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A reproductive justice approach to pregnancy, childbirth and parenting for trans people in Sweden

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Abstract

Less than a decade ago, Swedish law demanded that a person who wanted to change their legal gender had to be without any ability to reproduce. This demand led to many trans people being forcibly sterilized. Even though the demand is now removed from law, lingering effects continues to affect trans people in their reproductive journey. This study examines barriers faced by trans people in three stages of reproduction: pregnancy, childbirth and parenting. Information on trans people's experience is gathered through narrative reports, in depth interviews and a literature review of the research field on trans* studies relating to reproductive issues. The information is analyzed through an expanded reproductive justice framework that is developed to include the perspective of trans people. The main finding of this study is that trans people in Sweden are subjected to reproductive injustice due to the cis- and heteronormativity's governance of reproductive care. Highlighted are also methods that can help mitigate the negative effects, such as birthing plans, safe spaces and the possibility to bring someone with you to health care visits. Lastly, the study gives recommendations for further research in the field of trans people's reproductive circumstances.

Keywords

Reproductive justice
Trans people
Pregnancy
Childbirth
Parenting

Reproduktiv rättvisa
Transpersoner
Graviditet
Barnafödande
Föräldraskap

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Vocabulary[1]

Assigned gender	Gender that health personnel determine that an infant (or fetus) has by assessing their genitalia. The assigned gender is registered with the authorities and becomes the person's legal gender.
Birthing center	Place where people give birth, usually in a hospital.
Birthing person	Person that 1) intend to become pregnant, 2) is pregnant, and 3) gives birth.
Chest feeding	To feed a baby with milk from the chest.
Child health care center	Place where babies and young children's health is monitored and taken care of.
First-time birthing person	Person who 1) intends to become pregnant, 2) is pregnant, and 3) gives birth for the first time.
Gametes	Reproductive cells such as ovum and sperm.
Gender-affirming hormone therapy	Hormonal treatment that is meant to alter physical characteristics to better reflect a person's gender identity.
Gender-affirming surgery	Surgical procedures that are meant to alter physical characteristics to better reflect a person's gender identity.
Gender dysphoria	Medical diagnosis involving distress over incongruence between assigned gender and gender identity.
Gender expression	Behaviour, clothing, manners, etcetera that are associated with gender, i.e., how a person express their gender externally.
Gender identity	The individual's sense of their own gender, i.e., the gender a person identifies with.
Genitalia	Organs of reproduction such as testis, ovaries, vagina and penis.
Health personnel	A combined word that refers to people who work in health care. Includes for example, doctors, midwives and nurses. Sometimes the actual title of a person is used instead.
Non-birthing person(s)	Person(s) who is not pregnant or deliver a child but still involved in the process.
Parental health care center	Place where birthing people's health is monitored and taken care of during pregnancy and postpartum.

[1] Note that descriptions in this list are not universally accepted. Definitions should be read as an explanation of how the terms are used in this research.

Parents	People who care for, nurture and raise a child. Does not necessarily have to entail a legal guardianship.
Reproductive health care	Combined word for all health care that is concerned with reproduction. Includes for example, obstetric care, fertility care, endocrinology and assisted reproduction.
Reproductive system	Bodily regime involved with reproduction. Include among other things genitals, cells, hormones and hypothalamus.
Second-time birthing person	Person who 1) intends to become pregnant, 2) is pregnant, and 3) gives birth for a second or additional time.
Trans person	Person whose gender identity and/or gender expressions are incongruent with the assigned gender. There is no need to have experienced gender dysphoria nor to have undergone any gender-affirming treatment, self-identification is the only requirement. This term includes non-binary as well as binary people.[2]
Trans assessment	The processes of getting a medical diagnosis that allows a patient to get access to treatment.
Transitioning	Gender-affirming process that involves what the person who's undergoing the process needs to feel that they can live in accordance with their gender identity.

[2] Sometimes in the text I use words such as trans man or trans woman. I do this when a reference or informant use the term.

1. Introduction

1.1 Background

In 1972 Sweden was the first country in Europe to allow its citizens a right to change their legal sex in the civil register. But the right was not unconditioned. On the contrary, to access the right, people had to be unmarried and sterile or without an ability to reproduce. According to the proposition (Royal Majesty 1972) that lead to the law, the condition to be unmarried was a consequence of the, at the time, ban on same-sex marriage. The need to be sterile or without an ability to procreate was to prevent that "[…] the person who is given male sex becomes a mother or that the person who is given female sex becomes a father" (Royal Majesty 1972:23, my translation). The proposition includes a questioning whether this demand is necessary, not due to bodily integrity that might be the most reasonable but because it is considered as out of the question that "[…] a transsexual, after having been allowed to change registration of sex, would out of own free will initiate a sexual relationship with someone that belongs to the same official sex as himself [sic]" (Royal Majesty 1972:49, my translation).

However, in January 2013, the condition to be unmarried and a Swedish citizen was removed from the law after a public debate in which the demand to be sterile or without an ability to reproduce was also discussed. In the government's proposal, the demand to be sterile or lack an ability to reproduce was not suggested to be removed but rather investigated further. This was the proposal that the Swedish Parliament approved (Swedish Parliament n.d.). In a parallel process, the Swedish administrative court of appeal judged that the demand to be sterile or lack an ability to reproduce stood in conflict with the right to respect for private and family life (article 8) in the European Convention on Human Rights (SFS 1994:1219) and the right for protection against coerced bodily interventions (SFS 1974, 2 chap. 6 §) in the Swedish Constitution (Administrative Court of Appeal 2012). This ruling meant that in practice, the demand was not allowed to be enforced from the same time as the other changes in the law. Half a year later, in July 2013, the demand was officially removed from the law (SFS 2013:405).

In the time of writing this study, less than a decade has passed since forced sterilization of trans people was legal and enforced in Sweden. Considering Sweden's history, this might not be a big surprise. In 1922, the Swedish State Institute for Racial Biology opened in Uppsala

with the purpose to document and classify people into different races. The sentiment of the eugenics movement was that the superior "Nordic race" was threatened by inferior races. The data that the institute produced intended to be a foundation for policies aimed at securing the "Nordic race" (Kjellman & Eld 2015). In 1934 the first of two sterilization laws that allowed involuntary sterilization for eugenic, social and medicinal reasons, was introduced. Before the law was replaced with a new that only allowed sterilization upon own request in 1976, more than 30,000 people were forcibly sterilized. The majority of which, without any application or consent of the person. Others handed in their own application and gave consent but were persuaded to do so. Similar to the case for trans people, some were conditioned to undergo sterilization to get access to something else, i.e., not truly being voluntary (Inquiry on Sterilisation 2000).

Repronormativity is the concept used by heteropatriarchal states to premier family formations for those deemed legitimate - i.e., heterosexual, cis-gendered, white, non-disabled, etcetera – and to discourage those deemed illegitimate to reproduce – i.e., trans people homosexuals, disabled, etcetera (Weissman 2017). The aim is to keep the nation "pure" and "[…] improving a healthy livestock by securing the Nordic (Swedish) race" (Kjellman & Eld 2015), as was the aim of the Swedish State Institute for Race Biology. A number of scholars argue that non-normative reproduction destabilizes traditional gender roles and family values and threaten the heteronormative nuclear family upon which the heteropatriarchy thrives (Weissman 2017). A fundamental point of departure for this study is that forced sterilization of trans people is a manifestation of repronormativity and even though forced sterilization no longer is performed in Sweden, repronormativity still thrives and manifests itself in other ways.

1.2 Purpose and aim

This study aims to examine barriers to reproduction faced by trans people in Sweden. Although generally explained as an event starting with sexual intercourse between two people (most often referred to as and classified as a man and a woman), sexual reproduction can take many forms and involve many more people than those who produce the ovum and the sperm. The merge of an ovum and sperm can occur inside or outside of a body, as well as in another body than the person that will assume the role of parent. Although the gestation period takes place in a body, the person the body belongs to does not necessarily need to assume the role of parent just as a person who has no bodily involvement in fertilization or gestation can

assume this role. In this study, reproduction is understood as having more stages than only the meeting of ovum and sperm, gestation and childbirth. For many, the journey starts earlier, for example through a process of accessing assisted reproduction technology through health care institutions. The length of the reproduction process, the number of actors involved and forms to achieve reproduction are different for different people, there is not just one way to reproduce. I will only examine three specifics, but broad, stages of reproduction: pregnancy, childbirth and parenting. The first stage, pregnancy, involves the path to becoming pregnant as well as being pregnant. The second, childbirth, refers to the time of delivery of a baby (either through adoption or birth) and the third, parenting, is the time after delivery when raising and caring for the child.

There are three aims with this study. First, the study aims to expand the scars research field on trans people's reproductive conditions. Second, I want to explore the theoretical framework of reproductive justice in two ways, 1) introduce it to a Swedish context where the framework is rare, and 2) broaden it to also include the perspective of trans people. The reproductive justice frameworks is an ideal framework to deal with the root-causes of reproductive oppression. The embedded intersectional lens makes sure that the experiences of minorities will not be neglected in favor of the majority. Although, the framework risk to reinforce cis- and heteronormative assumptions regarding reproduction due to it only taking into account the perspective of cis persons. Thus, it needs to be developed and dismantled of the cis- and heteronormative presumptions that it is built on in order to reach its full potential.

Although the framework is by default intersectional, intersectionality (see Crenshaw 1989) will not be a focal point in this study. Trans people are not a homogenous group and the lack of an intersectional lens in this research should not be interpreted as a claim that trans people only are affected by power structures concerned with gender identity. Socio-economic factors have an effect on reproductive health (National Board of Health and Welfare 2016b). Trans people, like all people, are of course affected by it. With that said, given the broad scope of this study - examining three stages of reproduction in the light of a theoretical framework that, to my knowledge, have not been tested in a Swedish context before – limitations had to be done. As I saw it I could either narrow the scope of the study and include other power structure in the analysis or broaden the scope and only focus on one power structure. I chose the latter simply because I wanted to highlight that the available research in all three stages of reproduction is scarce and needs to be further developed. If this study would have unlimited

space, I very much would have liked to explore further how other identity markers, such as ethnicity and class, together affect trans people's ability to achieve reproduction.

