and white compulsory parenthood, establish why several feminist scholars problematize gestational surrogacy and egg donation. Briggs (2018) notes that reproductive technologies generally are “intensely about economic and racism politics” (p. 111) with egg freezing being no exception. Egg freezing has been promoted as a technology providing reproductive choice (Carbone & Cahn, 2014), however, reproductive choice continues to be provided to some over others. Briggs (2018) notes that reproductive technologies are “haunted by eugenics” (p. 107) where “the ghost of eugenics” is “reappearing as genetic selection” (Mamo, 2007, p. 214). Complex histories and legacies of white supremacy could continue to influence those seeking out egg freezing, and reproductive technology use generally.

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Chart 3: Self-Identification as Indigenous

The term Indigenous is used to describe any individuals who did not immigrate to Turtle Island and Inuit Nunangat.⁷² Indigenous individuals in Canada fall into three established categories: First Nations⁷³, Métis⁷⁴, and Inuit.⁷⁵ Indigenous communities have continuously been questioned

regarding their ancestry and cultural heritage. Currently, Indigenous individuals who identify as First Nations are provided with legal recognition as Indigenous Peoples under the problematic *Indian Act*.⁷⁶ However, this act only recognizes First Nations individuals in the Indian

⁷² Turtle Island and Inuit Nunangat are Indigenous terms for what is colonially known as North America.

⁷³ First Nations is the term used to describe Indigenous Peoples who are not Inuit or Métis. First Nations has been used since the 1970s-1980s to describe Indigenous Peoples, replacing the settler-colonialist slur of “Indian” (Indigenous Foundations University of British Columbia, 2009).

⁷⁴ Métis is the term used to describe individuals with European and Indigenous ancestry resulting from the unions of settlers and Indigenous Peoples. are not provided with legal recognition as Indigenous People. (Indigenous Foundations University of British Columbia, 2009).

⁷⁵ Inuit is the term used to describe Indigenous Peoples who tended to live in more northern parts of the country. Inuit individuals are separate from Métis and First Nations individuals. They are not provided with legal recognition as Indigenous People (Indigenous Foundations University of British Columbia, 2009).

⁷⁶ The term “Indian” has been used by the Government of Canada as a form of ongoing discrimination against Indigenous Peoples across the country. This includes the Indian register and the *Indian Act*. This thesis uses the term Indigenous to describe any individual who is native to Turtle Island and Inuit Nunangat.

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Register.⁷⁷ Métis, and Inuit communities continue to receive no legal recognition for their status as Indigenous. Indigenous communities have been fragmented and displaced, thus losing cultural heritage, language, and knowledge regarding kinship (Mann, 2007; Assembly of First Nations, 2023). Indigenous communities remain resilient despite the settler-colonialist state's destruction of their communities through the Residential School system (Wilk et al., 2017); Indian Day School system (DeJong, 2007); the Sixties Scoop (Stevenson, 2021); forced and coercive sterilization (Stote, 2015, Mercredi & Fire Keepers 2021); anti-Indigenous racism in healthcare (Browne et al., 2022); and the ongoing genocide of Missing and Murdered Indigenous Women, and Two-Spirit, Transgender, and Gender Diverse (MMIW2S+) individuals (Pabla, 2021). These are some of the reasons why the number of Indigenous communities across Canada is low.

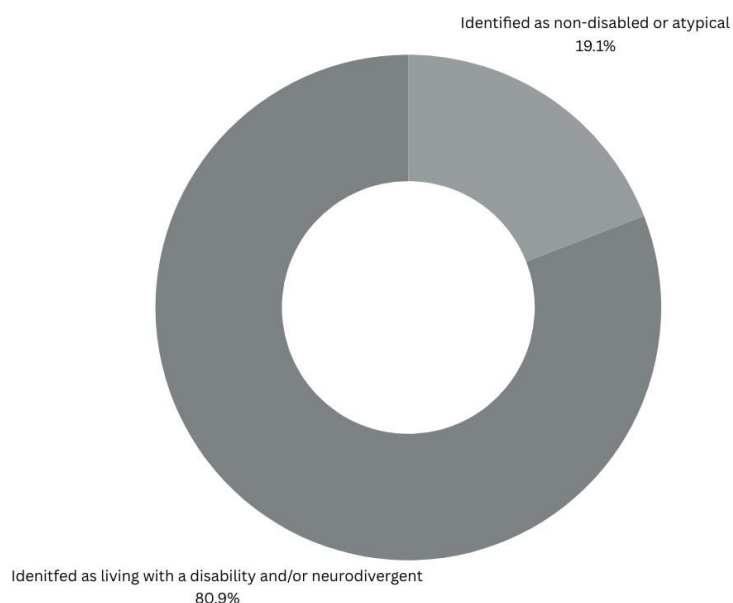
In 2021, Statistics Canada noted there were 1.8 million Indigenous identifying individuals that represent five percent of the overall population (2022b). At the time, 406,590 Indigenous identifying individuals lived in Ontario, accounting for 2.9 percent of the population of Ontario (2022b). It was statistically significant that 13 percent of survey participants self-identified as Indigenous because this is far more representative of Indigenous communities than seen in the province of Ontario. The same 202 census data found that 374,395 individuals in Ontario identify as Indigenous with 236,685 First Nations identifying individuals, 120,585 Métis identifying individuals, and 3,860 Inuit identifying individuals (Government of Ontario, 2019). Of the 14.3 percent of survey participants who self-identified as Indigenous, 9.5 percent identified as Métis and 4.8 percent identified as First Nations. No participants identified as Inuit.

⁷⁷ According to the Government of Canada, an individual who is registered “are persons who are registered under the Indian Act of Treaty Indians are persons who belong to a First Nation or Indian band that signed a treaty with the Crown. Registered or Treaty Indians are sometimes also called Status Indians” (2022b, n.p)

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These numbers are not surprising given that Inuit individuals are only one percent of the population of Canada.

Chart 4: Self-Identification as Living with a Disability and/or Self-Identify as Neurodivergent



Survey data demonstrated that 80.9 percent of all participants self-identified as living with a disability and/or neurodivergent. This includes, but was not limited to cognitive, intellectual, physical, and/or neurodivergence. Allowing participants to provide their own

terms regarding their own lived experience was critical. Varying language is used in this thesis, including person-first language and “trans disabled folks” or “disabled trans folks” in accordance with other scholarship. I did not require participants to have a formal medical diagnosis to self-identify as someone living with a disability. Some participants self-identified under the blanket terms of disability and/or neurodivergent in the survey, while others provided more detailed accounts, such as living with attention deficit hyperactivity disorder (ADHD), being on the autism spectrum, and/or living with a non-verbal learning disability.

According to Baril (2015a), disabilities are infinite, and “people may have physical, mental, psychological or emotional impairments or health conditions that may be stable or

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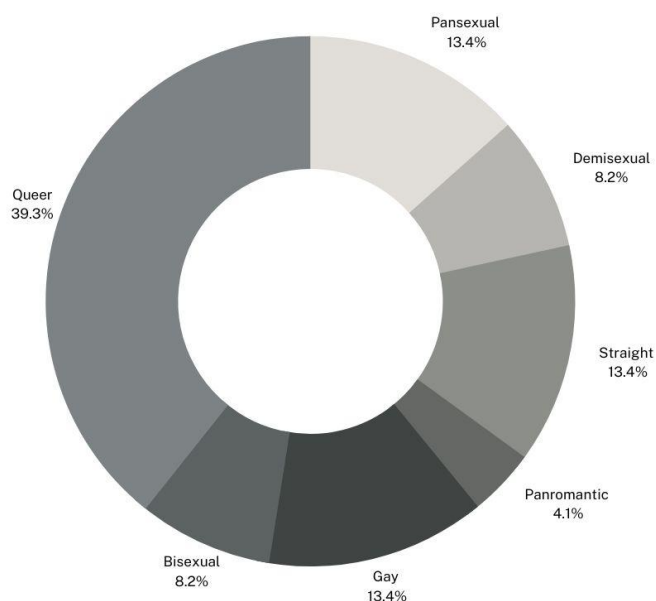
degenerative, visible or invisible, chronic or intermittent, mild or severe” (p. 61). In 2012, 55 percent of the transgender population of Ontario self-identified as being disabled or living with a chronic illness (Bauer et al., 2012). In 2014, it was estimated that there were approximately 135,000 individuals living with autism in Ontario, accounting for approximately one to two percent of the province’s population (Anagnostou et al., 2014, p.509). In Ontario as of 2019, there were approximately 2.6 million people living with a disability (Government of Canada, 2023). Strong connections between TGGD identity and disability have been noted in recent studies. In 2020, a University of Cambridge study found that of their sample of 641,860 individuals, 30,892 self-identified as being on the autism spectrum, or autistic, and 3,777 self-identified as TGGD (Dattaro, 2020, n.p). While not all TGGD individuals are living with autism or identify as autistic many do (Kirbyson, 2023). A 2022 US study found of 1,400,043 adults over 18, TGGD individuals were almost twice as likely to be living with a disability (Smith-Johnson, p. 1471). In the same vein, TGGD individuals are much more likely to be living with one or multiple disabilities such as being on the autism spectrum, or self-identifying or being on the autism spectrum, schizophrenia, depression, and attention deficit hyperactivity disorder (Dattaro, 2020, n.p). With the ageing TGGD population, scholarship continues to address the gap in age-related disabilities such as the experiences of those living with dementia and Alzheimer’s (Baril & Silverman, 2019).

For some, disability “is the social process that turns an impairment into a negative by creating barriers to access” (Timmons, 2021 p.250), meaning that social factors create and reinforce barriers for both disabled and TGGD individuals. Baril argues that transness and disability are linked through the “psychological/mental perspective” where a psychological diagnosis of gender dysphoria or previously, Gender Identity Disorder, was given to TGGD

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individuals (2015a, p.62). The second link is through the ways that TGGD bodies are classified as lacking cisnormative bodies or parts. TGGD bodies in this way are classified as the “dysfunction or absence” of certain body parts that are deemed proper to classify bodies as male and female. Until 2013, the American Psychological Association’s (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) classified TGGD individuals under the medical condition of Gender Identity Disorder (GID). This diagnosis was conflictual as it classified TGGD individuals under mental illness but also provided some individuals with access to critical health insurance coverage under the diagnosis. While social and medical models of disability explore the ways that individuals and society shape the lived experience of those living with disabilities, scholars differ in their opinions on medical versus social models.

Chart 5: Sexual Orientation Among Survey Participants



When completing the survey, participants were asked to describe their sexual orientation, in an open answer format allowing them to self-identify in multiple ways. This also means this statistic did not add up to 100 percent. The term “queer” was used by 38 percent of the sample to identify their sexual

orientation. This included 8 percent who also self-identified as bisexual, 13 percent identified as gay, 13 percent identified as pansexual, 13 percent identified as straight, eight percent self-

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identified as asexual, eight percent self-identified as demisexual, four percent self-identified as panromantic, and four percent identified as biromantic. According to Statistics Canada, the number of 2SLGBTQQIA+ individuals in Canada between 2006 and 2016 increased by 60.7 percent in this decade (2021, n.p). As of 2021, over one million individuals over the age of 15 self-identified as 2SLGBTQQIA+ (Statistics Canada, 2021). Transness and queerness are commonly linked together in research under the 2SLGBTQQIA+ umbrella, sometimes resulting in an underrepresentation of TGGD individuals (Riggle et al., 2011). In their 2011 study, Riggle et al. (2011) found that of the 61 TGGD individuals who completed their online survey, only 15 percent self-identified as straight or heterosexual (p. 148). A 2014 Dutch study including 115 TGGD individuals found 32.9 percent of participants had a shift in their sexual orientation once they transitioned (Auer et al., p. 7). In my survey, nine out of 21 individuals mentioned a change in their sexual self-identification at some point during their transition.

Just as sex/gender works as a binary system, sexual orientation revolves around a strict understanding of heterosexuality (Schilt & Westbrook, 2009). For Rich (1982), heterosexuality is normalized and compulsory, meaning that everyone is expected to be heterosexual. Butler (1990) named this expectation the “heterosexual matrix” where individuals are expected to follow a trajectory based on their sex assigned at birth. Individuals assigned female-at-birth are expected to be raised as young girls, grow into women, and marry men. TGGD individuals disrupt this system intrinsically by refusing the trajectory laid before them. Torturous practices such as conversion therapy have been used to try and correct individuals who do not identify as heterosexual and/or cisgender as they show the fragility of heterosexuality (Salway et al., 2021; Blais et al., 2020; Kinitz et al., 2022).

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Preciado (2017) argues that we “risk turning the term [queer] into a description of a neoliberal, free market identity” (p. 341) that neglects its radical importance to many minority groups. Puar (2007) mirrors these sentiments through her discussion of the concept of “good gays” versus “bad queers”. Good gays contribute to the neoliberal and capitalist economies through the consumption of commodities such as tourism, or in this case, fertility tourism⁷⁸ and reproducing the idealized biogenetic family. In contrast, bad queers continue to subvert heteronormativity and homonormativity, using queer as the radicalized identity it was intended to reclaim. In the fertility clinic setting, good gays use reproductive technologies to recirculate idealized forms of parenthood that reinforce the importance of biogenetic connection. While this concept is explored later in the thesis, it is critical to note the importance of queerness and transness as contributing to the destruction of homonormativity. At the same time, the inclusion of TGGD individuals in the fertility clinic can also denote neoliberal and capitalist desires to recreate good gays through the consumption of fertility services.

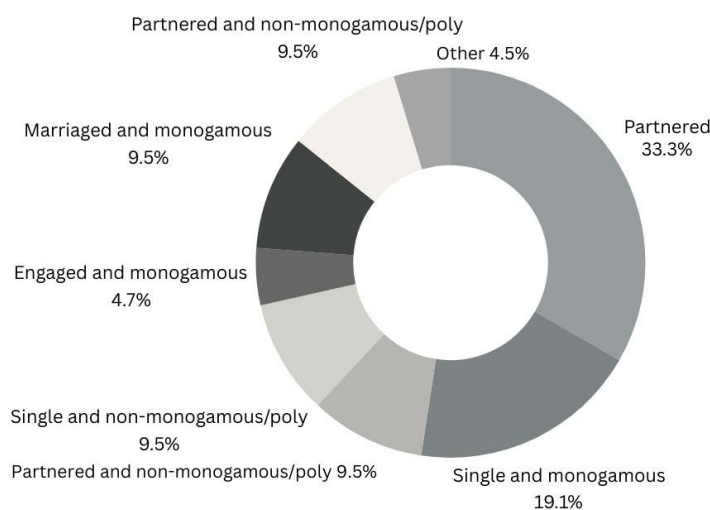
Chart 6: Relationship Status

This thesis survey provided a wide range of options for participants to describe their relationship status. Options provided ranged from currently single and non-monogamous to currently married and non-monogamous/polyamorous.⁷⁹ Of survey participants, 31.8 percent of

⁷⁸ Also known as “cross-border reproductive care” or “reproductive tourism” (Deonandan, 2015, p.111).

⁷⁹ Non-monogamy and/or polyamorous relationships are defined as relationships with sexual and romantic elements. While this is different for everyone, non-monogamy or polyamory differs from other forms of open sexual based relationship such as “swinging” or “open” arrangements (Balzarini et al., 2017, p. e0177841)

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individuals identified as partnered, 18.2 percent identified as single and monogamous, 12.5 percent identified as partnered and non-monogamous/polyamorous, 8.3 percent identified as married and monogamous, 8.3 percent identified as single and non-

monogamous/polyamorous, and 4.2 percent identified as under partnered and non-monogamous/polyamorous with multiple partners. Under the other category (chosen singledom),⁸⁰ married and non-monogamous or polyamorous, single and non-monogamous or polyamorous, and engaged and non-monogamous or polyamorous.

In 2016, married couples accounted for 49.2 percent of the population of Ontario (Government of Ontario, 2024). However, there has been a decrease in the number of individuals choosing to marry, with more couples choosing cohabitation without marriage (Horowitz et al., 2019), and many other individuals choosing singlehood (Fraser, 2024). The survey did not inquire about divorce or cohabitation habits among participants.⁸¹ While only 12.5 percent of all

⁸⁰ Other was an additional option. One participant chose “other” and specified their relationship status is “chosen singledom.” While single was an option, this individual wanted to express their desires to remain single.

⁸¹ This is a retrospective limitation of the research since there are strong connections between family experience and an individual’s choice towards marriage (Pinsker, 2019). Moreover, it would have been important to note which participants are currently cohabitating but are not married to their partners. Another important element of family planning is marriage. This thesis should have inquired about desires for marriage for non-married or engaged participants.

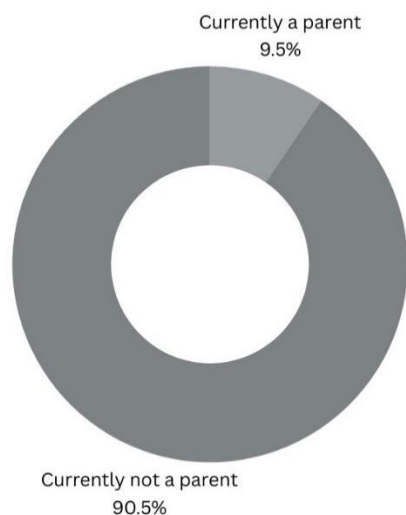
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participants were married, 68.1 percent of all participants identified as being partnered, engaged, or married. The low number of participants who were married could be attributed to the age of the sample, with the majority under age 25. In 2017, the average age of marriage among Canadians was 30.7 years of age (Bush, 2024); therefore, it is to be expected that many participants in this sample would not be married.

In addition to marital status, I also wished to know if participants were in monogamous or non-monogamous/polyamorous relationships. While non-monogamous or polyamorous relationships have been practiced throughout history (Anapol, 2010), there has been a drastic increase in these relationships in Generation Z (Hamid, 2024).⁸² According to Tinder, a popular dating application, 41 percent of all Generation Z Tinder users were having or open to the idea of having a non-monogamous or polyamorous relationship (2023, n.p). In 2019, in Canada and the US, one in five individuals identified as non-monogamous (Fairbrother et al., 2019). It has also been found that non-monogamy and polyamorous relationship can be more common for 2SLGBTQIA+ individuals (Barrett, 2020), with queer- identifying men being the most common practitioners (McNaughton, 2016). I found that 18.1 percent of all participants in the survey engaged in non-monogamous/polyamorous relationships. This statistic is on par with Canada and the US with approximately 20 percent of the population identifying as having non-monogamous/polyamorous relationship.

⁸² Generation Z is defined as individuals born after 1997 (Dimock, 2019).

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Chart 7: Currently a Parent

Currently, it is more common for participants not to have children, than to be parents. In 2016, Statistics Canada found that fewer married couples were having children with only 44.3 percent of married couples, 5.1 percent of common-law couples, and 9.3

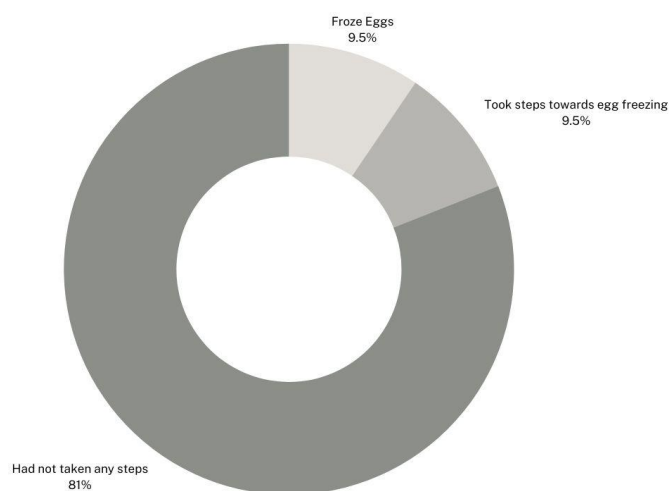
percent of single parents having children (2023, n.p). In 2021, there were over 2,776,165 married and 189,835 common-law couples in Ontario. However, of these couples, only 56.6 percent of married couples and 36.8 percent common-law couples are parents (Statistics Canada, 2024, n.p). Of all participants in this thesis, only 9.5 percent of participants were parents. This is a very low percentage given the overall percentage of parents across Ontario. In their 2015 survey, Pyne et al found that of the 455 TGGD individuals surveyed, only 110 were parents (p.113). However, regardless of gender or sexuality, there has been a significant decrease in overall fertility and number of children across Canada (Statistics Canada, 2024). It has been hypothesized that the decrease in the number of children being born is due to the rising cost of living across Canada, including high housing costs,⁸³ high cost of child rearing, and an increase in infertility rates among those living in Canada (Statistics Canada, 2023b).

⁸³ The same 2021 Statistics Canada study found that 63 percent of individuals between 15 and 29 are renting their current homes, over twice the national average of 33 percent (2023).

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At the same time, the two participants who currently have children exceeded the average number of children per family in Ontario. In 2021, the average family in Ontario had 1.43 children per household. In contrast, of the two participants in this thesis, one had two children, and the other had seven (with three children prior to transitioning and four following their medical transition). The first participant was involved in a follow up interview; however, the second participant was not.

Chart 8: Fertility Preservation Use Among Survey Sample



Another trend found in this thesis sample was a lack of use of fertility preservation. Only 9.5 percent of participants mentioned taking steps towards fertility preservation and only 4.7 percent of participants had frozen their eggs. Given the low rates of egg

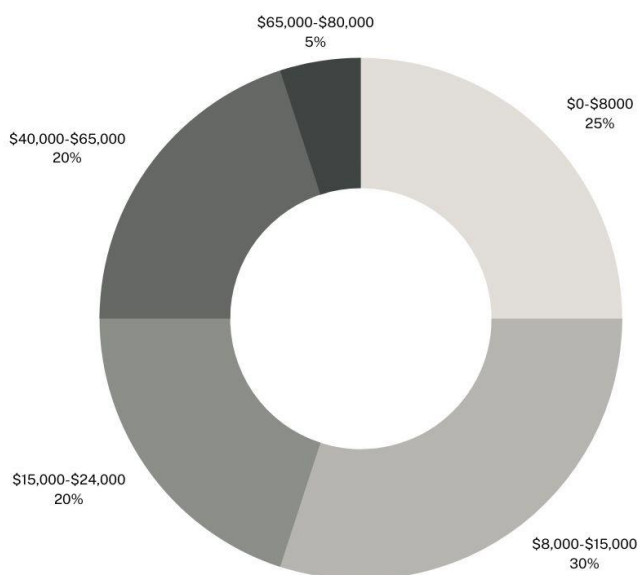
freezing among TGGD individuals internationally, it was not surprising to learn that only one participant had frozen his eggs and only one participant had reached out to a fertility clinic for more information. However, of the 11 participants who answered Q26, “Have you experienced any barriers to freezing your eggs? If so, what were they?” 63.4 percent of participants mentioned the cost of the procedure, and 18 percent referred to OHIP coverage specifically.

As I have shown, the connection between cost and conflicted hope has been explored in many studies demonstrating that finances are a barrier to egg freezing for both cisgender and

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TGGD individuals. The participant who froze his eggs, mentioned that insurance did not cover the cost of expensive medications or storage fees.

Chart 9: Annual Income for 2019 Among Survey Participants



Another significant trend found in this thesis sample was the low annual income of the survey participants for 2019. Thirty percent of survey participants made less than \$8,000 as their 2019 income, and 20 percent made less than \$15,000. The 2019 annual income for 50 percent of the sample made was under \$15,000.

Fifty percent of participants were also under the age of 25 and many were students, which could explain the income disparity. In Canada, TGGD individuals commonly experience alarming rates of unemployment (Leppel, 2016; Waite et al., 2019; Waite, 2021). This lack of employment can cause many TGGD individuals to experience poverty (Kinitz et al., 2021) and be unhoused (Bauer et al., 2012; James et al., 2016; Scheim et al., 2017; Kia et al., 2021). Similarly, a recent Trans PULSE Canada survey of 820 participants found 58 percent of individuals aged 15-75 had an annual income of less than \$30,000 in the previous year (Kia et al., 2021, p. 11).

This income disparity could also be impacted by COVID-19, which left many individuals with lost wages due to illness, caregiving, provincial lockdowns, and other related factors.

During COVID-19, the Canadian Government provided essential financial support bridging the

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gap between the lowest and highest income households in 2020 (Statistics Canada, 2021), and the Government of Ontario implemented “temporary pandemic pay,” with many workers receiving a four dollar increase in their hourly wage (Government of Ontario, 2022). While these measures provided some relief to those living in Ontario, other critical aspects of identity could impact the income of participants. In their Canadian study, Kia et al. (2022) interviewed 697 participants and found that the financial and employment instability for TGGD individuals was particularly precarious. Kia et al. (2022) also noted that COVID-19 only heightened some of the other forms of marginalization and lack of access experienced by TGGD individuals in Canada (Ghabrial et al., 2023).

Despite the legal protection against discrimination based on TGGD identity under Canada’s *Bill C-16*,⁸⁴ many TGGD individuals remain vulnerable to financial hardship due to transphobic policies and employers (Canadian Labour Congress, 2019). A 2019 Pride at Work study showed that over 50 percent of 2SLGBTQIA+ individuals do not feel comfortable being out in the workplace (Bainbridge, 2022). Among those interviewed by Kia et al., (2022), financial strain among TGGD individuals was commonly linked to “limited options for safe and well-compensated employment among trans and non-binary people specifically” (p. 6). Not only do TGGD individuals remain un/under employed (Irving, 2017) but instances of transphobia in the workplace have become more common with the worsening increasing hateful anti-trans rhetoric in Canada (Bellmare et al., 2021). In Canada, TGGD individuals are 2.2 to 2.5 times more likely to experience discrimination in the workplace than their cisgender male counterparts (Waite, 2020, p. 1833).

⁸⁴ *Bill C-16* was an amendment to the *Canadian Human Rights Act* and *Criminal Code* in 2016. This added legal protection from discrimination based on gender identity and gender expression (House of Commons Canada, 2016).

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Previous annual income for TGGD individuals may also be impacted if they are living with a disability and/or neurodiversity, and/or chronic illness. Waite (2020) found TGGD individuals living with a disability reported even higher instances of discrimination in the workplace causing a greater desire to leave an unsafe workplace. In 2014, of those individuals living with a disability aged 25-64 in Canada, 23 percent were living on a low-income (Statistics Canada, 2023). Only 59.4 percent of Canadians living with disabilities were employed in 2015 (Maroto & Pettinicchio, 2020) and by 2017, Statistics Canada found 40 percent of those living with a disability were among the low-income population (Statistics Canada, 2023). In 2021, individuals living with disabilities in Canada were two times more likely to earn \$50,000 or less per year than their able-bodied counterparts (Government of Ontario, 2023). The annual income for 2019 among those living with disabilities could potentially explain some of the income disparities experienced among the thesis participants given the high number of those living with disability and/or neurodivergent.

Conclusion

The survey data demonstrated key demographic trends among the thesis participants. Trends in the survey data were explored throughout this chapter. A trend was defined in this chapter as a statistically significant event where a larger number or percentage of participants responded in the same manner or a common manner. This chapter has outlined the construction of the thesis survey, the questions included, and some of the ways the survey addresses the objections and questions of the thesis. At the same time, this chapter also provides reference to some critical insight into the participants of this thesis. The survey results provide key demographic data and reveal several themes. Thesis participants were largely young, under age

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25, placing them in Generation Z and were primarily white or Caucasian, but overall, were more representative of Indigenous communities. Many self-identified as living with a disability and/or neurodivergent, self-identified as queer, and were in lower annual income brackets for 2019.

Previous income for 2018 and before were not asked. Participants tended to be partnered, engaged, or married with an average number of couples engaging in non-monogamy or polyamorous relationships. They were less likely to be parents. While some participants were curious about egg freezing and fertility preservation, there was only one participant who sought out information, and only one participant who froze his eggs.

This chapter has demonstrated some of the ways that this thesis sample represents and does not represent the overall population of the province of Ontario and has explored why this may be the case. Critical reflection is essential when discussing the ways that socio-economic status, race and ethnicity, disability, queerness, and other identities come together for TGGD individuals. The following chapter will explore the quantitative data sets derived from the in-depth interview process.

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Chapter 4: Making Chilling Discoveries, Interview Methods, and Participant Profiles

“One of the things that was really difficult about this interview was the fact he [Salem] had lost his mother to cancer in 2020. He mentioned she had been trying harder to be accepting and making more of an effort prior to her passing. I was in a similar situation. In 2021, one of my stepmothers passed away suddenly after being sick for 6 years. I had created distance between us because she and I did not communicate well, and things had been civil but distant. It is a confusing feeling when this happens, when they are putting in more effort and then you run out of time.”⁸⁵

This chapter is dedicated to outlining the methodological approaches used to identify themes and interpret data from the follow up semi-structured, in-depth interviews. Sixteen participants initially showed interest in a follow up interview but only nine responded to recruitment emails and seven did not respond. All participants were sent a total of two emails to set up an interview. An initial email was sent following completion of the survey, and if no response was received, one additional follow up email was sent. If the participant did not respond to the second email, it was assumed that they were disinterested or had changed their minds. Nine individuals responded and participated in in-depth, semi-structured interviews. Each interview lasted approximately 45-60 minutes in length and was conducted online via Zoom. All Zoom interviews took place between November 21, 2021, and June 1, 2022.

Prior to all interviews, participants were emailed consent forms and asked to carefully review the content of the consent form and provide a signature to show their acknowledgement (See Appendix D). The consent form was used to provide interview participants with the context for the thesis, including the purpose, benefits, potential harms, and future use of their data. Interview participants were asked if they consented to having their interview audio recorded using the Zoom application and if they wished to use a pseudonym to protect their identity. To

⁸⁵ Research journal excerpt, 05/05/2022.

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ensure the practice of ongoing informed consent. Ongoing informed consent in this thesis meant I demonstrated transparency, open communication, and honesty, allowing information-based decision making by all participants throughout the entire process. The consent form notified participants they were able to withdraw their participation and contributions at any time. However, if a participant anonymously contributed to the survey, this made removing their contributions impossible. However, this was made clear in the consent form. Moreover, interview participants were provided with their interview transcripts once the interview was completed. This provided interview participants with the ability to remove, add, or clarify and then approve their interview contributions.

Attached to consent forms, participants were provided with the terms of service for Zoom and were told that technology use could weaken confidentiality and protection. Therefore, I could not guarantee confidentiality. At the beginning of each interview, I reviewed consent forms with the participants and confirmed their names, pseudonyms, pronouns, and reiterated ongoing consent processes. During all Zoom interviews, I appeared on camera for all participants. This allowed participants to see my responses and hear my voice during the interview. The use of the camera function was optional for all participants and was based on the comfort of the individual. Of the nine participants, two decided they did not want to use their camera function during the interview.

Methodological Approaches to the Interviews

Throughout the data collection process, feminist research methodologies were employed to best reflect “the research process and co-producing data with respondents” (Raun, 2022, p. 122). This methodology, including interview creation, preparation, execution, and analysis was

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guided by intersectional thinking (Crenshaw, 1991), queer theory, trans*-epistemology (Radi, 2019), and the practice of ongoing informed consent. Intersectional thinking considers how experiences of oppression like sexism, racism, and classism co-exist simultaneously (Crenshaw, 1991). An intersectional and trans*-epistemological approach that includes “a way to contribute to a dialogue fundamental both from a scholarly perspective and from the point of view of trans* advocacy” (Radi, 2019, p. 43) can be used effectively to understand the experiences of TGGD individuals. Ongoing informed consent is employed in both intersectional and trans*-epistemological methods. Ongoing informed consent in this thesis means that each participant was provided with the right to accept the risk of the research process (Kim et al., 2022). Risks for this thesis were mainly emotional and psychological risks that arise from discussing experiences of navigating family formation, the medical system, and familial relationships. Risks can be anticipated and unanticipated and therefore, ongoing informed consent provides participants with the anticipated risks to ensure they are making an informed decision (Coleman et al., 2022).

As a TGGD researcher, I employed a trans*-epistemological and gender-affirming approach to my research. My identity as a transgender person led my ethical process during the interviews and allowed me to gain access to very intimate information about my participants. Gender-affirming research employs respect for TGGD individuals and allows participants to use their selected names and pronouns (Vincent, 2018); acknowledges intersecting struggles (including cissexism, racism, queerphobia, ableism) (Hendrickson et al., 2020); uses inclusive language or language chosen by the participant (Hendrickson et al., 2020; Vincent, 2018); avoids pathologizing participants (Hendrickson et al., 2020); includes extensive reflection by the researcher regarding their own bias (Hendrickson et al., 2020); and shows commitment to research that reflects the lives and experiences of participants. Gender-affirming research applies

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a trans*-epistemological framework when the researcher understands that “trans people are experts in their own lives” and prioritizes the participants’ words over their own (Radi, 2019). Everhart notes TGGD individuals “are not merely research subjects; we are also researchers and knowledge producers. We carry embodied knowledge and lived experience that our advocates, allies, and co-conspirators must recognise” (Gruskin et al., 2019, p.71). At the same time, Raun (2014) notes:

I am not implying that going through a social and medical transition necessarily makes one a hyper aware human being, but it certainly has literalized within a fairly short span of time how my perceptions of the world are framed by my embodied and intersubjective self (p. 15).

During interviews, I was reminded about the difference in the lived experiences among all TGGD individuals. This was a critical component in my research journal.

Interview Process

All interviews were semi-structured to allow for flexibility and freedom during the interview process (Hesse-Biber & Nagy, 2014). Semi-structured interviews are helpful “to understand the reasons why people act in particular ways, by exploring participants’ perceptions, experiences and attitudes” (Harvey-Jordan & Long, 2001, p. 74). When investigating egg freezing among TGGD individuals in Ontario or Canada, interviews with participants have not been a method used to discuss lived experiences. Outside of Canada, semi-structured interviews have been used by other researchers to inform their research (von Doussa et al., 2015; James-Abra et al., 2015; Payne & Erbenius, 2018; Kyweluk et al., 2019; Voultsos et al., 2021; Birenbaum-Carmeli et al., 2021). An in-depth and semi-structured interview format was chosen

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for this thesis. A semi-structured approach allowed for the ongoing development of rapport with participants and provide flexibility if interviews required it, while an in-depth approach created space to ensure the opportunity to allow participants to speak openly and acknowledge their experiences of marginalization (Hesse-Biber, 2014). An in-depth and semi-structured format led to more time for reflection, allowed me to revisit statements, ask for clarification, and elicit more elaboration on specific topics or points.

Interview Participant's Profiles

The nine interview participants are:

Andy (he/him) is a 23-year-old, Métis trans man. Andy identifies as living with a disability and/or neurodiversity that was not disclosed during our interview. Andy has an assigned-female-at-birth⁸⁶ non-binary partner who is also 23 years of age. Andy does not currently have any children. Andy has a strained relationship with both of his parents, but they are generally supportive. He is close with his sister who has been supportive of his transition. He began his medical transition in December of 2016 at the age of 17 at the Children's Hospital of Eastern Ontario. He started using HRT in November 2017 and had top surgery in July of 2018. Andy and his partner may be interested in having children in the future but, due to health problems and lack of desire for biogenetic parenthood, neither Andy nor his partner wish to become pregnant. Andy and his partner are open to adopting animals and children in the future. Despite his lack of desire for biogenetic parenthood, Andy disclosed that he feared his mother would be upset at him for not providing her with biogenetic grandchildren. Driven by this fear, Andy reached out to the

⁸⁶ Andy's partner's sex assigned at birth is only medically relevant in this thesis since they also produce eggs and are unable to biogenetically reproduce with Andy without technological intervention and/or sperm donation.

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Ottawa Fertility Centre in 2020 to learn more about egg freezing. This occurred in the beginning of COVID-19, and Andy was not provided with any follow up because the fertility clinic was not taking on patients. He has not sought further fertility clinic services since then. During our interview, Andy was open to having non-biological children but felt the pressures from his mother for biogenetic parenthood.

Seth (he/him) is a 32-year-old white, pansexual trans man who identifies as being on the autism spectrum. Seth has a transgender male partner with whom he coparents his two children, ages 13 and six. Seth came out as transgender to his partner ten years before he felt comfortable enough to begin his medical transition in December 2020. Seth does not speak to his parents because they are not supportive of his gender identity. Of his two children, Seth gave birth to his first child, and adopted his second. Seth unexpectedly became pregnant with his first child prior to transitioning and was approached post transition by the biogenetic mother of the second child during her pregnancy to adopt the second child. Seth was not provided with any information regarding his fertility or possible options for fertility preservation. Seth mentioned that cost would have been a big consideration for him not to freeze his eggs had he been presented with the option. He wishes the option had been provided to him openly at the beginning of his transition.

MK (they/them) is a 38-year-old bisexual, Jewish- and white-identifying non-binary person living with “non-verbal learning disability.”⁸⁷ MK is partnered to a cisgender man and is currently childless. MK is not close to their parents. Their parents were not very supportive when

⁸⁷ Language used by MK.

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they came out as transgender, despite their father being a gay man. MK began their social transition in 2018 and started HRT in December 2020. MK ended their testosterone use in March of 2021 due to personal reasons. MK wishes to have children in the future and has desires to become pregnant and give birth. However, they have concerns about what it would mean to be a non-binary pregnant person and parent due to lack of support and resources for TGGD parents. MK discussed their desire for biogenetic children in the future and talked about desires for pregnancy and giving birth.

Logan (he/him) is a single, white, 23-year-old genderqueer transmasculine/transgender man who identifies as being on the autism spectrum and asexual biromantic. Logan does not have any children but might desire some in the future. He began his social transition at end of 2018 and began HRT in 2020. Logan and his family doctor discussed fertility preservation in 2018. Logan said he lacked interest in egg freezing because he did not want to deal with his bottom dysphoria, however, he mentioned an ongoing desire to carry his own child. Logan notes that his special interest has always been pregnancy, and also, trans-related health. Logan mentioned wanting children in the future, but he worries about overstimulation and child rearing. Logan is also unsure about how a romantic relationship would come into play in his life, but he would enjoy the stability and emotional comfort of a partner.

Charlie (they/them) is a 21-year-old queer and non-binary identifying person. Charlie identifies as living with a disability and/or neurodiversity that was not disclosed in our interview. Charlie began their social transition at 16 years of age at the Children's Hospital of Eastern Ontario. However, they aged out of Children's Hospital of Eastern Ontario at the age of 18, before they

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were able to begin their medical transition. Charlie felt uncertain as a non-binary person regarding HRT because there was very little reference to non-binary individuals and their reproductive desires at the time. At the Children's Hospital of Eastern Ontario, Charlie's initial hesitations regarding beginning HRT were later used against them because it was not believed they wanted HRT.

After waiting a year, Charlie was no longer able to use the Children's Hospital of Eastern Ontario's services due to the age limit cut-off, at which point they went to an endocrinologist who provided them with hormone blockers. At age 18, Charlie began a low dose of testosterone. Charlie is on testosterone and remains on hormone blockers because they remain anxious about their menstrual cycle returning. When beginning the process with their endocrinologist, Charlie was adamant they were not interested in having biogenetic children and has been planning on getting a hysterectomy in the future. They also mentioned that they did not want to freeze their eggs because they had a friend at the time going through the process and felt it would be deeply uncomfortable. Despite their lack of desire for biogenetic children, Charlie was strongly drawn to the idea of fostering and adoption. Charlie had a partner for six years but is currently single.

Olive (they/he)⁸⁸ is a 21-year-old who identifies as white, queer, and non-binary transmasculine individual. Olive identifies as living with a disability and/or neurodiversity that was not disclosed during the interview. Olive began their transition at the age of 16 through ARCH Clinic in Guelph. The ARCH Clinic is a gender clinic commonly used by TGGD individuals in Guelph and surrounding areas. Their parents are both generally supportive. Their mother was a key

⁸⁸ Olive uses they/he pronouns, so I have used them interchangeably throughout their interview profile.

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support system during their transition and top surgery and their father has come around but can sometimes act questionably. They began HRT in 2016 and had top surgery the same year. Olive mentioned they were aware of egg freezing but knew the cost would be prohibitive. Olive continued HRT to 2018 or 2019 when they found that they had trouble maintaining their injections due to their “alcohol dependency issues.”⁸⁹ At this point, they determined they no longer wanted to be on testosterone since it had achieved all the physical traits they wanted. They were keen on having a hysterectomy and had all paperwork and appointments completed but became resistant to the thought of having to go on hormones to avoid going into early menopause. They no longer wish to have a hysterectomy.

They spoke with their ARCH Clinic doctor recently about fertility and parenthood despite no longer being on testosterone. At the time of interview, they were engaged to their cisgender female partner and getting married in the Fall of 2020. Both he and his partner desire to become pregnant and give birth in the future. They had discussed IVF, sperm donor clinics, and low-tech known donor methods considerations associated with seeking out a sperm donor including

⁸⁹ Olive noted that he has struggle with this since before he began his transition. This was only one of the reasons they decided to cease HRT. While they found that injections were difficult to manage due to their alcohol consumption, they also felt that they had achieved the desired physical changes associated with HRT.

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medical history,⁹⁰ physical traits,⁹¹ and even their astrological sign.⁹² Olive mentioned that the desired traits of their sperm donor shifted depending on whether they were to use an anonymous sperm donor from a clinic, versus a known sperm donor using low-tech methods such as a “turkey baster.” Low-tech options may be more affordable for Olive since they are working as a barista and made only \$8,000 to \$15,000 in 2019.

Salem (he/him/they/them)⁹³ is a 23-year-old white, queer, transgender, demi-gender-male, and agender identifying person.⁹⁴ Salem identifies as living with a disability and/or neurodiversity that was not disclosed. Salem began their social transition in February 2016 and HRT at the age of 17. Salem is currently waiting for approval for funding for his top surgery. When beginning HRT, Salem said he wished his doctor would have mentioned egg freezing and fertility preservation, however, they did some research on their own through a Google search. Salem received support from their dad, but their mother was less supportive. She passed away from

⁹⁰ They were avoiding medical conditions that neither they nor their partner had including infections such as herpes.

⁹¹ Olive and their partner discussed the traits they would want in a sperm donor. They wished to use the same sperm donor to impregnate themselves and their partner. Olive discussed physical traits of sperm donor as “deal breakers” or not deal breakers. While educational attainment was not important, they mentioned that they desired their potential donor to have dark hair and blue eyes. Olive has dark hair, and their partner has blue eyes, so they believe this is a good combination of traits. Olive also mentioned enjoying traits such as having larger ears that are a bit more prominent as being a desirable trait in a donor. In contrast, Olive mentioned how he and his partner would be more focused on personality if they went with a known donor, prioritizing the personality traits and disposition of the person over their genetic makeup. Personality traits they like in one of their potential friends who could be a known donor includes that he is a social butterfly, he is an artist, and that he is compassionate and kind.

⁹² One’s astrological sign is a way of finding “a link between an individual’s personality traits and the positions of the sun, moon, and planets in the zodiac at the moment of birth” (Clarke et al., 1996, p.131).

⁹³ Salem used he/him and they/them pronouns. Salem is comfortable with he/him pronouns being used predominately.

⁹⁴ This is Salem’s language to describe his gender.

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cancer in 2020. Salem himself has been struggling with their own health as it is connected to their disabilities. Salem noted that their disabilities are among the reasons they do not wish to procreate biogenetically. Salem also has friends who have gone through the process of using fertility clinics and claimed the process was “messy.” Despite coming from a conservative Christian background, Salem highlighted how his cisgender, female partner did not adhere to the same restrictions regarding biogenetic parenthood, gender, and sexuality. Salem and their partner have expressed the desire to foster transgender youth. He mentioned wanting to provide support and love to those who are going through the difficult processing of self discovery and authenticity.

Milo (he/him) is a 29-year-old white, gay, married, transgender man and healthcare professional. Unlike some of the other participants, Milo transitioned in his 20’s with HRT. At the time, there were few resources and Milo was not sure how to begin his transition. He sought help through Facebook groups. When he began his transition, Milo knew about egg freezing but was not aware it was possible after beginning HRT. Four or so years after beginning HRT, Milo began nursing school and attended a trans-based health conference where he learned more about egg freezing. He was under the impression that he would have to cease HRT for a year before freezing his eggs but learned more. Going off HRT for a maximum of six months seemed very doable for Milo and he decided he wanted to freeze his eggs. Milo did some research when he returned home and determined he wanted to use Toronto’s Mount Sinai Fertility Clinic and not the local Ottawa Fertility Clinic to freeze his eggs.

Milo began his egg freezing journey in 2020 by getting a referral from his family doctor for a consultation. Milo explained how freezing his eggs during COVID-19 was beneficial for

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him due to additional privacy he received. However, he said it could have been very difficult for other TGGD individuals because he was unable to bring his husband to appointments. Milo recounted his egg-freezing experience as “not awful.” As his legal names and gender marker had already been changed, he felt comfortable going to appointments on his own. Milo also noted that since he has been on HRT for over five years, it was easier for him to cease HRT for the three months required.⁹⁵ Milo explained he ceased HRT for four to six weeks and then began “cross-therapy hormones”⁹⁶ for two to four weeks. Milo noted that at the time, his fertility doctor was uncertain if Milo had to begin menstruating again before beginning cross-therapy hormones but determined it was not required. Following the egg retrieval, Milo ended up having 22 eggs removed, with eleven eggs viable. Following the process, Milo mentioned he experienced some of the common side effects of the hormones, including bloating and discomfort. Reflecting on the process, Milo mentioned having to pay for the trips from Ottawa to Toronto, taking time off work, paying for hotels and meals, and paying for the hormones required for ovarian stimulation as barriers.

Milo froze his eggs knowing he would not want to carry any pregnancy himself in the future. He discussed the complications of surrogacy and adoption. Milo had done some research regarding the legal restrictions surrounding surrogacy in Canada and explained how despite the altruistic restrictions, the process was very expensive. Milo was concerned about the cost

⁹⁵ While ceasing HRT for TGGD individuals can cause distress, especially for individuals who have been on HRT for shorter periods of time, those who have longer HRT results may not feel as distressed by potential changes to their bodies.

⁹⁶ Milo uses the term cross-therapy hormones to describe the hormones required to simulate the ovaries and ensure faster egg maturation rates. This hormone therapy is, for Milo, cross-therapy because this is an estrogen-based hormone regiment which can be distressing for some TGGD individuals on HRT.

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because he and his cisgender husband intended on moving out of Ontario.⁹⁷ At the same time, Milo was realistic about the strong possibility of also needing to adopt. Statistically, it takes at least 10 viable eggs for a live birth. Since Milo had one retrieval that resulted in only 11 viable eggs, it is possible that Milo's frozen eggs may not result in a live birth. Milo and husband want at least two children, which means adoption will likely be required at some point to have a second child, if not both children.

Ollie (they/them/he) is a 25-year-old white, queer, genderqueer identifying individual on the autism spectrum. Ollie began their transition in 2016, began HRT in 2017 and, had top surgery in 2019. Following this, Ollie underwent a hysterectomy in 2021 but kept their ovaries intact. In 2022, Ollie ceased HRT. Ollie told their mother they were going to transition, and she was supportive. With their mother's support and some therapy, Ollie came out to their father who took time to accept the transition. Ollie's parents struggled with fertility, which was one of the reasons why Ollie is an only child. When they were younger, Ollie envisioned themselves forming a nuclear family with four children. However, Ollie came to realize they were not interested in the institution of marriage. Ollie is also not interested in biogenetic children or reproductive technology use based on their own parents' experiences of infertility, and their own value system. Ollie feels strongly about supporting the trans community and mentors trans youth through the Children's Aid Society.

⁹⁷ As explored, other provinces tend to have less coverages for fertility clinic services and so Milo worried about being able to have coverage for In-Vitro Fertilization and surrogacy services.

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Research Journal and Ethical Considerations During Research Process

Maintaining a research journal is form of autoethnography that remains “a highly personal process” (Cheng, 2013, p. 107). Autoethnographic methods such as research journals continue to be a primary tool for queer and marginalized researchers (Jones & Adams, 2016) to bring to light silenced voices in academia (O’Shea, 2019). Among TGGD researchers, autoethnography becomes critical autoethnography when integrating intersectionality as a means of exploring the impact of oppression and privilege in our own lives (Zaharin & Pallotta-Chiarolli, 2022). Autoethnography through journal writing and memoirs have been extensively used by the TGGD community to explore the complexities of identities, gender, queerness, disability, and spirituality. While other TGGD researchers have questioned the balance between critical reflection, “self-indulgence,” and “bad writing” (O’Shea, 2019), my research journal acted as a means of providing space for this process of exploration.

Given the need to conduct ethical research with the TGGD community, critical reflection before, during, and following interviews was essential to me. Following each interview, I engaged in a 30-minute self-reflection about the interview process. This included considering what was achieved during the interview, the overall feel of the interview, and my own thoughts. As a transgender person who has experienced systemic, structural, and institutional transphobia, personal reflection was done to ensure that my mental health and safety were being considered. Despite my lived experience as a TGGD individual, I was reminded of the importance of not grouping lived experience together. Excerpts from my journal are seen throughout the thesis. The reason for including these excerpts is because my own understanding of parenthood, family formation, and reproductive technology use has shifted over the years. Moreover, my research journal created space to sensitize me as a researcher and ground myself in my own experiences.

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Reflecting later on my research journal, including the content and process, provided essential reference points for my thoughts and feelings. While much of my research journal remains unseen in this thesis, the content of entries is meant to act as a subtle time machine, placing me back in the researcher's seat to recall some of the important and humbling moments of my thesis. When beginning the process, I believed I would struggle most with the emotional baggage of trauma and the medical system. However, what was most difficult to navigate as a researcher was not only shared trauma, but shared grief.

In March of 2021, I lost a parent due to illness. Her passing was unexpected. While she had been ill for many years, she was young. Following her passing, I interviewed Salem. This interview was among the most emotionally difficult. Salem lost their mother the same year that I lost my own due to ill-health. We were both working through our feelings of grief. Salem and I shared a common experience of a tense relationship with our parent. Like Salem's mother, my own stepmother had begun to feel more confident about and outwardly supportive of my gender identity right before her passing. While researchers can anticipate the ways that shared lived experience and trauma can be brought up in the interview process, there are always points of similarity that seem to hit harder. While many participants and I share the trauma of having ambiguous relationships with our parents, I had to reflect deeply on how my interview with Salem impacted me as a child who has lost a parent as well as a transgender researcher.

Some of the most important ethical considerations I had to explore throughout the research process include:

1. An ethical consideration that I must contemplate as a researcher is to check my own biases as a member of the community with which I work. For instance, although I decided against my

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own fertility preservation, I must not pass judgement on participants who choose to go that route. I must not project what I believe the experience of my participants will be based upon my own.

2. As a transgender researcher with an insider perspective on the TGGD community, I had to be cognisant of the privileged information I received. Community-based solidarity among TGGD individuals may allow for access to information that may not have been possible if I were cisgender. For this reason, I must be cautious to ensure that information provided during interviews are used as data with the explicit consent of the participant.
3. I must be conscious of the prejudice experienced by individuals who do not identify under a gender binary category. Hierarchies exist within all communities, and individuals who identify outside the identity of transgender man, trans male or male experience the delegitimization of their gender identities.
4. I must be aware of the psychological violence of gender-based language to many TGGD individuals. This includes the medical terms used to describe body parts and biological processes. While all TGGD individuals within the thesis were comfortable using scientific language like menstruation, eggs, egg freezing, ovaries, etc., there is always a potential that language will cause feelings of dysphoria. Therefore, I asked if each participant was comfortable with scientific language or if their own terms be used to describe their bodies and processes. For this reason, this study allowed all participants to self-identify and incorporate gender-neutral language to ensure the comfort of as many participants as possible. These results were carefully incorporated into every interview.
5. I was aware of the potential for TGGD individuals to be “triggered” by questions in the survey and/or interview. Meaning, some TGGD individuals could have found a question

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caused traumatic experiences to surface, or feelings of gender dysphoria may emerge during the process. The Transgender Help Line (1-877-330-6366) was provided to all participants in the survey and interview process.

6. As a researcher seeking to utilize an online forum to seek out research participants, I had to be mindful of access to the racial demographics of online spaces based on intersecting forms of institutional and systemic oppression. I recognized the extensive barriers to these spaces as well as the continued forms of settler colonization, colonialization, xenophobia, queerphobia, transphobia, cissexism and ableism that exist within the healthcare system.
7. Power relations were also considered between myself and research participants, including the researcher-participant relationship, socially constructed hierarchies of educational attainment, employment, location within my own transition, my class-based privilege, my geographic privilege, and my white privilege.
8. Self-care was a critical element of this work. As a transgender researcher doing work with TGGD individuals, my participants had the potential to trigger personal experiences of gender-based distress and trauma. For this reason, I engaged in self-care, self-preservation, and self-reflection during the research process.
9. Since this research will take place entirely through Survey Planet and online video conferencing forums, privacy and security for participants become more sensitive and difficult matters. Participants were provided with a disclaimer (See Appendix E) alongside the privacy guidelines of the two online resources used: SurveyPlanet (Appendix F) and Zoom (See Appendix G).

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Interviews, Interview Guides, and Questions

Once a participant completed a survey via SurveyPlanet, I was notified via email. Following each notification, I would review each participant's answer to the final question inquiring if they wished to have a follow up interview. If the participant indicated that they wished to be contacted for a follow up interview, an initial email was sent. If the participant responded with interest and completed the consent letter, I prepared for their interview. Each participant had their own individual interview guide created based on their survey responses. I constructed in-depth, semi-structured interview guides with the intention of exploring the themes of biogenetic parenthood, egg freezing, and conflicted hope.

An interview guide (see below and Appendix H) is a “practice-based tool that can help researchers achieve rigorous data collection and trustworthiness” by providing guidelines to keep them on track during data collection (Kallio et al., 2016, p. 2954). Interview guides can validate data sets by ensuring the interview questions address the main thesis and influences the outcome of the study (Kallio et al., 2016). Interview guides were created for each of the nine participants I interviewed. Interview guides began by confirming the quantitative demographic information provided by each participant in their online survey. Quantitative survey data including if they identify as living with a disability and/or identifying as neurodivergent, their age, race, and gender identity were used to provide a snapshot of the participant prior to their interview. Qualitative survey data was also used to determine potential themes and influence interview guides and was used alongside interview data and my research journal data sets. In the interviews, participants were asked questions that spoke to their specific lived experience, identities, and choices they have made regarding family formation.

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Sample Interview Guide

- Introduce myself, name, affiliation, and pronouns. Provide three resources in chat should TGGD interview participant wish to call a helpline to speak with someone. Three resources include Trans Lifeline, Pride Crisis line, and Brightlight Crisis Line.
- Thank participant for being apart of the process, their time, and their emotional labour.
- Confirm their name, pseudonym, pronouns, and if they have any accessibility needs not already mentioned in emails. Let them know we will be discussing some of their survey responses to guide interview questions.
- Review consent form, confidentiality, and technology use, and explain voluntary inclusion. Let participant know they can withdrawal consent at any time for survey and interview. Let
- Discuss my own identity and transition briefly to develop trust, ease, and rapport.

Potential Interview Question

1. Tell me about your transition.
2. Now thinking back to when you started testosterone, did your healthcare professional mention fertility preservation?
3. Was egg freezing something you were interested in/not interested in. Why or why?
 - a. Have you done any personal research on egg freezing?
 - b. What do you know about egg freezing?
4. Are you interested in becoming a parent in the future? If so, how?
 - a. What interests you/disinterests you about biogenetic parenthood?
 - b. Has being a parent always been something you were interested in?
 - c. Did your desires for parenthood shift when you transitioned?

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- d. Are you interested in becoming pregnant or carrying your own children?
 - e. Do you and/or you and partner(s) share the same aspirations for parenthood and family formation?
 - f. Do you and/or you and partner(s) require any other reproductive tissue to form your family?
 - g. Will you and/or you and your partner(s) use reproductive technologies to form your family?
 - h. Do you and/or you and your partner(s) want to adopt?
 - i. What do coparenting look like for you and/or you and your partner(s)?
5. How was your relationship with your parent(s) growing up?
- a. Were your parent(s) supportive when you told them you were transitioning?
 - b. (If mentioned) Were your parent(s) upset when you told them you did not want to have children/biogenetic children?
6. What support systems do you currently have? Do you use social media such as META groups to find out information about family formation and fertility?
7. Do you think that there's more of a shift now or more pressure for trans and non-binary folks to have biogenetic children?

Conclude interview:

- Provide a list of resources I collected for the interview participant and let them know I was available via email to answer any questions.

The interview questions I asked were supplemented by probes. A probe is a comment, question, prompt, or follow up a researcher might use in an interview setting to ensure that specific information is provided by participants and elaborated upon (Turner, 2010). Probes were

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either predetermined or unscripted. Predetermined probes were included in the interview guide. For instance, if interview participants mentioned having children in their survey, I inquired about how their children came into their care. Unscripted probes were created during the interview to address statements made by the interview participant more profoundly. Commonly, when they mentioned their medical transition, I asked if they were aware of their fertility options at any point during that transition. If participants mentioned barriers to fertility preservation in the survey, I used this information to ask additional questions or direct participants to address their insights. Some probes were formulated to meet the three objectives I set out for this thesis. I asked: Tell me about your experiences with your current primary healthcare professional. Are you still seeing the same professional when you began your medical transition? Do you believe they provide clear information about your fertility options? How do you assess your healthcare professional in terms of providing for your reproductive needs as a transgender person? These questions pertained to Objective 3 of the thesis, which sought to determine any positive or negative experiences impacting the participant's access to care, quality of care, and/or health. This probe also addressed Objective 1 and 2 regarding understanding what impedes individuals from freezing their eggs. Some participants mentioned lack of knowledge about egg freezing, not knowing about egg freezing at all, and lack of funds to be reasons for not partaking in egg freezing.

After each interview, participants were provided with three helplines and an extensive list of TGGD resources, including community health centers, parenting groups for 2SLGBTQQIA+ parents, and the Trans Help Line. Such resources constitute an ethical step critical to ensuring “support and guidance” for participants in research interactions (Husband, 2020, p. 216). While the Ethics Board of the University of Ottawa requires three resources to be provided to all thesis

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participants, I employed a more trans*-epistemological approach (Radi, 2019) by also providing extensive resources on egg freezing, fertility clinic use, and family formation to participants and other TGGD folks who desired the information. While academic research on TGGD individuals is meant to benefit communities, it commonly falls flat, lacking accessibility and impact on a community-based level (Owen-Smith et al., 2106). Many TGGD individuals also commonly lack access to basic health information of TGGD individuals (Safer et al., 2016), especially when it comes to conception and reproduction (Riggs et al., 2020) meaning that providing such resources is also prioritizing the health of the TGGD community. TGGD communities (Halberstam, 2018), youth (McBride & Neary, 2021), and allies remain united in our struggles against cisnormativity.

Interview Transcription

I found that interviews came to a natural conclusion, but some participants wanted to speak off the record after the interview ended. Off-the-record communication was not included in the interview transcripts. Speaking off-the-record commonly included checking in regarding how the participant was feeling post-interview, adding any resources, thoughts, or moments of empathy that I did not feel comfortable contributing while in interview, and thanking them again for their time. Some off-the-record discussions were shorter, and some were over an hour in-length. Once the interview was completed, all transcriptions were transcribed by Otter.ai. I paid the monthly subscription fee for Otter.ai and used it exclusively to ensure consistency. Once completed by the online program, transcripts were copied and pasted into a Microsoft Word document to be reviewed. At this point, I listened once more to each interview and adjusted the wording in the transcripts as required. This stage also allowed for a review of emerging themes. The transcripts were stored on a personal laptop that was locked in my home office, and the

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laptop was password protected. Fillers such as “mhm” and “um” were excluded from the transcripts and were omitted by Otter.ai. Once completed, transcripts were converted from a Word document into a PDF document and emailed to participants to review. Initially, each participant agreed to one week to approve the transcript; however, this time varied.

If a participant shared complex or sensitive personal information or experiences, they were able to take more time to determine what they wished to have included in or excluded from the transcripts. Providing flexibility was part of this thesis’ intersectional, trans*-epistemological, and ongoing consent framework that sought to not retraumatize participants but to provide them with the tools and time required. No participants requested extensive revisions or removed any content from their transcription; however, minor revisions such as removing a filler word such as “like,” as well as the revision of dates and clarifications regarding the spelling of names were made. Permitting participants to adjust their transcripts gave them increased autonomy. It allowed them to reflect on their experience, catch any miscommunication, and add anything they wanted to contextualize or elaborate upon the interview. This practice aims to ensure that all participants are comfortable with the content, and that ongoing consent is achieved.

Qualitative Data Results and Thematic Analysis

All interviews were analyzed using thematic analysis. Thematic analysis has been used by various research topics relating to TGGD individuals, including employment and employment experiences among TGGD individuals (Brewster et al., 2013; Krishna & Sharma, 2024), voices of educators and educating TGGD students (Martino et al., 2022), and representations of TGGD individuals in media (Arbatani et al., 2016). Thematic analysis has been used regarding TGGD

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individuals in healthcare specific fields including reproductive and sexual healthcare (Gerritse et al., 2018; Mendieta & Vidal-Ortiz, 2020; Asklöv et al., 2021; Agénor et al., 2022), contraception (Gomez et al., 2020), fertility preservation (Wingo et al, 2018; Riggs & Bartholomaeus, 2020; Armuand et al., 2020; Lai et al., 2021; Ker & Shaw, 2024), pregnancy and birth (Charter et al., 2018; Besse et al., 2020; Fischer, 2021), pregnancy loss (Riggs et al., 2020), and even about TGGD individuals considering parenthood (Tasker & Gato, 2020).

Thematic analysis is an interdisciplinary method commonly used to analyze data including participants' unique experiences to highlight beliefs, ideas, and feelings (Castleberry & Nolan, 2018). Braun and Clarke's (2006) approach to thematic analysis was used in this thesis to identify "patterns of shared meaning" (p. 593) found "deep within the data" (p. 591). Data sets analyzed using this method included all qualitative data including the nine in-depth interview transcripts, qualitative data from surveys, and my own research journal. This thesis sought to discover how key themes such as egg freezing, conflicted hope, and biogenetic parenthood were or were not connected for TGGD individuals living in Ontario. While the meaning of biogenetic parenthood, reasons for or against egg freezing, and potential experiences of conflicted hope were central themes, thematic analysis allowed for separate accounts on a theme to be examined side by side. While participants were all asked about their desire for biogenetic parenthood; their lived experiences, thoughts, feelings, and opinions differed. Thematic analysis allows for a theme to be explored without requiring all participants to share the same meaning for the theme (Braun & Clarke, 2006).

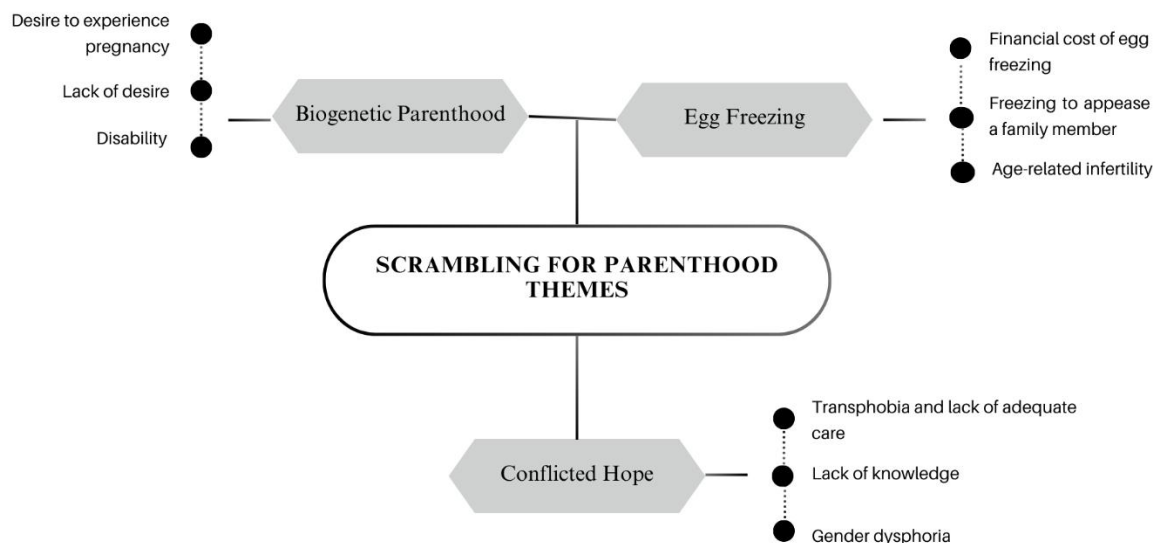
Using thematic analysis, themes were identified throughout the qualitative data sets. Based on the objectives and research questions of this thesis, three initial themes were coded. Coding is a term used to describe the decision-making process used during data analysis to

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determine if/how data relates to a given theme (Elliott, 2018) or may become a theme itself. All coding was done in-vivo by the researcher without the use of data analysis software. A theme book containing all codes was created using Microsoft Excel. All coding was done using different coloured highlighter in the interview transcript, qualitative survey data, and my research journal. Coded excerpts that were previously highlighted in the interview transcripts were later copied into the theme book where all coded themes could be collectively reviewed.

Coding for this thesis began once a participant had approved their transcript and all corrections were made. The first review of each transcript included coding for the themes of conflicted hope, biogenetic parenthood, and egg freezing. After the initial review, other themes were seen to be emerging in interview transcripts. A secondary theme was identified if the topic was addressed by numerous interview participants. When a secondary theme was determined, all interview transcripts were reviewed again to ensure coding of the new theme. Secondary themes that emerged from biogenetic parenthood included lack of interest in biogenetic parenthood, desires for pregnancy, and disability. Secondary themes in egg freezing included financial cost, freezing eggs to appease a family member, and age-related infertility. Finally, under conflicted hope, secondary themes that emerged included a lack of knowledge about fertility preservation, gender dysphoria, and transphobia and inadequate healthcare (See mind map below).

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Map A: Scrambling for Parenthood Themes***Themes in Qualitative Survey Data***

Themes in qualitative survey data were determined using initial three themes of biogenetic parenthood, egg freezing, and conflicted hope. In the survey, participants were asked if they experienced any barriers to egg freezing. Q26: Have you experienced any barriers to freezing your eggs? If so, what were they? Fourteen of the 21 participants answered this question and ten participants provided experienced barriers. Qualitative survey data demonstrated that there are barriers to egg freezing including financial cost (mentioned by nine participants); waiting to go on HRT (mentioned by one participant); previous hysterectomy (mentioned by one participant); no offer of egg freezing options or information about egg freezing (mentioned by two participants); a lack of interest in egg freezing (mentioned by one participant); and the egg freezing procedure was too invasive (mentioned by one participant).

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Conclusion

Following the survey process, nine survey participants continued to the in-depth, semi-structured interview process. Interviews were conducted via Zoom, and each lasted approximately 45-60 minutes in-length. Interviews and data analysis utilized intersectional thinking, queer theory, trans*-epistemology, alongside the practice of ongoing informed consent. Following all interviews, I reflected for 30-minutes using my research journal. My research journal was a critical form of autoethnography that allowed me to explore my feelings as a transgender researcher engaging in research within my own community. When transcribing interviews, Otter.ai was used and transcriptions were reviewed and adjusted. All interview participants were provided with the opportunity to review and revise their own transcript. Once transcripts were approved, all transcripts were coded and analyzed using thematic analysis using the initial themes of biogenetic parenthood, egg freezing, and conflicted hope. Additional themes that arose from the interview data included COVID-19, family formation over biogenetic parenthood, quality of care provided to participants, barriers to adoption, barriers to egg freezing including cost, COVID-19, physical risks, lived experiences of disability and how these impacted perceptions and desires for parenting. The next chapter will provide an in-depth exploration of each interview participant's contributions during their interview and their reflections on all the themes they addressed.

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Chapter 5: Freezing Time in a Frozen World? Interview Data Results

“When I began my dissertation, I wondered if biogenetic parenthood would be as important for TGGD individuals as it is for cisgender and heterosexual individuals? I worried about who was told about egg freezing and other fertility clinics services. Does a white, male, genetic legacy come into play? Does compulsory parenthood get pushed on TGGD individuals as well? Do TGGD individuals feel the same gender-based pressures they are raised with? I was surprised by the results of the interviews, pleasantly surprised.”⁹⁸

Coding began after the final interview had been completed, and transcriptions were reviewed and approved by all nine interview participants. The coding process identified the initial themes of biogenetic parenthood, egg freezing, and conflicted hope in interview participants’ transcripts. Secondary themes that emerged from the theme of biogenetic parenthood included lack of interest in biogenetic parenthood, desires for pregnancy, and disability. Secondary themes that emerged from the theme of egg freezing included financial cost, freezing to appease a family member such as mother, and age-related infertility. Finally, under the theme of conflicted hope, secondary themes that emerged included lack of knowledge about fertility preservation, gender dysphoria, and transphobia and inadequate healthcare. This chapter is dedicated to exploring how the nine interview participants demonstrate the experience of conflicted hope in their responses.

Theme 1: Desire for Biogenetic Parenthood

Among many cisgender, heterosexual couples, biogenetic parenthood is not only prioritized but idealized (Mamo, 2007) as the ultimate means of family formation. While TGGD individuals and their cisgender counterparts desire parenthood at similar rates (Tornello & Bros, 2017; Neblett & Hipp, 2019), TGGD individuals commonly do not consider biogenetic

⁹⁸ Research journal excerpt, 06/15/2022.