1.3 Research questions

The aims have resulted in several research questions that will guide this study:

1. How would trans people in Sweden describe their experiences of pregnancy, childbirth and parenting?
2. How can the experiences during the stage of pregnancy, childbirth and parenting be understood by using the reproductive justice framework?

2.1 How can the reproductive justice framework develop to include a trans perspective?

Operationalization of the research questions is explained in table 1.

Research question	**How will it be answered**
1. How would trans people in Sweden describe their experiences of pregnancy, childbirth and parenting?	Interviews or surveys with trans people in Sweden who have experience of either pregnancy, childbirth or parenting. Additional findings in research from other countries help put the results in a wider context.
2. How can the experiences during pregnancy, childbirth and parenting be understood by using the reproductive justice framework?	Through analysis of the experiences (RQ1) and previous research with a reproductive justice-lens.
2.1 How can the reproductive justice framework develop to include a trans perspective?	Suggest alternations of the reproductive justice framework based on the results of RQ1 and previous research.

Table 1: Operationalization of research questions.

1.4 Language

In some feminist circles there is a fear that the increased use of gender-neutral language erase women's identities (Dunne 2017). Using, for example, the term 'birthing people' instead of 'women' when referring to people who give birth is, following this logic, a way to hide that women are those primarily affected by birth-related issues. To not highlight that women are the overwhelming majority of those giving birth thus disguise the fact that gender discrimination occurs.

I would like to suggest that the use of gender-neutral language can lead to the opposite. Consider we had a world where no specific experience or circumstance is thought to be the result of your gender. People can be what they want instead of being put into categories that

contain a script of how to look, behave and think. Where those who have a uterus and the ability to give birth not instantly are considered as women but simply people with a uterus and possibly also with the ability to give birth. No predetermined script of how a woman should act would be used to evaluate the birthing experience. No discrimination only because this person is placed in a category in which the members in this category are considered inferior to another category.

I am aware that this is quite a visionary picture I am painting. In no way do I believe that the use of gender-neutral language alone can lead to this utopian society. But it is a modest adjustment of one's vocabulary while being a significant act for inclusion. Simply put, recognizing that not only people who define themselves and are defined by society as women are those giving birth, do not in any way diminish the fact that also those who define themselves and are defined by society as women give birth.

Therefore, I use the word 'birthing person' to refer to a person who 1) intends to become pregnant, 2) is pregnant, and 3) gives birth. For the person or people who is not pregnant or deliver a child but still involved in the process, I use the word 'non-birthing person(s)'. Both the birthing person and the non-birthing person(s) are 'intended parent(s)'. People who care for, nurture and raise a child I simply call 'parent(s)'. Where many refer to 'vagina'/'vaginal' I have instead used the word 'genital' since a vagina is often associated with women, which might not be in line with the birthing-persons definition of themselves.

When I refer to sources that do not use a gender-neutral language, I have sometimes made changes where I have considered that the meaning of the text is applicable for all birthing people. In the literature I have examined for this study, I very seldom encounter a gender-neutral language. Thus, in many cases, the use of gender-neutral words should not be credited to the original author(s). Lastly, I have purposely refrained from making changes in chapter 3, in order to highlight that the language used for the reproductive justice framework is not gender-neutral and argue that it should be. Neither have I made any linguistic changes in direct quotes.

1.5 Outline

The next chapter will present the methodology and the method used while conducting this study. It will explain my position as a researcher and how I went about to gather data. In chapter three, I present the reproductive justice framework, as well as the alternations that I recommend for making it more trans inclusive. Thus, chapter three strives to answer research question 2.1. Chapter four is divided into two sections, the first explains the Swedish reproductive health care. In this section, none of the material used had a specific trans perspective but was still necessary to include since it helps paint a picture of the reproductive health care in Sweden. Seeing that most research about Swedish reproductive health care did not have a trans perspective, the second section mostly contains studies from other countries. This section is focused on trans people's experiences of reproduction and should be viewed in conjunction with the analysis presented in chapter five. In the fifth chapter, I present the analysis of primary data. This chapter together with the former, intend to answer research question 1. Further, in chapter six I will present my analysis of the primary and previous research through the lens of the theoretical framework. It is in this chapter that research question 2 will be answered through analysis of research question 1. Lastly, in the seventh and final chapter I will conclude the findings and end the study with giving recommendations for further work.

2. Research design

2.1 Research paradigm

For you as a reader to better understand this study, it is important for me, as a researcher, to reflect on my own location, worldviews, perspective and beliefs. Since this stance surely inflicts on the choices I make and how I interpret the data collected. What constitutes a research paradigm differs depending on scholar, but most often the positivist, critical and interpretivist-paradigms are presented as the three schools, from which a researcher needs to select one (see for example Kivunja & Kuyini 2017; Rehman & Alharthi 2016). I refrain from referring to myself as a researcher within any pre-determined categorical research paradigms. The reason for this is that I do not want to limit myself to a specific paradigm that makes methodological choices for me regarding the study. Instead, I want the study itself to determine the methodological choices that are needed to be made. Some might say that this perspective would fall within the category of a pragmatic paradigm (Kivunja & Kuyini 2017). I reject this position as well since it is also a pre-determined set of rules (although more flexible) on what a researcher should believe and thus act which I do not subscribe to. Therefore, I will not present my epistemological and ontological stance within a certain paradigm but rather as two individual positions that I have and that influence this study.

The epistemological stance that I take is that there is not one truth but multiple and that these are shaped in correlation with the particular cultural and historical context they exist in and in conjunction with societal structures in those existences. Thus, truths are not consistent but rather change over time, space and interpreter. This means that the stories collected in this study are considered the truth, because they represent the truth for that particular informant. Therefore, I put no emphasize in proving the truth that have been described because being the story that the participant tell makes it the truth in that particular moment for that particular informant. In other words, the results cannot be considered replicable because that specific time and context cannot be emulated. In reference to ontology, I do not believe in more than one reality or existence. Although, there are as many interpretations of said reality as there are people and these interpretations are influenced by the interpreter's cultural, socioeconomical, political and personal position. Finding the one true reality is neither possible nor desirable. Thus, both my epistemological and ontological position emphasize on the interpretation of reality and truth. This indicates a great trust in informants and their stories.

2.2 Primary data

The primary data of this study consists of a collection of two written narratives and two online interviews. Due to personal reasons associated with the coronavirus pandemic I had to take a few months hiatus from the study. For this reason, data has been collected in both spring and fall of 2020. The target population is trans people in Sweden who have experienced or are experiencing pregnancy, childbirth and/or parenting. The broad criteria for inclusion allows a large population from which a randomized sample can be drawn. It felt important to have a large population to draw from, since a small sample is common in research with this population (Hafford-Letchfield, Cocker, Rutter, Tinarwo, McCormack & Manning 2019).

Methods

The initial idea was to conduct face-to-face semi-structured interviews, but the global coronavirus pandemic made me rethink this option due to the demand for social distancing and conduct the interviews online instead. The semi-structured format of the interview was preferable since this gave the informants more leeway to express themselves and tell their story, compared to for example structured interviews (Bryman 2012). Informants had been given the interview guide in advance (see attachment 2) and therefore knew where to steer the interview themselves. Thus, my participation was limited. Questions coming from me had two purposes, 1) clearing up potential misunderstandings from my part, and 2) to stimulate the informant to tell their story.

The video meeting platform Zoom was supposed to be used for all interviews. I prefer this platform since it has a well-functioning recording feature. Although in one case, we experienced technical difficulties in Zoom and instead switched to conduct the interview via Facebook Messenger while I recorded the interview using QuickTime installed on my computer. This option was chosen after testing other options such as Skype, Microsoft Teams and recording phone calls, since this alternative was the most accessible and user-friendly. The informant was asked and agreed to using this option.

Given that the subject of the study can be considered sensitive and private I wanted to include another method for participation. I settled for written narratives because this allows the informants to be the agents of their own story. They make the selection of what they believe is important to tell, in contrast to me leading the conversation towards where I want the

interview to result (see for example McAlpine 2016). Thus, my influence is limited which can be both an advantage and a disadvantage. The data collected can, for example, turn out to be of no use to answer the research questions. This is something that can be limited during an interview by steering the conversation towards where you want it to lead. The advantage of written narratives is that informants can be completely anonymous, not only when presented in the study but also during data collection. This complete anonymity can lead to more open answers since I believe that many people want to tell their story but feel restricted in doing so because of social norms that dictate that topics around pregnancy, childbirth and parenting should be kept in private. I base this assumption on the fact that there are many anonymous forums on the internet in which people share their story and discuss personal topics with other people. Also, given that I myself am queer and that the queer communities in Sweden are not very large, I am afraid that my presence could lead to informants feeling inhibited since it is possible that we move in the same circles. Thus, anonymity can make people feel safer to share their story.

Data collection and sampling

The process of locating informants begun with producing flyers in both Swedish and English that explained the study and its aim as well as information on the two options for participation in the study, i.e., written narrative or online interviews. The flyers also included information on options for how to send in their written story anonymously, instructions on how to write their own story and how the collected data will be handled. Those who chose the option to do an online interview were asked to send an e-mail to book a time (see attachment 1[3]). An information sheet on how data from the interview would be handled as well as the interview guide was prepared in advance to send to those who chose this option (see attachment 2).

The information flyer was sent to personnel in organizations working with trans issues and other key figures in different trans communities, with a request that the information would be shared with members and followers. This was done both during the spring and then later again in the fall. The request was embraced by for example, the personnel behind the Swedish website Transformering.se[4], who marketed the information flyer on Transformering.se's

[3] Note that in the time of writing Attachment 1 the theoretical framework of obstetric violence was also planned to be a part of the study. Later on, the obstetric violence framework was removed due to limitation purposes.
[4] Transformering.se is a Swedish website run by two of the largest LGBTQI organizations in Sweden (RFSL and RFSL Youth). The site is full of information about being trans and relating questions as well as offering support through e-mail.