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parenthood important (Goldberg & Allen, 2022). A recent 2023 US study found many of their 10,270 TGGD sample aged 18 to 44 desired future biogenetic parenthood (Kyweluk et al., 2023). However, biogenetic parenthood was not a significantly sought-after goal for most interview participants in this thesis. While this thesis centered around egg freezing, other forms of family formation become highlighted. For many interview participants, the prospect of egg freezing took a back seat to non-biogenetic means of family formation such as adoption, fostering, or mentorship. Even among interview participants seeking to use biogenetic methods of family formation such as pregnancy, biogenetic connections were not necessarily a priority.

Of the nine interview participants, MK, Olive, and Logan mentioned possibly wanting to become pregnant in the future, and Seth had already been pregnant and given birth. In contrast, Charlie, Salem, Milo, and Ollie were not interested in future pregnancy. While MK, Olive, and Logan noted the possibility of a future pregnancy, only MK mentioned biogenetic parenthood as being something they would be interested in. MK was the only participant in this thesis who spoke about biogenetic connection as being truly desirable.

Secondary Theme: Pregnancy and Desires for Biogenetic Parenthood

Of those who were considering future pregnancy, including MK, Olive, and Logan, Olive and Logan did not care about the biogenetic link between themselves and their child. Instead, Olive and Logan discussed their desires for the *experience* of pregnancy. Logan specifically had been fascinated with pregnancy since he was a child, and Olive and their partner each desire to carry at least one of their children in the future. For Olive:

I quite enjoy the idea of being pregnant and having a child and being a parent to that kid or multiple kids. Whatever way that looks like, I'm very interested in that. My partner

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and I are both working towards [pregnancy] in our futures... we are both very familiar with the different ways that you [can] find your own family, and how family is not biological all the time. So, I'm not really concerned about that.

During their interview, Olive spoke openly about the idea of pregnancy and the various methods to pregnancy they and their partner could have. For Olive, the idea of having children that were biogenetically related to them was not a key concern. Olive's partner felt the same lack of prioritization of biogenetic parenthood towards their future offspring. However, Olive and his partner felt a biogenetic connection between their children would be desirable. While Olive would become pregnant and give birth to one child, their partner would become pregnant and give birth to the other child, however, they could ensure the children were biogenetic related *to each other* through a shared sperm donor. The children would share one biogenetic parent, making them half siblings. Olive claims:

I think it'd be fun, because then they [the children], especially if we use the same sperm donor, then they'd have some sort of biological tie to each other as siblings in a way too, which, again, to me, isn't the be all and end all.

Olive was not the only interview participant who wanted to experience pregnancy. Logan also mentioned wanting to become pregnant in the future. For him, pregnancy was something he had thought about since childhood. Despite experiencing “a lot of bottom dysphoria,”⁹⁹ throughout his life, Logan explained that pregnancy for him felt desirable even if it was “very contradictory” and complex:

⁹⁹ Bottom dysphoria is a specific aspect of gender dysphoria where the individual experiences discomfort that occurs based on the individual's feeling that their genitalia does not match their gender identity (Emisil, 2021).

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One, I have a lot of bottom dysphoria, and I just can't stand anything touching down there... which was the main reason it kind of triggered me to question what my gender was. Yeah, and the second one, which is extremely contradictory, is that I've always, ever since I was a kid, I've always wanted to carry my own child.

Pregnancy and birth for TGGD individuals can be a very desirable lived experience, even among those who are not prioritizing biogenetic parenthood. At the same time, it can also be very difficult for some TGGD individuals to navigate, especially when considering how experiences of bottom dysphoria can seem to conflict with one's future parenthood. Like Olive and Logan, MK wanted to become pregnant in the future. However, unlike other interview participants, MK placed importance on biogenetic parenthood. While MK did not fear experiences of bottom dysphoria as a barrier to pregnancy, MK was cognisant of the difficulties of being pregnant as a non-binary person. Like Olive and Logan, MK wanted to experience pregnancy and birth but also noted some of the barriers they would experience such as lack of resources for non-binary pregnant people.

Of all the interview participants in this thesis, MK was the only interview participant to demonstrate an interest in future biogenetic parenthood. MK seemed to desire a biogenetic connection with their future child however, they were also open to other forms of parenthood. For MK, biogenetic connection was linked to a deeper meaning of family belonging. They stated: "like, I hate, I hate saying this, but I want a person who belongs to me. I want to create something [and], to be part of something bigger?" MK reflected of the weight of their thought, claiming "I hate saying this." By beginning their feelings with this statement, MK acknowledged how their coming words might have an impact on the perception I had of them. MK asserts "I want a person who belongs to me" which could be linked to their deeper desires for feelings of

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family belonging. This deeper need for belonging is a common experience among many 2SLGBTQIA+ individuals, especially among TGGD individuals who feel neglected by their families (Troia, 2021). At the same time, MK strongly identifies with queer personhood, stating “you know, I’ve pretty much never done anything in a conventional way.” They are “prepared to do what they need to,” to form their future family. MK’s key concern when it comes to biogenetic parenthood include age-related infertility and partnership.

Finally, Seth had already been pregnant. Seth had become unexpectedly pregnant and given birth to his oldest child prior to transitioning. Of all interview participants, Seth was the only one who was already a parent. Seth had given birth to one child, B, and later adopted his second child, M. Seth’s experience of pregnancy was not intentional; however, he refers to the experience as being a “cool” one. While the idea of pregnancy as a pleasant experience is steeped in gender socialization, Seth’s enjoyment of pregnancy seemed to surpass his lived experience of feminine childhood gender socialization. Despite having one biogenetic child and one adopted child, Seth felt the same connection with both of his children. Seth claimed:

So, I guess that I hate to say this, anyway, I’m just gonna say, there is no difference to me. Sometimes I forget that I didn’t give birth to M, or, you know what I mean. You know people often wonder if it’s gonna feel different, and it doesn’t for me. So, there was no true benefit to biologically parenting B over adopting M for me, other than I guess, I got to experience pregnancy, which was a cool experience.

Despite having given birth to his eldest child, Seth clearly believes that there is no distinction in connection or feeling towards his adopted child. Seth explored this belief further by explaining that he forgets that he did not give birth to M. Pregnancy for Seth was not to prioritize biogenetic parenthood, but rather, began as an unexpected pregnancy that led to a beautiful

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relationship with one biogenetic and one adopted child. As the only interview participant who has children, Seth is an excellent example of how many interview participants felt about biogenetic parenthood.

Secondary Theme: Burning Desires or Lack of Desire for Biogenetic Parenthood?

Andy, Charlie, Salem, Milo, and Ollie were all disinterested in future pregnancy. Despite their lack of interest, each explored various ways they wanted become parents in the future. Many interview participants had various intentions regarding future family formation, however, one similarity was found: a lack of desire for biogenetic parenthood.

Like some other interview participants, Charlie was not keen on biogenic parenthood. Charlie spent their interview discussing possibilities for future family formation. Charlie remained very fond of children but clearly illustrated that having children who are genetically related to them is not foundational to parenthood. As someone who is pansexual, Charlie mentioned that they could end up with a partner who may or may not be able to create biogenetic children with them. Despite their love of children, Charlie does not believe in the importance of biogenetic connection:

I've always really like[d] kids. I'm not the kind of person who is like, 'I'm never gonna have kids.' I do think at some point, I will have kids; I just think that this whole obsession with biological material is not something that fits into my worldview.

During their interview, Charlie claimed biogenetic parenthood does not feel like it “fits into my worldview.” Charlie is not simply disinterested in biogenetic parenthood but is opposed. They disagree with the “worldview” that prioritizes genetic procreation. When asked about desires for biogenetic parenthood and egg freezing Charlie said: “if that's something, someone needs to

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feel fulfilled in life, or whatever, then it is what it is.” Charlie distances themselves by saying that they don’t require biogenetic parenthood to feel fulfilled, however they acknowledge others might. While many interview participants do not feel drawn to biogenetic parenthood, some remain sympathetic to the importance biogenetic connection may have to others. Another interview participant, Logan noted similar feelings to Charlie saying:

Yeah, I think genetic parenthood is starting to get less important to some people and more important to others. Like I've noticed that genetic parenthood seems to be very important, or seems to be very important for cisgender men, which is interesting... I've heard of a couple instances where people later find out they [the sperm bank or fertility clinic] used the wrong sperm, woo. Which worries people because a lot of people want to know all the medical history of their [donor]. But yeah, there seems to be a lot less of that, like, among more secular people.

Logan mirrors Charlie’s thoughts and adds that he had observed a strong connection between biogenetic parenthood and masculine gender identity, especially among cisgender men. Again, this concept of belonging and biogenetic connection is highlighted. While MK discussed biogenetic connection and wanting a child that belongs to them. Logan later uses similar phrasing in his interview, talking about how some individuals seek out parenthood with a child that is “biologically yours.” Logan feels the desire to have biogenetic connection between parent and child is a strong component to masculine gender identity and paternity. During his interview, Logan provided an example of how he felt this connection was evident in his own family. Logan notes:

[A] relative [of mine] split up with his longtime wife after finding out that his youngest son wasn’t really [biogenetically] his. And so, his youngest son is not in his life anymore.

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His two oldest [biogenetically related] sons are. But yeah, he doesn't really consider his youngest son, his son [anymore], even though he raised him from like [the age] 6 [for] 15 years.

Logan uses his male family member and his wife's separation for reference as an example of how biogenetic parenthood is coveted in his own family. Logan focuses on the fact that despite his male family member's extensive and loving relationship with his youngest child, he refuses to acknowledge this child as his own after discovering that he was not the child's biogenetic father. However, his male family member maintains a relationship with his other children whom he is the confirmed biogenetic parent. The way Logan linked masculine gender identity, legitimacy of paternity, and biogenetic connection was particularly interesting. However, this link may be stronger among cisgender men than it is among TGGD individuals. In this thesis, even among interview participants who identified with a more masculine gender identity there was a lack of this deep and significant desire for biogenetic legacy.

For instance, after coming out as a transgender man and being on HRT for years, Milo froze his eggs. Milo, the only participant who froze their eggs, was vocal regarding his lack of desire for biogenetic connection. After learning he was able to cease HRT to freeze his eggs, Milo decided to go through with the process of egg freezing. Despite having frozen his eggs, Milo remained open to both biogenetic and social means of family formation. He claimed, "I didn't have the mindset of like, oh, I really want to have a biogenetic child... I want the option to be there." Milo and his husband presented an interesting case should they choose to have biogenetic children together. Milo reflection on how biogenetic parenthood would be complicated to explain as a gay trans man in a relationship with a gay cisgender man. Milo claimed that he would be put in situations where he would have to explain that he and his

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husband were biogenetic parents to a child, forcing Milo to disclose he is transgender. As a gay man, Milo also felt less societal pressure to become a biogenetic parent since it is not typically expected of gay male couples. Milo concluded: “it’s almost like we have this special option as like, a gay couple to have a biogenetic child.”

Milo acknowledged there is a small likelihood of becoming a biogenetic parenthood using his frozen eggs because of the low success rates of egg freezing and In-Vitro Fertilization. In one successful round of In-Vitro Fertilization at least 10 viable fresh or frozen eggs are typically required to have a 69% chance of one live birth (Armstrong, 2023, n.p). During his egg freezing retrieval, Milo had 11 viable that were extracted and successfully frozen eggs for future use. This means statistically speaking, Milo may or may not have one biogenetic child that comes from his frozen eggs. Milo and his husband discussed wanting at least two children in the future. This would require them to adopt at least one child, perhaps more depending on the success of his frozen eggs leading to a live birth. Milo was very open to the idea of biogenetic and social means of family formation.

For some interview participants, biogenetic parenthood was a possibility, while for other interview participants social kinship was desired. Andy, Salem, and Ollie all stressed they wanted to form their families outside of biogenetic means, highlighting social bonds over biogenetic ones. For Andy, biogenetic parenthood was not important to him or his partner. Andy stated: “you know, there's more to life than just, you know, making babies, and then raising babies” and “as far as me having biological children, I am rather disinterested or indifferent.” Andy denounced the importance of biogenetic connection or blood-based relationships, stating:

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Family by blood doesn't matter at all but at the end of the day, like when you're coming home to your family, it's not important as to whether they're related to you by blood or not. It's the bond that you share with that person that's way more important than, I guess, actual kinship via blood.

For Andy, family is about the strength of the relationships of family members as opposed to the blood-based or biogenetic connection. Andy and his partner had several reasons for not prioritizing biogenetic parenthood including their lived experiences with disability. While Andy and his partner may want to become parents in the future, they would happily engage in alternative means of family formation such as adoption. In any case, for Andy, children in general are not a given:

We're not carrying children. As far as having children, whether it be biological or not, I don't think it's much of a priority. But I've also haven't really seen much reluctance, reluctance from my partner as far as having non-biological children. So, adopting or, you know, whatever else fostering, but as far as I'm concerned, we're both not super keen on having actual [biogenetic] kids.

Like Andy, another interview participant Salem did not find biogenetic connection to offspring important but had the potential for future parenthood. For similar reasons, Salem felt that he did not want to have biogenetic children in the future for fear of passing of certain genetic traits. Salem concluded, "I am just not super into the idea of my own biological children." While a lack of desire for biogenetic parenthood for Andy and Salem is based in disability, another interview participant, Ollie stated:

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When I was starting off my university career in the environmental studies, like climate change was a big thing in my head. And I was like, I don't think I can bring another human into this world. I can absolutely help take care of humans already in this world.

Like other interview participants considering adoption and fostering, Ollie found that the best way to parent was to ensure children who need a loving home were provided with one. 2SLGBTQIA+ individuals are commonly left without safe spaces and homes as youth, inspiring many to choose adoption as a future means of family formation. At the same time, Ollie described the connection between climate change and caring for those who are currently inhabiting this world. It aligns with other interview participants who disregarded biogenetic connection and prioritized family formation where social kinship and other social factors were key.

Secondary Theme: Disability

Given the significant number of participants that self-identify as living with a disability and/or as neurodivergent, it was critical to address the intersections of transness, disability, and biogenetic parenthood. There remains a lack of discussion regarding disability and TGGD identity (Baril, 2015b), especially when it comes to desires for biogenetic parenthood. Of the nine interview participants, eight self-identified as living with a disability and/or as neurodivergent. While Milo does not identify as neurodivergent, he did outline how mental health concerns affect his desires for biogenetic parenthood. At the same time, mental health is a key component to lived experiences of disability (Centre for Addiction and Mental Health, 2024). While Andy, Charlie, Olive, and Salem did not disclose specifics regarding their lived experience, or how they self-identify, MK self-identified as living with a “non-verbal learning

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disability,” and Seth, Logan, and Ollie all self-identified as being on the autism spectrum. Some interview participants mentioned their partners also live with a disability and/or neurodiversity, creating additional layers to discussions of biogenetic parenthood. The intersections of disability and biogenetic parenthood were explored by Andy, Salem, Charlie, and Milo, some of whom were motivated against biogenetic reproduction based on their lived experiences.¹⁰⁰

Unlike other interview participants, Andy discussed a lack of desire for biogenetic parenthood. This was based on his lived experiences, but more importantly centred on his partner’s. Despite having called a fertility clinic to appease his mother, Andy and his partner “we’re both not super keen on having actual kids” who were biogenetically related to them. Andy notes his partner was born with birth defects they fear might be genetically passed on. While Andy would not pass this potential to their offspring, the couple collectively decided they wished to prioritize adoption. While Andy himself was to be the one freezing his eggs, the overarching conversation regarding disability was a common thread among several interview participants. Other interview participants noted their own live experiences and the lack of desire for biogenetic parenthood.

Fear of passing on certain traits was mirrored by several interview participants. In his survey, Salem commented: “I do not want any biological children. I fear the disabilities that run in my family would pass to the child and that they would have as hard a time as myself.” Salem later restated: “I have a bunch of disabilities in my family history that I wouldn’t really want to

¹⁰⁰ Note interview participants did not stress a desire for their children to be able-bodied or atypical. However, their reflections were based on experiences of chronic conditions or ongoing pain they did not want a child to endure. Disabilities and neurodiversities remain on a spectrum, meaning many lived experiences are unique to the individual. While there is a strong component between disability and genetics (Koi, 2021), every individual will have their own lived experiences.

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see a child go through. So, I [am] just not super into the idea of my own biological children.”

During his interview Salem explained that once he unpacked his TGGD identity, he also found the thought of pregnancy unappealing. Salem later elaborated that if they were in a different position where they desired pregnancy, it might be a different experience. Concerns regarding biogenetic parenthood for him related to the potential to genetically pass on “a bunch of disabilities” or “mental health things” to his offspring.

For Charlie, living with a disability manifested in physical forms. While Charlie did not openly disclose the specifics of their disability, they spoke briefly about being “very certain in the fact that my body is not made to make humans.” Charlie did not elaborate whether pregnancy would be too difficult for their body, or if they feared their biogenetic offspring would also have to live with a disability. Regardless, Charlie is among those who mentioned the intersections of biogenetic parenthood and disability during their interview.

Finally, another link between disability and biogenetic parenthood was made by Milo. While Milo did not identify as living with a disability and/or as neurodivergent, he mentioned key mental health considerations. While Milo froze his eggs, he was very concerned about having a biogenetic child:

I also didn't want to have a genetic child because I didn't want them to have like the same mental health issues that I was having. I was like, oh, if I carry the child there's chance that they might have the same mental health struggles that I was having at the time, like when I was [in my] early to late teens, and early 20's. And so that was a big thing. I was like, I don't want to pass that down. So, I was like, I don't really want a genetic child for that reason.

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Despite this fear, Milo went through with freezing his eggs. While some interview participants refused to biogenetically reproduce due to their concerns regarding passing on certain forms of disability, Milo's decision to freeze his eggs showed differently. At the same time, Milo also noted that the potential of having a children come from his frozen eggs was less likely based on only have 11 viable eggs frozen. This could mean Milo either is unsure about whether or not his eggs will be used, if their will yield a live birth, or he may have decided his mental health concerns would not impeded his decision to freeze his eggs.

All interview participants who discussed disability and the possibility of passing traits onto biogenetic children highlighted the struggle of living with certain forms of disability and/or mental health concerns. This discussion was incredibly important. These interview participants were not rejecting biogenetic children living with a disability and/or neurodivergence. However, they did not want any future biogenetic offspring to experience certain forms of disability that are chronic and painful, or the harsh impact of mental health concerns that come with some forms of disability. Nor would they want these children to experience the same physical and mental difficulties they have faced themselves.

Theme 2: Freezing Time and Biogenetic Parenthood

The second key theme in this thesis was egg freezing. Egg freezing remains one of the most heavily utilized reproductive technologies (Braich et al., 2024). However, use among TGGD individuals remains low globally. This thesis found of all survey and interview participants living in Ontario, only two individuals had interacted with egg freezing. However, interview participants Seth and MK also mentioned egg freezing in some capacity. As mentioned, only one interview participant, Milo froze his eggs, and another, Andy, was

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interested in learning about egg freezing from a local fertility clinic. Seth and MK mentioned the option of egg freezing. While the potential benefits of egg freezing were discussed by interview participants, many survey and interview participants cited the various barriers they would have to egg freezing.

Regardless of gender, barriers for those seeking to freeze their eggs can include medical risk, high financial cost, and uncertain success rates. Like cisgender women, many TGGD individuals must consider the impacts of age-related infertility, as they can also feel the pressures of the biological clock. Unlike their cisgender counterparts, TGGD individuals may also experience additional anxieties when considering freezing their eggs. Additional concerns for TGGD individuals can include an increase in gender dysphoria because of the need to cease or delay HRT during the egg freezing process. Concerns regarding the medical risk, high financial cost, uncertain success rates, and gender dysphoria can act as barriers to accessing egg freezing in a timely manner.

Of those who considered freezing their eggs, Milo was the only interview participant who completed the process. Milo froze his eggs in 2020, during the beginning of COVID-19, through Mount Sinai Fertility Clinic in Toronto. During his time as a nursing student, Milo was able to attend a conference dedicated to TGGD healthcare. During the conference, Milo learned that despite being on HRT for many years, he was still able to temporarily cease HRT and freeze his eggs. After discussing their options, to either freeze Milo's eggs or fertilize and freeze embryos using Milo's eggs and his husband's sperm, Milo and his husband chose to freeze Milo's eggs. At the time, freezing embryos was more financially costly and would require Milo's husband to travel from Ottawa to Toronto for fertility clinic appointments during COVID-19. Despite living in Ottawa, Milo chose to freeze his eggs at Mount Sinai Fertility Clinic in Toronto, based on it's

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positive recommendations by other TGGD patients. Milo's decision to freeze his eggs was not based in the typical desire for biogenetic parenthood, but in his mid 20s, he was focused on concerns regarding age-related infertility.

The second interview participant who interacted with egg freezing was Andy. In contrast to Milo, Andy did not freeze his eggs. Rather, Andy contacted the Ottawa Fertility Centre in 2020, during the beginning of COVID-19, to learn more about egg freezing. At the time, due to increasing COVID-19 illnesses and provincial lockdowns, the Ottawa Fertility Centre was not taking on new patients. Andy left a message with the clinic's voicemail system and assumed he would be contacted when the clinic was accepting new patients again. However, at the time of our interview, over a year following his call, Andy had not received a call from the Ottawa Fertility Centre, nor had he reached out again. Instead, Andy said: "I'm probably going to be talking to my endocrinologist about that as soon as I have my appointment with her at the end of the month. Like, it's on the to do list."

Milo and Andy had taken steps to freeze their eggs or learn about egg freezing, however, two other interview participants considered what egg freezing would mean for them. MK remained open to the idea of freezing their eggs in the future and Seth discussed how he would have considered freezing in the past had it been accessible. For MK, egg freezing was only one of the possible options for future parenthood. They stated: "I'm prepared to do what I need to. And at some point, I'm probably going to bring this up with my doctor... so, you know, I could potentially freeze [my] eggs." While MK was open about the desire for future parenthood, both biogenetic and non-biogenetic, they were influenced by their fear of age-related infertility. Like Milo, MK felt their age was a key factor in their journey to parenthood and wanted to ensure they had different options.

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While MK noted they could still freeze their eggs for future use, Seth reflected on the past. Despite his lack of interest in freezing his eggs now, Seth mentioned that he would have been more open to the idea of freezing his eggs earlier in his life, prior to having children. If Seth had frozen his eggs prior to medically transitioning, it would have been an interesting case study for the difference between TGGD individuals who use SEF prior to medically transitioning and those who engage in MEF before beginning, or after having medically transitioned. Ultimately, Seth claimed he would have been interested in egg freezing if the barriers were not too stringent. Seth was causal in his explanation:

You know, like if it was something that was not at a great expense to me, physically and financially, then it's something that I probably definitely would have done, because it's just a positive thing that I could do.

Seth claimed egg freezing could be a “positive thing I could do,” he did not consider egg freezing as an additional option in future family formation, nor a remedy to age-related infertility. Rather, if it was not too stringent in its barriers, Seth claimed egg freezing could have been a positive thing for him if he was able to donate unused eggs in the future. Providing the opportunity for others to use his eggs in their future family formation. Seth was the only interview participant who considered egg donation as a potential reason to freeze one’s own eggs. While almost half of all interview participants discussed egg freezing, one interview participant had frozen his egg due to age-related infertility, one interview participant had called a local fertility clinic for additional information, one interview participant could still freeze their eggs in the future, and another considered the implications of freezing in the past prior to parenthood.

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Secondary Theme: Financial Cost

Despite the number of interview participants who were thinking about what egg freezing would mean for them, some continued to outline the struggle of financial feasibility of egg freezing. Financial cost can be an extensive barrier to egg freezing and other reproductive technologies (Nadgauda & Butts, 2024) regardless of one's gender identity. Both cisgender women and TGGD individuals can experience the financial pinch of family formation using fertility clinic services. This thesis yielded similar findings. In survey data, of the ten participants who answered the survey question inquiring about potential barriers to egg freezing, eight responded with financial cost. During interviews, Milo, Seth, Logan, Ollie, Olive, and Charlie mentioned financial cost as a deterrent or barrier to freezing their eggs. Survey and interview participants noted egg freezing had additional costs such as medications, travel, and storage fees that could become tedious. Others voiced how reproductive technologies such as In-Vitro Fertilization, surrogacy, and purchasing donor sperm were also expensive with, or without egg freezing. By itself, egg freezing can come with many hidden and unanticipated costs, including lost wages from requiring time away from work, the cost of transportation to and from a fertility clinic, lack of health insurance coverage (Inhorn et al., 2018), costs of medications and hormones required for ovarian stimulation and egg maturation, and annual storage fees for the frozen eggs (Walls et al., 2018; Defreyne et al., 2019; Moravek et al., 2018; Bartholomaeus & Riggs, 2019; Jones et al., 2016). While some survey and interview participants knew about the additional costs of egg freezing, many did not know what was covered under OHIP (See Appendix C) and what would need to be paid out of pocket.

When freezing his eggs in 2020, Milo was fortunate to receive partial financial coverage through OHIP since he was classified as freezing for medical reasons as a TGGD individual.

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Milo was excited for the financial relief but asserted: “it’s expensive, but like it’s not as expensive, if I had to pay for the whole thing.” Milo articulated the process was costly and he was responsible for several expenses, however, found it much more reasonable because he was able to use OHIP funding. The financial cost of egg freezing was also explored by Seth, who mentioned he might have been more interested in egg freezing in the past if it was more financially feasible. Seth claimed, “you know, like if it was something that was not at a great expense to me, physically and financially, then it’s something that I probably definitely would have done.” For Seth, egg freezing needed to be more accessible, physically, and financially for him to go through with the procedure. Another interview participant, Logan, also commented on the fact that egg freezing “would be pretty cost prohibitive,” with or without OHIP coverage. While Milo was open to paying the additional fees associated with egg freezing, Logan said, “I’m not gonna pay for that.” Logan considered the cost of egg freezing now, and the potential future costs that could occur when attempting In-Vitro Fertilization. Finally, Ollie made a strong connection between financial feasibility and other extensive costs he had to deal with outside of family formation, specifically student loans. Ollie had said to their endocrinologist, “oh, I can’t afford that as a student who has too much student loan debt.” While many survey and interview participants in the thesis are students, only Ollie mentioned the financial weight of student loans alongside the financial cost of egg freezing. For some TGGD individuals, they must prioritize different facets of life over future family formation.

For some survey and interview participants egg freezing was unimportant, not a viable option, or an unnecessary step for family formation. However, egg freezing was not the only reproductive technology mentioned by interview participants. For Olive, Charlie, and even Milo, the high cost of reproductive technologies generally was a factor.

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Financial cost of reproductive technologies remains difficult to manage, even with partial OHIP coverage:

- Egg freezing (vary depending on coverage).
- Sperm (\$750-1200 per vial as purchased from a sperm bank) (Ontario Fertility Centre, 2023).
- Surrogacy (\$18,000-\$33,000/child) (Surrogacy in Canada, 2023).

Among those who discussed the financial cost of reproductive technologies, Olive and Charlie both debated the cost of In-Vitro Fertilization, while Milo mentioned the high cost of surrogacy. For some 2SLGBTQQIA+ individuals, achieving biogenetic parenthood would require they seek out reproductive technologies. As explored, some interview participants would require sperm donors, In-Vitro Fertilization and/or surrogacy for family formation.

Olive mentioned that they and their partner could potentially need to use sperm donation and In-Vitro Fertilization to become pregnant in the future. Olive explained that while they do not know the exact cost of In-Vitro Fertilization, they know it “is very expensive, and if it doesn’t work then it doesn’t work.” For them “that kind of sucks because [if it doesn’t work that is] money down the hole.” Since both Olive and their partner wish to become pregnant in the future, there is a greater need to balance the success rates associated with In-Vitro Fertilization against the high financial cost of reproductive technologies. However, like many 2SLGBTQQIA+ individuals, Olive and their partner might be more comfortable using more low-tech options. During their interview, Olive noted they could use the more low-tech, do-it-yourself option of the “turkey baster” method at home to form their family. Olive and their partner were open to low-tech options and known sperm donors to reduce the financial cost of family formation for them, but they knew they may use reproductive technologies in the future.

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While Olive was open to different future possibilities, other interview participants like Charlie demonstrated a strong opposition to the reproductive technologies, especially In-Vitro Fertilization. For Charlie, the financial cost was too extensive, stating: “I think [In-Vitro Fertilization] is stupid, because it’s expensive. And there are so many children who need homes. So, I wouldn’t be necessarily super happy about paying for it.” Charlie’s disagreement with reproductive technology use reflects some capitalist critiques of how reproductive technologies idealize biogenetic parenthood while neglecting children who need homes.

Finally, Milo explored the unseen costs that could be associated with freezing his eggs. Since he does not want to become pregnant in the future, Milo and his husband would require a surrogate to turn their frozen eggs into a live birth. Once again, OHIP provides some financial coverage for surrogacy services, however, the costs can quickly add up. Milo had already paid out of pocket to freeze his eggs, and now was worried about the financial costs of other reproductive technologies such as In-Vitro Fertilization and surrogacy. Surrogacy remains a very complex reproductive process in Canada. According to the *Human Reproduction Act*, all surrogacy services in Canada must remain altruistic.¹⁰¹ Milo was somewhat knowledgeable about the costs of surrogacy because he and his husband had explored some of the legal repercussions of using a surrogate. Milo declared:

So, you’re not paying them [the surrogate] to carry your baby, but you’re still looking at like \$50,000, roughly, after legal stuff... [and] all the[se] things add up together, [and become] like, ridiculously expensive.

¹⁰¹ According to the *Human Reproduction Act*, all surrogacy in Canada, must be altruistic (2004). It is illegal to engage in commercial surrogacy in Canada. Altruistic means that the individual who is providing surrogacy services is providing services based on good will. Altruistic surrogacy means the individuals may only be financially compensated for the medical expenses associated with surrogacy (Health Canada, 2020).

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While financial cost was a key concern for Milo, he also feared the implications that moving outside the province of Ontario would have on his ability to receive this financial relief. Since OHIP only provides funding to those living in Ontario, Milo and his husband may find they are not provided with any coverage for In-Vitro Fertilization or surrogacy if they reside outside of Ontario. Milo and his husband could find they are forced to pay out of pocket to use their frozen eggs in the future. Financial cost acts as a barrier for Milo in many ways because he has already spent funds to freeze his eggs but may find he will not be provided any financial relief for In-Vitro Fertilization or surrogacy services in another province. Financial cost is therefore a complex barrier because it can determine where TGGD individuals choose to live when engaging in family formation and can keep them from other opportunities in their lives.

Secondary Theme: Tick Tock Goes the Biological Clock

While cost can be a varying factor, many, regardless of socio-economic status, are subject to the biological clock. Globally, age-related infertility remains one of the largest motivators for cisgender women to freeze their eggs (Harwood, 2009; Göçmen & Kılıç, 2018; Myers & Martin, 2020; Delbaere et al., 2020; van del Wiel, 2020; Varlas et al., 2021). In this thesis, age-related infertility was mentioned by two interview participants as a reason they had frozen their eggs, or a reason to freeze their eggs in the future. Both MK, aged 38, and Milo, aged 29, said that aging eggs were a concern for them. Age-related infertility appears to be a shared concern among both cisgender and TGGD individuals who consider freezing their eggs. While a recent US study by Jensen et al. found that among 990 female participants, pregnancy was achievable until the age of 46, (2017, p.1507), many still fear the biological clock. In Canada, the average age of new mothers between 2018 and 2022 has remained the same with many first-time mothers giving

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birth at 31 years of age (Statistics Canada, 2024, n.p). A 2019 US based study found of 331 TGGD individuals, the average age of parents was 26.52 years of age with 66 percent reporting conceiving children prior to their transition and 15 percent reported they conceived post transition (Tornello et al., 2019, p.237). Regardless of gender, the “fertility cliff” is a frightening prospect for those who fear they will be unable to reproduce within a narrow, age-determined, reproductive window (Waldby, 2015).

In this thesis, both MK and Milo noted fears regarding age-related infertility. MK was concerned about becoming pregnant at an older age, and Milo froze his eggs younger because he was concerned about decreasing egg quality over time. At 38 years of age, MK feared they would become pregnant at an older age, however, they also worried about what it meant to be an older parent. MK noted: “at this point, like, the biggest impediment is my age, I’m 38. And I don’t have piles of time.” MK’s concern demonstrates how TGGD individuals remain tied to the same reproductive timeline as cisgender women. While the ways of becoming a parent may be different among each collective, the desire against becoming pregnant and parenting older is shared. Like some cisgender women, Milo decided to freeze his eggs at a younger age to avoid this concern. Milo cited age-related infertility as a contributing factor to why he chose to freeze his eggs:

So, at the time, I was 25 or 26, I was in my mid 20’s. And I knew that my fertility would just start to decline over time from then on. So, I should do it [egg freezing] now before like, I get into my 30s. And then the chances of getting viable eggs decreases significantly. Like, you know what, this is the time to do it. [There were] a lot of different factors, I would say, but you know, together, they all made sense.

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Egg freezing was a way for Milo to remain proactive in his own reproductive future. As a technology, egg freezing commonly references reversing the biological clock or stopping time. For Milo, he felt his decisions for freezing his eggs aligned more with those freezing for social reasons and not those freezing for medical reasons. Despite being considered under MEF as a TGGD individual, Milo felt he was different from someone “who freezes for medical reasons” because of his fear of age-related infertility. This could be because Milo understands that prolonged testosterone use does not cause infertility in TGGD individuals, or he does not feel he aligns with those freezing “for medical reasons” such as those with a cancer diagnosis or reproductive diseases. Instead, Milo classified himself alongside other egg freezers who want to get ahead of the biological clock providing additional options for family formation in the future.

Similarly, MK noted their concerns regarding age-related infertility and egg freezing. Being an older parent was a key concern for MK, who was still considering freezing their eggs in the future. As explored, MK worried about advanced age in pregnancy, but they also brought up an important element of being an older parent, worrying about their energy. MK stated, “yeah... I don’t want to have a baby at 45; in terms of fertility, I feel fairly confident I will be able to give birth for a while [yet] but it’s also just having the energy [to be a parent].” Energy is one of the considerations that many older individuals must contemplate when engaging in family formation regardless of the biological clock. While MK did not freeze their eggs, the hardships of older parenting weighted on their minds, providing some challenges to freezing their eggs now. As seen in this thesis, both MK and Milo demonstrate a clear link between age-related and egg freezing. While Milo noted age-related infertility as being a motivator for him to freeze his eggs for future use, MK worried about their current age and how being an older parent would come

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into play. MK considered freezing their eggs now, but also contemplated the difficulties of parenting as an older adult.

Secondary Theme: Freezing to Appease Family

Freezing for family was a less common secondary theme among the interview participants, however, it is critical to note. International scholarship shows that many 2SLGBTQIA+ individuals feel pressure from their families to reproduce biogenetically (Nordqvist, 2017). Of all the interview participants, Andy felt the most pressure to provide biogenetic offspring to appease a family member, his mother. Other interview participants like Charlie were required to navigate a similar situation with their parents. Finally, while Milo, MK, Seth, Ollie, Salem, Olive, and Logan discussed how while their families wanted them to have children, biogenetic connection was not an issue for their families. Pressure to have biogenetic children was only experienced by Andy and for some time Charlie, while other interview participants were free to form families using non-biogenetic means.