Facebook page to their more than 3000 followers. The information was also shared on a Facebook page for LGBTQI-families ('Regnbågsfamiljer')[5] with more than 800 followers. From there, the study was further marketed in different internet forums beyond my control, by people who had picked up the information.

Handling data

Those who chose to use the method of written narratives had the possibility to be completely anonymous (even to me) by using one of the options for anonymous hand-in that was included in the information flyer. Even if informants use their personal e-mail or an anonymous option, the e-mail was deleted within 24 hours of receiving it, both from the inbox and the e-mail program's trash bin. The file that contains the written narrative was renamed to a random letter combination - to ensure that I did not remember who sent which file - and stored on an external hard drive.

Online interviews do not allow the same degree of anonymity since I had to be in contact with the informants in order to set up and conduct the interview. When an informant got in touch with me, wanting to participate in the study with the online interview-option, they were asked whether they consent to the interview being recorded and given further information on the handling of data (see attachment 2). Similar to the written narratives, the recording of the interview was deleted from the computer and stored on an external hard drive. The recorded file was transcribed (with the computer in offline mode) using the free trial version of the program InqScribe. The transcription was stored on the external hard drive together with the recording. Until the study was completed, all recorded files, transcriptions and sent in narratives were stored on the external hard drive.

Once I felt content with the collected data, I read through the data without taking any notes before inserting it in the computer program NVivo for coding[6]. Although the written narratives had less amount of text than the transcribed interviews, I used the same method for coding. Reading through each text one by one I initially coded the data into the three stages of reproduction used as categories throughout this study: pregnancy, childbirth and parenting. I

[5] The Facebook page RFSL Regnbågsfamiljer is part of the project Regnbågsfamiljer i väntan ('Rainbow families in the process of waiting') that shares information on ways to become parents, law and tips to LGBTQI-people who are or want to become parents.

[6] To read more about coding in qualitative data analysis and the program NVivo see chapter 24 and 25 in Bryman (2012).

went through the material in each of the three categories one by one, coding responses into different themes that I identified. Going through each theme I started making notes in English, translating the text subsequently. Up until this point, the process was done with the computer in offline mode. From the notes I wrote the final text which can be found in chapter 5 of this study.

Gathered data

A total of four informants participated in the study. Two chose the option of online interviews and two sent in written narratives. All interviews were conducted in Swedish and the written narratives were both written in Swedish. None of the two who sent in written narratives chose to do it through a program that made them completely anonymous. Given that no informant was anonymous to me, I cannot make any comparisons to back my argument that complete anonymity would lead to more open answers. Although, the data that I did collect was more open and informants were more outspoken than I expected from informants that were not anonymous to me. This can indicate that neither my presence nor the fact that informants were not anonymous to me, was an obstacle for the informants to share their stories. As expected, the data that came from the two in-depth interviews were richer than the data from the written narratives. Although including the option of written narratives made it possible for the informants who wrote them to share their unique stories, which would not be the case if interviews were the only option.

2.3 Overview of the research field

When combing through previous research I had two purposes: first, creating a context in which the experiences are lived, i.e., presenting the situation of the Swedish reproductive health care. Secondly, to map out the result of previous studies of experiences of reproductive health care for trans people. Whilst the first part is focused solely on Sweden but not specifically on the target group the second part focus solely on the target group. That means that not all research presented in the second part is based in Sweden. Thus, in the second part research from other countries is included while the first part only consists of data produced in Sweden, primarily from government agencies.

I have collected articles through the search engine at Lund University Libraries, using keywords relating to the topic of the study and filtered the results to only include peer

reviewed articles in Swedish and English that are available online and produced in the last ten years. This initial search gave me a handful of articles from which I used the references to snowball to other sources. By this point I had approximately 30 articles and decided that I was satisfied. Those that were referred to in several other articles were prioritized and read first and others read subsequently. While reading I took notes which later was used when writing my own text. All articles were first divided into the two purposes mentioned above. In each of these categories, articles were divided into one or more subsections (pregnancy, childbirth and parenting). The result is presented in chapter 4 of this study.

2.4 Ethical considerations

In reference to the Declaration of Helsinki, the Swedish Research Council's guidelines (2017) proclaim that it is necessary for researchers to take precautions to ensure that the informant's personal integrity and right to privacy is protected. In this study, informants have the choice of two different methods with different levels of anonymity for participation. Thus, they are given the agency to decide freely on the level of anonymity they want. Being the most anonymous option, written narrative is presented as the premier method in the information flyer. Regardless of option all informants will be unidentified. I have not provided background information of any kind that makes it possible to identify the informants. More so than what is common given that the trans communities are very small. For this reason, I will not include any demographic data of the informants in order to ensure anonymity. The informants will not be asked to provide this and if anything in their story can be used to identify the informants this will be omitted from the study. Moreover, the instructions for writing the written narrative are broad and give the informants the opportunity to include as much or as little in their story as they feel comfortable with sharing. This is also the strategy during the interviews, meaning that I will refrain from asking follow-up questions if these are not crucial for my understanding, but simply ask them to tell their story regarding the different topics. Furthermore, all data gathered for the study will eventually be deleted once the study is completed. Until then, the data is stored on an external hard drive which will only be available to me. Most of the handling of data will be done with the computer in offline mode, decreasing the risk of infringement. However, the interviews are conducted online and through a platform owned by a third party, which is not preferable from a security aspect but necessary considering the (in the time of writing) demand for social distancing due to the

coronavirus pandemic. All the above-mentioned precautions are put in place in order to secure the informants personal integrity and right to privacy.

Other than reflecting on anonymity for the informants it is important to also consider possible risks or negative side effects that the study may produce. What if, for example, the results of this study would be misused to serve a purpose different from the intended aim of the study? When writing about a vulnerable population, it is important to be aware of the forces in society that work to miscredit or undermine the rights of the population. If this study in any way would be used to do this, it would not only be unfortunate but also a misinterpretation of the data provided. Potential misuse cannot be a factor that hinders research about vulnerable populations to develop. Instead, researchers must do what they can to prevent this. Speaking for myself, I make an effort throughout the text to be clear with my intentions and formulate the text in a way that does not give any room for misinterpretation.

2.5 Reflexivity

To enable readers to fully grasp the research it is important to address the conditions under which it was conducted. This will help the reader to comprehend the considerations, interpretations and choices the researcher has made (See for example O'Reilly 2012). In this section, I will present the political context in which the research was conducted as well as addressing my position as a researcher and the relation between me and the subject of research.

Recently, trans identity has been questioned by public figures such as the Harry Potter-author J.K Rowling (Haynes 2020) while countries such as the US under the Trump administration continuously introduce bills that inflict harm on trans people on both federal and state level (American Civil Liberties Union 2020). In Sweden, public service broadcasted three programs in 2019, about the care for young people with gender dysphoria. The programs were criticized by LGBTQI organizations for being one-sided, simplified and possibly stigmatizing (Jansson 2019). The first program was also condemned by the Swedish Broadcasting Commission ('Granskningsnämnden') for not respecting private life since it was possible to identify one person who was not part of the program (Wester 2020). The program can be viewed in light of a law proposal from 2018 in which the Swedish government suggested, among other things, that people under 18 years could apply to the National Board of Health

and Welfare (‘Socialstyrelsen’) and plead for access to gender-affirming surgery (Ministry of Health and Social Affairs 2018). Discussions about young trans people’s possible access to gender-affirming surgery has flourished in the aftermath of the broadcast and so has discussions about so-called rapid-onset gender dysphoria - a highly criticized term without any medical or scientific standing (WPATH 2018) – i.e., that young trans people are influenced by the internet and their peers to experience gender dysphoria (RFSL 2019). Moreover, Swedish feminist figures such as Kajsa Ekis Ekman (2018) and Cissi Wallin (2020) and the radical feminist site Gardet (2020) have questioned trans identity and trans peoples place in the feminist movement publicly, similar to Rowling above.

These arguments from public figures are attacks on trans people since they not only question their right to self-determine their gender identity but, given that they are public, also are attempts to form public opinion in a way that is harmful to trans people. Thus, I hold the position that safeguarding trans rights is of upmost importance. In contrast to the above-mentioned people, I do believe that trans people belong in the feminist movement. To me, feminism is about questioning gender identities and norms that are harmful, unjust and stifle individual and collective expression and societal development. The goal is to dismantle structures that allow more power and preference to some over others. This is by no means a radical opinion, but one that is aligned with that of many trans people. To me, working against people that aim for the same goal as you strive for, is entirely contra productive.

Furthermore, me being a cis person without experience of the three stages of reproduction that the research explores – pregnancy, childbirth and parenting – conducting research in which the target population are trans people who reproduce can raise eyebrows. I am aware that I cannot fully understand all the experience that are presented in this study. For some, this might be considered a flaw that would affect my research negatively. Contrarily, I believe that this is something that strengthens me as a researcher since this gap in information is what makes me engage in my research. My awareness of my position can even have the opposite effect since it makes me resign from making conclusions that align with my experiences instead of the ones provided by the informants. With that said, lacking the above-mentioned personal experiences does not necessarily mean that I am completely oblivious. Sexual, reproductive, judicial and medical rights for LGBTQI people are topics that I have actively explored and worked with for years. Moreover, I define myself as queer and have a sense of belonging in a community that involves the target group. Being a child of immigrants and

racialized as Arab, I have noticed that many assume that I will write about (anti-)racism. Although it is a subject that I am very much interested in it is not something that will be explored in this research.

3. Reproductive justice framework

This chapter has two purposes. First, I will present the reproductive justice framework. Second, I will give suggestions on alternations to the framework in order to include a trans perspective. Thus, in this chapter research question 2.1: *How can the reproductive justice framework develop to include a trans perspective?* will be answered.