As noted, Andy appeared the most concerned about biogenetic connection for the sake of his mother. He felt pressure to provide biogenetic offspring for his mother who is “very... fond of the idea of having grandchildren.” The topic of biogenetic offspring has become a point of disagreement between Andy and his parents. Andy’s partner is AFAB and non-binary,¹⁰² creating an additional barrier to biogenic parenthood since both Andy and his partner produce eggs. Andy notes that being in a relationship with another AFAB person, “kind of doesn’t work out super well for my parents [when it comes to] me having biological children.” Despite Andy

¹⁰² The sex assigned at birth of Andy’s partner is only medically relevant when discussing biogenetic means of family formation.

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and his partner's choice to prioritize social forms of family formation, Andy's mother was "very, very upset" at the possibility that Andy might have a full hysterectomy in the future. Andy's mother wishes he would keep his "options open." Andy commented: "I don't think they [my parents] really understand that [I don't want biogenetic children] because that's something that's a very big point of contention." Andy noted there was a strong disconnect between "my own dysphoria and my parents wanting to have grandchildren." Andy's mother was aware of the couple's choices against biogenetic parenthood; however, she continued to place emphasis on having a biogenetic grandchildren. Andy's decision to call the Ottawa Fertility Centre to learn more about egg freezing was purely motivated by his mother, and not his own parenting desires.

Another interview participant Charlie had a similar experience to navigate, however the outcome was very different. Like Andy, Charlie remains uninterested in biogenetic parenthood but wishes to adopt in the future. When Charlie originally discussed adoption with their family, Charlie heard their mother say, "stupid things" claiming how an adopted child "is not really your child." Unlike Andy's mother, Charlie's parents warmed up to the idea of adoption. Charlie said what changed his parents' perspective on adoption as a valid means of family formation was meeting their neighbours who had adopted grandchildren. Charlie noted: "that has very much changed the view that my parents have on the matter, and they've become a lot more supportive." For parents of 2SLGBTQQIA+ individuals, the idea of not becoming grandparents in the future can be a primary fear when their child comes out as 2SLGBTQQIA+ (Loewen, 2023). Andy and Charlie both demonstrate how exploring various ways of family formation can be tricky with cisgender, heterosexual parents. For cisgender, heterosexual individuals, the idea of not wanting biogenetic connection can be seen as a break down the nuclear family (Sardadvar & Miko, 2013). However, for many 2SLGBTQQIA+ individuals, adoption is a common means of family

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formation since many community members can not procreate using sexual intercourse (May, 1997) and reproductive technologies are a pricey and intrusive option. The desires for biogenetic grandparenthood and their own lack of desire for biogenetic children created complex tension for both Andy and Charlie. Despite their lack of desire for biogenetic parenthood, they will both form their families in their own ways despite familiar pressure.

Theme 3: Complicating Conflicted Hope

Conflicted hope is commonly associated with the lived experiences of cisgender, heterosexual women who freeze their eggs. Hope becomes conflicted for these women when they go to freeze their eggs and discover that egg freezing is neither as easy, nor as effective as advertised (Martin, 2010; Harwood, 2015; Jackson, 2018; Borovecki et al., 2018; Bhatia, 2021; Cameron & Garcia, 2023; Drost et al., 2023). They can quickly find that they lack the needed knowledge regarding the high financial costs, potential medical risks, and low success rates associated with freezing their eggs. This reality check leads many cisgender, heterosexual women to feel that they have been left out in the cold, without a baby or a backup plan. This can be particularly devastating for those who freeze for medical reasons since they may be unable to reproduce biogenetically with reproductive technologies following their medical intervention. Since TGGD individuals are classified as freezing for medical reasons, I was curious if conflicted hope would apply to their lived experiences of freezing their eggs. While TGGD individuals experience high financial cost, medical risks associated with freezing their eggs, and low success rates, they also have unique circumstances that could lead to conflicted hope including a lack of knowledge about egg freezing when they medically transition, gender dysphoria during the freezing process, and transphobia and inadequate care.

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Secondary Theme: Lack of Knowledge Regarding Egg Freezing

Despite guidelines promoting gender-affirming healthcare such as the *Standards of Care* (V8), TGGD individuals remain largely unaware of their fertility options (von Doussa et al., 2015; Jones 2016, Mitu, 2016; Moravek et al., 2018; Cheng et al., 2019; Defreye et al., 2019; Kyweluk & Fiester, 2023). A 2015 Ontario study conducted by Pyne et al., found that of their 433 TGGD survey participants, only 11.0 percent of current parents and 22.7 percent of nonparents had a healthcare professional discuss fertility preservation options with them prior to medically transitioning (p.122). In this thesis, the only interview participants who had fertility preservation discussed with them when they medically transitioned were Andy, Logan, and Charlie. Both Andy and Charlie began their transitions younger in life, giving them more opportunities for healthcare professionals to discuss their fertility, and Logan's family doctor discussed his fertility when he began HRT in 2018. In contrast, Seth, MK, Salem, Milo, Olive, and Ollie did not recall being told about their fertility preservation options or lacked a cohesive conversation with their healthcare professionals when they began their medical transitions.

When Seth medically began his transition at 32, he already had two children. When he began HRT, fertility preservation was never formally discussed with him by his doctor. He was provided with some resources but had no in-depth conversation with his doctor. Seth claimed: "I was actually kind of stunned that it was never brought up again, [like] what my options were [or] anything like that." Seth commented that he was provided with pamphlets, but additional information or context to the resource was never given. Seth said:

I think I did mention it. I know I definitely mentioned it to my GP [general practitioner], so I don't know if that somehow got passed along. I may have mentioned it to Dr. V [my endocrinologist] as well but, I don't recall. But I for sure brought it up to my GP.

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Despite having initiated the conversation about fertility preservation with his doctor and his endocrinologist, Seth continued to feel like he was left without adequate information regarding his future fertility options. This lack of prioritization of Seth's fertility could have been based on the fact he already had children; however, lack of knowledge regarding fertility preservation was also common among those who were currently childless.

MK was also left with no information regarding their future fertility. MK did not have their fertility preservation options discussed with them when they began HRT at the age of 35. While MK was older than most when they began HRT, the same quality of healthcare should be provided regardless of age. When they began HRT, MK said they were not made aware of their fertility preservation options. While egg freezing facilities like EVOLVE in Ontario promote egg freezing before the age of 35, egg freezing remains a viable option until an individual is in their late 30's (2024, n.p). Moreover, OHIP funding for most fertility clinic services is made available to Ontarians until the age of 43 (Ontario Fertility, 2024, n.p). Based on their age, MK's healthcare professional may have believed they were uninterested in hearing about fertility preservation, which resulted in MK receiving minimal information about their current and future fertility options. They stated:

I just know that so much of this stuff can be individual, like, you know, I might be fertile, I might not be. There might be some [problem], like even if you freeze your eggs, you might still have an issue with your uterus.

MK was uncertain about their own fertility and was even unsure about their current reproductive health and capacity to reproduce. Despite having been provided with no information at the time of beginning HRT, MK said they wished they had been provided with their fertility options. At the time of their interview, MK was concerned about age-related

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infertility, becoming an older parent, and the chances of being pregnant at their current age of 38. However, Seth and MK were not the only ones who received poor fertility preservation information. Similarly, Salem's doctor did not mention their fertility preservation options. Salem recalls "he [the doctor] didn't actually mention anything directly, if the memory serves." Salem did not recall receiving any information about fertility preservation, demonstrating a lack of consistent and gender-affirming care during their medical transition.

The final interview participant who discussed a potential lack of adequate care was Olive. Unlike Seth, MK, and Salem, Olive claimed that fertility preservation was mentioned to them by their healthcare professional at the time they began HRT. However, they quickly dismissed the idea. Olive said:

So, I do very vividly remember the conversation about freezing eggs. And I very quickly [said I was uninterested] and didn't ask any further questions. And I wish that I had a little bit [more information] but whatever, this past is past.

In hindsight, Olive wished they had been more open to hearing about fertility preservation options. At the time, they dismissed the idea, which they came to regret. Instead, they wished their doctor had provided resources in case they wanted to do more research in the future or changed their mind about freezing their eggs.

While some interview participants were unaware of the fertility preservation options available to them, others demonstrated some understanding and knowledge regarding the process. Milo, Logan, Andy, and Charlie all demonstrated a basic knowledge regarding the possibility of fertility preservation. Of these interview participants, Milo had frozen his eggs and understood the process, Logan had independently done research to learn more about fertility preservation options, Charlie had spoken with a friend who had frozen his eggs, and Andy had

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planned to learn more about egg freezing at his upcoming appointment with his endocrinologist. While Milo and Logan demonstrated knowledge about their fertility preservation options, neither gained this information from their healthcare professionals when beginning HRT. Charlie's limited understanding was based on a poor experience his friend had freezing his eggs, and while Andy had already heard about fertility preservation, he wanted to learn about the process of egg freezing. Of all interview participants, only Olive and Andy claimed they had heard any information about fertility preservation from their healthcare professional.

Of those with knowledge regarding fertility preservation, Milo was the most well versed. As someone who had frozen his eggs, Milo had an intimate understanding of the process. However, Milo did not learn about egg freezing at the time of beginning HRT but learned about it years later. During his nursing degree, Milo attended a conference dedicated to TGGD healthcare, where he learned more about fertility preservation and reproduction. Milo began HRT in his 20s and said:

I did know that it was an option to do fertility preservation [when I began my medical transition]. At the time when I started [HRT], I didn't know that it would be an option to do it [freeze my eggs] later. I don't think they [healthcare professionals] told me that.

I think it was like, "do it now or you may not ever be able to."

After freezing his eggs, Milo obviously became much more aware of the process and was able to relay his experience to others. Milo uses his knowledge in his own nursing and advocacy for TGGD reproductive healthcare.

Andy was among one of the two interview participants who began their transition younger in life, providing additional opportunities to learn about their fertility. Andy began their medical transition with the Children's Hospital of Eastern Ontario, which provides gender-

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affirming care for TGGD youth under the age of 18. When beginning hormone blockers, Andy remembers: “it was my endocrinologist who was talking to me about all of that stuff.” At the time, and despite their young age, Andy was interested in a hysterectomy over egg freezing and had discussed a possible hysterectomy in the future with their endocrinologist.¹⁰³ As explored above, Andy’s own desires for a hysterectomy were impacted by their mother. It was during this discussion period with their endocrinologist that Andy initially learned about egg freezing. Andy claimed:

[The doctors/surgeons] leave most of the uterus intact, they remove the eggs, [and] they preserve the eggs for an indefinite amount of time [or for] as long as you want.

And then whenever you want to access them [your eggs], you would have to call the clinic and discuss what you want to do with them [the eggs]. I’m not entirely sure though, this is me paraphrasing [the endocrinologist] very vaguely, and kind of just... assuming.

While Andy had learned some information about egg freezing during their discussions about having a hysterectomy with their endocrinologist, they had reached out the Ottawa Fertility Centre in 2020 for more information. At that point, they had not heard back from the clinic and planned on having another conversation with their endocrinologist following our interview.

Similarly to other interview participants, Logan was not provided with information about fertility preservation by his healthcare professional when he began HRT at the age of 23. Eventually, Logan found “trans-related topics”, especially health-based topics, to be his special interest.¹⁰⁴ Logan said: “I kind of just gradually figured things out because I guess my special

¹⁰³ The Children's Hospital of Eastern Ontario provides care to individuals under the age of 16. Therefore, at 16 years of age, a person is required to seek care elsewhere.

¹⁰⁴ A “special interests are frequently developed by individuals with autism spectrum disorder, expressed as an intense focus on specific topics. Neurotypical individuals also develop special interests, often in the form of hobbies” (Jordan & Caldwell-Harris, 2012, p.391).

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interest has always been on trans-related topics.” Logan’s lived experience with autism created a keen interest in discovering more information about his own reproductive and sexual health. Logan was the only interview participant who actively sought out information on fertility preservation on his own. This made Logan more knowledgeable than most interview participants regarding how fertility and fertility preservation works for TGGD individuals. During his interview, Logan enthusiastically shared what knowledge he had about egg freezing and other various health-related topics.

Finally, Charlie had a similar experience to Olive in that they were dismissive when egg freezing, and other fertility preservation options were discussed with them when they began HRT. Charlie’s experience differs from Olive because at the time, they were strongly against the idea of egg freezing. Charlie recalled “it [egg freezing] was like brought up [and] I was very dismissive of it. So, I don’t want to blame her [the doctor] for being nonchalant about it.” While some interview participants such as Seth, Olive, and MK mentioned they wished they had the opportunity to learn about egg freezing, Charlie was the only one who outright rejected the idea. Charlie was, however, the only interview participant who was close friends with a fellow TGGD individual who had frozen his eggs. After speaking with their friend, Charlie became highly skeptical of the process of egg freezing claiming it was too invasive and time consuming. Early in their interview Charlie commented, “it [egg freezing] just sounded so horrible, and so not worth it.” While other interview participants were open-minded about learning more about fertility preservation generally, Charlie was avidly against it.

Overall, while some interview participants had some knowledge about fertility preservation, most lacked basic knowledge of their reproductive options since they did not have their fertility preservation options explained when they began HRT. This limited understanding

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of fertility preservation demonstrated by many interview participants proves a need for increased gender-affirming reproductive care. It also highlights how while younger TGGD individuals may be provided with additional opportunities to learn about their future fertility, regardless of age, all TGGD individuals deserve to have their fertility options discussed when they medically transition.

Secondary Theme: Gender Dysphoria and Conflicted Hope

Of those survey and interview participants who mentioned considering egg freezing, the fear of gender dysphoria was common. While the term gender dysphoria began as a medical diagnosis by the American Psychiatric Association's Diagnostic and Statistical Manual, today is commonly used as a term to describe the discomfort many TGGD individuals feel regarding the disconnection between their bodies and gender expression (Atkinson & Russell, 2015). The actual lived experience of gender dysphoria can be debilitating, however, there are many techniques TGGD individuals use to help manage their gender dysphoria (Trans Hub, 2021). As explored, gender dysphoria is among a key concern for some TGGD individuals considering freezing their eggs across the globe. Gender dysphoria is a key component of potential conflicted hope that is unique to TGGD individuals who may find the process of egg freezing particularly dysphoric (Moravek et al., 2018; Cheng, 2019; Jarin et al., 2019; Armund et al., 2020; Segev-Becker et al., 2020; Nadgauda & Butts, 2024). Gender dysphoria for TGGD individuals can arise when seeking out reproductive technology use in general. Some of the ways gender dysphoria has been experienced by TGGD individuals seeking out egg freezing and fertility preservation include having to cease HRT or wait to begin HRT (Mattawanon et al., 2018; Bartholomeaeus & Riggs, 2019; Charter et al., 2019; Cheng et al., 2019; Defreyne et al., 2019), undergoing intrusive

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pelvic examinations (Nadgauda & Butts, 2024), having to take gender-incongruent hormones, and encountering instances of transphobia (James-Abra et al., 2015; Mamo & Alston-Stepnitz, 2015; Hoffling et al., 2017; Leibetseder, 2020; Kyweluk & Fiester, 2023; Kolbe et al., 2023; Paul et al., 2023; Nadgauda & Butts, 2024).

In this thesis, the survey was created to address questions that specifically reflect on the connection between egg freezing and gender dysphoria. In the survey, ten participants responded to Q:26 Have you experienced any barriers to freezing your eggs? If so, what were they? Of the ten survey participants who responded to this question, two survey participants answered by writing the “difficulty” and “invasiveness of the procedure” were barriers to freezing their eggs. The word “invasive” was used by one survey participant and the phrase “hard to do” was used by another. During follow-up interviews, Seth, Milo, Charlie, and Ollie all mentioned the medical risks and physically invasive nature of egg freezing. The invasiveness of egg freezing was discussed in two ways; the physical invasiveness of having to have pelvic exams and internal ultrasounds done, and the ways that the steps required for egg freezing could trigger gender dysphoria. Gender dysphoria adds an element of physical and emotional invasiveness for TGTD individuals considering egg freezing. For interview participants, both physical invasiveness and gender dysphoria were a concern.

During their interview, Charlie claimed that the idea of having to cease HRT to freeze their eggs was “unthinkable.” Charlie noted:

I think [the patient has to] go under general anaesthesia and, it's not like a sperm bank [because with] eggs [it] is a [much] more challenging process and there's fertility drugs and medications. And, I think the thing for me that is unthinkable, is just having to stop testosterone.

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For many TGGD individuals like Charlie, even the idea of ceasing HRT to freeze their eggs could cause concerns regarding experiences of gender dysphoria. This is where conflicted hope comes in play for TGGD individuals considering egg freezing. While some TGGD individuals like Milo cease HRT and freeze their eggs without experiencing gender dysphoria, others feel this is not an option for them. All TGGD individuals experience gender dysphoria in different ways that are unique to them and their bodies. For those interview participants such as Logan who experience extensive bottom dysphoria, egg freezing may come with more concerns regarding gender dysphoria. In contrast, there will be other TGGD individuals like Milo, who may not experience gender dysphoria but can understand how others might be triggered by the process of egg freezing. During his interview, Milo highlighted some of the reasons why TGGD individuals could experience gender dysphoria caused by the physical invasiveness of the process of egg freezing. Milo believes: “if you’re somebody who’s ... very uncomfortable with your downstairs region, and has never had an inside ultrasound, this is not a fun time.” Milo stated that the steps required to freeze your eggs could be “super dysphoric” naming how gender incongruent hormones, physical examinations, and ceasing HRT could also contribute to gender dysphoria. Milo’s comments align with the narratives of many TGGD individuals who consider egg freezing or have already frozen their eggs (Moravek et al., 2018; Cheng, 2019; Jarin et al., 2019; Armund et al., 2020; Segev-Becker et al., 2020; Nadgauda & Butts, 2024). When it comes to experiences of conflicted hope, some TGGD individuals may find themselves feeling anxious and uncertain when considering freezing their eggs or during the process of egg freezing due to ways the gender dysphoria can unexpectedly creep into their experience.

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Secondary Theme: Transphobia, Cisgenderism, and Lack of Adequate Care

Across the globe, many TGGD individuals struggle to receive adequate and gender-affirming healthcare. Experiences of transphobia can be one of the foundational barriers to seeking out fertility clinic services and reproductive technology use (James-Abra et al., 2015; Mamo & Alston-Stepnitz, 2015; Hoffling et al., 2017; Leibetseder, 2020),¹⁰⁵ deterring many TGGD individuals from seeking out services or completing fertility clinic services.

Previous research has found transphobia is experienced by TGGD individuals in healthcare setting, including instances of misgendering (Charter et al., 2018), being dehumanized, being called “it” (Riggs et al., 2014), not being allowed to use their pronouns (James-Abra et al., 2015), and other various forms of violence (Voultsos et al., 2021). At the same time, TGGD individuals receive inadequate healthcare from many healthcare professionals based on the lack of gender-affirming training and education healthcare professionals receive (Korpaisarn & Safer, 2018; Mousavian et al., 2023). Healthcare professionals must also work through their own cisgenderism and cisgender privilege to determine gaps in knowledge and care.

Many TGGD individuals have spoken out about their experiences of transphobia in healthcare settings, forcing them to self-advocate for their own reproductive and sexual healthcare (Gruskin et al., 2018). For example, in a recent 2024 UK article, well-known British transgender man and “Seahorse Dad” Freddy McConnell stated, “if I’d believed doctors during my transition, my kids wouldn’t be here” (2024, n.p). McConnell, like many TGGD individuals on HRT, was told he would be unable to achieve pregnancy in the future because prolonged testosterone use causes infertility and reduces egg quality. Like McConnell, many TGGD

¹⁰⁵ Also see Kyweluk & Fiester, 2023; Kolbe et al., 2023; Paul et al., 2023; Nadgauda & Butts, 2024.

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individuals have been required to advocate for themselves to achieve reproductive justice and ensure they have the right to biogenetic family formation. Many TGGD individuals fear transphobic healthcare professionals and policies will deny them reproductive services, removing their ability to become biogenetic parents (Kyweluk & Fiester, 2023). Transphobia in healthcare settings, especially reproductive healthcare settings such as fertility clinics, can lead to conflicted hope. Not only do TGGD individuals fear transphobic experiences, but they also fear the questioning of their parental rights (Nixon, 2013) based on their gender identity (Lowik, 2018).

Fear of transphobia and trauma due to transphobic encounters weighed heavily on the minds of some interview participants. Ollie, Seth, Salem, and Charlie all explored this theme in some fashion. When reflecting on the reasons against egg freezing, Ollie articulated they had experienced “enough trauma from the medical system [and it’s] people [because healthcare professionals] don’t know what they’re doing.” Many TGGD individuals have ongoing experiences of transphobia in healthcare settings which can contribute to their reluctance to seek out fertility clinic services including consultations. Healthcare professionals have been found to lack adequate knowledge regarding the unique needs of TGGD patients (Mikulak et al., 2021), and while some healthcare professionals acknowledge their limitations, lack of basic knowledge regarding gender-affirming care remains a major concern (Hobster & McLuskey, 2020).

Ollie was not the only interview participant to claim they feared the lack of knowledge many healthcare professionals have. During their interview, Charlie discussed their desire for a hysterectomy and expressed:

My doctor approved it, knowing that I’d always expressed interest in it. But then, I had to meet with a second doctor [to get approved] for OHIP [coverage], and that was kind of stressful, because I was like, what if he [the second doctor] doesn't believe me?

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Even in instances where one healthcare professional provides gender-affirming care, there are times many TGGD individuals in Ontario are required to seek out approval from multiple healthcare professionals. As explored by Charlie, they were required to receive approval from two healthcare professionals to be approved for OHIP funding for their hysterectomy. Other instances where TGGD individuals in Ontario might require additional healthcare professional approval include when changing gender markers on provincial and federal identification and gender-affirming surgeries. Each interaction with a healthcare professionals and healthcare settings can lead to more potential for violence, trauma, and stress for TGGD individuals.

During their interview, Seth commented on how inexperience with TGGD individuals can lead healthcare professionals to provide inadequate care regardless of intention. When reflecting on his last visit with his doctor, Seth claimed: “I think there’s a fine line of like, where people [healthcare professionals] are trying to not be offensive.” For Seth, a “fine line” exists between healthcare professionals wanting to provide gender-affirming care to patients and simultaneously worrying about being insensitive. Seth believes this fine line is “detrimental” to ensuring adequate gender-affirming care for TGGD individuals. While healthcare professionals should always consider the feelings of their patients, avoiding transphobia comments and cisgenderism, their duty is to ensure they provide adequate care. Salem is a prime example of how information can be forgotten or misunderstood between TGGD individuals and healthcare professionals.

Due to inadequate knowledge caused by transphobia and cisgenderism, Salem asserted he felt he received inadequate healthcare by his healthcare professional, leaving his reproductive and sexual healthcare needs unmet. Like many TGGD individuals in Ontario, Salem received

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lack luster care due to his gender identity (Gilbon & Bauer, 2017). Like other interview participants, Salem was not told about fertility preservation when he began HRT with this healthcare professional. In another appointment, Salem claimed his doctor casually brought up the topic of birth control without additional context. Salem said his doctor: “only really briefly mentioned, ‘hey, you know that testosterone isn’t a contraceptive on its own. You still have to keep up with that [birth control]’.” Salem exemplifies how inadequate knowledge or fear of the fine line of offending a TGGD individual can lead to serious misconceptions regarding reproductive and sexual healthcare. Inadequate care is a direct result of transphobia and cisgenderism in healthcare education. Both fears of transphobia and inadequate care by healthcare professionals can create opportunities for conflicted hope for TGGD individuals with desires for future family formation. TGGD individuals continue to experience muddled and unreliable healthcare causing mistrust in healthcare professionals and healthcare settings. This ties to the need for self-advocacy among many TGGD individuals who want to ensure they receive proper gender-affirming care.

Like some other interview participants, Charlie also demonstrated instances of inadequate healthcare by healthcare professionals. Charlie feels:

It's definitely exhausting needing to know your own care. I think that's like a big thing [that some TGGD individuals] aren't ready for or capable of... I was always told when I was younger, like, “you matured really fast.” And [I was] like “I ha[d] to, because I'm responsible for my own care because, doctors don't know what they're doing.” That in of itself can be really exhausting [especially] when you have other health issues, or conflicting things. Sometimes, I just want someone else to tell me what to do, you know, but I can't trust anyone now.

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Charlie highlighted how he had been required to self-advocate, educate, and understand his own healthcare needs. Sadly, Charlie's experience is common. TGGD individuals can quickly become burnt out and fall exhausted when having to work tirelessly to ensure they receive proper healthcare. Not only do TGGD individuals experience increased barriers to accessing healthcare (Kattari et al., 2021), but they must become more knowledgeable about TGGD healthcare than their cisgender healthcare professionals (Huttunen, 2023). This was the case for interview participant Logan who said:

We discussed it [egg freezing] and she [the doctor] [said she] would go over it quickly for the purposes of informed consent. But generally, I knew just as much as she did, if not a little bit more [based on my] previous experience.

During visits with their healthcare professionals, interview participants felt they either received little information about fertility preservation, or they knew more information than their healthcare professional. For those such as Ollie, who have experienced transphobia from healthcare professionals, the fear of transphobia keeps them from considering fertility preservation. Especially during times of high tension and emotion, TGGD individuals' experiences of inadequate healthcare can lead to gaps in reproductive and sexual healthcare or result in TGGD individuals not understanding their fertility options. Ultimately, the strong connection between inadequate healthcare is due to transphobia and cisgenderism in healthcare education and training. When healthcare professionals lack adequate knowledge regarding TGGD healthcare, this can lead to instances of transphobia in healthcare settings. Experiences of cisgenderism and transphobia in healthcare settings continue to create extensive anxiety and mistrust in many TGGD individuals. For this reason, both transphobia and inadequate

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information regarding their reproductive options can cause conflicted for TGGD individuals who may decide they wish to start biogenetic family formation too late.

Conclusion

Interview participants' transcripts explored the context of biogenetic parenthood, egg freezing, and conflicted hope. Secondary themes that emerged from biogenetic parenthood included lack of interest, desires for pregnancy, disability, and family pressures to reproduce biogenetically. Secondary themes in egg freezing included financial cost, freezing to appease a family member such as mother, and age-related infertility. Finally, for conflicted hope, secondary themes that emerged included lack of knowledge about fertility preservation, gender dysphoria, cisgenderism, transphobia, and inadequate healthcare. Regardless of whether (or not) they chose to freeze their eggs, interview participants mentioned various barriers they had encountered to gender-affirming reproductive healthcare. Provincial closures due to COVID-19, the expensive financial costs, the physical invasiveness, gender dysphoria, and the uncertain success rates were all barriers noted by interview participants. Many interview participants discussed the importance non-biogenetic family formation using adoption, fostering, and mentoring. While biogenetic parenthood may not be a major goal for many interview participants, the desire for some kind of parenthood was strong.

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Chapter 6: Queer and Queering Parenthood

“When I was a heterosexual woman, motherhood was the ultimate. In fifth grade I wrote that my life’s dream was to be a mother. As I grew older, motherhood began to seem alien to me. The thought of my body pregnant was unsettling, and the idea that I would be pumping out children to feed the machine was terrifying. My generation (Gen Y/Millennials) has considered parenthood in many ways. What does this mean for me economically? What does this mean for our dying planet? What does this mean for over population? As a queer woman, motherhood seemed doable. At the same time, I couldn’t say for sure that parenthood was for me. I certainly didn’t want to be a “mom”, but it was expected. When I transitioned in 2017, I remained unsure about parenthood. I kept economics, politics, the planet, and my career in the front of my mind. In 2023, as a trans man in my 30s, I could want to give being a Papa a try.”¹⁰⁶

Despite my initial concerns that TGGD individuals living in Ontario would feel pressure to engage in heteronormative family formation, this thesis found a lack of interest in biogenetic parenthood among interview participants. Of all interview participants, Andy, MK, Logan, Olive, Salem, Milo, and Ollie all stressed wanting children in their life in some fashion. Biogenetic means of family formation were considered by Milo who had frozen his eggs, MK, Logan, and Olive who planned to become pregnant in the future, and Seth who already parented a biogenetic and adopted child. Interview participants, even those who considered biogenetic means of family formation also considered social means including adoption, fostering, and mentorship. This chapter is dedicated to exploring the various ways interview participants considered social means of family formation over biogenetic ones. While this chapter addresses the larger desire for social parenthood among 2SLGBTQIA+ individuals, TGGD individuals often face specific barriers to family formation based on transphobia and cisgenderism. The terms queer and queering parenthood can be applicable to all 2SLGBTQIA+ individuals.

Given that biogenetic parenthood, egg freezing, and conflicted hope were discussed in Chapter 5, this chapter will explore how conflicted hope can manifest for TGGD individuals

¹⁰⁶ Research journal excerpt, 06/30/2022.

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when seeking out social means of family formation. While biogenetic parenthood tends to highlight white, middle-class, cisgender, heterosexual family values, interview participants discussed how disability, class, and queerness remain foundational considerations in all family formation. Even among interview participants interested in future parenthood, there were ways that their hopes for adoption, fostering, and mentorship could become conflicted. This chapter centralizes how conflicted hope exists in all forms of family formation for TGGD individuals with many of the same barriers to biogenetic parenthood persisting.

Picture Perfect Parenthood

While interview participants expressed a lack of desire for a typical nuclear family, nuclear family formation remains the idealized norm in our society. Historically, the nuclear family became synonymous with white, middle-class, cisgender, heterosexual family values (Halberstam, 2005). For some, a family can be defined as a genetically related group consisting of a mother, father, and their children (Corea, 1979). Throughout the history of the Western world, nuclear family formation has been coveted, idealized, and highly gendered (Stritzke & Scaramuzza, 2016) as a settler-colonialist strategy (Phillips, 2009). Maintaining white, cisgender, and heterosexual family structures acts as a way of preserving the status quo with law (Springett, 2019), popular culture (Auer et al., 2022), and social policy (Guest & Parr, 2012) as critical building blocks cementing its importance. Heterosexual family structures reinforce the need for reproduction among white, heterosexual, and cisgender middle-class individuals (Riggs and Bartholomaeus, 2018) naturalizing their desires for reproduction (Halberstam, 2005). The heterosexual family remains a deep part of our social structures with heterosexuality acting as the norm. White, cisgender, heterosexual individuals are anticipated to have an “innate desire” to

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procreate once they have achieved strict middle-class expectations of education completion and homeownership (Riggs & Bartholomaeus, 2018). Such attributes promote the illusion that a “stable family environment” and “good parenting” require middle-class status (Murphy, 2010, p.86). Biogenetic parenthood is normatively expected within heterosexual relationships and reinforces the “cultural demand that biological procreation should occupy the center-ground of the social formation” (Santos, 2018, p.3).

The nuclear family is not only about heterosexual values, but it is carefully intertwined with whiteness. Following the Second World War, the Canadian government provided support for white, heterosexual, middle-class families by way of the *Family Allowance Act*.¹⁰⁷ This act allowed the Canadian government to ensure the prosperity of certain Canadians by creating middle-class havens, or suburbs (Guest & Parr, 20). However, the prosperity of the white, heterosexual, middle-class continues to come at the expense of others. While the nuclear family thrived, the 1950s brought poverty and disease to Indigenous communities living on reserves (Bercuson et al., 2024). The Canadian Government continued to kidnap Indigenous children from their homes, claiming Indigenous parents were unfit to raise their own children (Forani, 2018). As mentioned, law was paramount in the promotion of the white middle-class. In 1951, the Canadian government released legislature that provided social workers and other professionals to right to remove Indigenous children from their homes to place them in the care of white families (Indian Residential School History and Dialogue Centre, n.d). From 1945 to 1971, over 600,000 Indigenous children were taken from their “illegitimate” mothers and forced

¹⁰⁷ The *Family Allowance Act* was established in 1941 and was made dedicated to ensuing economic opportunity for all regardless of socio-economic status. At the same time, the allowance given to everyone has been critiqued as benefiting the already financially stable and well-off (Guest, 2018).

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into adoption (Forani, 2018, n.p). The Sixties Scoop and *Family Allowance Act* were legally enforced eugenic and white supremacist strategies like the Nuremberg Race Laws the Nazi party used to promote the “Aryan” race (Pendas et al., 2017). This time of Canadian history is only one example of how the thriving of white, heterosexual, middle-class families is prioritized over the basic needs and human rights of non-white families.

As demonstrated “white genetic ties” remain at the heart nuclear family formation (Roberts, 1999, p. 269). This causes infertility and voluntary childlessness among white, heterosexual, couples to be viewed as a “breakdown in gender identity and the life course” (Murphy, 2005, p. 5). This is why the lack of desire for parenthood among many in Generation Z remains so precarious for older generations who did their duty to build Canadian society. This chosen lack of parenthood is only remedied through biogenetic reproduction. This pressure for certain individuals to reproduce biogenetically demonstrates how intersections of whiteness, eugenics, and age come together. There remains a dichotomization between who is seen fit to biogenetically reproduce, and all others. For example, while infertility of white women is projected as a tragedy, the rapid rates of infertility among BIPOC women continues to be overshadowed (Agarwal, 2019, n.p). During the time white women were gaining reproduce rights, BIPOC individuals experienced forced and coerced sterilization (Stote, 2015; Mercredi, 2022), neglect in all aspects of reproductive care (Roberts, 1999; Coates-Davies, 2020), and high infant mortality rates (Coates-Davies, 2020).

These disparities in reproductive care clearly translate into fertility clinic settings. Today, fertility clinics are here to help with the problem of white infertility. While fertility clinics continue to promote “the very white face of infertility” (Agarwal, 2019, n.p), they also promise white individuals a cure from their tragic infertility using reproductive technologies. Fertility

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clinics and reproductive technologies are highly critiqued as centering whiteness, promoting their use among white families over others (Hardwood, 2018). Fertility clinics centralize “the typical white, middle- or upper-income patient couple” (Thompson, 2005, p. 86) and are structured to ensure that the reproductive wishes of white individuals are fulfilled (Roberts, 1999) making “whiteness and white experiences... the norm” (Tam, 2021, p. 168). Even when seeking out fertility clinic services as middle-class individuals, Black women can find they face the additional barrier of racism. While Black women experience higher rates of infertility, they also experience extensive racism in fertility clinic settings, and are commonly portrayed as “overly fertile” (Roberts, 1999, p. 270). The fertility and reproductive abilities of BIPOC women is promoted in the fertility clinic setting, however, it is as reproductive labourers and not intended parents.

Due to racial hierarchies reinforced by white supremacy, BIPOC women are commonly used for their reproductive labour instead of provided fertility clinic services. Fertility clinics provide ongoing international outsourcing of reproductive labour for certain fertility clinic services where the importance of whiteness and hierarchies of racial purity can be maintained (Deomampo, 2019). International outsourcing can mean white, cisgender, heterosexual couples go to Spain, Ukraine, and Czech Republic for desirable white egg donors (Speier, 2016) only to use racialized women in countries such as India as gestational surrogates to carry their white babies (Roberts, 1999; Twine, 2015). Race, class, and gender intersect in various forms when considering how reproductive technology use can reinforce a white, heterosexual nuclear family framework (Deonandan, 2020).

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What's Queer and Queering Reproduction?

Historically, 2SLGBTQQIA+ individuals have always been “queer” parents, commonly “queering” reproduction. The terms queer and queering are used in this thesis to describe family formation that occurs outside “heteronormative scripts” (Gibson, 2014, p.3). This commonly means engaging in “acts and ideas that resist heteronormativity by challenging the gender, sexuality, and/or family binaries” (Oswald et al., 2005, p.146). This resistance to heteronormative scripts has left some cisgender, heterosexual individuals to critique 2SLGBTQQIA+ families for contributing to the decline of the nuclear family (Lehr, 1999). Queer and queering forms of reproduction can be considered dangerous as they shift the sands of family formation (Mamo, 2007) with 2SLGBTQQIA+ individuals demonstrating the legitimacy of non-biogenetic family.

Many 2SLGBTQQIA+ individuals do not have the same options as their cisgender, heterosexual counterparts. While many cisgender, heterosexual couples “can make babies by having sex,” “the vast majority of us [2SLGBTQQIA+ individuals] must utilize outside resources” for family formation (Kali, 2022, p. 1). For 2SLGBTQQIA+ individuals, the journey to parenthood can include many complex decisions, starting with whether they wish to engage in biogenetic means of family formation and/or social forms. 2SLGBTQQIA+ individuals create families in unique and diverse ways (Mamo, 2008) including:

- Parenthood and pregnancy through sexual intercourse.
- Parenthood and pregnancy using a sperm donor in low-tech, non-fertility clinic settings.¹⁰⁸

¹⁰⁸ Low-tech options can include the “turkey baster” method, where insemination is done using known donor sperm in the home. Individuals may choose to become parents using this method, or they may choose to become pregnant themselves using this method. For instance, Olive and their partner may choose to use a known sperm donor for their conceptions. While Olive could

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- Parenthood and/or pregnancy using reproductive technologies such as artificial insemination, intrauterine insemination, egg freezing, sperm freezing, and/or surrogacy.
- Parenthood through adoption and/or fostering.

The history of 2SLGBTQQIA+ parenthood and their choices for family formation can be hard to trace back (Heyam, 2022), however 2SLGBTQQIA+ individuals have used everything from “queering motherhood” (Gibson, 2014) to trans* kinship (Halberstam, 2018) to form their families.

The terms “queer” and “queering” are not interchangeable but two distinct ideas. Queer and queering reproduction can both be ways of alternative family formation that remain outside “heteronormative scripts” (Gibson, 2014, p.3). Queer reproduction can be defined as any 2SLGBTQQIA+ individual who becomes a parent, regardless of the means of family formation. While queer reproduction is used to describe the achievement of parenthood among a 2SLGBTQQIA+ individual, queering reproduction can be done by anyone. What distinguishes queer reproduction is the use of “diverse forms of family making” (Silver, 2020, p. 219). Fish and Russell claim “queer[ness] and queer families does not [necessarily] presume personal identities (as lesbian, gay, bisexual, and transgender (LGBT) or queer [identity]” (2018, p.16). These queer forms of reproduction are “recasting the meaning of reproduction itself” (Mamo, 2007, p. 5) by moving beyond the binary opposition of masculine fatherhood and feminine motherhood (Oswald et al., 2005; Sardadvar & Mike, 2014; Martinez, 2022). Instances of queering reproduction can include:

- Lesbian motherhood and parenthood (Thompson 2005; Mamo 2007; Roth, 2016).

become pregnant using the donor sperm, Olive could also become a parent when their partner became pregnant using donor sperm.

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- Chosen mono-parenthood (Gibson, 2014; Silver, 2020).
- Gay or queer fatherhood (Layne, 2018).
- Gender neutral and trans parenthood (Garner, 2014; Halberstam, 2018; Silver, 2020).
- Forms of adoption (Silver, 2020).

While anyone can demonstrate queer reproduction, some scholars claim that the process of queering reproduction is an ongoing one, requiring one to also engage in queering parenthood. Queering parenthood can range from ongoing chosen-single parenthood among cisgender, heterosexual women to 2SLGBTQQIA+ parents deconstructing all gender-based parenting practices. Queering parenthood is the act of using alternative and queer forms of family formation, but it can also encompass queering practices as a parent (Mizielińska, 2022). Queering is a range based on the individual. For some, “what seems to be very (homo) normative from the Anglo-American perspective might be a radical transgression of norms in particular geopolitical location” (Mizielińska, 2022, p.34). Queering parenthood can be as simple as refusing to use the terms mother or father to describe yourself as a parent, therefore demonstrating feminist reflexivity that can be used against heteronormativity. Gender-inclusive language has been used throughout history to erase Two-Spirit, transgender, gender diverse, and Intersex people’s experiences (Rioux et al., 2022). Both cisgender, heterosexual individuals and 2SLGBTQQIA+ individuals can exhibit queering parenthood through the removal of gender-bias and gender-based language. Another example of queering parenthood can be seen among many BIPOC and/or 2SLGBTQQIA+ communities. Commonly, BIPOC and 2SLGBTQQIA+ youth can be separated from their biogenetic parents by institutionalized forms of racism (Mercredi & the Fire Keepers, 2021), xenophobia as immigrants (Goddard-Durant et al., 2023), and queerphobia, cisnormativity, and heteronormativity (Marzetti et al., 2022). Among BIPOC

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and/or 2SLGBTQQIA+ communities, the concept of “mutual bonds” through biogenetic connection defeats the purpose of queer forms of kinship where “new families” are created by those who felt disregarded and outcast by their biogenetic one (Halberstam, 2018, p.65). This means of kinship building is most noticeable in the ballroom and house scene in large cities such as New York City, United States. BIPOC 2SLGBTQQIA+ individuals continue to thrive in the drag scene where chosen family bonds and new family names are based on love and social ties (Tucker, 2022; Gleason, 2024).

It is critical to note not all 2SLGBTQQIA+ reproduction is innately queer and subversive (Mamo, 2007; Briggs, 2016). While families such as drag families and chosen families subvert the need for nuclear family recognition, other forms may not engage in the same rejection. Queering reproduction is related to the challenging of heteronormative scripts that connect “proper parenthood” with homeownership and heterosexual partnership (Mayes et al., 2017). This does not mean that 2SLGBTQQIA+ individuals who seek out the stability and enjoyment of homeownership or partnership are all engaging in homonormativity.¹⁰⁹ Rather, the social construction of proper parenthood, biogenetic connection, and ties to white supremacy are key. Many 2SLGBTQQIA+ individuals seek out traditional means of family formation due to desires for conformity, or to ensure “a place at the table” (Ahmed, 2010), where their queerness and family are accepted and legitimated by heteropatriarchal structures. Gibson (2014) warns, “there is danger in seeing queer parenthood as relentlessly modern, unprecedented, and divorced from

¹⁰⁹ Like heteronormativity, homonormativity is “the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption” (Duggan, 2002, p. 179). Homonormativity seeks to create consumer driven domesticate individuals that reinforce the status quo including nuclear family formation and white, middle-classness. Homonormativity removes the political and historical significance of queer identity and rebrands it to create a queer individual who reinforces heteronormativity as a queer individual.

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historical legacies” (p. 209) because 2SLGBTQQIA+ individuals may wish to engage in heteronormative scripts (Mayes et al., 2017) that prioritize biogenetic parenthood through egg freezing (Carroll & Kroløkke, 2017). Butler and Halberstam (2025) assert that there is no prize for engaging in the most non-normative lifestyle or structure, and heterosexual scripts begin early in childhood with gender socialization (Halberstam, 2018). At the same time, 2SLGBTQQIA+ individuals are building their own tables outside of heteronormativity and cisnormative family formation (Bawer, 1994). While many 2SLGBTQQIA+ individuals, especially TGGD individuals, may push the boundaries of sex/gender binaries and concepts of gender normality (Pfeffer, 2016), Puar (2017) cautions against engaging in capitalist practices that reinforce homonormativity. Homonormativity does “not contest dominant heteronormative assumptions and institutions but upholds and sustains them” (Briggs, 2018, pp. 171-172).

At the same time, 2SLGBTQQIA+ individuals have lacked the political and legal rights to family formation that their cisgender, heterosexual counterparts have been privy to. While there must be skepticism regarding homonormativity through the emphasis placed on biogenetic reproduction, 2SLGBTQQIA+ individuals are only recently receiving the rights to family formation. This includes the increase in acceptance of 2SLGBTQQIA+ individuals in fertility clinic settings. Until the *All Families are Equal Act* was introduced in Ontario in 2016, 2SLGBTQQIA+ individuals and their families were not legally recognized or protected. The Act was passed to ensure legal recognition of parentage regardless of the sexual orientation of the parents. This also provided support for 2SLGBTQQIA+ parents regardless of the way they formed their family (2016). While this change provided additional support and rights to 2SLGBTQQIA+ individuals seeking out fertility clinic settings, the complexity of lived experience and intersecting identities in the community must also be addressed.

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When approaching fertility clinic services, Mamo and Alston-Stepnitz (2015) caution that queer use of “biomedical fertility services in ways similar to their heterosexual counterparts [can] reproduce more than humans: they reproduce consumer marketplaces, normativities, notions of belonging, and intensifying inequalities” (p. 519). Reproductive technologies can reinforce biogenetic thinking (Nordqvist, 2017) in both heterosexual and 2SLGBTQQIA+ individuals and couples, which means not all forms of queer reproduction are in fact subversive (Mamo, 2007). Reproductive technology use, especially egg freezing, has been critiqued as a neoliberal technology (Baldwin, 2018) that engages in forms of “stratified reproduction” made more available and accessible to some individuals over others (Rapp, 2004; Roberts, 2015). Reproductive technology use remains stratified based on sexuality, gender, and race, commonly reinforcing white supremacist legacies (Roberts, 2015).

Making Queer Families Happen

So, what is keeping queer parenthood from happening? Many interview and survey participants in thesis desired future parenthood or were already parents, however, they noted low socioeconomic status and other concerns that would impact their ability to become parents and parent their children. While many cisgender, heterosexual individuals may face similar adversities, TGGD and 2SLGBTQQIA+ individuals, experience disparities that can impact their ability to find meaningful and ongoing employment (Irving, 2017) that allows them to begin and support their families. This is exacerbated by the expensive financial cost of family formation in Canada. In 2022, the average Canadian family was expected to spend an average of \$281,880 to raise a newborn child to the age of 18 (Liew, 2022). The financial cost of children alongside rising inflation, environmental crises (DeMay & Krähenbühl, 2023), and the physical toll of

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raising a child, is leading to increased instances of voluntary (Iverson et al., 2020) and involuntary childlessness.

Despite mentioning the desire for children in the future, many interview participants discussed student loans, the environment, and economic uncertainty, including the high cost of raising children as reasons they were concerned about becoming parents (Garcia, 2024). Additionally, among Generation Z, or those on the cusp of the Millennial generation, fear of infertility is rampant, and “fertility anxiety is trending” (Howard, 2024, n.p). However, the desire for personal freedom is also very common among Generation Z, who wish to have fewer children and engage in a more “double income no kids” or DINK lifestyle (Khandpur & Huang, 2024). As well, a 2023 US study done by the HRC Fertility, a large US based fertility centre, found that of their 1200 respondents aged 18 to 42, 49.8 percent of all Generation Z respondents noted they did not want children, claiming financial concerns and generational trauma (Howard, 2024).

While voluntary childlessness among cisgender, heterosexual couples is commonly frowned upon (Burçak, 2022) and considered selfish (Kelly, 2009; Coates-Davies, 2020), Generation Z may be breaking the gender norms association with parenthood (Mayes et al., 2017). Generation Z has been found to have the largest number of 2SLGBTQQIA+ identifying individuals of any generation. Unlike some of the Generation Z interview participants in my thesis, Generation Z as a population is generally uninterested in future parenthood. Some 2SLGBTQQIA+ individuals actively choose childlessness (Sappleton, 2018) while others financially struggle with the process of family formation (Anttila et al., 2023). Among 2SLGBTQQIA+ individuals, seeking out parenthood can be challenging for:

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- Gay, bisexual, and transgender fathers' barriers to surrogacy and adoption have been explored (Goldberg et al., 2022).
- Lesbian mothers seeking sperm (Nordqvist, 2012; Nordqvist, 2017).
- Transgender and non-binary parents seeking pregnancy (Moseson et al., 2021), examples include Thomas Beattie in 2008 (Grigorovich, 2014), and Freddy McConnell, the “seahorse dad” in 2019 (Atkinson, 2020).
- Intersex folks seeking pregnancy (Costello, 2015; Moseson et al., 2021).
- Polyamorous family formation (Young & Massey, 2017).
- The political recognition of the legitimacy 2SLGBTQQIA+ individuals and their families (Young & Massey, 2017).
- People seeking sperm donors who are not heterosexual or cisgender (Epstein, 2014).

Being a parent is inaccessible to many in the 2SLGBTQQIA+ community, but TGGD individuals experience intersecting forms of discrimination that make family formation even more unpredictable.

Despite obstacles to future parenthood, interview participants were interested in becoming parents. In this thesis, MK, Olive, and Logan considered becoming parents through pregnancy, Seth had experienced pregnancy and given birth, Milo had frozen his eggs and Charlie, Ollie, Salem, and Andy potentially wished to adopt, foster, or mentor. Some interview participants were able to achieve biogenetic parenthood with their partner, however, many were required to adopt or seek out reproductive technologies for family formation. However, Chapter 5 found that interview participants experience the same barriers to egg freezing as cisgender, heterosexual women such as age-related infertility, limited financial resources, and concerning success rates. At the same time too, interview participants demonstrated barriers unique to

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TGGD individuals including lack of knowledge regarding their own fertility, transphobia, and gender dysphoria. Despite these barriers, interview participants discussed pregnancy, adoption, fostering, and mentorship as viable options for future parenthood.

What To Expect When You're Trans and Expecting?

It has been found that fertility rates across Canada are rapidly declining (Fostik, 2021) with one in six Canadian couples experiencing infertility (Society of Obstetricians and Gynaecologists of Canada, 2025, n.p). Canadians, especially members of Generation Z remain heavily anxious about their future fertility (Howard, 2023). While TGGD individuals are commonly excluded from wider research examining population-based fertility rates, they experience some of the same concerns as cisgender individuals. Knowledge regarding fertility among TGGD individuals remains low with some TGGD individuals not knowing they are infertile until they seek out fertility clinic services (Swanson & Braverman, 2021). TGGD individuals experience the doom and gloom of the fertility cliff in the same ways as their cisgender counterparts; however, time is commonly not on their side.

While TGGD individuals are seeking out HRT at younger ages than ever before (Leinung & Joseph, 2020), as we have seen, TGGD individuals are not necessarily thinking about biogenetic parenthood for various reasons (Krempasky et al., 2020; Persky et al., 2020). A 2021 US study found out of 1694 TGGD participants, 115 had been pregnant in the past, 47 had been pregnant twice, and 48 had been pregnant more than three times (Moseson et al., 2021, p.30). Despite the joys that pregnancy and parenthood can have for TGGD individuals, some may find their hopes for pregnancy, birth, and postpartum care shattered. Even when TGGD individuals wish to become parents through pregnancy (Moseson et al., 2021) their healthcare professionals'

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knowledge may be limited regarding TGGD pregnancy (McPhail et al., 2016; Porsch et al., 2016; Tishelman et al., 2019; Fix et al., 2020; Gomez et al., 2020; Chu et al., 2023), which can lead to inadequate care (Hoffkling et al., 2017). In this thesis, interview participants noted their lack of knowledge regarding their own fertility and fertility preservation. At the same time, interview participants also discussed the lack of adequate reproductive and sexual healthcare to be a barrier to future parenthood.

One instance of inadequate care from a healthcare professional was discussed by interview participant MK. During one of the appointments with their healthcare professional, MK was poorly informed about the connection between testosterone and cancer. TGGD individuals taking HRT are commonly told that prolonged testosterone use can lead to cancer (Folx, 2022a). Interview participant MK said that they had considered a total hysterectomy¹¹⁰ after a recommendation from a healthcare professional. According to MK it is “because apparently, it [a total hysterectomy] reduces your risk of ovarian cancer.” While MK, and many other TGGD individuals taking HRT have been advised by their healthcare professional regarding the potential risk of cancer, few studies have established a connection between ovarian cancer (Wesp, 2016), cervical cancer (Hsiao, 2016), and endometrial cancer (Braun et al., 2017) and prolonged testosterone use (Braun et al., 2017; Joint et al., 2018). New research has shown that androgens like testosterone may actually decrease the likelihood of breast cancer (Chen, 2023). To ensure all potential for cancer in reproductive organs is eliminated, a total hysterectomy with salpingo-oophorectomy (removal of ovaries and fallopian tubes) would be required (Burnett, 2022). Moreover, menopause would begin in TGGD individuals who had their

¹¹⁰ A total hysterectomy includes removal of the cervix and the uterus (John Hopkins University, 2024).

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ovaries removed, requiring they reestablish their testosterone levels and prepare themselves for menopause.

However, what remains concerning is that healthcare professionals are using inaccurate information to provide medical advice to TGGD individuals. This would also mean TGGD individuals would experience an unnecessary removal of reproductive organs, removing their ability for biogenetic reproduction. Forms of sterilization have been used on the TGGD community in Canada before. In the past, TGGD individuals in Ontario, and throughout Canada have had to navigate transphobic legislation requiring sterilization to be able to change their gender marker on provincial documentation (Lowik, 2018). Now, inaccurate information from healthcare professionals could lead to the removal of reproductive organs without medical need, which is a well-known eugenic strategy (Toze, 2018). Inaccurate information can include lack of knowledge about recent studies regarding the long and short-term impacts of estrogen and testosterone on TGGD reproductive health of reproductive organs. Reproductive and sexual healthcare is a foundational human right (Ross & Solinger, 2017; Ross, 2020; Luna 2020), however, TGGD individuals continue to receive last lustre and neglectful the reproductive and sexual healthcare.

The Gendering of Pregnancy

Based on poor knowledge regarding TGGD reproductive and sexual health care, TGGD individuals can experience reproductive care that is “prurient, exotifying, voyeuristic, and superfluous” (Hoffkling et al., 2017, p. 350). Instead of treating TGGD individuals with respect, they can be used as “exceptional cases” where their difference is centralized (Dietz, 2020). This can be especially evident during pregnancy. While white, cisgender, heterosexual women can

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commonly navigate pregnancy with relative ease in society, many 2SLGBTQQIA+, especially TGGD individuals, feel like pregnancy is not meant for them. This is especially true for BIPOC folks who experience elevated rates of poor post birth care and lack of birthing autonomy (Ibrahim et al., 2022). This is based on the continued connection made by heteronormative structures, white supremacy, and connecting pregnancy with white feminine gender identity (Ryan, 2013; Walks, 2018b; MacLean, 2021). Despite desires for pregnancy, TGGD individuals may find they experience conflicted hope when the feminine gendering of pregnancy makes them feel their pregnancy is unnatural. Many TGGD individuals are left to “feel not man enough, not trans enough, not pregnant enough, and not safe enough during pregnancy, birth, and the postpartum” (Greenfield & Darwin, 2021, p.203). The intrinsic gendering of pregnancy with the female sex can harm TGGD individuals considering becoming pregnant, this makes “unsexing pregnancy for individuals” an “urgent project for pregnant people who are not women” (Clarke, 2022, p.177).

In this thesis, three interview participants noted a potential desire to become pregnant in the future. MK, Olive, and Logan all discussed future pregnancy and their own beliefs, feelings, and opinions about what it means to be a pregnant TGGD individual. Each interview participant outlined some of the ways that pregnancy for TGGD individuals can come with additional challenges. During their interview, MK expressed how both pregnancy and parenthood tend to be feminized. They said, “I think, you know, parenthood [and pregnancy] can be incredibly gendered, and, you know, we need new language [for pregnancy].” Removing gender from pregnancy and gestation not only benefits TGGD individuals but everyone regardless of gender (Horn, 2022). The removal of gender from biological processes such as pregnancy and gestation benefits cisgender individuals because it removes “the normalization of the white, male body”

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reiterating the “lack of data and bias against all women's bodies” (DuBois & Shattuck-Heidorn, 2021, p.4). Cisgender women remain disadvantaged by the gendering of biological processes as some cisgender women’s bodies do not menstruate, ovulate, or gestate a pregnancy. This inability is considered unwomanly when womanhood is measured by pregnancy and childbirth (Lisle, 2022). The same cisgender-based logic reinforces the belief that transgender women cannot be “real” women due to their inability to ovulate, gestate, and give birth. Simultaneously under this system, transgender men and trans masculine folks who ovulate, gestate, and give birth can never be “real” men (Karaian, 2013).

Interview participants, regardless of whether or not they intended to become pregnant in the future, noted how gender and pregnancy harm the TGGD community. Despite having no desire to become pregnant in the future, Milo remarked: “it [pregnancy] was a thought but it’s just so uncommon [among trans men], and the all the extra things that come with being a pregnant man...just seems like a lot.” Milo reflected on pregnancy, but noted the experience would be “a lot.” For this reason, Milo never plans to become pregnant, and he and his husband determined they may use a surrogate if they choose to use Milo’s frozen eggs. This ongoing gendering of pregnancy does not benefit anyone but serves to disadvantage anyone whose body does not reproduce cisnormative ideals (Fischer, 2020). Jacobsen challenges the assumption that gender and bodies must align because it reinforces “you are either a man or a woman—you can’t do both” (2022). This assumption permeates the medical system where heteronormativity, cisgenderism, and cisnormativity allow for “inappropriate and oppressive reproductive and perinatal health care” (Kirczenow MacDonald et al., 2021, p.18). It leads to the neglect of TGGD pregnant individuals (Clarke, 2019), provides poor or little safe sex education for TGGD

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individuals (Haley et al., 2019; Hobaica et al., 2019; Tordoff et al., 2021; Warwick et al., 2022), and can result in their isolation (Ellis et al., 2014).

Gender Dysphoria and Pregnancy

While some interview participants mentioned their interest in future pregnancy, one of the barriers that could cause conflicted hope for TGGD individuals is gender dysphoria. Like with egg freezing, gender dysphoria may prove a hurdle for some TGGD individuals considering pregnancy in the future. As demonstrated, MK and Milo acknowledged their concerns about the gendering of pregnancy. Other interview participants including Logan and Olive also reflected on this connection. In terms of future pregnancy, Logan was afraid about potentially experiencing gender dysphoria should he choose to become pregnant. In contrast, Olive seemed very excited about pregnancy and appeared comfortable with little fears regarding gender dysphoria. TGGD individuals seeking to become pregnant may find they experience conflicted hope since pregnancy remains unfairly gendered and trans exclusionary (Charlton et al., 2021; Kirczenow MacDonald et al., 2021). While Logan was concerned about bottom dysphoria during pregnancy, this was disconnected from the gendering of pregnancy. For Logan, pregnancy was not gendered at all. Logan claimed: “if it’s a man who’s pregnant, then it’s a man who’s pregnant.” As noted in Chapter 5, Logan experiences the contradiction of experiencing bottom dysphoria but also wanting to become pregnant and carry his own child.

For some, parenthood and “pregnancy as a transgender man is unlike any other kind” (Marantz Henig, 2014, n.p). Experiences of gender dysphoria must be carefully navigated during pregnancy to ensure that TGGD individuals feel comfortable. Gender dysphoria can manifest due to isolation, the feminization of clothing for pregnant individuals, and the gender-based

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language associated with pregnancy (Fischer, 2021). Gender dysphoria may go undetected because of little research with pregnant TGGD individuals experiencing gender dysphoria (Brandt et al., 2019). To ensure that pregnant TGGD individuals receive the care they require, healthcare professionals must continue to provide open communication regarding aspects of discomfort when it comes to being pregnant and transgender.

Despite the concerns that interview participants expressed, pregnancy was something that they felt positively about. While the gendering of pregnancy and gender dysphoria can create conflicted hope for TGGD individuals seeking a gender-affirming pregnancy experience, there are many ways that TGGD individuals navigate pregnancy. Pregnant TGGD individuals such as Trystan Reeves (Hanawalt, 2022), Jay Thomas (Compton, 2019), Zahaad Paval (Qureshi, 2023), and Freddie McConnell (Lewis, 2019), have acted as role models increasing the visibility, representation, and understanding of the needs of pregnant TGGD individuals. They have also shown that pregnancy is not only a viable option for TGGD individuals but can also be a highly desirable one. This visibility led some interview participants to feel positively about the future for pregnant TGGD individuals. Salem reflected that in recent years, the visibility of pregnant TGGD individuals was impactful:

In these past few years, I've seen quite a few articles of [trans]men carrying their own children... And the articles were pretty respectful. And it's been exciting to just feel like, oh, wow, I guess the world isn't completely awful all the time.

While Salem does not wish to become pregnant in the future, there is a deep appreciation for the ways that resources and visibility help other TGGD individuals achieve their parenting goals. For other interview participants such as MK, Logan and, Olive, the idea of being pregnant was appealing. When Seth was pregnant prior to his transition, he relayed how “cool” the

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experience of pregnancy was. While they wanted to become pregnant, Olive made the joke that they could consider themselves a “back up uterus,” making light of the fact they have the same reproductive capacity as their AFAB non-binary partner. Despite the fears that many interview participants had regarding future pregnancy, there was excitement for the opportunity to experience pregnancy as a TGGD individual.

Navigating Adoption

While interview participants mentioned pregnancy was one option they wanted to explore when forming their families, more commonly desired forms of family formation included adoption, fostering, and mentorship. During their interviews, some interview participants noted the importance of providing homes for 2SLGBTQQA+ youth, especially those without homes of their own. In 2021, the Children’s Aid Foundation of Canada claimed there were over 63,000 children in their care. The same year, over 30,000 children were available for adoption, but only 2,000 adoptions took place (2021, n.p). These startling numbers are nothing compared to the potential 235,000 children who could be introduced into the foster care system per year (Children’s Aid Foundation of Canada, 2021). A 2011 Statistics Canada survey found there were over 11,375 foster children in Ontario (2011). Between 2022 and 2023, the Ontario Association of Children’s Aid Services (2024a) found there were over 8,600 children in foster care, with over 60 percent between the ages of 16 and 20 (n.p). Ontario-based adoption agencies facilitated over 456 adoptions between 2022 and 2023 (Ontario Association of Children’s Aid Services, 2024b, n.p). The number of youths requiring homes in Ontario remains staggering. While the reasons for why these youth are without homes can be based on discrimination and oppression, some are also fleeing their homes due to violence and conflict (Homeless Hub, 2021). Interview

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participants such as Seth, Milo, Charlie, and Ollie all mentioned feeling drawn to adopting in the future or providing homes for children in need of supportive families. However, Seth was the only interview participant who had undergone an adoption and had experience with the adoption process.

In Ontario, there are the three types of adoption including private, public, and international (Senett, 2021). Public adoption can be done through organizations such as the Children's Aid Society and is relatively affordable, with costs ranging from no charge to \$3,000 (Senett, 2021, n.p). Private adoptions are facilitated by a "provincially-approved licensees or agencies" and can cost \$10,000 to \$15,000 (Canada Adopts, 2024). International adoption ranges in price from \$25,000 to over \$50,000 (Government of Ontario, 2015) and must be done through private agencies (Canada Adopts, 2024). For this reason, adoption remains inaccessible financially to many Canadians (The Belonging Network, 2023), and especially to TGGD individuals who struggle financially due to various intersecting forms of oppression (Irving, 2017).

Among interview participants who all discussed adoption, the cost of adoption was explored by both Seth and Milo. Seth relayed his experience of adoption and Milo talked about the potential financial difficulties of adopting in the future. Since Milo had already paid funds out of pocket to freeze his eggs, he weighted the financial cost of In-Vitro Fertilization and adoption. Like egg freeing, Milo felt there was no guarantee adoption would result in him becoming a father. Milo claimed:

You spen[d] all this money [on egg freezing] and you're not even guaranteed [a] child, you know. Whereas you could spend a similar amount of money going through

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adoption and you're sort of like, I bet you're [not] guaranteed a child at the end of adoption... but usually you spend the money, and you wind up with a child.

Milo fears that regardless of whether he uses his frozen eggs or adopts, he and his husband will end up childless. This can be a scary realization for TGGD individuals who have limited options regarding family formation. It can also be a difficult process for individuals like Seth. Seth's journey to adopting his youngest child was very different from the one that many 2SLGBTQIA+ individuals take. Seth and his partner, also a trans man, had discussed adopting a second child together. Seth spoke openly with a cisgender, female friend about he and his partner's decision to adopt. Seth explained that at the time the couple met her, they were unaware she was already pregnant. However, she later came to Seth and his partner asking if they were interested in adopting the unborn child she was pregnant with. Unlike some other circumstance, Seth said the pregnant friend "didn't have to pick an adoptive family or have them pick us or any of that scenario." However, Children's Aid Services did become involved in the adoption. Despite already having a child and knowing the woman who was giving birth to the child, Seth and his partner still "had to jump through all their [Children's Aid Services] hoops." During our interview, I asked Seth what was among the biggest barriers to the process of adoption, Seth said:

Cost is a big one. Like normally, adoptions through CAS [Children's Aid Services] are funded by the government, but because M was adopted at birth, they didn't want to make him a Crown ward. [Instead], they placed him with us under a kinship, and then made us go through the [private] adoption process ourselves. In terms of all the paperwork and the finances, cost is a really big barrier [especially] when parenting is expensive, in and of itself, right?

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Seth articulated that with adoption, even in his circumstances where he had a prearranged adoption, there was a high financial cost to M's adoption, creating a strain on the family. Seth also highlighted that raising a child is already a costly endeavour. For many 2SLGBTQQIA+ individuals who are unable to use methods outside of adoption to form their own families, it can be disheartening to go into the process with positive intentions but deal with the financial burden.

Discrimination and Adoption

Financial cost can strain the desires and abilities of TGGD individuals to begin and engage in the adoption process; however, once an individual determines they want to adopt, the additional red tape that 2SLGBTQQIA+ individuals must jump through can make family formation seem impossible. For those TGGD individuals seeking adoption, there are very similar hurdles to their cisgender counterparts, but 2SLGBTQQIA+ individuals have limited support and resources and must commonly face instances of queerphobia (Belonging Network, 2024; Ross et al., 2008; Brown & Rogers, 2020). However, instances of queerphobia are only one way that discrimination can impact the ability for 2SLGBTQQIA+ individuals to adopt.

For some 2SLGBTQQIA+ individuals, their sexual orientation will not be the only limiting factor in adoption. Many 2SLGBTQQIA+ individuals experience the impact of white supremacy including poorer healthcare outcomes leading to chronic health conditions such as HIV/AIDS (Underhill et al., 2016), increase in incarceration and arrest rates (Federal Pardon Waivers Services, 2024), and mental health concerns above their heterosexual counterparts (Goldberg et al., 2020). Disparities in health, healthcare, and other factors can create conflicted hope for TGGD individuals seeking to adopt. Some survey and interview participants may find that they will struggle with adopting in the future given the potential for queerphobia,

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transphobia, and ableism asserted in the adoption system (Ross et al., 2009; Pyne, 2012; Epstein, 2014a). Based on the higher instances of intersecting experiences of homelessness, poverty, unemployment, mental health concerns, disability and neurodiversity, TGGD individuals may face a multitude of different forms of discriminations when it comes to trying to adopt. Placing such strict regulations on adoptions for communities who already struggle with complex lived experiences is one way the white, heterosexual, nuclear family continues to be covered with white, middle-class, able-bodied, heterosexual, and cisgender adoption candidates deemed as most fit for parenthood.

During his interview, Seth noted some of the ways that he felt disadvantaged as a 2SLGBTQQIA+ individual. Seth explored how 2SLGBTQQIA+ individuals experience barriers to parenthood that many others do not. Seth stated that adoption: “Was a little difficult. Some of their standards [for adoption] are just kind of ridiculously out there.” While these standards apply to all those seeking to adopt, TGGD individuals must also navigate forms of discrimination that can hinder their chances of being seen as a suitable parent. Seth noted the importance of safety for all families but felt those adopting are expected to follow every safety precaution. For Seth, having his home visits at three, six, and nine months was intrusive and felt “unfair.” He felt he was judged during the home visits and worried that being a queer and transgender person might lessen his chances of being seen as a suitable parent. Seth advocated for the universalization of safety precautions for all prospective parents. He said: “so there are things that I think either they should be doing for everybody who has a baby or for nobody.” Regardless of whether or not someone is adopting, Seth felt that smoke detectors, cribs, and safe environments for children should all be in place, and if needed, provided.

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Seth claimed that discrimination and judgment for 2SLGBTQQIA+ individuals was still common during adoption. He felt that given the number of 2SLGBTQQIA+ individuals who go through the adoption process, this was truly unfair. Seth asked how can “Joe Blow off the street can give birth to a baby” when someone from a “more vulnerable population is being subjected to all these assets and rules and scrutiny?” Since Seth had already given birth to one of his children, he was able to clearly illustrate his experience between birth and adoption. Despite all the work that he and his partner went through, Seth said that once M was in their care, there was nothing to ensure the ongoing safety and care of the child. Even when trying to achieve social parenthood and kinship, the ways that heteropatriarchal systems enforce proper parenthood and parental expectations can work against those seeking adoption. Such surveillance may make some homes safer for children, while others just reinforce notions of who is deserving of children, and who must give their children away (Collins, 1990).

Passing the Torch

Queer and queering parenthood continue to thrive, despite the struggles that 2SLGBTQQIA+ individuals face when it comes to family formation. Social parenthood and kinship¹¹¹ were preferred by many interview participants. Fostering and mentorship were highly desired by Charlie, Salem, and Ollie. When I began this research, I worried that forms of homonormativity would creep into TGGD individuals’ desires for parenthood, causing many to seek out reproductive technology use and egg freezing. Since the 2SLGBTQQIA+ community has flourished using unique ways of family formation, I feared that like white, cisgender,

¹¹¹ The terms parenthood and kinship are used together in this section because while TGGD interview participants want to support TGGD youth, some do not wish to adopt but mentor.

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heterosexual couples, TGGD individuals would feel pressure to procreate biogenetically.

However, this was not the case. Rather, interview participants demonstrated types of family formation that mirror historical 2SLGBTQQIA+ communities and benefit the next generation of 2SLGBTQQIA+ individuals.