3.1 Historical context

There are several events in the history of the United States that involves the US government restricting reproduction for women of color that has contributed to the need of developing a reproductive justice framework. The Eugenics movement of the early 1900s is one such event. The theory of the movement was that socially deviant traits and characteristics were biological and thus hereditary and by restricting reproduction for people with these traits you also stopped them from spreading, all in the name of population control. Racist ideologies in the US society – with roots in the Atlantic slave trade – coincided with the Eugenics theory to target people of color, immigrants, queer, poor and other that were deemed unfit to parent (Jolly 2016). One way to enforce population control was to increase access to birth control. This issue had two advocates: people fighting for women's empowerment and self-control and people fighting for population control. Women of color - coming from the experience as "[…] enslaved breeders for the accumulation of wealth of White slave-owners" (Asian Communities for Reproductive Justice (ACRJ) 2005, 3) – was in the premier group and the US government – funding family planning both nationally and internationally as a means to control population growth – was in the latter (ACRJ 2005). Another way to enforce population control was through involuntary mass sterilization of for example working-class women, black women, immigrants and indigenous women (Jolly 2006). In the 1970s a women's health movement emerged and focused on establishing health clinics and ensuring access to family planning and reproductive health services. For this movement, emphasis was on abortion rights which culminated with the Supreme Court ruling in the case of Roe v. Wade in 1973[7], which legalized abortion throughout the US (ACRJ 2005).

[7] Roe v. Wade was a landmark case in the Supreme Court that affirmed that the 14th amendment of the United State Constitution, which ensured a right to privacy, included a legal right to abortion (CNN 2020).

3.2 The birth of a movement

Reproductive justice was coined by women of color in the US in the beginning of the 1990s. They felt that the movements fighting for women's rights, such as the pro-choice movement, was individualistic, narrow and white-centric and thus failed to take into account social issues that became barriers for women of color to attain full reproductive health (Ross 2006). An example of this is given by the organization SisterSong Women of Color Reproductive Justice Collective's, stating that "[m]ainstream movements have focused on keeping abortion legal as an individual choice. That is necessary, but not enough. Even when abortion is legal, many women of color cannot afford it, or cannot travel hundreds of miles to the nearest clinic. There is no choice where there is no access." (SisterSong n.d.) The critic of the women's movement was thus the spark that led to the development of a reproductive justice framework and with the formation of the above-mentioned organization, the framework evolved into a movement (Ibid.).

3.3 A Reproductive Justice Framework

Drawing upon the World Health Organizations definition on health, Loretta Ross, one of the founders of SisterSong and a prominent reproductive justice activist, defines reproductive justice as "[...] the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Ross 2006, 14). Another founding member, the organization Asian Communities for Reproductive Justice (ACRJ) defines that reproductive justice "[…] will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives" (ACRJ 2005, 1). Both definitions highlight that reproduction is not only a process connected to physical health but a question of resources, power and social justice. The founders emphasize that reproductive justice is positioned within a human rights framework (Ross 2017; SisterSong n.d.). Ross (2017) distinguishes eight categories of human rights upon which reproductive justice rest: civil, political, economic, social, cultural, environmental, developmental and sexual.

Noticeably, reproductive justice is broad and is not only – as the name might imply – concerned with issues related to childbearing, family planning, abortion and so on but also on the treatment by states and the barriers this creates that hinders marginalized groups to live

safe and healthy lives. Reproductive justice acknowledges that to be able to live safe and healthy lives it is crucial to "[…] also address the varied components that shape our well-being, such as the right to quality education, housing, health services, clean drinking water, and safe and toxin-free environments" (Jolly 2016, 168). In other words, reproductive justice aims to make long time change of the root causes - based on racism, xenophobia, misogyny, homophobia, transphobia and so on – that lead to reproductive oppression for marginalized groups. Reproductive oppression is explained by Ross (2006, 14) as "[…] the control and exploitation of women, girls and individuals through our bodies, sexuality, labor and reproduction". Ross argues that practices that control other people's reproduction is a form of genocide[8], thus making the conclusion that "[r]eproductive oppression is genocide, or 'reprocide', as I prefer to name it" (Ross 2017, 293).

Rooted on the neglected experience of intersectional oppression of women of color in the US, reproductive justice is inherently intersectional. Ross (2017, 288) states that "[t]he concept of intersectionality describes the confluence of oppressions […]", i.e. for women of color this means that the racial and gender identities will not be separated, rather they are intertwined and describes the specificities to the oppression experienced by women of color.

3.4 Reproductive justice, reproductive health and reproductive rights

Simply put, reproductive justice is the merger of reproductive rights and social justice (Ross 2017; SisterSong n.d.). Addressing for example abortion only with a reproductive rights approach, i.e., legal rights and policies, and isolate the problem from other social issues such as discrimination based on race, sexual orientation, immigration status, etcetera, marginalized communities that suffer from other obstacles will still not have reproductive justice, even though there are laws and policies in place to ensure the right to abortion (Ross 2006).

Researching the reproductive oppression of female agriculture migrant workers in the US Galarneau (2013) expresses the same dilemma. With the story of Luz, a young farm worker, the author illustrates the issue at hand. One summer, Luz becomes pregnant and decides

[8] The United Nations' Convention on the Prevention and Punishment of the Crime Genocide states that "[…] genocide means any of the following acts committed with the intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: […] (d) Imposing measures intended to prevent births within the group; (e) Forcibly transferring children of the group to another group" (United Nations General Assembly 1948/1951, article 2).

together with her mother to end the pregnancy. With the presence of a student health worker team, Luz has more options than what is usually available, but the services needed had a price Luz could not pay and were located in a place Luz had no possibility to go to. The situation, Galarneau states "[…] constrained her ability to make healthy decisions about her body and reproduction" (Galarneau 2013, 147). For Luz, the efforts made in the name of reproductive health and rights (i.e., legal access to abortion and the presence of health clinics) were of course beneficial but not enough. Galarneau states that:

"[W]hile critical in addressing immediate needs [the reproductive health and reproductive rights efforts] are ineffective in making long term change because they neglect the root causes of health problems […]. The reproductive justice framework does not replace these other frameworks, but rather engages with them in adding critical structural and intersectional dimensions imperative for achieving health and rights" (Galarneau 2013, 153).

Thus, it is important to understand all three frameworks and how they are similar and different from each other. In the table below (table 2) the central themes of the three frameworks are addressed and put together to enable comparison.

	Reproductive health	**Reproductive rights**	**Reproductive justice**
Problem	Lack of information, accurate health data or available services leads to lack of access to health care	Lack of legal protection, laws or enforcement of laws that protect individuals' reproductive choices	Power inequities in our society limit women's ability to exercise self-determination
Answer	1) Create and develop progressive health care clinics to improve health and level health inequalities, 2) Ensure that women have access to a full range of reproductive health services and are empowered to understand their health care needs	Using various legal, advocacy, and political means to contest damaging legislation and advocate or influence public policies that protect reproductive choice. Focus on keeping abortion legal and increasing access to family planning	1) Organize women and girls to change structural power inequalities, 2) Focus analyses on interconnecting social justice and human rights issues that affect women's bodies, sexuality and reproduction
Strategy	Improving and expanding services, research and access, particularly prevention and cultural competency in communities of color	Protecting reproductive rights of individuals through legal, legislative or advocacy	Elevate, empower and support leaders in marginalized communities and advance an agenda that brings real individual, community, institutional and societal change

Table 2: Reproductive health, rights and justice comparison. Information from ACRJ (2005), table made by author.

3.5 Reproductive justice in action

Ross has defined three rights that reproductive justice strives to ensure. The definition of the rights has varied slightly throughout the years, but the core understanding has always been the same: "[…] (1) the right to have a child under the conditions of one's choosing; (2) the right not to have a child using birth control, abortion, or abstinence; and (3) the right to parent children in safe and healthy environments free from violence by individuals or the state" (Ross 2017, 290). These three rights are repeated as cornerstones in the reproductive justice framework in various articles. An example of this is an article on incarcerated women of color by Hayes, Sufrin and Perritt (2020) who use the three rights when analyzing whether reproductive oppression occurs during incarceration. One by one they go through the three rights and determine that they are not fulfilled for incarcerated women, making the conclusion that incarcerated women suffer from reproductive oppression. Furthermore, the authors argue that structural racism and the run-for-profit prison system – a profit they receive by imprisoning people – in the US work together to make it more likely for women of color to be incarcerated than other women. Thus, the authors conclude, "[r]eproductive justice recognizes that control over one's fertility is complex and cannot be fully understood outside the social conditions that affect it – including the racialized phenomenon of mass incarceration and its historical relationship to slavery and Jim Crow" (Ibid., 522)

3.6 Anti-heteropatriarchal reproductive justice

Thus far, the literature has mostly focused on reproductive justice in relation to the intersecting oppression that women of color meet. Lane (2019) calls for a broadening of the reproductive justice framework. She argues that as of now the reproductive justice framework is heteronormative and does not take into consideration the reproductive oppression that non-heterosexual[9] women face nor the rights that non-heterosexual women need access to in order to achieve reproductive justice, such as assisted reproductive technologies (ART) or adoption. Non-heterosexual women are often faced with normative presumptions by health care providers that assumes that she will engage in traditional family formation. Accessing paths to parenthood which are not infested with heteronormativity often leaves the woman overwhelmed and unable to make informed decisions about her reproduction. These

[9] The term "non-heterosexual women" is used by Lane (2019) and adopted by her from Judith Butler. Lane explains that it is chosen for its inclusiveness in contrast to, for example, the term "queer" which is not universally accepted within the LGBTQ communities.

experiences reveal how some women's need for protection is different from others. For non-heterosexual women, the need is rather to have different choices because they have different choices to make in comparison to hetero women (Lane 2019).

Heteropatriarchy is a social system that 1) depend on the oppression of women and non-heterosexuals, 2) obtains its power through racist, sexist and classist ideologies, and 3) is maintained by normative beliefs and values. Heteropatriarchal societies value heterosexual partnerships and reproduction since this is a way for the state to protect its power and reproduce a social order in which women and non-heterosexuals are oppressed. Thus, by challenging the social norms of heteropatriarchal societies, non-heterosexuals disturb and threaten heteropatriarchal societies to the core (Lane 2019). Applying an anti-heteropatriarchal perspective to the reproductive justice framework has "[…] the potential to disrupt underlying assumptions of heterosexuality, thus challenging normatively constructed notions of family formation" (Lane 2019:897) and this challenging of heteronormativity disrupt power structures that constrain all women's reproductive choices. Therefore, all women benefit from an anti-heteropatriarchal reproductive justice framework.

3.7 Including a trans perspective

The reproductive justice framework is developed in a context where women of color felt that their experiences and specific needs were not met within the (white) feminist movement. Being non-white came with additional struggles than those that came with being a woman. Founded within a feminist framework with a focus on women's rights, the reproductive justice movement focused on the diversification within the group "women", criticizing that the (white) feminist movement did not include all women. Thus, womanhood is the common ground that connected these movements. Termination of injustices that women face in a patriarchal world order is both these movements raison d'être. The reproductive justice movement add perspectives that are important in order to include more women, it makes sure that not only the women with the most power are the once for which the fighting will lead to a termination of injustice.

The gendered language used by the founders and users of the reproductive justice framework does emphasize the connection with the feminist movement and womanhood as the common ground connecting these movements, but at the same time exclude many others. For this

reason, I want to suggest the use of a gender-neutral language. It is a simple modification that will include more people. Removing a gendered language from the framework will not alter who will be benefit from it since it is built in the framework to target the most marginalized. There is no need to specify which gender these marginalized people might have and thus potentially exclude some.

Further, the three rights that Ross (2017) defines as aims for reproductive justice are, in my opinion, paramount but should also include:

- Right to affordable and safe cryopreserving of gametes before gender-affirming treatment if the patient wishes to do so,
- Right to affordable access to ART and adoption,
- Right to visibility in health care settings, including: (1) the right to have your preferred pronoun and name used, (2) having the preferred pronoun of the future child respected, and (3) including non-normative family constructions in material and classes.
- Right to legal parenthood regardless of biological connection to the child,
- Right to a safe and respectful childbirth free from any form of obstetric violence,
- Freedom from cis- and heteronormative assumptions regarding reproductive choices, parenthood and family formation.

4. Overview of the research field

4.1 Reproductive health care in Sweden

The Swedish welfare state is often ranked highly and acknowledge as a great example internationally. For example, Sweden ranks number 8 in the world in the Human Development Index (United Nations Development Programme 2019). Reviewing the European Health for All database (HFA-DB) on the World Health Organization's (WHO) website we see for example that, compared to the average of all EU members, Sweden has a lower rate of fetal, neonatal and postneonatal deaths per 1000 births (WHO 2020). Globally, Sweden only has a higher maternal mortality ratio per 100,000 births than 9 countries (WHO n.d.). Nevertheless, the indicators on whether the Swedish reproductive health care earn the title of world leading cannot solely be based on whether birthing persons and infants survive or not.

Pregnancy

In Sweden, assisted reproduction can be done through either artificial insemination[10] or in-vitro fertilization (IVF)[11]. The treatment can be carried out with either the eventual birthing person or non-birthing person's gametes or with donated gamete(s). The parents who are allowed the treatment can be of the same-sex or opposite sex (note that only two sexes are acknowledged in Swedish law). The birthing person may also be single. (The Swedish National Council on Medical Ethics n.d.; See also Föräldrabalk (1949: 381); Lag (2006:351) om genetisk integritet m.m.) Regardless of constellation, the rules for accessing donated gametes are the same. Before the treatment can be performed an investigation into the patient(s) medicinal, psychological and social circumstances is conducted by health personnel. The purpose of the investigation is to make sure that the future child will be brought up in good conditions. In the assessment, health personnel are supposed to take into consideration the patient(s) age, health condition, possible disabilities, living conditions and the attitude towards informing the future child of its genetic origins. If the patients are a couple the assessment should also look at the relationship. If the patient is single, the patient's social network is investigated. Factors that can be considered a risk toward the intended

[10] Artificial insemination or insemination is when semen is intentionally introduced, with the help of for example a catheter, in the internal genitals, uterus or cervix with the intention of accomplish a pregnancy.
[11] IVF is when an egg and sperm is combined outside of the body and after a few days implanted in a uterus with the intention of accomplish a pregnancy.

parent(s) ability to nurture and care for the future child and its need include for example: mental instability, addiction, severe disabilities, previous neglect of child, unemployment with little possibility of getting a job, lack of living space or homelessness, criminality such as violence or assault and lack of social network and support. Since it is a right for children who have been born through donation to find out about their genetic origins, the intended parent(s) also needs to show that they will actively inform the future child that it has other genetic links than to the intended parent(s). During the assessment, potential protective factors that can reduce the risk factors should also be considered. If the investigation leads to the decision that the intended parents are not allowed assisted reproduction from the Swedish health care, the decision can be appealed to the Swedish National Board of Health and Welfare (National Board of Health and Welfare 2016a).

In a study about female same-sex couples family formation journey through assisted reproduction technique (henceforth, ART[12]), the participants stated that the process was stressful, heteronormative and lacking in support. Getting information about ART and finding someone who could answer their questions proved difficult for the participants. When they finally started the process, the first meeting in the clinic, with a counsellor, was for some participants filled with feelings of anxiety and a fear of not being approved. The treatment that the participants received from the reproductive health care and sometimes the health personnel as well as parental groups was described as heteronormative. For example, information material did not include pictures of same-sex families and the non-birthing person was regularly described in these as the father. Participants expressed a need for psychosocial support since the process of ART was demanding and stressful (Appelgren Engström, Häggström-Nordin, Borneskog & Almqvist 2018).

A pregnant person with a physically demanding job can be allowed a pregnancy benefit to stay at home with pay (approximately 80 % of the regular income) from the Swedish Social Insurance Agency 60 days prior to expected time of birth (Swedish Social Insurance Agency n.d a). It is also possible for a pregnant person to start their parental leave 60 days prior to the expected childbirth. The non-birthing parent is also allowed to take parental leave to be able

[12] ART are different procedures that involve both egg and sperm and which are conducted outside of the body. The purpose of ART is to achieve a pregnancy. IVF is usually included in the umbrella term ART but not artificial insemination.

to attend parenting classes or attend reproductive health visits (Swedish Social Insurance Agency n.d b).

Childbirth

In her book about Swedish reproductive health care, journalist and author Lisa Bjurwald reports about a dangerous culture in Swedish birthing centers in hospitals. A culture that is upheld by health personnel and highly affects birthing people. Bjurwald states that genital births, being "natural", are preferred and thus there is a strive to avoid cesarean section even in cases when this is the preferred method (Bjurwald 2019). Not allowing cesarean sections has led to death in some cases (Forsell & Morén 2019). Refraining from doing cesarean sections could possibly be a consequence of the urge from politicians to lower the number of unnecessary cesarean sections and thus save money (Bjurwald 2019). In Sweden, the most common reasons for birthing people to get an urgent cesarean section is the threat of fetus asphyxiation, that the fetus is in the breech position and uterine inertia. For second-time birthing people a previous cesarean section (11 %) is also a common reason for an urgent as well as a planned cesarean section. In almost half of the cases of planned cesarean section for first-time birthing people, the reason is that the fetus is in the breech position. A cesarean section done based on the birthing persons own wish (which is what I interpret is meant with "unnecessary cesarean sections" above) is the most common reason for second-time birthing people and second most common reason for first-time birthing people to have a planned cesarean section (National Board of Health and Welfare 2019). Planned cesarean sections, regardless of reason, stands for only 7,6 % of deliveries in Sweden (National Board of Health and Welfare 2020) and the prevalence increases with the birthing persons age and Body Mass Index (National Board of Health and Welfare 2016b).

The strive to not perform cesarean section can lead to the use of other methods, such as fundal pressure, vacuum extraction and forceps. Fundal pressure is a method that can lead to severe genital tears[13] and rupture of placenta and inner organs (Bjurwald 2019). Vacuum extraction and forceps are associated with severe genital tears. For first-time birthing people, 10,7 % has a severe genital tear in deliveries with instruments compared to 3,7 % in non-instrumental deliveries (National Board of Health and Welfare 2020). Statistics from Sweden shows that

[13] A severe genital tear is a tear of degree III or IV. Degree III are tears that extend into the pelvic floor muscles and muscles surrounding the anus. Degree IV includes tears in muscles surrounding the anus and the mucous membrane in the rectum.

there is a heightened risk to obtain a severe genital tear if the birthing person is 30 or older, shorter than 150 cm, has been subjected to genital cutting, was in South-East Asia or sub-Saharan Africa and depending on which Swedish region the birthing person lives in. Severe genital tears are associated with a high risk of fecal incontinence. Complications are often different depending on the way of delivery. Genital birth, for example, increase the risk for severe genital tears and following fecal incontinence as well as uterine incontinence and need for surgery for prolapse. Usually, the more children a person has given birth to genitally, the higher risk. Cesarean section on the other hand is associated with a higher risk of infections and blood clots as well as uterine rupture and placenta complications during a potential next pregnancy. In a longer period of time, cesarean section also leads to a heightened risk for hernia than genital births (National Board of Health and Welfare 2018). Some complications are noticed and treated right away. But many are the people who have had troubles with sex, defecating and pain and who, when seeking help, have been told that everything is normal and thus not receiving much-needed help (Bjurwald 2019).

In the spring of 2020, a Swedish court sentenced a midwife to probation and fine for causing bodily injury (‘vållande till kroppsskada’). The case concerns a labor almost four years prior in which the sentenced midwife increased the drip of labor stimulation medicine when she should have decreased or stopped the drip or called a doctor. Increasing the drip led to contractions that were so close that the fetus did not get enough oxygen which resulted in brain damage (Kristianstad district court 2020). Although this specific case is unique as it led to a criminal investigation, the inappropriate use of labor stimulating medicine is not uncommon. Reviewing cases of malpractice involving pregnancy and delivery from the Swedish Medical Responsibility Board during 1996-2003, a study found, among other things, that it was a common negligence to increase oxytocin (labor stimulation medicine) although the fetal heart rate was worrying. Coincidental, failure in fetal monitoring and thus not recognizing fetal distress was common (Jonsson, Lindeberg Nordén & Hanson 2007). Administrating oxytocin without caution was also common in cases of suspected malpractice from the Patient Advisory Committee during the period 1990-2005 (Berglund, Grundewald, Pettersson & Cnattingius 2007).