Charlie, Salem, and Ollie all mentioned wanting to support 2SLGBTQQIA+ youth, and especially, TGGD youth. Support systems are crucial for 2SLGBTQQIA+ youth who commonly experience homelessness due to lack of parental support in their biogenetic families (McConnell et al., 2016). In 2016, it was determined that of the 150,000 homeless youth in Canada, 25 to 40 percent identify as 2SLGBTQQIA+ (Abramovich, 2015, n.p). In 2022, 2SLGBTQQIA+ youth were found to be 120 times more likely to be homeless than their cisgender, heterosexual counterparts (Ormiston, 2022, p.217). Especially during times such as COVID-19, 2SLGBTQQIA+ youth lack the necessities to have their basic needs met, and struggled with food insecurity, mental health, and substance use (Abramovich et al., 2023). Other 2SLGBTQQIA+ youth during COVID-19 were “stuck at home” and vulnerable to transphobia and queerphobia, hostile environments, and a lack of safety due to unsupportive families of origin (Fish et al., 2020). 2SLGBTQQIA+ youth experience mental health issues that can lead to self-harm and suicide (Hunt et al., 2018) when they are not provided with safe, caring, and supportive environments (Taliaferro et al., 2019; DeChants et al., 2022). BIPOC youth are particularly venerable due to intersecting forms of racism, queerphobia, and transphobia. Resources such as shelters are commonly not safe spaces for BIPOC 2SLGBTQQIA+ youth (Coolhart & Brown, 2017). For these reasons, adoption, fostering, and mentorship by 2SLGBTQQIA+ individuals is so important.

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During interviews, Salem, Ollie, and Charlie discussed how they wish to contribute to the crisis of unhoused 2SLGBTQQIA+ youth. Salem spoke of his openness to fostering, he stated: “actually, more recently, I’ve been kind of [been] looking into what it would be like to foster teenagers, or possibly even adopting them.” Many TGGD individuals like Salem wish to provide a safe space for 2SLGBTQQIA+ youth to ensure the thriving of the next generation of queer and TGGD individuals. Like Salem, Ollie emphasizes queering forms of parenthood over biogenetic ones. Ollie noted:

If anything, I’m just going to help with fostering young trans kids... because so many children out there are either taken by the state or their families have that intergenerational trauma that we can help support.

For Ollie, fostering TGGD youth was about ensuring the acknowledgement and treatment of trauma while providing autonomy to the TGGD youth. Similarly, Logan commented on the importance of fostering, wanting to foster older youth:

[What I] want to do is probably foster [or] adopt older kids. But I’d have to make sure I have the mental health supports and other supports there [for myself] because I think people are complicated and people with trauma are complicated.

Both interview participants Ollie and Logan understand the weight of being a 2SLGBTQQIA+ youth and want to ensure they can help. Logan explained how he might want to emotionally prepare himself for providing support to a TGGD youth. This means ensuring he has all the support he needs to deal with potential trauma that the youth may be working through.

Two interview participants mentioned wanting to adopt older TGGD youth. In 2022, the average age for adoption in Canada was estimated at 7.5 years of age (Dave Thomas Foundation for Adoption, 2022, n.p). This can mean the older a child gets, the harder it is for them to find a

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new home. While some prefer younger children, Salem found “that teens get a bad rap of just being so dramatic and mean, and I just have a lot of empathy for them because I had such a hard time [when I was young].” Wanting to provide care to 2SLGBTQQIA+ youth can stem from lived experience (Halberstam, 2018), intimate knowledge of the foster care system (Paul, 2020) or having been unhoused (Robinson, 2020; Ormiston, 2022). These combined with the hyper-incarceration rates of 2SLGBTQQIA+ individuals (Robinson, 2020) can work against 2SLGBTQQIA+ youth.

Interview participants such as Ollie wanted to ensure they were keenly aware of the ways that the legal system has worked against 2SLGBTQQIA+ youth. When discussing fostering and adoption, Ollie was critical of the Canadian legal system. Ollie felt that adoption can place youth in a precarious legal position. They were adamant that they did not want legal recognition as a parent or guardian unless the adopted youth consented. Ollie said:

[If] I was fostering them, or we had a relationship and they were like, “can you please adopt me?” I [would] want to be able to. [I want to be there if] ever there was emergency. [I would like to be] the person that they would call [and I would be there] no ifs ands or buts about it.

While Ollie appreciated the ability to be able to foster, adopt, and mentor youth, they were highly skeptical of the legal system. They feared children would be placed in unhealthy homes young and would not be provided the legal safety to leave. Ollie illustrated how adoption has been used against marginalized youth. Giving back to community was one of the principal reasons why some interview participants such as Ollie and Salem wanted to adopt. The idea of creating spaces of belonging for TGGD youth was a common thread. Interview participant Salem

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commented on their happiness with providing support to their current family unit. When asked about their time spent with TGGD youth, they remarked:

My partner has a younger niece, who's in a really nice situation, who has a few friends who are realizing they're trans. And I was kind of giving them pep talks of just being like, I know, it's really scary.

Providing support to younger generations is a common kinship practice among 2SLGBTQQIA+ individuals. Salem emphasized the value of providing support to those inside and outside their family remembering “it’s really scary” to be a young TGGD individual. Studies continue to illustrate how advocacy and allyship are life saving (Church, 2022), whether it is through gay-straight alliances (Watson, 2010; Mayberry, 2013; Porta et al., 2017), in school settings (Wozolek et al., 2017; Goldstein et al., 2018), youth organizations (Bochicchio, 2020), community spaces (Vaccaro et al., 2011), or within family units (Luke & Goodrich, 2015; Moore, 2021). Providing allyship and advocacy to TGGD youth, especially during political difficult times in parts of Canada, cannot be understated. A key component to queering kinship is about giving back to community and providing resources when possible.

A final way that interview participants demonstrated queering reproduction was through discussions centering around egg donation. Seth was the only interview participant who commented on the importance of accessibility of parenthood to all 2SLGBTQQIA+ community members. While Seth had not frozen his eggs, he said that in hindsight, it might have been a good idea, if only he had known about the procedure. Seth claims:

Well, it [egg freezing] might have been something that I would have considered, even if it was [not fully] covered simply for the fact that I could donate my eggs if I chose not to use them... because it’s just a positive thing that I could do. And if I didn’t want to use

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my eggs, then I could donate them. Right, so, accessibility to services is a big one [barrier].

Seth explored the connection between lack of egg donors and the need that many 2SLGBTQIA+ individuals have when it comes to family formation.

Conclusion

This chapter has explored queer and queering reproduction and parenthood, highlighting how both operate outside of cisgenderism and heteronormativity. At the same time, this chapter cautions against identifying all forms of queer and queering reproduction and parenthood as radical. While fertility clinics remain sites that recirculate homonormativity, interview participants wanted pregnancy, adoption, fostering, and mentorship over egg freezing. Notably, pregnancy remains highly gendered, which can cause or exacerbate gender dysphoria for TGGD individuals who wish to become pregnant. For those interested in pregnancy, the gendering of pregnancy may mean fewer options for adequate health care, misgendering, and lack of support and resources. When it comes to adoption, discrimination and financial cost are barriers for 2SLGBTQIA+ individuals. Given the number of children and youth requiring homes in Canada, interview participants question the ways that trauma, foster care, and other factors can make feeling safe more difficult. Interview participants support all forms of parenthood, including fostering, and mentorship on a formal level through social services and in their own families. This passing of the torch from one generation to another demonstrates how TGGD individuals living in Ontario participate in queer family formation.

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Conclusion: The Bittersweet End

“Parting is such sweet sorrow. I feel like doing a dissertation is one of the most challenging but most rewarding things I could have done for myself. During these last seven years I have transitioned, lost a parent, got married, engaged in a major lifestyle change, and moved across the province. It feels surreal to feel like this time is coming to an end, but I am ready for the end of this chapter of my life.”¹¹²

In 2017 I began to explore egg freezing with the intention on focusing on corporate egg freezing policies. However, this thesis has shifted and changed with my own research and self-reflection, and I am overjoyed by the results. Over the years, I have found that Ontario has gone through meaningful change regarding access, resources, and education provided to TGGD individuals. While anti-trans rhetoric is on the rise across Canada, TGGD individuals are becoming more acknowledged in healthcare settings and research. However, there is still a long way to go.

In this thesis, egg freezing has been explored with a new lens, one that centers TGGD individuals and their desires, or lack of desire, for biogenetic parenthood. It has demonstrated that research and literature addressing TGGD individuals, and their lived experiences has lagged in Canada. It has also illustrated the thoughts, feelings, and considerations of TGGD individuals during their medical transitions. While this thesis began as a story of egg freezing, it has ended as a story about how TGGD individuals navigate parenthood, institutions, decision-making, partnership, and HRT. The three key findings of this thesis are:

Key Findings

1. Belonging over Biogenetic Parenthood

¹¹² Research journal excerpt, 03/01/2024.

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TGGD individuals in this thesis demonstrate a desire for belonging over biogenetic connection. While previous generations of 2SLGBTQQIA+ individuals did not commonly have the option of biogenetic reproduction, recent legislation such as the *Marriage Equality Act* of Canada, and the *All Families Are Equal Act* of Ontario have provided more freedom and rights to 2SLGBTQQIA+ families. At the same time, interview participants showed a keen interest in socially based means of family formation including adoption, fostering, and mentorship. Only one interview participant MK, stressed a desire for future biogenetic parenthood. While MK wanted to have someone that “belonged” to them, they were motivated by their need to feel a sense of belonging in their own family. While they desired biogenetic parenthood, they would be happy to use reproductive technologies or adoption to achieve parenthood. Of all participants, Milo was the only one who froze his eggs. However, he and his husband also planned on adoption in the future to form their family. Biogenetic parenthood was not the reason for freezing his eggs and it remained secondary to fears of age-related infertility. Three interview participants emphasized the need to create safe spaces for 2SLGBTQQIA+ youth, especially those TGGD youth who are displaced. Finally, one interview participant, Ollie, was already mentoring TGGD youth as a way of giving back to the community. Despite the concerns I had when beginning this thesis, homonormativity does not permeate the desires for parenthood among these TGGD individuals in Ontario.

2. Cisgender vs. Transgender Cohorts and MEF vs. SEF

A second key finding of this thesis is the precarity of the division between MEF and SEF.

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Cisgender, heterosexual women and TGGD individuals preserving their fertility through egg freezing are divided into MEF and SEF based on the reason for freezing. Those choosing to freeze their eggs due to age-related infertility remain classified under SEF, assuming they are freezing for elective reasons. Cisgender, heterosexual women who have medical reasons for freezing their eggs are classified under MEF. While research has demonstrated that prolonged testosterone use does not cause infertility in TGGD individuals, they remain classified under MEF. In this thesis, interview participants demonstrated a complex logic when determining whether they wished to freeze their eggs. Despite being a TGGD individual, Milo mentioned age-related infertility as the reason for freezing his eggs. Unlike SEF, MEF is partially covered under OHIP. Those cisgender, heterosexual women who wish to freeze their eggs due to age-related infertility would not be awarded coverage under OHIP.

This thesis has found that infertility due to prolonged HRT use is not a concern for TGGD individuals taking testosterone. Rather, age-related infertility is mentioned by two interview participants as a fear that drives their decisions when it comes to biogenetic reproduction. This finding brings into question the validity of the medically imposed distinction between MEF versus SEF. At the same time, the label of MEF is critical to ensure that TGGD individuals who wish to freeze their eggs receive some financial assistance during the process. However, if TGGD individuals can freeze due to fears of age-related infertility, why are they different from their cisgender counterparts, some of whom will also be members of the 2SLGBTQQA+ community?

3. Generations and reproductive technologies

The final key finding from this thesis is based on the age of the survey and interview sample. Many TGGD individuals in this thesis were below the age of 25, commonly placing

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them in the Generation Z category. Despite assumptions that Generation Z is “coddled,” this generation has been found to be “collaborative, self-reliant and pragmatic” (Stanford Report, 2022, n.p). These traits have been seen in the form of egg freezing. Across the globe, young cisgender, heterosexual women are choosing to freeze their eggs to ensure the possibility of biogenetic children in the future (May, 2023). Young Generation Z women have used social media platforms like TikTok to discuss their choices for freezing their eggs, prompting others to do the same. It has created a potential boom in egg freezing numbers (May, 2023) among Generation Z who are, in fact, looking to have it all by establishing a career, getting an education *and* having biogenetic children (Stearn, 2023). This increase in egg freezing could also be based on the overall comfort Generation Z has with technology. Generation Z uses technology more than any previous generation. Their tech-savvy nature coupled with increasing concerns over infertility in this generation (Howard, 2024) could also mean Generation Z could be the most comfortable reproductive technology users yet.

Yet despite being very technologically comfortable, Generation Z has also been found to lack the desire for any form of parenthood. This finding conflicts with reports of Generation Z seeking out egg freezing in larger numbers. Trends among Generation Z generally indicate a lack of desire for children and fear of financial uncertainty (Garcia, 2024). In this thesis, many interview participants were members of Gen Z. However, my small sample of interview participants appear to be outliers from their generation. While some interview participants agreed, like their peers, that they would be comfortable with egg freezing and reproductive technology use, most interview participants want to have children in the future but did not prioritize having biogenetic children. Interview participants indicate that they commonly want to experience parenthood of some kind but do not have to be biogenetically related to their children.

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Looking Back

My Introduction began with the topics of biogenetic parenthood, egg freezing, and conflicted hope. It outlines the stages of the thesis and describes the research objectives and guiding questions. The introduction explores the origins of my thesis and outlines my motivation for studying TGGD individuals and biogenetic parenthood. The introduction prepares the reader with the various methodologies and sets the stage for future chapters.

Chapter 1 detailed the medically imposed distinction between MEF and SEF and places TGGD individuals in this discussion. It outlines how TGGD individuals' desires for biogenetic parenthood, fears of age-related infertility, and medical need to freeze their eggs remain in question. Until recently, the prolonged impacts of testosterone on TGGD individuals have been unresearched. Many healthcare professionals have understood their TGGD patients to be infertile. Research has shown it is not the case, and that gender-affirming sexual and reproductive healthcare remains a foundational human right. Labelling TGGD individuals as freezing for medical reasons may be medically inaccurate, however, TGGD individuals need the partial OHIP coverage provided to those who freeze for medical reasons. Age-related infertility was cited as a reason for freezing eggs by some interview participants, aligning TGGD individuals alongside their cisgender, heterosexual counterparts. However, TGGD individuals have additional considerations many cisgender, heterosexual counterparts do not. Like many cisgender, heterosexual women, TGGD individuals must consider the high financial cost, potential medical risks, and concerning success rates associated with freezing their eggs. While age-related infertility was a factor, interview participants also demonstrated that transphobia, cisgenderism, and gender dysphoria actively contribute as barriers to freeze their eggs. TGGD

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individuals remain different from their cisgender, heterosexual counterparts, whose egg freezing is usually categorized under SEF.

Chapter 2 described the often cold and icy landscape of fertility clinic regulation in Ontario. While egg freezing is promoted as an easy fix to an age-old problem, fertility clinics are difficult to navigate. Despite the extensive number of fertility clinics in Ontario, few promote themselves as 2SLGBTQIA+ friendly or providing gender-affirming fertility care. Milo noted the precarities of having to travel to Mount Sinai Fertility Clinic in Toronto from his hometown of Ottawa. While Ottawa has several fertility clinics, Milo felt safe traveling to Mount Sinai Fertility Clinic based on its record of gender-affirming care. This chapter also explored how egg freezing works, its various risks, and how it is commonly not all it's cracked up to be. Chapter 2 also outlines the use of queer theory and theoretical concepts of biogenetic parenthood, egg freezing, and conflicted hope throughout this thesis. This chapter emphasizes how white, cisgender, heterosexual, and middle-class family formation is idealized in western society. This contributes to the othering of many 2SLGBTQIA+ individuals.

Chapter 3 focused on methodology. It provides data from the 31-question survey. This chapter outlines the key demographic information gathered from the survey. Demographic information included age, race/ethnicity, self-identification as living with a disability and/or neurodivergent, gender, sexual orientation, and 2019 income. Of the 23 surveys completed, 21 were eligible to be included in the data set. Survey results found that participants tended to be under the age of 25, be a member of Gen Z, identify as white, queer, living with a disability and/or identify as neurodivergent, and earned an income of less than \$15,000 in 2019. The survey found that despite the overwhelming number of white participants, there was representation of queer, Indigenous, and disabled/neurodivergent individuals. The chapter

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explores the logics behind why the sample might be made up largely of participants who are white, of lower socio-economic status, and examines the statistical significance of higher rates of queer, Indigenous, and disabled/neurodivergent participants.

Chapter 4 outlined the qualitative methods used in this thesis. After the survey, in-depth and semi-structured interviews took place. This chapter explores the recruitment process, ethical considerations, eligibility for the thesis, the coding process, and the use of thematic analysis. It also incorporates the use of my research journal and its importance as a methodology tool for a transgender-identifying researcher like me. I contributed to my research journal following each interview, and throughout the research process itself. This chapter provides a profile of each of the nine interview participants: Andy, Seth, MK, Logan, Charlie, Olive, Salem, Milo, and Ollie.

This chapter looks at the use of intersectional, trans*-epistemological, and ongoing consent frameworks that guided the entire research process. The importance of ensuring considerate, kind, and gender-affirming research can not be overstated. Many TGGD individuals continue to experience exploitation by researchers, which can lead to poor research that only benefits heterosexual, cisgender researchers. In contrast, my research sought to explore how research could be done to understand how intersecting forms of privilege and oppression must be reflected upon by the researcher throughout the process. I highlight the need for ongoing consent from participants and show how extra steps were taken to verify that all interview participants were accommodated.

Chapter 5 is among the most exciting chapters. It delineated the findings of the nine in-depth, semi-structured, follow up interviews and delves into the three initial themes of biogenetic parenthood, egg freezing, and conflicted hope as discussed by interview participants. Interview participants outlined their lack of prioritization of biogenetic parenthood. Despite this finding,

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several interview participants desired to become pregnant in the future; one had even frozen his eggs, and another had already become a parent through pregnancy. Other forms of family formation desired by interview participants included adoption, fostering, and mentorship. At the same time, interview participants explained how disability impacted their decision-making process about biogenetic parenthood. When it comes to egg freezing, age-related infertility was cited as a primary reason for freezing one's eggs. The main reason that many interview participants did not freeze their eggs was due to financial cost, concerns regarding gender dysphoria, and lack of knowledge about fertility preservation. Despite the ongoing promotion of gender-affirming healthcare, interview participants demonstrate how conflicted hope can arise as a result of inadequate care.

The final chapter, Chapter 6, tackled queer and queering reproduction and parenthood. This chapter explores the ways in which 2SLGBTQQIA+ individuals continue to engage in alternative forms of family formation. Simultaneously, it illustrates how some scholars caution against heteronormativity seeping into queer kinship through reproductive technology use and fertility clinic services. Despite having reproductive technologies as an option for family formation, many interview participants wanted to adopt, foster, or mentor non-biogenetically related children. During their interviews, participants outlined their desires for pregnancy and adoption but drew on the difficulties of each aspect of family formation. When it comes to desires for pregnancy, interview participants noted that the gendering of pregnancy and forms of gender dysphoria can be difficult to navigate. Fears about a lack of adequate reproductive care while pregnant remain a key concern for many TGGD pregnant individuals.

Throughout this thesis, the concept of biogenetic parenthood, egg freezing, and conflicted hope were central. These were grounding concepts based on their relevance to the

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field of egg freezing. I wanted to explore how experiences and desires for biogenetic parenthood among cisgender, heterosexual women were similar to but also differed from TGGD individuals. I carefully note how age-related infertility, fear of the biological clock, and biogenetic connection can have lasting impacts on both groups. At the same time, TGGD individuals must commonly weather the trials of transphobia, queerphobia, ableism, class, and racism. This is not to say that many cisgender women do not experience these same barriers; however, TGGD individuals experience these barriers at a disproportionate rate. This can make the pathway to parenthood even more complex and nuanced (Carone et al., 2021). During COVID-19, all those considering freezing their eggs had to freeze their aspirations. COVID-19 restrictions made egg freezing more difficult or concerning (Murugesu et al., 2023; Botelho, 2022; Allahbadia, 2021). However, the majority of interview participants were not impacted by COVID-19 due to their lack of interest in freezing their eggs. One interview participant Andy had called the Ottawa Fertility Centre for a consultation; however, he was unable to get an appointment because the fertility clinic was not taking on new clients due to COVID-19. In contrast, Milo froze his eggs during COVID-19 at Mount Sinai Fertility Centre, but was unable to freeze embryos due to COVID-19 restrictions. Only these two (out of nine interview participants) froze their eggs, or took steps to learn more about egg freezing, but referred to COVID-19 as a barrier to the process.

Don't Leave Us Out in the Cold- Recommendations to Healthcare Professionals

This thesis will conclude with recommendations for future research and how this thesis can contribute to better gender-affirming practices in healthcare.

1. Make healthcare spaces and fertility clinics gender-affirming healthcare spaces.

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During my time with Centretown Community Health Centre in Ottawa, I experienced exemplary care. Regardless of my legal name at the time, reception always used my new name, “Elgin,” and correct pronouns. Centretown Community Health Centre employs TGGD healthcare professionals and workers. This practice is essential to making TGGD individuals feel safe, understood, and listened to. A fertility clinic or healthcare setting can place identifiers such as the progress pride flag and trans pride flag to show support for the 2SLGBTQIA+ community. However, if a fertility clinic or healthcare setting is promoting itself as inclusive, it must be truly inclusive. When it comes to fertility clinic services, this thesis has noted how TGGD individuals globally experience unacceptable forms of cisgenderism and transphobia including deadnaming, using the wrong pronouns, being called by the incorrect gender, being referred to by offensive terms like “it”, and paperwork that does not align with their lived experiences. Reworking important documents is an excellent opportunity to consider how the clinic can ask about gender-based needs, accessibility, and experiences that will inform the best possible care.

Resources:

- Rainbow Health Ontario: Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients guidelines
<https://www.rainbowhealthontario.ca/product/4th-edition-sherbournes-guidelines-for-gender-affirming-primary-care-with-trans-and-non-binary-patients/>
- Gender-affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Care Toolkit
<https://www.transcarebc.ca/sites/default/files/2024-03/Primary-Care-Toolkit.pdf>
- Creating Authentic Safe Spaces: A Gender Identity and Gender Expression Toolkit to Support the Implementation of Institutional and Social Change

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https://www.the519.org/wp-content/uploads/PDF_Download/519_CASToolkit_ENG_AODA.pdf

- Promoting 2SLGBTQI+ Health Equity

<https://drive.google.com/drive/u/0/folders/1JpTW8zAngsotRra0zgOyVolLDDtDYXKs>

2. Do not use terms like “preferred” pronouns. TGGD individuals do not prefer their pronouns or new name; they are the person they are.

At the University of Ottawa health clinic, I was often in the waiting room, wondering which name would be used to identify me, even though I adjusted my name on the tablet presented to me when checking in, every time. When I mentioned this concern to staff behind the registration counter, I was told there was no way to add my new name on my chart without the legal name change paperwork. I was told there were previous systems in place that had allowed it, but students were using fake names like “John Snow,” and “King of the North,” and the clinic had to remove this option. Fundamentally, such experiences can leave TGGD individuals feeling like healthcare professionals and systems would rather remove options for inclusivity than deal with some of the folks who will pull pranks. While computer-based systems may not allow for names to be adjusted, it is best to provide a section where individuals can write down their new name and pronouns. This option would alleviate some of the fears for those in waiting rooms who are unsure if they will be outed.

Resources:

- Gender Inclusive Language Toolkit

https://psacunion.ca/sites/psac/files/psac_genderinclusivelanguagetoolkit_en.pdf

- Trans Care B.C. Education Centre

<https://www.transcarebc.ca/education-centre>

- Inclusive Language For Midwives And Birth Workers

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https://www.rainbowfamilies.com.au/inclusive_language_for_midwives_and_birth_workers

3. *Provide comprehensive and intersectional healthcare.*

The lived realities of many TGGD individuals are complex and intersectional, requiring that healthcare professionals acknowledge how many aspects of lived experience can contribute to poorer health outcomes. Implementing culturally relevant¹¹³ and trauma-informed¹¹⁴ models of care benefits everyone. When considering gender, class, race or ethnicity, and sexual orientation, many individuals have lived experiences that have created invisible scars. Implementing a routine that considers how every individual might have different healthcare needs, is paramount. Experiences of violence can happen to anyone. However, BIPOC, 2SLGBTQIA+ and folks living with disabilities are far more vulnerable to violence. Acknowledging how forms of violence have been used against certain communities can help lead to the best possible healthcare models, even in fertility clinic settings.

Resources:

- DEI: Diversity, Equality, and Inclusion for IVF clinics

<https://artcompass.io/dei-diversity-equity-and-inclusion-for-ivf-clinics/>

- Culturally Safe Care

¹¹³ Culturally relevant, or competent care “is seen as foundational for reducing disparities. Culturally competent care respects diversity as well as the cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors” (Butler et al., 2016, n.p).

¹¹⁴ A “trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient’s life situation — past and present — in order to provide effective health care services with a healing orientation” (Trauma-Informed Care Center, 2024, n.d.).

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<http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/education-and-training/culturally-safe-care>

<https://www.rainbowhealthontario.ca/resource-library/providing-culturally-safe-care/>

- Provincial Council for Maternal and Child Health - New Resources Support Healthy Pregnancies for People with Disabilities

<https://www.pcmch.on.ca/new-resources-support-healthy-pregnancies-for-people-with-disabilities/>

4. *Inclusive and honest promotion*

Fertility clinics have been critiqued extensively in this thesis; however, they are also very important spaces. While we can consider how fertility clinics perpetuate forms of eugenics, it is also critical to understand that many clinics personnel want to make them inclusive, safe, and for everyone. When reviewing fertility clinic websites, I noticed the lack of representation or mention of the needs of 2SLGBTQQIA+ individuals, especially TGGD individuals. This exclusion demonstrates why many TGGD individuals believe egg freezing to be a white, cisgender, heterosexual, middle-class woman's technology. If egg freezing is to be promoted, there must be equal access and representation on fertility clinic websites. If a fertility clinic wants to ensure representation, the creation of boards and committees devoted to 2SLGBTQQIA+ inclusion are one way to ensure community inclusion and feedback. Inclusion is an ongoing mission. When seeking to represent communities, their involvement is always essential. When nominating 2SLGBTQQIA+ board members, clinics must ensure that BIPOC, folks living with disabilities, and other minority communities are included.

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Resources:

- Inclusive Fertility for Transgender and Non-Binary People

<https://www.apricityfertility.com/uk/treatments/transgender-fertility>

- Considerations for 2SLGBTQI+

<https://mountsinaifertility.com/fertility-treatments/2slgbtqi/>

5. Engage in additional training on your own time.

Many healthcare professionals must engage in a certain number of hours of training per year, but it is also important that training be wide ranging. Many healthcare professionals are overworked, especially so during COVID-19, and there remains a lack of support from the provincial government. The provincial government in Ontario has prioritized its agenda to privatize healthcare in Ontario over the needs of those living in the province. The conservative government continues to allow a vulnerable healthcare system to push against those working the most diligently within it. However, resource pooling, training, and ongoing learning are critical to ensuring adequate healthcare for all. I recommend that healthcare professionals do the best they can to stay updated regarding the ongoing needs of 2SLGBTQQIA+ individuals. Taking time during the day to listen to a video, podcast, read an article, or speak to another healthcare professional will help with this journey. As someone who has recently worked to create and facilitate webinars regarding 2SLGBTQQIA+ reproductive healthcare for healthcare professionals, the attendance and participation of healthcare professionals are cherished and encouraging.

Share the experiences that have worked well for you with other cisgender, heterosexual healthcare professionals and do not expect 2SLGBTQQIA+ healthcare professionals to be the

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experts in all things related to queer and trans healthcare. The same applies for BIPOC healthcare professionals, healthcare professionals living with disabilities, etc. Assuming universal understanding or knowledge based on similar experiences lacks intersectional thinking. If you want to ask a fellow 2SLGBTQIA+ healthcare professional a question, ask first if they have the time and emotional energy to discuss it. If you need to schedule a longer discussion with them, bring them a small gift or treat for their efforts.

Resources:

- Sharman, Z. (Ed.). (2016). *The remedy: queer and trans voices on health and health care*. Arsenal Pulp Press.

https://transreads.org/wp-content/uploads/2021/07/2021-07-23_60fa117812561_TheRemedyQueerandTransVoicesonHealthandHealthcarebySharmanZenaz-lib.org_.pdf

- Kali, K. (2022). *Queer Conception. The Complete Fertility Guide for Queer and Trans Parents-to-Be*. Sasquatch Books.

<https://www.penguinrandomhouse.com/books/675793/queer-conception-by-kristin-l-kali/>

- Rainbow Health Ontario Podcast and Webinars

<https://www.rainbowhealthontario.ca/>

<https://www.rainbowhealthontario.ca/education-training/>

<https://www.rainbowhealthontario.ca/podcast/>

- The Queer Collective Podcast

<https://www.queercollectiveto.com/>

<https://www.youtube.com/channel/UCetETiJl2e1BWPl9IAAl93w>

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6. *As beloved childhood icon Ms. Valerie Frizzle¹¹⁵ says, “take chances, make mistakes, get messy!”*

Allyship is a journey, and we all miss the mark at points. When one is a healthcare professional, one is faced with moments where allyship can make or break a patient’s experience. No one is perfect, nor do I suggest that anyone will ever become perfect, but we can do our best and learn from our moments. One of the recommendations I have made to fertility clinics in the past is to learn from what went wrong. Mistakes are important teaching tools. If a receptionist misgenders a patient, uses the wrong name, or provides inaccurate information, this is a moment to learn. One of my foundational recommendations is to have active conversations in fertility clinic settings. How are policies, paperwork, and day-to-day operations making things more difficult for patients? When a patient brings up a concern, it is necessary to do the work and dig for an answer or send them to someone who is better informed. Healthcare professionals cannot be experts in all forms of healthcare, but a basic understanding and a collection of resources can mean that a healthcare professional is prepared. As a TGGD individual, nothing has been more gender-affirming than when a healthcare professional, including social workers and counsellors, has provided me with a response like: “I am not sure, and I do not want to mislead you. I am going to look into that for you.”

My doctor at Centretown Community Health Centre was often surprised about the different things that I was told, the lack of knowledge about different elements of care, and the hoops I had to jump through to help my University of Ottawa doctor with OHIP paperwork. She asserted I should not have been required to assist with paperwork, and that it wasn’t my job.

¹¹⁵ Ms. Frizzle was a beloved female character in the popular television series *The Magic School Bus*.

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Allyship can also mean calling a local gender clinic and asking questions. How can a health professional make the process of medically transitioning and dealing with OHIP funding more accessible to the patient? The priority is to take away some of the administrative burdens from the patient. Once health professionals have an idea of how to complete the tasks at hand, they will have references for the next time a concern comes up.

Resources:

- Tips for Providing PAP tests to Transgender Men

https://www.rainbowhealthontario.ca/wp-content/uploads/2020/04/Tips_Paps_TransMen.pdf

- May Clinic: Gynecological care for trans men

<https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/gynecological-care-for-trans-men/art-20473719>

- Trans-Inclusive Abortion Services

<https://static1.squarespace.com/static/5cef632e66e9b80001f24e05/t/5d4104ad89ce3b0001de98ef/1564542127747/FQPN18-Manual-EN-NTL-web.pdf>

- Morningstar Mercredi, M & Fire Keepers (2021). *Sacred Bundles Unborn*. Friesen Press.

<https://www.indigo.ca/en-ca/sacred-bundles-unborn/9781039116375.html>

Finally, for healthcare professionals interested in more resources, I have created a Google Drive <https://drive.google.com/drive/u/0/folders/1FxKLTxY2QYmyar-sKvRbEsMtyytUqAJp>

Recommendations for Future Research and Thesis Limitations

Based on the scope and limitations of this thesis, I have some recommendations for future research.

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1. One of the limitations of this thesis was geographic scope. Based on the resources at my disposal, I chose to focus on Ontario alone. I recommend a Canada-wide study be conducted. This research would require the participation of individuals from various provinces, territories, and communities for the best understanding of each provincial or territorial healthcare system. The advantage of undertaking this research would be to further knowledge of TGGD individuals and egg freezing across the country.

2. Another limitation of this thesis was the lack of representation of Black individuals and People of Colour.¹¹⁶ When beginning my recruitment, a friend of mine in my department noted that it would be difficult to get BIPOC representation. As a Black woman, she reminded me of the ways that research continues to be used against BIPOC communities and how this intersects with ongoing reproductive violence. As a white researcher, her point would be something I had to keep in mind. Therefore, future projects should prioritize the employment and involvement of BIPOC researchers and community members.

3. While this thesis was fortunate to have many folks who self-identify as neurodivergent, the unique experiences of those living with disabilities is significant. While neurodiversity remains a key part of reproductive surveillance, those living with disabilities have experienced overt forms of negative eugenics that have been implemented legally and politically in Canada. For future research, consulting and employing those living with disabilities in a similar research project could assist in seeing if healthcare has become more

¹¹⁶ There was some Indigenous representation in this thesis.

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cognisant of the reproductive and sexual healthcare needs of those living with disabilities, and their plans for future parenthood.

4. Based on the interesting connection between neurodiversity and a lack of interest in biogenetic parenthood, I would love to investigate further how neurodiversity, societal expectations, and gender come together. For many neurodivergent individuals, societal expectations and norms can be jarring, with some claiming “rules can feel prescriptive, arbitrary, and pointless” (Wayne, 2023, n.p). As seen in this thesis, many TGGD individuals may also identify as neurodivergent. TGGD individuals may not desire or care for biogenetic parenthood because of their common lack of adherence to societal pressures. This would be an incredibly interesting and dynamic project.

5. Data collection for this thesis took place during the beginning and height of the COVID-19 pandemic. Due to pandemic restrictions, fertility clinics were not accepting new patients, health clinics were closed, and healthcare professionals were less accessible. COVID-19 acted as a barrier for many seeking to freeze their eggs during 2020 and 2021 (Murugesu et al., 2023). During this time, TGGD individuals had less access to gender-affirming hormones and care (D’Angelo et al., 2021) which could have included a higher instance of poor counselling regarding their fertility options. Finally, the COVID-19 pandemic led to “zoom fatigue” due to overuse of videoconferencing technology (Lestari & Fayasari, 2022, p.151). For this reason, recruitment during COVID-19, especially among marginalized communities, may have been more difficult. If this thesis had not been conducted during the pandemic, it is possible that the numbers of participants and their survey and interview data may have

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differed from the numbers and data I have reported in this thesis, but by how much is impossible to determine.