Another reported culture in birthing centers is paternalistic treatment from health personnel. Not being listened to, having your experience diminished and being treated as a child is something many birthing people testify to have experienced. In some cases, the disregard of a

birthing person's pain and worry has led to life-threatening consequences. In birthing centers there is a norm that pain is something natural which one should endure, an approach which is not common in other parts of the hospital. An example of this is the disuse of anesthesia when sewing genital tears. Although the use has increased since 2010 and it is now a recommendation to use, there are still many complaints of anesthesia not being used. Another example of paternalism in birthing centers are complaints from birthing people about lack of information in matters that concern them, for example about possible pain associated with different methods. This treatment is sometimes explained by health personnel as protective, that is, they do not want to scare birthing people (Bjurwald 2019).

Just after the child is born the non-birthing parent - or if the birthing parent is single, a close relative - is allowed ten days off work with pay (approximately 80 % of the regular income) from the Swedish Social Insurance Agency for each child born (Swedish Social Insurance Agency n.d c). Parents who adopt are also allowed ten days, however these need to be shared by both parents – the parents decide how to divide them (Swedish Social Insurance Agency n.d d).

Parenting

In 2019 the parental law (SFS 1949:381) was updated with specific rules regarding the determination of parenthood for people who have changed their legal sex. The law change was both celebrated – for making the law clearer – and criticized – for being discriminating toward trans people - by lawyers and interest organizations. In short, in the parental law there is an assumption that a man who is married to a woman is the legal father and thus is determined to be the father automatically (if not established otherwise). The change in the law removed this assumption for trans non-birthing people who now have to get their parenthood determined by the social services. Inherently, in a couple where one of the parents have changed their legal sex the parenthood will not be automatically determined for the non-birthing person, even if the gamete's used were from the intended parents (Mägi, Westerlund, Burman, Ehne & Mire Åsell 2018).

However, the law stipulates that a legal man that gives birth to a child assumes the role of father, but the same legal rules as for mothers apply (SFS 19491, ch. 11§). The non-birthing parent can be determined to be mother or father (SFS 1949, 1 ch. 13-14 §) if there is an established genetical connection to the child (SFS 1949, 1 ch. 5 §) or if the non-birthing

parent has given consent to artificial insemination with donated sperm (SFS 1949, 1 ch. 8 §). The same rules apply if the birthing parent is legally a woman and the non-birthing parent has changed their legal gender. Note that if the birthing parent is not married to, lives with or is a registered partner to the non-birthing parent no mother- or fatherhood for the non-birthing parent is established (SFS 1949, 1 ch. 12 §).

Being a parent most often also means being the legal guardian of the child until they mature age (eighteen in Sweden). The legal guardian has the responsibility to make sure that the child is cared for (SFS 1949, 6 ch. 1-2 §). Married parents automatically have a joint legal guardianship. For unmarried couples the birthing-person is lone legal guardian until the parents have registered the non-birthing person as legal guardian at the Swedish Tax Agency (SFS 1949, 6 ch. 3-4 §). If the care for the child is neglected the court can decide to remove legal guardianship of one of the parents or change legal guardians to one or two appointed legal guardian(s) (SFS 1949, 6 ch. 7 §).

Parental leave with pay (usually 80 % of the regular income) from the Swedish Social Insurance Agency is allowed for 480 days for each child. Days can be taken by legal guardians, parents or a person who is married or lives with the parent(s). If two people are sharing the days, at least 90 is reserved for each person. If there are multiple children being born (twins, triplets) the number of days increase (Swedish Social Insurance Agency n.d. e).

4.2 Trans reproduction

A person's ability to reproduce is individual and depend on different factors such as timing, age, lifestyle, laws and medical conditions. Physiological, being trans has no impact on the ability to reproduce per se, but some treatments that many (but of course not all) trans people go through can have an effect on fertility. The impact of gender-affirming hormone therapy on fertility is not completely determined (Cheng, Pastuszak, Myers, Goodwin, Hotaling 2019), though studies have indicated that ovaries exposed to testosterone treatment and testicles exposed to estrogen treatment can recover after stopping the treatment (World Professional Association for Transgender Health (WPATH) 2012). This, for example, makes it possible for trans people born with a uterus to become pregnant after suspending testosterone treatment (see for example Charter, Ussher, Perz & Robinson 2018; Ellis, Wojnar & Pettinato 2014; Light, Obedin-Maliver, Sevelius & Kerns 2014; Leung, Sakkas, Pang,

Thornton & Resetkova 2019). Preservation of fertility can be achieved through cryopreservation (freezing) of ovum and sperm prior to or during hiatus of gender-affirming hormone therapy (Cheng et al 2019; WPATH 2012). Harvesting ovum is more intrusive than harvesting sperm since it requires hormone treatment and an invasive procedure compared to sperm harvesting where ejaculation is the only requirement. Although both of these practices may be troublesome for the patient due to their gendered connotations (Mitu 2016; De Sutter, Verschoor & Hotimsky 2002). The impact of gender-affirming surgery on fertility depend on what kind of surgery the person choses to have. For example, removing uterus, ovaries and testicles results in sterility (Cheng et al 2019).

The Swedish National Board of Health and Welfare recommends that health personnel inform and counsel people who will undergo gender-affirmative treatment about the potential effects the treatments can have on fertility and about what kind of measures they can take, such as freezing ovum or sperm. The National Board of Health and Welfare accentuate that since studies (see for example De Sutter 2002; Wierckx, Van Caenegem, Pennings, Elaut, Dedecker, Van de Peer, Weyers, De Sutter & T'Sjoen 2011) show that many prefer to get immediate treatment rather than having the possibility to have biological children, counseling also needs to include other paths to parenthood than biological, such as ART or adoption (National Board of Health and Welfare 2015).

Pregnancy

In a study from Australia on 25 trans men's experiences of parenthood and pregnancy, the first step in the process was to discontinue testosterone treatment. Given that this treatment had been significant for the participants to feel validated in their masculinity, the withdrawal had a negative impact on the well-being of the participants. Stress, depression, shock over the bodily changes, distress and a return of previous negative feelings about the self as well as lack of energy and mood swings, were all reported by the participants (Charter et al 2018). Similar results were found in a British study that examines eight previously pregnant trans men and non-binary people. In this, the discontinuation of testosterone and the feminizing retrogression of the body was explained to involve feelings of fear and loss of control over the body. Overall, the pre-conception period was reported to be a particularly lonely time for the participants. For example, one participant explained that during this period he distanced himself from his group of friends who were transmen, due to a feeling of doing something wrong (Ellis et al 2014).

Likewise, pregnancy is also reported to be a period of isolation and loneliness. In an American study involving 41 trans men who experienced pregnancy, feelings of isolation were often reported by participants who explained this to be due to, for example, lack of visibility, feelings of being the only one with this experience and lack of support and resources for pregnant trans men (Light et al 2014). Further, the pregnant body was cause for much distress. Some even reported feeling disgusted about their body, especially due to the feminine retrogression of it, such as changes to the chest. For many this was the most challenging physical change during pregnancy which was further exasperated by not being able to bind or hide the growing chest. This made many resort into isolation, both by not meeting other people but also in the shape of distancing and disassociating oneself from the own body (Charter et al 2018). Strategies to handle the distress included, for example, wearing large clothing that covered the body and avoid social activities (Ellis et al 2014). Others saw their pregnancy as a sacrifice they had to do in order to create a family (Charter et al 2018; Light et al 2014). Some reported a sense of loss of anonymity and comfort since the disclosing of pregnancy also meant disclosing their gender identity to people who did not know of their trans history (Ellis et al 2014). For many, pregnancy was a time of great discomfort and loneliness, not even being able to feel a connection to oneself as well as the developing fetus in one's body (Ellis et al 2014). Contrarily, others reported the opposite. For them, pregnancy was an aid for gender dysphoria since it helped them find new ways to connect to their bodies (Light et al 2014) and actually helped feeling at peace with oneself (Ellis et al 2014). Similarly, transitioning has given some the ability to even consider parenthood since figuring out their gender identity and transitioning had opened doors to construct their own parent identity (Charter et al 2018).

In regard to interactions with health care and health personnel, participants had different experiences. Some reported negative experiences, for example being misgendered and not called by their preferred name or pronoun (Light et al 2014; Charter et al 2018; Ellis et al 2014), or that health personnel were visibly uncomfortable, awkward and/or only focused on their gender identity (Charter et al 2018). Others reported positive experiences, which often were related to the use of an inclusive language in regard to their gender identity (Light et al 2014). Some were surprised that their interactions had been positive (Ellis et al 2014), indicating that many had a preconception that they would be subjected to ill-treatment. Outside of the health care, several participants reported feeling ignored, misunderstood and alienated by social services as well as other intended parents (Ellis et al 2014).

An American survey study from 2017 explored 32 self-identified trans people's approach to different methods to become parents. Given that, the authors assert, most research on trans people's parenthood focus on people who start identifying as trans after they have had children – these authors wanted to focus on people who will become parents after they have started to identify as trans. The results of the study show that the method that will be used to become parents was adoption (31%) followed by traditional sexual intercourse (25%). Trans women chose the first option to a higher degree than trans men who were more inclined to use the latter option. Even though often described as an unideal method, sexual intercourse was chosen by participants due to financial and legal barriers connected to other methods. Almost half reported to have chosen method based on the desire to have biological children. Thirty-eight percent stated that their status as trans was hindering them to reproduce through their ideal method. This was often described in relation to wanting the reproductive system that was in congruity with their gender identity. Other aspects that dominated some of the participants choice of method was financial barriers, infertility, legal situation and the potential infliction on their transition or gender identity. The latter was reported by a few trans men who did not desire to become pregnant (Tornello & Bos 2017).