Conclusion

This thesis began by discussing the ways that egg freezing has been both idealized and critiqued as a technology for white, cisgender, heterosexual, middle-class women. It has dived deep into the complexities of MEF versus SEF and placed TGGD individuals in this important dialogue. I received 21 survey responses and conducted nine in-depth, semi structured interviews. Using intersectional thinking, queer theory, trans*-epistemology, and the practice of ongoing consent, I explored the complex ways that TGGD individuals living in Ontario deprioritize biogenetic parenthood and wish to adopt traditionally queer and queering means of family formation. Despite my concerns that TGGD individuals were reproducing heteronormative and cisnormative forms of family formation, I discovered that queer and queer reproduction remains highly desired by TGGD individuals living in Ontario but on their own biogenetic or non-biogenetic terms. I end my thesis with this excerpt from my research journal:

“When I began my thesis in 2017, I had no idea what it would become. I wanted to interweave the stories of how eugenics, stratified reproduction, and white supremacy are used against TGGD individuals. I wanted to fill a gap in research regarding egg freezing and desires for biogenetic parenthood among TGGD individuals in Ontario, but never knew my thoughts could come together this way. This experience has been humbling. A gentle and kind reminder of the ways that my lived experience as a TGGD individual differs from my siblings. So many TGGD individuals lack access to their basic reproductive and sexual healthcare needs. How could I not bring attention to my forms of privilege over the ways that many still beg for basic care? This thesis has reminded me of my own place in my community, my duty to their lived experiences, and my ongoing and lifelong passion for reproductive and sexual healthcare justice for all.”¹¹⁷

¹¹⁷ Final research journal excerpt, 05/16/2024.

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Appendices

Appendix A
Recruitment Poster (v1)

My name is Elgin Pecjak, I am a Ph.D. Candidate, a transgender man and researcher in the Institute of Feminist and Gender Studies at the University of Ottawa, in Ontario. My dissertation topic is fertility preservation through oocyte cryopreservation among AFAB transgender and gender diverse individuals:

- Are you between the ages of 18-35?
- Are you possibly a member of one or more of these Facebook groups: CANADIAN TRANS MEN and/or TRANS ONT FTM OR MTF
- Were you assigned female at birth (AFAB)?
- Have you transitioned medically in Ontario between 2000-2020 or are you considering transitioning medically?
- Are you aware of your fertility preservation options?
- Willing to fill out a research survey and follow-up in-depth interview (up to one hour) on your fertility options?

- Complete the survey using the following link to Survey Monkey:

https://s.surveymonkey.com/JZ_p3RhES.

At the end of the survey, interested participants are invited to provide information to participate in 45–60-minute in-depth interviews where they will be able to elaborate on answers provided in the survey and share personal experiences.

- Please email Elgin Pecjak (researcher) at [REDACTED] with any questions pertaining to this research.



Recruitment Poster (v2)



CALL FOR PARTICIPANTS

- Are you between the ages of 18-35
- Are you possibly a member of one or more trans-based Facebook groups
- Have you medically transitioned in Ontario between 2000-2020 or are you considering transitioning medically?
- Are you aware of your fertility options?
- Willing to fill out a research survey and follow-up in depth interview (up to one hour) on your fertility options?



Complete the survey using the following link:
https://s.surveyplanet.com/JZ_p3RhES



- At the end of the survey, interested participants are invited to provide information to participate in 45-60 minute in-depth interviews where they will be asked to elaborate on answered provided in the survey and share personal experiences.

Please email **Elgin** at with any questions.



about the researcher

My name is Elgin Pecjak (he/him) and I am a Ph.D. Candidate, a transgender man, and a researcher with in the Institute of Feminist and Gender Studies at the University of Ottawa. My dissertation topic is fertility preservation through oocyte cryopreservation and transgender, and gender diverse individuals.

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Appendix B
Survey Sample

Question Number	Question	Type of Question	Possible responses
Consent 1	All information from this survey will remain confidential and will only be viewed by me, the researcher, Elgin Pecjak, my supervisor Dr. Christabelle Sethna, and my thesis committee. Ethical approval has been granted by the University of Ottawa in Ottawa, ON. As a transgender researcher, I am dedicated to ensuring the emotional, physical and psychological well-being of the trans and gender diverse community. The intention of my research is to provide scholarship on the topic of fertility preservation, parental choice and reproductive desires of transgender AFAB (assigned female at birth) individuals within Ontario, Canada. Participants are welcome to email me at any point. Disclaimer: Questions within this survey may provide some individuals with gender-based forms of distress, or trigger feelings/memories of difficult times. I want all participants to be aware that I am a self-identifying queer, AFAB transgender male myself and have provided this survey to other transgender and gender diverse individuals who have medically, or socially transitioned. I want to ensure as little emotional and psychological distress as possible to participants. At the end of the survey, there will be a list of resources should you find yourself feeling any form of upset or trauma during the survey process. If you at any point wish to not respond to a question, please feel free to click the NA (not applicable) option. You may also write NA in any of the text-based answer boxes. By clicking “Yes, I consent” below, you will be choosing to participate in this survey. Note that all information in this survey will be used to further trans-affirming research on reproductive health care, parenting, fertility preservation and reproductive choice among AFAB transgender and gender diverse individuals. If you provide your names and contact information as requested at the end of the survey, it will only be used for the purposes of asking clarifying question or to contact you for a follow up interview.	Multiple Choice (MC)	· Yes, I consent · No, I do not consent
2	What pronouns do you used	Essay	

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3	Do you currently live in Ontario	MC	· Yes · No
4	Have you begun, or are planning to begin your medical transition using HRT in the province of Ontario between 2000-2020?	Multiple Choice	· Yes · No · Unsure
	What is your current status within Canada?	Multiple Choice	· Canadian citizen · Permanent resident or immigrant · Visitor · Student · Work permit (Skilled worker, temporary foreign worker, caregivers, working holiday) · Business permit (start up visa, investor, self-employed, entrepreneur) · Sponsored by a family · Refugee or protected person · Asylum or refugee claimant · Pending status (Judicial review or pre-removal risk assessment) · Admission on humanitarian and compassionate groups · Undocumented person (irregular immigrant, non-status, etc.) · Unsure · Other (please specify)
5	Which language(s) are you most comfortable speaking?	MC	· French · English · Other
6	What is your age?	MC	· Under 25 · 25-30 · 31-35 · 36-40 · 41-45 · Over 45
7	How do you racially identify?	Essay	

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8	Do you self-identify and/or have been diagnosed as a person with a disability or as a disabled person? (this includes all forms of disability including neurodiversity and cognitive disability)	Multiple Choice	· No · Yes (please specify)
9	What is/are your current relationship status(es)?	Multiple Choice	· Single and monogamous · Single and poly or non-monogamous · Engaged and monogamous · Engaged and poly or non-monogamous · Married and monogamous · Married and poly or non-monogamous · Partnered · Partnered and non-monogamous or poly but currently have only primary partner · Partnered and non-monogamous or poly with a secondary partner · Partnered and non-monogamous or poly with multiple partners · Other (please specify)
10	Do you currently have any children? If so, how many?	Essay	
11	If you have children, what are their ages?	Essay	
12	Did you have your children prior to your medical transition? If so, how many did you have prior to transitioning, and how many did you have after?	Essay	
13	Are you currently employed?	Multiple Choice	· Yes · Yes, but have not begun my position · Yes, but I have been displaced from my position due to COVID-19 · No, my employment ended due to COVID-19 · No
14	What was your last 2019 annual income	Multiple Choice	\$0-\$8000 \$8000-\$15,000 \$15,000-\$25,000 \$25,000-\$40,000 \$40,000-\$65,000 \$65,000-\$80,000

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			\$80,000-\$100,000 \$100,000-\$150,000 \$150,000+
15	Are you currently a student?	Multiple Choice	· Yes · No · I have applied but have not been accepted · I have been accepted but have not begun my studies
16	What is your highest level of education completed	Multiple Choice	· Some high school, no diploma · Highschool (GED) · Some college · College diploma · Some university, no degree · Undergraduate degree · Some graduate work, no degree · Master's degree (MA, MS, MBA) · Some doctoral work, no degree · Doctoral or professional degree (MD, JD, Ph.D.)
17	Please provide your residential postal code if you feel comfortable doing so	Essay	
18	What is your gender identity	Essay	
19	Have you ever identified with a transgender identity other than the one you currently use? (i.e. Have you previously identified as genderqueer but now identify as a transgender man?)	Multiple Choice	· No · Yes (Please Specify)
20	What is your current sexual orientation?	Essay	
21	Has your sexual orientation or attraction changed since transitioning?	Essay	
22	Please provide postal code, if you feel comfortable doing so.	Open	
23	How do you racially identify?	Essay	
24	Have you ever taken hormone blockers between 2000-2020?	MC	· Yes · No · Unsure
25	Have you or a medical professional ever taken steps to preserve your fertility in any way since 2000-2020		· Yes · No · Unsure

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26	Have you ever engaged in oocyte cryopreservation (freezing your eggs)? If so, when? Where?	Essay	
27	Have you experienced any barriers to freezing your eggs? If so, what were they?	Essay	
28	What trans based Facebook group(s) are you apart of?	Essay	
29	Why did you join this Facebook group?	Essay	
30	Are there any questions I should have asked you? If so, could you suggest some?	Essay	
31	Is there anything else you would like to add?	Essay	
	Would you be willing to participate in a follow-up in-depth interview with the researcher (approximately 1hr)?		· Yes (provide email) · No · Unsure

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Appendix C
Coverage for Egg Freezing by Province

Province	Coverage	Details
Alberta	None	Alberta Health Services does not cover any fertility treatments (Oasis Fertility, 2022).
British Columbia	Taxable	- BC Medical Services Plan covers fertility testing and surgery but not fertility treatments (Genesis, 2023) - Residents can claim under Section 118.2 of the Income Tax Act and can claim fertility treatment as a medical expense (Genesis, 2023)
Manitoba	Taxable	- Manitoba Health does not cover any costs associated with fertility treatment. - Fertility Treatment Tax Credit of “\$20,000 in annual eligible costs for a maximum yearly Fertility Treatment Tax Credit of \$8,000” equally “<i>equal to 40% of the cost of fertility treatments</i>” (Government of Manitoba, n.d, n.p).
New Brunswick	Partial funding with infertility diagnosis	New Brunswick Medicare provides a one-time payment of \$5,000/household through The Special Assistance Fund however, an infertility diagnosis is required (Government of New Brunswick, 2023).
Newfoundland and Labrador		- Provides Fertility Subsidy Program through Newfoundland Medical Care Insurance “\$5,000 per In-Vitro Fertilization (IVF) cycle to applicants who meet clinical eligibility” - Up to a maximum of three IVF cycles throughout their lifetime. - Services included in the subsidy program may include: IVF, frozen embryo transfer, donor egg cycles, donor embryo cycles, oocyte cryopreservation, intracytoplasmic sperm injection (ICSI), and gestational carrier cycles as well as medications associated with these services.” (Eastern Health News Centre, 2022, n.p)
Northwest Territories		Northwest Territories Health Care Plan does not cover any fertility treatments (Braich et al., 2024).

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Nunavut		Nunavut Health Care Plan does not cover any fertility treatments (Braich et al., 2024).
Nova Scotia	Fertility and Surrogacy Rebate	Nova Scotia's Health Insurance Programs known as Medical Services Insurance Programs covers fertility treatment and surrogacy under the Nova Scotia Fertility and Surrogacy Rebate. This provides “no limit on the number of treatments that an individual can claim, but the maximum annual claim is \$20,000 in eligible costs for a maximum annual tax credit of \$8,000.” (Province of Nova Scotia, 2023, n.p).
Ontario	Partial Coverage	- Ontario Health Insurance Plan covers: - Up to two attempts at cycle monitoring - One attempt at egg retrieval - Freezing of one batch/sample of eggs or sperm with no time restriction (however freezers must pay storage fees) - Sperm collection or, if required, one attempt at surgical sperm retrieval using certain techniques - One round of In-Vitro Fertilization - Ontario Health Insurance Plan does not cover: - Storage fees (\$300-500 per year) - Fees associated with ovulation stimulated medications. - Sperm donor (if required) - Additional rounds of In-Vitro Fertilization (if required) \$8000-\$10,000/cycle (Ontario Fertility, 2023).
Prince Edward Island	Fertility Treatment Program	- Prince Edward Island's Provincial Health Plan provides some coverage based on income; however, egg freezing is not listed specifically. - Fertility Treatment Program provides funds for In-Vitro Fertilization, intrauterine insemination, and associated prescriptions but does not mention egg freezing. - Program provides funds based on household income with the potential of receiving \$5,000 and \$10,000 annually in coverage (Government of Prince Edward Island, 2020).

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Quebec	None for TGGD individuals	• Québec Health Insurance Plan covers only for cancer related fertility treatment. Treatment for these individuals include: - up to two ovarian stimulations as per medical indications - one egg retrieval, - standard IVF services, - one surgical sperm cell collection - freezing and storage of a sperm sample, oocytes, or embryo (Government of Québec, 2023).
Saskatchewan	Taxable	• Saskatchewan Health covers some costs for fertility evaluation but does not cover for fertility treatments (Aurora Reproductive Care, n.d.) • Residents can claim under Section 118.2 of the Income Tax Act and can claim fertility treatment as a medical expense (Aurora Reproductive Care, n.d.)
Yukon		• Yukon Health Insurance Plan does not cover any fertility treatments (Braich et al., 2024).

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Appendix D

Consent Form and Disclaimers



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et de genre / Institute of
Feminist and Gender Studies



CONSENT FOR INTERVIEWS

Title of the project: Scrambling for Parenthood: Oocyte cryopreservation, conflicted hope, and biogenetic parenthood in AFAB transgender and gender diverse individuals in Ontario, Canada.

Researcher: Elgin Pecjak, BA, MA, Ph.D. Candidate (he/him)


University of Ottawa
Institute of Feminist and Gender Studies
Supervisor: Dr. Christabelle Sethna (she/her)
csethna@uottawa.ca

Invitation to Participate: Interested parties are invited to participate in the abovementioned research study conducted by Elgin A. Pecjak.

Introduction: As a member of the transgender and gender diverse community, I am committed to the sharing and production of positive and affirming research regarding the 2SLGBTQIA+ community. All information from this survey will remain confidential and will only be known by myself, my supervisor, Dr. Christabelle Sethna, and when required, members of my research committee, including Dr. Alexandre Baril, Dr. Vanessa Gruden, and Dr. Raywat Deonandan. The University of Ottawa has granted ethical approval for this research, ON.

I am a queer, transgender man and researcher who is dedicated to ensuring the emotional, physical, and psychological well-being of the trans and gender diverse community. The intention of my research is to provide scholarship on the topic of fertility preservation, parental choice, and reproductive desires of transgender AFAB (assigned female at birth) individuals in Ontario, Canada. Individuals are welcome to contact me at any point to ask questions or request more information: 

Purpose of the Study: The purpose of this project is to gain critical knowledge about what AFAB transgender and gender diverse individuals living in Ontario, Canada understand about their reproductive options. This project seeks to explore the decision-making process of these individuals regarding fertility preservation in order to raise awareness of the specific reproductive needs of AFAB transgender and gender-diverse individuals.

Participation: Individuals who have completed the survey (via Survey Planet) have had the option to continue to a voluntary follow-up interview. They will be asked if they wish to participate in one follow-up interview that will last approximately 60-90 minutes in length and will take place via Zoom and will auto recorded with the explicit consent of the participant. The general nature of the questions asked in the interview include experiences with healthcare providers and knowledge about fertility and reproduction. Interview participants

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may also be asked to elaborate on answers they submitted in the survey. The researcher will conduct the follow-up interviews in a private, quiet office in his home.

Audio recordings during the interview process is entirely voluntary and optional. By checking the yes box, participants indicate they are comfortable with having their interview audio recorded. If the participant checks the no box, they are indicating they do not wish to have the interview audio recorded.

☐

Yes, an audio recording may be during the interview

☐

No, an audio recording may not be done during the interview

Risks: Some of the questions I ask survey participants may evoke feelings of distress related to experiences of misgendering, transphobia and cisgenderism. Recalling information prior to an individual's gender expression can cause anxiety and distress among some transgender individuals. Participants may find discussing their experiences with medical professionals and their experiences of barriers to health care troubling. Participants who have engaged with fertility preservation may experience distress when recalling the highly gendered language used to describe their bodies, the ceasing of Hormone Replacement Therapy, taking gender incongruent hormones, transvaginal and transabdominal ultrasounds and the changes they see in their bodies that do not align with their preferred gender during this process.

Benefits: The possible benefits of this project include adding to the scarce information about AFAB transgender and gender diverse individuals' opinions about fertility preservation and connected issues such as reproduction, parenthood, and reproductive technology use. This study may also demonstrate the specific needs for transgender and gender diverse individuals which could contribute to future policy development, professional and medical guidelines, and training of reproductive and medical healthcare professionals.

Consent and Confidentiality: All participants have the right to withdraw consent from the study at anytime, and their data will be destroyed. They have the right to refuse to answer any survey or interview questions that may make them feel afraid or afraid, may put them in harm, or may cause ill treatment. All participants will be provided with pseudonyms to protect their privacy and identity. Any documents containing sensitive and confidential information will only be accessible to the researcher and his supervisor. While participant safety is the priority, the researcher is unable to guarantee complete confidentiality due to the use of online platforms including Survey Planet and Zoom. All participants are welcome to access each platform's confidentiality agreement for further information. To minimize the risk of security breaches and to help
2
ensure my confidentiality, it is recommended that participants use standard safety measures, such as signing out of my account, closing my browser, and

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locking my device when they are no longer using it/when I have completed the study. All participants are welcome to access each platform's confidentiality agreement for further information. All participants should keep a copy of any consent forms from this project for their personal records.

Pseudonyms will be used for all participants to ensure they remain anonymous. A pseudonym is a name that is used to refer to a participant instead of their real name/affiliations. By checking the yes box, participants indicate they wish to have a pseudonym used to protect their privacy. If the participant checks the no box, they are indicating they do not wish to use a pseudonym and their name will appear with any from this study.

☐

Yes, a pseudonym should be used to protect the participant's identity

☐

No, a pseudonym should not be used to protect the identity of the participant and the name of the participant will be used instead

Conservation of Data: All documents will be stored on the researcher's laptop. It is password protected for additional security should the laptop be lost or misplaced. All material will be backed up to a USB drive that will be secured under lock and key in my home office. The only individual with physical access is the researcher. All data will be retained for the period of 5 years. All data will be destroyed by permanently deleting and removing all required documents from my personal laptop after the 5-year retention period.

No compensation is provided to those who participate in this research project. No funding has been provided for this research.

Please be aware this project is conducted independently from the organizations and agencies from which participants may be recruited.

Should any participant feel the need to contact the University of Ottawa's Office of Research and Integrity that authorized this study, please do so via the telephone or email listed below.

Office of Research Ethics and Integrity
Tel.: 613-562-5387
Fax.: 613-562-5338
ethics@uottawa.ca

Participants are also welcomed to inquire with any questions to the researcher's supervisor Dr. Christabelle Sethna at the Institute of Feminist and Gender Studies via email at csethna@uottawa.ca

Acceptance: By signing their name below, the participant agrees to take part in this research study.

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Participant's name: _____

Date: _____

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

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Appendix E
Privacy Policy of the Researcher and “The Survey Creator”

The researcher, Elgin Pecjak will provide links to the pertinent information regarding the privacy and security of online information from SurveyPlanet and Zoom.

SurveyPlanet

For participants choosing to complete the online survey through SurveyPlanet please be sure to read the Privacy agreement provided from SurveyPlanet should you have questions regarding your safety, privacy or confidentiality. While the research maintains responsibility for the content of the survey, using online tools means the researcher can not guarantee that participant's computers or servers are secure.

Collected Survey Data

For privacy and safety information regarding the completion of the survey and the contents as submitted to SurveyPlanet, please see the following document *Appendix F: Privacy and Security Disclaimer SurveyPlanet*. All information collected from the survey as completed on SurveyPlanet will have restricted access. The researcher will be the only individual who is able to view the answers to questions, see any answers submitted, and have access to the personal information provided. SurveyPlanet allows “Survey Creators” to download content from the survey once completed by the desired number of respondents. The researcher will download this document into their password protected portable laptop in a Microsoft Office document saved with a password. The researcher can not guarantee the safety of information submitted through SurveyPlanet but will ensure privacy, safety and confidentiality with all downloaded results and email correspondence. The researcher will employ additional security means listed under the section *Personal Information of Participants*.

Please note the researcher is unable to guarantee the safety of your online information that you provide. For this reason, be aware of your privacy rights through both SurveyPlanet and Zoom. Please refrain from disclosing any information that you feel may put you in any type of harm or may threaten your physical safety.

Email Correspondence

The research will be the only individual permitted to review the collected data information from the surveys. Moreover, the researcher will be the only individual responding to emails, reviewing completed surveys and accessing any type of personal information provided. The email address _____ was created specifically for this project. The researcher will be the only individual who has permitted access to this email account. All emails sent to the researcher will remain confidential including their content and the personal information about the sender including their name and contact information. The researcher is the only individual provided with access to respond to your emails at this email address. Should you feel that your information has been compromised in any form, please notify the researcher immediately.

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Personal Information of Participants

The researcher will be the only individual permitted to review the collected data information from the surveys directly through SurveyPlanet. The researcher will be providing assigned *pseudonyms* for all participants within the interviews or will reference survey participants under *survey participant* (followed by a number). The pseudonyms and survey participant numbers provided to participants will be listed under an encrypted and password protected Microsoft Office document (named *Personal Information of Participants*). The researcher will be the only person capable of accessing the *Personal Information of Participants* document. Moreover, the researcher will be the only individual with the password for this password protected document. This document will not be stored through any online resource include The Cloud or Google Docs. The *Personal Information of Participants* document will be stored only on the researcher's computer with no USB or external copies available. The portable laptop of the researcher is encrypted with a separate password only privy to the researcher.

All information include survey responses will be downloaded onto the researcher portable laptop and will also be encrypted with a separate password. This information will be restricted to the use and viewing of the researcher alone.

Zoom and Interviews

Zoom takes the privacy and safety of their users very seriously. For privacy and safety information regarding the completion of the survey and the contents as submitted to SurveyPlanet, please see the following document *Appendix G: Privacy and Security Disclaimer Zoom*. Users including those who are being interviewed, are advised to view the [Best Practices for Securing your Zoom Meeting](#) document (click for link).

The researcher will be the only individual present during the duration of the interviews, he will be the only individual with the personal information of the interviewee and only one who has the participants responses to the survey. The researcher will be audio recording all interviews conducted but only with the explicit permission of the participants. Participants can withdrawal consent at any time during the interview process and can easily withdrawal consent for the audio recording of the interview via Zoom. The researcher understands that for some transgender and gender diverse individuals, the thought of having their voice recorded is difficult. The purpose of recording these interviews is to ensure the accuracy of information and ability to quote individual responses. The downloaded audio recordings will only be accessible by the researcher and will be kept with the *Personal Information of Participants* in a password locked folder.

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Appendix F
Privacy and Security Disclaimer SurveyPlanet

<https://surveyplanet.com/legal>

Promises for researcher

(ii) to protect your username and password at all times;

“You expressly agree: (i) that SurveyPlanet has the right to suspend and/or terminate your account and refuse any and all current or further use of the Service if SurveyPlanet determines, in its sole discretion, that any information you provide is untrue, inaccurate, not current and/or incomplete; **(ii) to protect your username and password at all times; (iii) to notify SurveyPlanet immediately of any unauthorized use of your account or any other need to deactivate your username and/or password due to security concerns; and (iv) that SurveyPlanet shall not be responsible for unauthorized access to or alteration of your data.** SurveyPlanet is not liable for any harm caused or related to the theft or misappropriation of your username and/or password, disclosure or your username and/or password, or your authorization of anyone else to use your username and/or password. **From time to time, SurveyPlanet may find it necessary to access your account. For instance, SurveyPlanet may access your account for support, maintenance or security-related reasons. In such event, SurveyPlanet will, if possible, provide you notice of its intent to use your username and password to do so.** Regardless of whether such notice is provided, you acknowledge and consent to such access. Furthermore, recognizing the global nature of the Internet, you agree to comply with all local rules regarding online conduct and acceptable content. Specifically, you agree to comply with all applicable laws regarding the transmission of technical data exported from the United States or the country in which you reside and to comply with any other local laws affecting the transmission or posting of content or affecting the privacy of persons.”

Survey Planet Privacy Terms for Survey Respondents (taken verbatim on 04-17-2020)

<https://surveyplanet.com/legal>

Privacy Terms for Survey Respondents

1. Types of Information We Collect

When you respond to surveys hosted by SurveyPlanet, we collect and store the survey responses that you submit. The Survey Creator is responsible for this information and manages it. A survey may ask you to provide Personal Information or data. **If you provide such information to the Survey Creator, the Survey Creator may have its own privacy policy that applies to the information you provide.**

You might provide us with your contact information (for example an email address) in an interaction with our customer, service or technical support representatives.

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SurveyPlanet may additionally automatically collect information about your visit to the Site, such as how you navigate within the Site, pages viewed and links clicked; device information such as IP address, location and provider and, if you are on a mobile device. We do not collect UUID of mobile devices, nor would we ever do so.

Our web server may log details such as your operating system type, browser type, domain, and other system settings, as well as the language your system uses and the country and time zone in which your device is located. The web server logs also may record information such as the address of the web page that linked you to our site and the IP address of the device you use to connect to the Internet.

We do use third party web analytics services on the Site such as Google Analytics, Google Ads, and Facebook Ads. The service providers that administer these services use technologies such as cookies, web server logs and web beacons to help us analyze how visitors use the site. Cookies from these applications are put into the browser of users who visit the SurveyPlanet website. For more information on cookies, see our Cookies Policy below. The information collected through these means (including IP address) is disclosed to these service providers, who use the information to evaluate use of the website. You may deactivate the ability of these analytics services to analyze your browsing activities on this site. This page describes how Google Analytics uses cookies:

<https://developers.google.com/analytics/devguides/collection/analyticsjs/cookie-usage>. We do not use Google Analytics to gather personally identifiable information about our users.

To disable Google Analytics, please download the browser add-on for the deactivation of Google Analytics provided by Google at <http://tools.google.com/dlpage/gaoptout?hl=en>. To learn more about privacy and Google Analytics please consult the Google Analytics overview provided by Google at: <http://www.google.com/intl/en/analytics/privacyoverview.html>.

2. Our Cookies Policy

SurveyPlanet ("us", "we", or "our") uses cookies on the <https://www.surveyplanet.com> website and the SurveyPlanet mobile application (the "Service"). By using the Service, you consent to the use of cookies.

Our Cookies Policy explains what cookies are, how we use cookies, how third-parties we may partner with may use cookies on the Service, your choices regarding cookies and further information about cookies.

What are cookies?

Cookies are small pieces of text sent to your web browser by a website you visit. A cookie file is stored in your web browser and allows the Service or a third-party to recognize you and make your next visit easier and the Service more useful to you.

Cookies can be "persistent" or "session" cookies. Persistent cookies remain on your personal computer or mobile device when you go offline, while session cookies are deleted as soon as you close your web browser.

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How SurveyPlanet uses cookies

When you use and access the Service, we may place a number of cookies files in your web browser.

We use cookies for the following purposes: To maintain your login session, application settings, and to record analytic data as referenced to third party services. enable certain functions of the Service

We use both session and persistent cookies on the Service and we may use different types of cookies to run the Service:

Essential cookies. We may use cookies to remember information that changes the way the Service behaves or looks, such as a user's language preference on the Service.

Accounts-related cookies. We may use accounts-related cookies to authenticate users and prevent fraudulent use of user accounts. We may use these cookies to remember information that changes the way the Service behaves or looks, such as the "remember me" functionality.

Analytics cookies. We may use analytics cookies to track information how the Service is used so that we can make improvements. We may also use analytics cookies to test new advertisements, pages, features or new functionality of the Service to see how our users react to them.

Third-party cookies

In addition to our own cookies, we may also use various third-parties cookies to report usage statistics of the Service, deliver advertisements on and through the Service, and so on.

What are your choices regarding cookies

If you'd like to delete cookies or instruct your web browser to delete or refuse cookies, please visit the help pages of your web browser.

Please note, however, that if you delete cookies or refuse to accept them, you might not be able to use all of the features we offer, you may not be able to store your preferences, and some of our pages might not display properly.

For the Chrome web browser, please visit this page from Google:

<https://support.google.com/accounts/answer/32050>

For the Internet Explorer web browser, please visit this page from Microsoft:

<http://support.microsoft.com/kb/278835>

For the Firefox web browser, please visit this page from Mozilla: <https://support.mozilla.org/en-US/products/firefox/protect-your-privacy/cookies>

For the Safari web browser, please visit this page from Apple:

<https://support.apple.com/guide/safari/manage-cookies-and-website-data-sfri11471/mac>

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For any other web browser, please visit your web browser's official web pages.

Where can you find more information about cookies

You can learn more about cookies and the following third-party websites:

AllAboutCookies: <http://www.allaboutcookies.org/>

Network Advertising Initiative: <http://www.networkadvertising.org/>

For any updates to our Cooke policy, please check this link: <https://termsfeed.com/cookies-policy/62ef071c3c14e071c074768c35f7a173>

3. How We Use the Information Collected

Your survey responses are owned and managed by the Survey Creator and such information and data is treated as private to the Survey Creator by SurveyPlanet. Some Survey Creators may provide you with a privacy policy or other privacy notice at the time you take their survey and we encourage you to carefully review it to understand how the Survey Creator will handle your responses. Please see the Privacy for Survey Creators above to understand how Survey Planet handles your responses. **SurveyPlanet does not sell your survey response to third parties and we not use any Personal Information collected by our customer survey to contact Survey Respondents.**

We process personal data about you where you have consented or for the SurveyPlanet's legitimate interests of improving service experience and developing new products and service features, as well as for compliance purposes.

When you have consented, we use contact information to respond to your inquiries, send you information about our Service, and send you marketing information (as long as you have expressly agreed to this when you provided your contact information and for so long as you don't opt out). You may opt out of receiving marketing communications at any time by support@surveyplanet.com.

We use information about how you use the Service to improve our services for you and all users. This may include performing analysis aimed at improving the Service and making the Site or the Service more user friendly by reducing the need for you to repeatedly enter the same information. We use device data and log data to troubleshoot, to create new services, features and content, to track behavior at the aggregate level to identify and understand trends and to fix bugs and troubleshoot functionality. We also infer your geographic location based on your IP address. We generally only use this data in aggregate form, that is, as a statistical measure, and not in a manner that would identify you personally.

We may also use your Personal Information to the extent necessary to enforce agreements or in response to a subpoena or other legal request.

SCRAMBLING FOR PARENTHOOD?

In all cases, we have undertaken to ensure that we place clear limitations on each use of your Personal Information so that your privacy is respected and only the information necessary to achieve these legitimate interests is used.

4. The Sharing and Disclosure of Your Information

SurveyPlanet hosts surveys for Survey Creators who are the owners and users of your survey responses. We do not own or sell your survey responses. **Anything you expressly disclose in your survey responses will be naturally disclosed to Survey Creators. Please contact the Survey Creator directly to better understand how they might share your survey responses.**

SurveyPlanet may provide aggregate information to our partners about how our users, collectively, use our site. If you do not wish to have your individual usage information collected, please email us at: support@surveyplanet.com.

We do not rent, lease, disclose, or sell your Personal Information to anyone. Except as described in this Privacy Policy, your Personal Information will be used only SurveyPlanet and its controlled subsidiaries and affiliates, and your Personal Information will not be disclosed to any other third party without your consent.

5. Your Rights to Your Information

SurveyPlanet is a service that collects survey responses on behalf of Survey Creators. **If you have any questions about a survey, or if you want to access, update or delete anything in your survey responses, please contact the Survey Creator directly. Once a survey is complete the answers are inserted into our database and removed from LocalStorage with the exception of the unique survey id and a binary variable (true or false) specifying that the survey was completed.** This helps prevent users from taking the survey multiple times. That said, I'd rather this information not be public since it would enable survey participants to take surveys multiple times by simply deleting their LocalStorage.

If you do not wish to be contacted to take surveys which are sent by Survey Creators via SurveyPlanet, you may opt out of receiving such invitations by emailing support@surveyplanet.com. You cannot opt-out of survey Campaigns unless you receive an email from us—this prevents people from “unsubscribing” email address they do not own. Once a person receives an email from us there is a link at the bottom which enables the owner of the address the email was sent to to opt-out from any further emails.

For information of how to opt out of marketing communications and other rights you may have, please see the section on “Your Rights” below.

Privacy Terms for Visitors

1. Types of Information We Collect

SurveyPlanet may receive and store certain types of information whenever you interact with our Site or Service. Generally, our Service may automatically collect usage information, such as the numbers and frequency of visitors to our Site and its components.

SCRAMBLING FOR PARENTHOOD?

SurveyPlanet may additionally automatically collect information about your visit to the Site, such as how you navigate within the Site, pages viewed and links clicked; device information such as IP address, location and provider and, if you are on a mobile device. We do not collect UUID of mobile devices, nor would we ever do so.

2. How We Use the Information Collected

We process personal data about you where you have consented or for the SurveyPlanet's legitimate interests of improving service experience and developing new products and service features.

When you have consented, we use contact information to respond to your inquiries, send you information about our Service, and send you marketing information (as long as you have agreed to this when you provided your contact information and for so long as you don't opt out).

We use information about how you use the Service to improve our services for you and all users. This may include performing analysis aimed at improving the Service and making the Site or the Service more user friendly by reducing the need for you to repeatedly enter the same information. We use device data and log data to troubleshoot, to create new services, features and content, to track behavior at the aggregate level to identify and understand trends and to fix bugs and troubleshoot functionality. We also infer your geographic location based on your IP address. We generally only use this data in aggregate form, that is, as a statistical measure, and not in a manner that would identify you personally.

We may also use your Personal Information to the extent necessary to enforce agreements or in response to a subpoena or other legal request.

In all cases, we have undertaken to ensure that we place clear limitations on each use of your Personal Information so that your privacy is respected and only the information necessary to achieve these legitimate interests is used.

3. The Sharing and Disclosure of your Personal Information

SurveyPlanet may provide aggregate information to our partners about how our users, collectively, use our site. If you do not wish to have your individual usage information collected, please email support@surveyplanet.com.

We do not rent, lease, disclose, or sell your Personal Information to anyone. Except as described in this Privacy Policy, your Personal Information will be used only SurveyPlanet and its controlled subsidiaries and affiliates, and your Personal Information will not be disclosed to any other third party without your consent.

4. Your Rights to Your Personal Information

For information of how to opt out of marketing communications and other rights you may have, please see the section on "Your Rights" below.

"Do Not Track" Signals

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Some browsers transmit Do Not Track (DNT) signals to websites. Due to the lack of a common interpretation of DNT signals, we do not currently alter, change, or respond to DNT requests or signals from these browsers.

Cross-Border Data Transfers

SurveyPlanet is located in the United States and accordingly data, including Respondent data, will be transferred to the United States. **If you are accessing our Site from the European Union, Australia, Asia, or any other region with laws or regulations governing personal data collection, use and disclosure laws that differ from the United States, we have measures in place that ensure that when your personal information is transferred internationally, it is subject to appropriate safeguards in accordance with data protection laws.**

How we Secure Personal Information

SurveyPlanet uses physical, electronic, and administrative safeguards to assist us in preventing unauthorized access, maintaining data accuracy, and correctly using Personal Information. Except as specified in this Privacy Policy, we use commercially reasonable efforts to limit access to your Personal Information to the employees, agents and officers of SurveyPlanet who need the information for their jobs.

The Personal Information SurveyPlanet collects is securely stored within our database, and we use standard, industry-wide practices such as firewalls, encryption, and Secure Socket Layers (“SSL”) for protecting your information. We regularly monitor our systems for possible vulnerabilities and attacks.

However, as effective as encryption technology is, no security system is impenetrable. SurveyPlanet cannot guarantee the security of our database, nor can we guarantee that information you supply won’t be intercepted while being transmitted to SurveyPlanet over the Internet. We recommend that you do not disclose your password to anyone.

How long we keep your personal information

For Survey Creators, we retain your personal data while your account is in existence or as needed to provide you the Service. This includes data you or others provided to us and data generated or inferred from your use of the Service. Even if you use the Service for a new survey every few years, we will retain your information and keep your profile open until you decide to close your account. We do reserve the right to delete inactive accounts and all data after three years. In some cases we may choose to retain certain information in a depersonalized or aggregated form.

We do not delete survey participants or answers. Survey answers are tied to the survey participant who created them. We do not store Participant email addresses unless they are asked for by the user who created the survey. For example, if you create a survey you can specify whether you want an email to be required or optional in order to take a survey. You can also specify that no email is required and that the survey be completely anonymous. You may read more here:<https://docs.surveyplanet.com/welcome-success-settings#email>.

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Safety of Minors

Our services are not intended for and may not be used by minors. SurveyPlanet does not knowingly collect any personal information from minors. During the registration process for a SurveyPlanet account, if users identify themselves as under 13 years of age, SurveyPlanet will block such users from providing personal information.

If it comes to our attention that we have collected personal data from a minor, we may delete this information without notice. If you have reason to believe this has occurred please contact us at support@surveyplanet.com.

Your Rights

You may have rights under European and other laws to have access to your personal information and to ask us to rectify, erase and restrict use of, your personal information. You may also have rights to object to your personal information being used, to ask for the transfer of personal information you have made available to use and to withdraw consent to the use of your personal information.

We will honor your rights under applicable data protection laws. You have the following rights under European laws, and may have similar rights under the laws of other countries.

Right of subject access: The right to make a written request for details of your personal information and a copy of that personal information.

Right to rectification: The right to have inaccurate information about you corrected or removed.

Right to erasure (“right to be forgotten”): The right to have certain personal information about you erased.

Right to restriction of processing: The right to request that your personal information is only used for restricted purposes.

Right to opt out of marketing: You can manage your marketing preferences by clicking on the unsubscribe link at the bottom of your email.

Right to object: The right to object to processing of your personal information in cases where our processing is based on the performance of a task carried out in the public interest or we have let you know the processing is necessary for our or a third party’s legitimate interests.

Right to data portability: The right to ask for the personal information you have made available to us to be transferred to you or a third party in machine-readable format.

Right to withdraw consent: The right to withdraw any consent you have previously given us to handle your personal information. If you withdraw your consent, this will not affect the lawfulness of our use of your personal information prior to the withdrawal of your consent.

These rights are not absolute and they do not always apply in all cases.

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In response to a request, we will ask you to verify your identity if we need to, and to provide information that helps us to understand your request better. We will respond to your request to exercise these rights within a reasonable time. If we do not comply with your request, whether in whole or in part, we will explain why.

order to exercise your rights, please contact us at support@surveyplanet.com.

If you are a Survey Respondent, you will need to contact the Survey Creator directly to discuss managing, deleting, accessing, restricting information which you provided to them in your responses. SurveyPlanet does not control your response data and, accordingly, is not in a position to directly handle these requests in relation to that data. If you need help finding the Survey Creator you can contact us at support@surveyplanet.com, and we will try our best to help you.

Where you have visited our website but have not opened an account with SurveyPlanet, and you want to exercise any of the above rights please contact us at support@surveyplanet.com.

Sole Statement of Privacy

This document contains and is the sole statement of SurveyPlanet's Privacy Policy. No summary, restatement or other version thereof, or other privacy policy or statement, in any form, is valid.

Modifications of this Privacy Policy

SURVEYPLANET MAY MODIFY THIS PRIVACY POLICY AT ANY TIME, IN SURVEYPLANET'S SOLE DISCRETION, AND SUCH MODIFICATION SHALL BE EFFECTIVE IMMEDIATELY UPON EITHER POSTING OF THE MODIFIED PRIVACY POLICY ON THE WEBSITE OR NOTIFYING YOU. YOU AGREE TO REVIEW THIS PRIVACY POLICY PERIODICALLY TO ENSURE THAT YOU ARE AWARE OF ANY MODIFICATIONS. YOUR CONTINUED ACCESS OR USE OF THE WEBSITE AND/OR THE SOFTWARE SHALL BE DEEMED YOUR CONCLUSIVE ACCEPTANCE OF THE MODIFIED PRIVACY POLICY. IF YOU DO NOT CANCEL YOUR SUBSCRIPTION AND CONTINUE TO USE OUR SERVICES, YOU WILL BE CONSIDERED AS HAVING EXPRESSLY CONSENTED TO THE MODIFICATIONS IN OUR PRIVACY POLICY. IF YOU DISAGREE WITH THE TERMS OF THIS PRIVACY POLICY OR ANY UPDATED PRIVACY POLICY, YOU MAY CLOSE YOUR SURVEYPLANET ACCOUNT AT ANY TIME.

Last Updated: June 2018

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Appendix G
Privacy and Security Disclaimer Zoom

<https://zoom.us/docs/en-us/privacy-and-security.html>

If you think you may have found a security vulnerability within Zoom, please [submit a vulnerability report](#) or contact our security team directly at security@zoom.us.

In-Meeting Settings

Zoom has controls at your fingertips to ensure your meetings are secure and disruption-free.

Security options in toolbar: Meeting hosts have a Security icon in the toolbar for quick access to essential in-meeting security controls. See it in action!

Lock the meeting: When a host locks a Zoom Meeting that's already started, no new participants can join, even if they have the meeting ID and password (if you have required one).

Remove participants: From that Participants menu, you can mouse over a participant's name, and several options will appear, including "Remove".

Put participant on hold: You can put an attendee on hold and their video and audio connections will be disabled momentarily.

Disable video: Hosts can turn someone's video off. This will allow hosts to block unwanted, distracting, or inappropriate gestures on video.

Mute participants: Hosts can mute/unmute individual participants or all of them at once. Hosts can block unwanted, distracting, or inappropriate noise from other participants. You can also enable "Mute Upon Entry" in your settings, which is a good option for large meetings.

Turn off file transfer: In-meeting file transfer allows people to share files through the in-meeting chat.

Turn off annotation: You can disable the annotation feature in your Zoom settings to prevent people from writing all over the screens.

Disable private chat: Zoom has in-meeting chat for everyone or participants can message each other privately. Restrict participants' ability to chat amongst one another while your event is going on and cut back on distractions.

Control screen sharing: The meeting host can turn off screen sharing for participants.

Control recording: The ability to record to the cloud or locally is something an account admin can control. If they have recording access, the host can decide to enable/disable a participant or all participants to record.

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Do not allow participants to rename their ID: The host can disable the ability for participants to rename their onscreen identity.

Turn on waiting rooms: The meeting host can turn on waiting rooms from within the meeting.

Protecting your data

You are entrusting us with your valuable data and information and we take great care to ensure your data is secure at all times.

Encryption: Protecting your event content by encrypting the session's video, audio, and screen sharing. This content is protected with the Advanced Encryption Standard (AES) 256 using a one-time key for that specific session when using a Zoom client.

Audio Signatures: Embeds a user's personal information into the audio as an inaudible watermark if they record during a meeting. If the audio file is shared without permission, Zoom can help identify which participant recorded the meeting.

Watermark Screenshots: Superimposes an image, consisting of a portion of a meeting participant's own email address, onto the shared content they are viewing and the video of the person who is sharing their screen.

Local Recording Storage: Recordings stored locally on the host's device can be encrypted if desired using various free or commercially available tools.

Cloud Recording Storage: Cloud Recordings are processed and stored in Zoom's cloud after the meeting has ended; these recordings can be password-protected or available only to people in your organization. If a meeting host enables cloud recording and audio transcripts, both will be stored encrypted.

File transfer storage: If a meeting host enables file transfer through in-meeting chat, those shared files will be stored encrypted and will be deleted within 31 days of the meeting.

Cloud recording access: Meeting recording access is limited to the meeting host and account admin. The meeting/webinar host authorizes others to access the recording with options to share publicly, internal-only, add registration to view, enable/disable ability to download, and an option to password protect the recording.

Security and Privacy Certifications

We are recognized by industry and security organizations for excellence.

SOC 2 (Type II)

FedRAMP (Moderate)

GDPR, CCPA, COPPA, FERPA and HIPAA Compliant (with BAA)

Privacy Shield Certified (EU/US, Swiss/US, Data Privacy Practices)

TrustArc Certified Privacy Practices and Statements

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Ensuring Privacy

Zoom takes your privacy extremely seriously and only collects the data from individuals using the Zoom platform required to provide the service and ensure it is delivered effectively. See our privacy policy [here](#).

Authentication: Zoom offers a range of authentication methods such as SAML, Google Sign-in and Facebook Login, and/or Password based which can be individually enabled/disabled for an account.

2-Factor Authentication: Admins can enable 2FA for your users, requiring them to set up and use 2FA to access the Zoom web portal.

Video Preview: Before you join a meeting, you can preview your video and select a virtual background, or decide to join without video.

Attendee consent for recording: Account admins or meeting hosts can require that all recordings of meetings are accompanied by a pop-up notice to attendees that a recording is taking place, and there is a visual indicator when recording is on.

Removed Attention Tracking: Zoom recently removed the option for training professionals to track if attendees were multi-tasking during a meeting.

Meeting participants' basic technical information: (Such as the user's IP address, OS details, and device details) is collected for troubleshooting and admin reporting.

Zoom stores basic information: Under user account profile information including: Email address, user password - salted, hashed, first and last name. Company name, phone number, and a profile picture are all optional to provide.

We never have, and have no future intentions, to sell your information to advertisers.

Zoom does not monitor your meetings or its contents.

Zoom complies with all applicable privacy laws, rules, and regulations in the jurisdictions in which it operates, including the GDPR and the CCPA.

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Appendix H
Interview Guide Sample

- Introduce myself, name, affiliation, and pronouns. Provide three resources in chat should TGGD interview participant want to call a helpline to speak with someone.
- Thank participant for being apart of the process, their time, and their emotional labour.
- Confirm their name, pseudonym, pronouns, and if they have any accessibility needs not already mentioned in emails. Let them know we will be discussing some of their survey responses to guide interview questions.
- Review consent form, confidentiality, and technology use, and explain voluntary inclusion. Let participant know they can withdrawal consent at any time for survey and interview.
- Discuss my own identity and transition briefly to develop trust, ease, and rapport.

Potential Interview Questions

1. Tell me about your transition.
2. Now thinking back to when you started testosterone, did your healthcare professional mention fertility preservation?
3. Was egg freezing something you were interested in/not interested in. Why or why?
 - a. Have you done any personal research on egg freezing?
 - b. What do you know about egg freezing?
4. Are you interested in becoming a parent in the future? If so, how?
 - a. What interests you/disinterests you about biogenetic parenthood?
 - b. Has being a parent always been something you were interested in?
 - c. Did your desires for parenthood shift when you transitioned?
 - d. Are you interested in becoming pregnant or carrying your own children?

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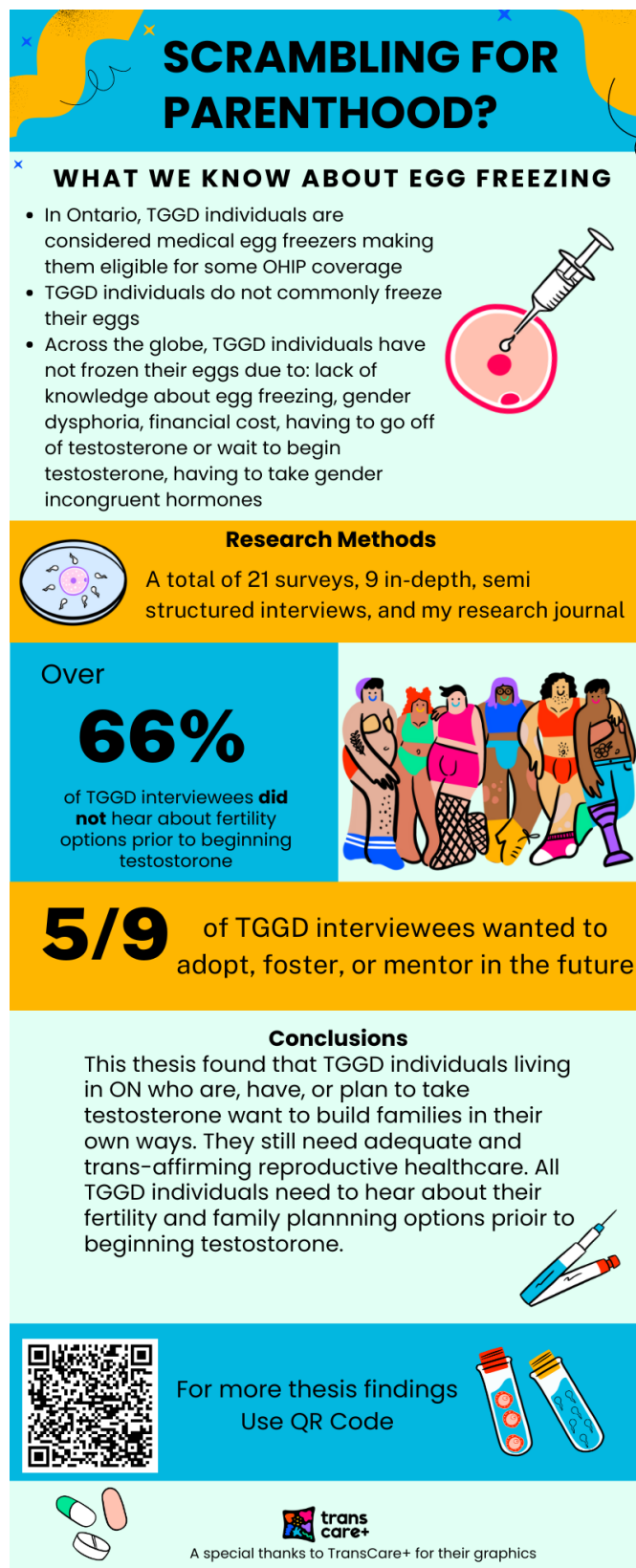
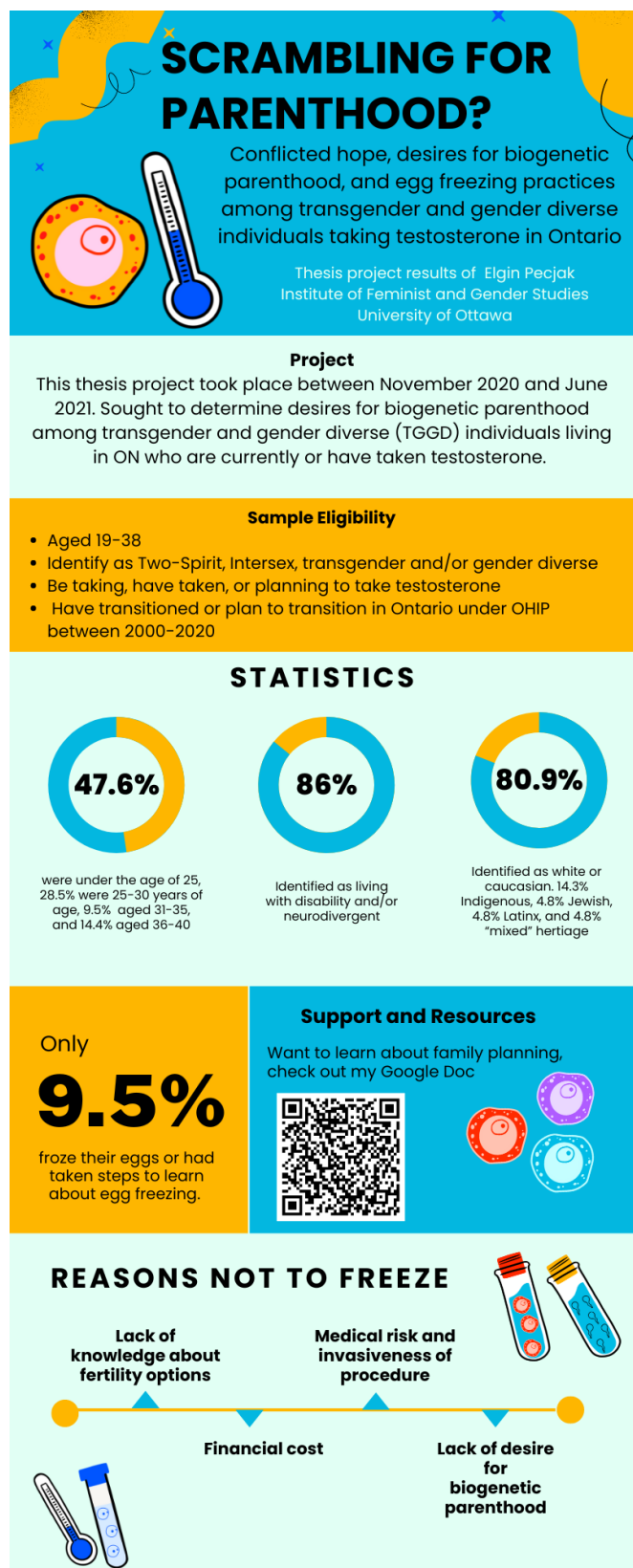
- e. Do you and/or you and partner(s) share the same aspirations for parenthood and family formation?
 - f. Do you and/or you and partner(s) require any other reproductive tissue to form your family?
 - g. Will you and/or you and your partner(s) use reproductive technologies to form your family?
 - h. Do you and/or you and your partner(s) want to adopt?
 - i. What do coparenting look like for you and/or you and your partner(s)?
5. How was your relationship with your parent(s) growing up?
- a. Were your parent(s) supportive when you told them you were transitioning?
 - b. (If mentioned) Were your parent(s) upset when you told them you did not want to have children/biogenetic children?
 - c. What support systems do you currently have? Do you use social media such as META groups?
6. Do you think that there's more of a shift now for and more pressure for trans and non-binary folks to have biogenetic children?

Conclude interview:

- Provide three resources including helplines, provided list of resources I had collaborated for TGGD interview participant, let them know I was available via email for further questions.

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Appendix I: Infographic



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Glossary

Glossaries are helpful for navigating through the terms used within a specific body of research, however, terms used by transgender and gender diverse individuals are constantly evolving and changing (Stryker, 2017), and therefore this glossary is not truly inclusive of the diversity of those included in its definitions or is it timeless.

	Abbreviation	Definition
Assigned female at birth	AFAB	An individual who was born with the sex characteristics “medically” assigned to female bodies including a vagina, uterus, ovaries and XX chromosomes. Also known as FTM, or FtM, however, this term is outdated and should be replaced with AFAB.
Assigned male at birth	AMAB (also known as MtF or MTF)	An individual who was born with the sex characteristics “medically” assigned to male body including a penis, testicles and XY chromones.
BIPOC		Black, Indigenous, People of Colour.
Bottom Dysphoria		Bottom dysphoria is a specific aspect of gender dysphoria where the individual experiences discomfort that occurs based on the individual’s feeling that their genitalia does not match their gender identity (Emisil, 2021).
Cisgender		“Cisgender individuals’ gender identity aligns with their sex assigned at birth.” (Maxwell et al., 2017, p.1031).
Cisgenderism		“the gender-entitled belief that all women should be feminine, and all men masculine-gives rise to transphobia, a gender anxiety that is directed against people who all outside the norms.” (Serano, 2007, p.90).
Cisnormative		Is the system that “highlights the privileging of a non-trans norm” (Pyne, 2011, p.129) where the ideal is “that everyone has a sexed body that matches their gender identity, limited to only binary options between male and female” (Jacobsen, 2022, p.5).
Cissexism		“is the belief that transsexual’s 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 ad physical sexes as being aligned)” (Serano, 2007, p. 12).

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Fertility preservation	FP	“Fertility preservation, refers to medical interventions used to cryopreserve, or freeze, gametes (oocytes or spermatocytes), embryos (an oocyte fertilized by a single spermatocyte), or gonadal tissue (ovarian and testicular) before the effects of time, disease, or medical treatment that may alter reproductive capacity” (Blackmore et al., 2019, p.495). Fertility preservation is used within this research as the term used to describe the freezing of reproductive tissue by AFAB transgender and gender diverse individuals, specially through the process of oocyte cryopreservation. Using the term FP allows for a gender-neutral term for this process that enables transgender and gender diverse people to use terms and definitions that they feel comfortable with. I.e. some AFAB individuals may find gender-based discomfort when discussing biological gendered processes that can affect both men, women, and gender non-binary folks.
Female to Male	FTM or FtM	See “Assigned female at birth” “the terms ‘MTF’ and ‘FTM’ have been criticised for implying that a person ‘changes’ their gender, rather than gaining recognition and affirmation of their gender through coming out (and for many, a medical and/or social transition). The terms MTF/FTM risk imply a validity to the status of the assignation made at birth, which AMAB/AFAB (assigned male/female at birth) avoids” (Vincent, 2016, p. 108)
Gender-Affirming		Gender-affirming health care can mean providing healthcare “designed to support and affirm an individual’s gender identity” (World Health Organization, 2024, n.p). Providing gender-affirming services can include “various procedures such as hormone therapy, genital reconstruction, breast reconstruction, facial plastic surgery, speech therapy, urologic and psychiatric services and primary care” to TGGD individuals (Johns Hopkins University, 2024, n.p).
Gender conformity		“is made possible through a sense of permanent visibility, a strong consciousness of shame before others, a rock-solid belief in what our bodies mean and that meanings’

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		utter transparency, and the continuous dance of gender that attaches binary meaning to every facet of our waking lives” (Wilchins, 2004, p.76)
Gender diverse		“gender and sex diversity refers to (1) transgender individuals for whom gender identity is incongruent with birth-assigned sex and (2) individuals with differences (disorders) of sex development (DSD), also known as intersex, for whom development of chromosomal, gonadal, or anatomic sex is atypical.” (Johnson & Finlayson, 2016 p. 41). The term gender diverse is added to this research following transgender as some non-binary, or gender diverse individuals may not identify as transgender (Vincent, 2019).
Gender Dysphoria		Note not all transgender or gender diverse individuals will experience gender dysphoria. This research is careful to consider how the term or experience can reinforce “concepts such as “true transsexualism” and “gender dysphoria” are part and parcel of the conceptual universe of transsexuality and contribute to delineate the “disembodied” model of trans* existences” (Radi, 2019, p. 51). “[gender dysphoria] refers to the psychological distress encountered in persons for whom sex assigned at birth is incongruent with their gender identity. The psychiatric focus is on the distress experienced due to the incongruence between assigned and affirmed gender, and current evidence supports that gender-affirming therapy greatly improves psychological outcomes” (Jarin et al., 2019, 57). "The DSM-5 diagnosis used by medical and mental health professionals to describe psychological distress caused by discontent with one’s natal sex. Gender identity disorder (GID) was the terminology previously used by the DSM-IV and has largely been abandoned" (Jarin et al., 2019, 57). “Gender dysphoria = distress caused by gender incongruence” (Feigerlová et al., 2019, p.19).
Gender Expression		“refers to the whether our presentation, behaviours, interests, and/or affinities are considered feminine,

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		masculine, or some combination thereof.” (Serano, 2007, p.97). “gender expression refers to the manifestation of an individual’s fundamental sense of being masculine or feminine through clothing, behaviour, grooming etc.” (Wilchins, 2004, p.13)
Gender Incongruence		“Gender incongruence = experience and/or expression of a gender identity that does not conform with the sex assigned at birth” (Feigerlová et al, 2019, p.19).
Gender Identity		“refers to the inner sense most of have of us have of being male or female” (Wilkins, 2004, p. 13)
Gender Non-Binary	Aka nonbinary, non binary, gender neutral or NB	“Non-binary also functions as an umbrella term, and is often taken as roughly synonymous with the older term genderqueer – although this risks erasing the specific, complex and differential ways in which both terms can be deployed by different people. In resistance to having gender identity defined in terms of what one is not, some non-binary people describe themselves as an ‘enby’, or ‘enbies’ (inspired through homonymy with ‘NB’). (Vincent, 2016, p.107). Gender identities under the umbrella of non-binary can include (but is not limited to) genderqueer, enby, demi-gender, agender, gender-fluid, gender non-conforming.
Heteropatriarchy/Heteropatriarchal		Heteropatriarchy “refers to the social, political, and economic system in which heterosexual men are the dominant group in a society or culture. The concept is made up of two parts: hetero, described as an inherent attraction to the opposite sex, and patriarchy, defined as systematic domination of men across a myriad of social institutions” (Kelly & Arce-Trigatti, 2022, p. 256).
Heteronormativity/Heteronormative		Heteronormativity is a term coined by Michael Warner in 1991, “to describe a pervasive discursive framework that is deeply embedded in social institutions and that perpetuates homophobia... through its presumption of heterosexuality as normal and natural, heteronormativity privileges heterosexuality in all its forms, including identities (i.e., heterosexual people) and arrangements (e.g., traditional family structures and romantic relationships)” (Stanley, 2021, p.250).

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		Like heteronormativity, homonormativity is “the possibility of a demobilized gay constituency and a privatized, depoliticized gay culture anchored in domesticity and consumption” (Duggan, 2002, p. 179). Homonormativity seeks to create consumer driven domesticate individuals that reinforce the status quo including nuclear family formation and white, middle-classness. Homonormativity removes the political and historical significance of queer identity and rebrands it to create a queer individual who reinforces heteronormativity as a queer individual.
Hormone Blockers	Also known as puberty blockers	Used to “delay the onset of irreversible physical changes at puberty for trans and gender-questioning youth” (Stryker, 2017, p.199). “Puberty blockers, usually in the form of a gonadotropin-releasing hormone (GnRH) agonist, suppress transmen’s hypothalamic-pituitary gonadal axis to suppress the sex hormones, estrogens, that would be endogenously secreted. As a result, the processes of initiating the secondary sex characteristics in contrast with the patient’s affirmed gender identity, such as breast development and menstruation, are inhibited. Genderaffirming hormones (for transmasculine individuals, the administration of testosterone or occasionally medroxyprogesterone to help with menstrual suppression) are also used to suppress endogenous estrogens and maintain testosterone levels to enhance male secondary sex characteristics, such as facial hair” (Blakemore et al., 2019, p.498).
Hormone Replacement Therapy	HRT (also known as GHRT: Growth hormone replacement therapy in some literature)	The practice of administering cross-sex hormones to physically change the body. For AFAB transgender and gender diverse individuals, this means taking Testosterone through injections, patches, gels etc. for the masculinizing qualities it provides including lowering of the voice, increase in body hair, redistribution of fat and ceasing on the menstrual cycle. For every individual, these desires are different, and Testosterone can also be used among AFAB gender diverse individuals to provide additional forms of androgyny.
In-Vitro Fertilization	IVF	According to the Mount Sinai Fertility (2023) “in vitro fertilization (IVF) is a method of assisted reproduction that involves the removal of eggs from the body, and the combining of eggs and sperm in the embryology laboratory to form embryos. The resulting embryos can

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		then be placed into the uterus in the hopes of achieving a pregnancy. IVF is a well-established and effective treatment for many people” (n.p).
Intersex		“Intersex is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside. Or a person may be born with genitals that seem to be in-between the usual male and female types—for example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening, or a boy may be born with a notably small penis, or with a scrotum that is divided so that it has formed more like labia. Or a person may be born with mosaic genetics, so that some of her cells have XX chromosomes and some of them have XY.” “What does this mean? Intersex is a socially constructed category that reflects real biological variation.” (Intersex Society of North America, 2008, n.p)
Male to Female	MTF	See “Assigned male at birth” “the terms ‘MTF’ and ‘FTM’ have been criticised for implying that a person ‘changes’ their gender, rather than gaining recognition and affirmation of their gender through coming out (and for many, a medical and/or social transition). The terms MTF/FTM risk imply a validity to the status of the assignation made at birth, which AMAB/AFAB (assigned male/female at birth) avoids” (Vincent, 2016, p. 108)
Medical egg freezing	MEF	The act of freezing one’s oocytes for medical reasons, this can include but is not limited to including individuals with scheduled sessions of cytotoxic chemotherapy (Inhorn et al., 2018), reproductive diseases (Inhorn et al., 2017), medical conditions (such as autoimmune disorders, severe endometriosis, genetic profiles including BRCA1 and 2, Turner syndrome and fragile X syndrome) (Inhorn et al., 2018), and disease-related/iatrogenic premature menopause (Bhatia & Campo-Engelstein, 2018). This can also include transgender and gender diverse AFAB individuals who freeze their reproductive tissue due to potential loss of fertility due to hormone use.

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Medical transition		A medical transition for many includes “the use of cross-gender hormone therapy to induce the secondary sex characteristics of the affirmed gender while suppressing those of the natal sex” (Radix, n.d., p.351). A medical transition can include but is not limited to hormone therapy, hair removal, speech therapy, and/or fertility preservation measures (UCSF Gender Affirming Health Program, 2019).
Oppositional sexism		“The belief that female and male are rigid, mutually exclusive categories, each possessing a unique and non-overlapping set of attitudes, aptitudes, abilities and desires” (Serano, 2007, p. 13).
Ovarian Tissue Cryopreservation		"an experimental procedure in which prepubertal ovarian tissue is harvested and preserved, is offered to women with cancer. OTC is a potential area of future investigation for peripubertal affirmed males, as it does not require hormonal stimulation” (Johnson & Finlayson, 2016, p. 42).
Pronoun		When addressing transgender and gender diverse individuals, always use the term pronoun, not preferred pronouns.
Puberty Blockers		See “Hormone Blockers”
Queerphobia		Queerphobia is used in place of homophobia commonly within this research. Queerphobia expands homophobia as a way of incorporating the fear, hatred, systemic and institutional oppression of those individuals who identify as other than heterosexual. This can include but is not limited to gay, lesbian, bisexual, pansexual, asexual, demisexual, or queer.
Social egg freezing	SEF	The act of freezing one’s oocytes for social reasons. This includes future partnership, career advancement, educational attainment, and fear of age-related infertility.
Social transition		A social transition consists of the “parts of transitioning that are not specifically medical” which can include “coming out” to family and friends as transgender, using new pronouns, changing your appearance through styling, changing the name you go by, and using different gendered spaces such as restrooms (Rainbow Health Ontario, 2022).

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Special Interest		A “special interests are frequently developed by individuals with autism spectrum disorder, expressed as an intense focus on specific topics. Neurotypical individuals also develop special interests, often in the form of hobbies” (Jordan & Caldwell-Harris, 2012, p.391).
Trans*		“the term trans*, not as a way of homogenizing the specificities that distinguish these (and many more) categories from one another, but rather as a way of evoking a multiplicity that is not limited to trans*women and men, but rather includes all those identities whereby a person does not identify with the gender they were assigned at birth” (Radi, 2019, p. 45).
Transition		"The process of physically changing external gender presentation to align with one's internal gender identity. Genital surgery is not a requirement." (Jarin et al., 2019, p. 57). Social transitioning is the process in which an individual decides to identify as transgender without engaging in HRT or surgical intervention.
Transphobia		For Bettcher, “while it is clear transphobia exists, however, it is far from evident what transphobia is” (2014, p.249). Transphobia related to “the irrational fear of, aversion to, or discrimination against people whose gendered identities, appearances, or behaviours deviate from social norms” (Serano, 2007, p.12). Transphobia ultimately “addresses fear of trans-identified individuals instead of capturing the critically central and evidently flawed assumptions that underlie the pervasive cultural system of prejudice and discrimination directed toward the transgender community” (Lennon & Mistler, 2014, p.63). Transphobia is not just about the intention of what is said or done but about “communicating othering messages” that reinforce “that individuals perceive difference” (Nordmarken, 2014, p. 131).
Trans-misogyny		Term used by Serano (2007) to detail the way that certain expressions of femaleness or femininity are dismissed and ridiculed. An example of this include the exclusion of transgender women from feminist spaces.

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Transgender	Also known under trans or trans*	An adjective used to describe someone who identifies outside the sex they were assigned at birth. “as an umbrella term for any individuals who do not identify with the sex/gender they were assigned at birth. This is inclusive of people with nonbinary or genderqueer genders, or those who are agender. While this choice raises its own difficulties, such as non-binary people who do not identify as transgender, my intention is to capture the disjunction between assignation and identity (partial, fluctuating, or complete) that is a centrally defining factor for the trans population – who are otherwise extremely heterogeneous” (Vincent, 2018, p.112). “The meaning of transgender has expanded, now used to describe almost all people who do not identify with their assignation at birth.” (Vincent, 2018, p.106). “people who move away from the gender they were assigned at birth, people who cross over (trans-) the boundaries constructed by culture to define and contain that gender.” (Stryker, 2017, p.1) “The term “transgender” describes a person whose gender identity is incongruent with the phenotypic sex assigned at birth.” (Cheng et al, 2019, p.209). “Transgender = gender identity and expression of the person do not align with the sex assigned at birth.” (Feigerlová et al, 2019, p.19) "A person whose gender identity does not match their anatomy and gender assigned at birth. Often also abbreviated as trans* to emphasize the range of individuals who do not identify as a traditional cisgender man or woman" (Jarin et al., 2019, p.57). Individuals who are AFAB transgender or trans can identify (but are not limited to) using the following terms: transgender man, transgender male, trans man, transmasculine, agender, demi gender, gender queer, gender non-binary, gender non-conforming, gender neutral or gender diverse.
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		“a broad umbrella adjective intended to capture the multiple forms of sex and gender crossing and mixing that are taken by their practitioners to be significant life projects.” (Heyes, 2003, p.1093).
Transgendered		“While used frequently by some community members, ‘transgendered’ has been heavily criticized for risking the implication that trans is something ‘done to’ an individual (‘gay’ versus ‘gayed’ illustrates the jarring difference effectively).” (Vincent, 2018, p.107). While the term transgendered has been used to describe the transgender population, this terminology is considered offensive and should not be used. Adding the “ed” to the end lengthens the word, turning it into a noun, when being transgender is an adjective. For more information see: https://www.vox.com/2015/2/18/8055691/transgender-transgendered-tnr
Transsexual		Term developed by German sexologist Magnus Hirschfield. Term was meant to determine an individual who was “having feelings or emotions or aesthetic sensibilities usually attributed to the binary gender other than the one assigned at birth” (Stryker, 2017, p.38). While some individuals still identify as transsexual, the term is considered old-fashioned and out of date. In its place transgender has been used to encompass the diversity of gender expressions and identities of those who identify with a gender not assigned them at birth.