Most research focus on trans people with the ability to carry a gestational pregnancy, either through sexual intercourse or ART. It is somewhat harder to find information surrounding the non-birthing parent, birthing-parents who are non-binary or where the intended parents adopt. In a European study from 2002, 121 trans women from 11 countries (the majority from France, the UK, the Netherlands and Belgium) were surveyed about their opinion about freezing sperm prior to starting any gender-affirming treatment. In the study, half of the participants answered that they would prefer to have biological children, whereas the other half did not care. At the same time, more than 90 % of the participants stated that loss of fertility was not a reason for them to delay their transition. One third agreed to the statement that freezing sperm would mean that they could not break free from their previous gender role. Nevertheless, a majority (76 %) believed that trans women should be informed about fertility preservation and offered to freeze sperm, before engaging in gender-affirming hormone therapy. Notably, in the free-text answers, fears around reproducing were visible. Some mentioned that they thought the physical trauma they endured due to gender dysphoria would damage the relationship with the child. Others highlighted that it would be very hard to bring up a child in a society intolerant of trans people. The financial situation was also noted by some, reporting that many trans people have to pay for gender-affirming treatments themselves and therefore find themselves in

a poor financial situation. Lastly, many participants also expressed their wish to being pregnant and giving birth themselves (De Sutter et al 2002).

Further, a Swedish study showed that although a narrow minority of respondents answered that they wanted to have children, the group that was categorized as non-binary had a lower wish for this compared to the two other groups, which were categorized in binary terms (Abrahamsson & Arinell 2015).

Lastly, in a government appointed committee report on the specific conditions in Swedish society that affect trans people, many participants describe that they have - in the trans assessment - been met with the preconception that they do not want to have genetical children and thus have no desire to cryopreserve gametes or preserve reproductive organs. Being afraid not to get the diagnosis that allows gender-affirming treatment if not agreeing to the preconceptions, people report that they have not asked for fertility preservation measures. The report concluded, among other things, that cis- and heteronormativity in the Swedish society including health care limit trans people's ability to attain sexual and reproductive health and rights. Another reported feature of cis- and heteronormativity is the lack of inclusive language and trans representation in written material which leaves many trans people feeling invisible (Inquiry on Trans People in Sweden 2017). This invisibility and lack of trans representation is reported from other countries as well, such as Australia (Charter et al 2018).

Childbirth

Relating to childbirth, indications were found that some birthing-persons had a preference for cesarean section because the thought of having their genitals exposed for a long time was distressing (Ellis et al 2014). One study found that of those who underwent cesarean section, one fourth reported this being self-selected (Light et al 2014). Others preferred a genital birth and described that although it was painful it was an "[…] emotionally meaningful experience" (Ellis et al 2014:66). The arrival at the birthing center can also bring about discomfort, for example when having to stay in areas where patients are expected to be female. This can generate a fear of being judged by other patients. Not being able to advocate for oneself during labor was also a noted fear (Ellis et al 2014). Notably, one study also recognized that many of the birthing-persons had reported having experienced depression around the time of childbirth (Light et al 2014).

In a study involving lesbian, bisexual and trans people who experienced fear of childbirth (FOC), it was noted that, in addition to the common fears that most people who experience FOC have – fear of pain, injuries, complications during labor, death, loss of control etcetera – the participants also had fears that were associated with their identity or relationship(s) being outside of the norm. For example, some had previous experiences of maltreatment due to homo- and/or transphobia in health care and consequently a lack of trust for health personnel, which lead them to expect and fear the same kind of treatment during childbirth. This fear was central to their FOC (Malmquist, Jonsson, Wikström & Neiminen 2019).

Parenting

In 2015, a study by two psychology students at a Swedish university investigated trans people's desire for children and parenthood. The study was conducted through a web-survey that was answered by 154 people. Results from the survey showed, inter alia, that the group that was categorized as non-binary were more worried about being questioned as parents compared to the two binary groups. This could be due to the fact that the non-binary group to a lesser degree felt that they could live in accordance with their gender identity (Abrahamsson & Arinell 2015). Accordingly, another study shows that although most participants found it hard to name their role as parents, the group that identified as genderqueer (a term that is often synonymous to non-binary) together with those who had not had any gender-affirming hormone therapy, found this particularly hard (Ellis et al 2014). When comparing those who had children and those who did not (trans men, trans women and non-binary people combined), those with children had a higher tendency to feel that they could live in accordance with their gender identity. Moreover, those with children had a more positive approach than those without children, on how trans people were viewed as parents in comparison with cis parents. This could indicate, the authors analyze, that these parents might not have as bad experiences as they first thought. Although, it should be noted that in the group in general there is a substantial worry to be viewed as bad parents just because they are trans people (Abrahamsson & Arinell 2015).

The fear of being considered a bad parent for being trans may be viewed in the light of findings of a Canadian study in which 110 of 433 surveyed trans people were parents. In this study, 10 % reported having lost guardianship of their child due to being trans while 7 % have had their guardianship limited for the same reason. In addition, 12 % report that they see their children less often for the reason of being trans (Pyne, Bauer & Bradley 2015). Although the study did not specify the reasons behind the guardianship limitations, one may be, according to Green (2006), that the other parent(s)

alienate the child from their trans parent, resulting in the trans parent losing or experience limitations to the guardianship. Notably, family conflict has been found to be obstructive to a child's possibility to adapt to a parent's transition (White & Ettner 2004). This might explain why only 43 % of trans parents in the Canadian study reported having strong support for their gender identity from their children. It should be noted that many of the surveyed parents had children who were adults, which could indicate that their parent transitioned when they were older (Pyne et al 2015). The child's age has been found to be important for the child's ability to adjust to the parent's transition, with young children adjusting better than adolescent children (White & Ettner 2004).

Further, a study recognized that "[c]ombined with feelings of isolation postpartum, many participants specifically mentioned having postpartum depression [which] seemed amplified by a lack of gender-sensitive resources for postpartum depression" (Light et al 2014:1124). The authors reason that "[o]ur findings suggest that transgender men [i.e., the target population of the study] may represent a high-risk population for postpartum depression […]" (Light et al 2014:1126). This can be viewed in light of the result of one study that showed that chest feeding was a considerable issue for the participants, and a trigger for gender dysphoria. The study showed that the inability to bind the chest due to it swelling and leaking from lactating lead to many isolating themselves (Charter et al 2018).

In 2016 a Swedish LGBTQI organization made a review of LGBTQI-peoples need of support in relation to parenting. The above-mentioned government appointed committee on the specific conditions in Swedish society that affect trans people, had access to the data and managed to filter out the answers of the 72 trans people that were included in the review. The results show that more than half of the respondents expressed a need to meet other people who lived in a similar situation as they did as well as having their children meeting families that looked like their family. Consequently, three quarters of the respondents reported a need of a meeting place free from heteronormativity. Multiple respondents highlighted the inability of professionals to understand that families can look in different ways as well as include more than two parents. The inability to legally be more than two parents is something that is noted as problematic. The committee report also mentions that there are a few cases of trans people who have temporarily lost legal guardianship of their child when changing legal sex due to their old personal identity number, which is connected to the guardianship, being deleted (Inquiry on Trans People in Sweden 2017).

Some studies have explored the experiences of children with trans parents. Although this study will not delve into the perspective of the children it can still be interesting to mention since arguments

against trans people's parenthood have been that them being trans gender will have a negative impact on their children. Looking at two areas that have been highlighted as concerns from opposition to trans people's parenthood – 1) that the children will themselves become confused about their gender identity and, 2) that the children will be subjected to negative reaction from their peers - Green (1998) conclude that these are not issues that warrant concern. Interviewing 18 children to trans people, Green finds that "[…] gender identity confusion does not occur and that any teasing is no more a problem than the teasing children get for a myriad of reasons" (Green 1998).

5. Analysis of primary data

In this section I present the analysis of the data collection. The intent is to give an answer for this study's first research question: *How would trans people in Sweden describe their experiences of pregnancy, childbirth and parenting?* For reasons of anonymity and given that not all informants revealed their preferred pronoun, I strive not to use any pronoun for the informants in the following text. When a pronoun is needed for the sake of flow in the text, I use the gender-neutral pronoun they/them in order not to reveal the identity of the informant. For the same reason I do not present any personal information about the informants such as their age, number of children or where they live. Divergence from this only occur when it is determined to be essential information for the story being told.

5.1 Pregnancy

Two of the informants have experienced being pregnant and the other two has had one or more partners being pregnant. The majority of information in this stage of reproduction came from informants who had been pregnant.

Concerns regarding the language being used to describe the informant, the partner or the future child is primarily repeated. Being asked questions concerning if the informant will be a mother or a father is common as well as others voicing their opinion on the matter, for example stating that using the word parent ('förälder') would be impossible for the child since it is too long. Normative notions are also ordinary in pamphlets where mother is the only optional choice. One informant explained that the expectations of the birthing person lie in the word for the reproductive health care center which in Swedish can be translated to care of mothers ('mödravård'): "[…] you can hear it in the name what is expected, or what they expect there […]" (Interview 1, my translation).
Informants have many times taken it upon themselves to explain to others that not all who are pregnant are mothers. An example of this is during courses that are offered to intended parents on childbirth and parenting when the instructor uses a cis- and heteronormative language, even when the instructor is fully aware that there are people participating in the course who do not identify in line with the normative notions of pregnancy. Asking the instructor to use a more inclusive language has had various effects. Some have chosen not to listen while others have learned from the feedback and made changes in their languages with

intentions of making more people included in the courses. Constantly meeting these normative expectations creates a feeling of being made invisible. Using words such as "pregnant person" rather than "mother" creates feelings of confirmation and appreciation, as explained by one informant who particularly mentioned the Swedish health care and pregnancy app 1177 as a positive example.

One informant explained that while attending a course on chest feeding - with a midwife who was aware about the informant's uncertainty about chest feeding due to plans on doing a mastectomy post-partum - those who took part in the course were supposed to talk about their feelings regarding chest feeding with others who attended the course. This made the informant very uncomfortable since they did not want to out their gender identity to complete strangers: "For me, it wasn't an option to dig into my gender identity and feelings about nursing with total strangers" (Narrative 1, my translation). In relation, the experience of being misgendered is common among the informants. One explained that they try to disregard any assumptions that people make about their gender, partly because they are aware that being pregnant is commonly something that people classify as feminine and partly because the informant does not want the focus to be on their gender identity but rather on the future child and their health. Also, the need to constantly explain oneself takes too much energy, even though it is tiresome to be viewed and called something that you are not. Needing to fend for yourself can be especially hard when feeling that you do not have anything to back up your claim. One informant expresses that before they had contact with trans specific health care they felt like they were making things up when, for example, asking people to use a certain pronoun when talking about them. This because the informant felt that they had no proof but only personal experience to back them up. If the informant would have had, for example, a diagnose they believe that it would be easier to be able to ask people to use their preferred pronoun:

> "[…] I had nothing that could support it [their gender identity], it is just my personal experience and then. Well you feel invisible and you feel […] that you don't have anything to say about how you are being attributed lots of things and that it is hard to say 'but this, this isn't right' and I'm thinking that if it was so, that I would have a diagnosis and maybe even a male personal identity number during the pregnancy and childbirth, then I would have had it [something to say about the matter]" (Interview 1, my translation).

Correlating to being misgendered are experiences of being questioned about your identity and choices. One informant explains that in contact with the psychiatric care they have received opinions on why they would want to be pregnant while also being a trans person: “But I had contact with the psychiatric care and received some, you know, opinions on it being contradictory to want to be pregnant if you are a trans person” (Interview 1, my translation). Ill-treatment from health personnel is prevalent in the material. For example, while getting treatment for ART, an informant explained that the doctors were unpolite and showed no empathy towards the pain their partner (who underwent the procedure) was in. Another informant argue that they always have low expectations when in contact with the health care and rarely expect to be met with any trans competence. During pregnancy, the informant had the strategy to be as open as possible towards the health personnel in order to give them the possibility to treat them right. Although this strategy backfired when: “The first midwife I met during pregnancy could obviously not handle it. When I told [them] that I was self-elected single parent and trans person, and father instead of mother, I weirdly enough got follow-up questions about how my own upbringing had been” (Narrative 1, my translation). Another informant explains that since it is unusual to receive good treatment from health personnel, the few times you do, you remember them. The bar for being considered good treatment is not set high, as one informant explains it: “[…] it’s not about something special, that they do anything more than thinking about what they say and in general treat you like anyone. So, it’s not that hard.” (Interview 1, my translation). With this said, there are also a few mentions of good treatment from health personnel that exceeded the informant’s expectations. For example, when one of the informant’s needed specialist health care during pregnancy due to an illness that could lead to complications, they were surprised to see that these doctors were trans competent.

Further, health personnel are not the only ones expressing their opinions on the informant’s reproductive choices. One informant explained that they have received comments from other trans people that, for example, make the assumption that the informant will take the role of mother since they will be pregnant. Also, questioning how a trans man can even think about being pregnant. The informant explain that they almost count on these comments coming from cis people, but when fellow trans people express these comments it hurts more since you are basically being questioned by “your own”. Another informant explain that their friends and family have had no problem with their use of parental pronoun. Although they have received questions regarding the family members own titles in connection to the informant

and the future child. For example, in Sweden there are different words if you are a parental grandmother (‘Farmor’) or maternal grandmother (‘Mormor’) as well as if you’re the child’s father’s sister (‘Faster’) or the child’s mother’s sister (‘Moster’). These types of questions are encouraged by the informant so that they who wonder will know.

5.2 Childbirth

Similar for all informants was that the childbirth stage of reproduction was not as much discussed as the other two stages. Almost all informants mentioned their birth plan[14] and how they had explained what their pronouns was and what pronoun they wanted the health personnel to use when talking about the child. One informant explains that for their partner (the informant did not attend the childbirth) it was important that the child would be regarded as a child and not a gender with accompanying expectations, demands and limitations. These precautions had various result. For one informant the birth plan was never read due to the birthing process being so advanced when reaching the birthing center. Although the informant and their partner had been in contact with this particular midwife before who knew not to gender the child and which pronouns the parents preferred: “We had regular contact with the midwife maybe, I don’t know, six months or something before [the child] was born […] so she was very careful with it, during and after delivery, not, you know ‘oh it is a [girl or boy]’ but rather ‘oh your child is healthy, it looks great’ […]” (Interview 2, my translation). The informant describes this as a good experience.

Another informant explains that they think their childbirth was different due to them being trans. During the childbirth process the staff group changed. The first group had read the birth plan and gendered the informant correctly, but the other group had most likely not read the letter. Not only did the midwife in this group keep misgendering the informant but also disregarded what the informant told them about an illness they have that could lead to complications during pregnancy. This led to strong and unnecessary pain for the informant during post-delivery exams. Since the child’s heartbeat was weak, the informant understands that the staff had to prioritize delivering the child rather than reading their birth plan. Although, a few days after the delivery one health personnel who had attended the childbirth

[14] In response to the increasing medicalization of childbirth, the birth plan made its way into the Swedish reproductive health care in the end of the 1970s. The birth plan is a letter written by the birthing person and, if any, partner(s) in order for them to assert their rights during childbirth (Ahrén & Flütsch 2014).

came to see the informant and explained that they had now read the birthing plan and acknowledged that they probably had called the informant "mother" a few times. During this conversation the health personnel kept asking the informant personal questions regarding their transition. Being in a vulnerable position, the informant did not appreciate this:

> "The situation one is in at the birthing center is already vulnerable as it is. I was lying in a hospital bed and tried to nurse my child, had a nerve damage in my leg from the epidural and could hardly walk and had issues with visiting the toilet due to the genital tear I got. To, on top of that, get private questions from someone wasn't so funny"
> (Narrative 1, my translation).

A third informant had a generally good experience and shared an example of what they felt was the health personnel's way to finally show what they have learned during an LGBTQ course. At many birthing centers a pink (for girls) or blue (for boys) card is given for each baby delivered, containing birthing information. In the informant's case, the card had another color. Lastly, one informant highlights the importance of having someone with you who can not only support you during childbirth but also correct people that misgender you. Also, another informant report that they had an accompanying person with them during childbirth that repeatedly said their correct pronoun in front of health personnel.

5.3 Parenting

Issues surrounding pronoun and gendering follow the informants even in this stage of reproduction. One informant explain that they have had to change child health care center four times because the health personnel have continuously gendered them and their child even after they have corrected them. Being constantly misgendered makes the informant feel misunderstood and, even though they want to go to the meetings to know that everything is okey with the child, they dread going since it does not feel like a place for them. Being at the meetings the informant is on tenterhooks waiting for the next time they or their child will be misgendered. This makes it hard for the informant to fully grasp the information they receive from the health personnel. Further, one informant explain that they are met with a lot of assumptions that they are a mother. Although frustrating, the informant understand that people might think this since they do not know the informant. However, when the informant has introduced themself as a father and trans person it is harder to accept the ignorance that

they meet. The informant states that: “I’m looking forward to when I will start testosterone, so that people can stop assume my parental role” (Narrative 1, my translation). Informants report that they are tired of having to constantly educate and correct people. In some cases, this has led to the avoidance of certain people for the sake of their well-being.

The informants use gender-neutral pronoun for their child (until the children are old enough to decide themselves) The reason for this is because informants believe this will be beneficial for the child. The reason for this is quite similar for the informants, they want to give their child(ren) the possibility to be whoever they are and to express themselves in their own way without assumptions regarding the child’s gender and sexual orientation. One informant also explain that they have chosen a gender-neutral name for their child which potentially could save the child from the troublesome bureaucratic affair of changing name in the future if they had a name that did not align with their gender identity. Using a gender-neutral pronoun for their child has not always been met with understanding from other people close to the child. The informant shared that they have noticed that questions about the child’s gender seems to be standard for new parents. That the informant and partner have chosen not to gender their child has been hard for people to handle, for example, relatives have claimed that they have trouble getting close to the child when they do not know the child’s gender or colleagues that have put the informant in uncomfortable situations when demanding to know the child’s gender. The informant shared a story of one person who: “[…] have actively asked about my child’s genitals because that person could not handle that we didn’t want to gender our child. Like ‘yeah yeah you say they [in Swedish ‘hen’] but does it have a penis or vulva?’” (Interview 2, my translation). These situations not only stress the informant but also make them more defensive when around people. Another consequence is that the informant feel that it is hard to connect with new people since they cannot know in advance whether the person will be reasonable or not regarding this matter.

Further, one informant shared a dilemma they had when about to choose pre-school for their child. The choice stood between a pre-school that was profiled in norm critical pedagogic and favored by many queers but situated a long way from their home in a predominantly white middle-class area, and a pre-school that was located in the multicultural suburb the family live in. Arguments for choosing the first was that their child would probably not be the only one with a gender-neutral pronoun and queer parents, thus would not stand out as different. Although, arguments against were that they would have to travel farther every day.

Arguments for choosing the latter was that not only was it closer to the home, but they also wanted to be part of the area they live in. Also, the children that the child would befriend in pre-school would be the same when they would start school. Although, there are many preconceptions about the area in which the informant lives, for example, that it is not queer-friendly. Thus, the informant had a fear that the child would stand out as different. Eventually, the informant chose the latter option, and it has worked better than they expected.

Another informant shared the process of them becoming the legal parent to their child. Even though the informant's own gametes were used they did not attain legal parenthood right away. During the time their partner was pregnant they had to sign documents that had the intention to "prove fatherhood". These documents had to be witnessed by other people and it was not until a couple of weeks after the child was born that the informant became a legal parent to their child. Stating that, although this affected the initial process of connecting to the child no practical repercussions occurred during the period that the informant was without legal parenthood. However, the informant expressed a fear and worry of how it could have been if, for example, their partner would have turned ill.

Lastly, one informant especially accentuates the importance of a network. For them, having a group of fellow parents have been a positive experience for the informant. The informant, who define as trans feminine, regularly attend a group of queer mothers that have not carried their child. They explain that: "[…] such a big part of womanhood is connected to motherhood, and motherhood […] entail that you have carried the child and nurse it, and that automatically makes you the arch-parent and it is this picture that we have to deal with […]" (Interview 2, my translation). Thus, having a group of other mothers that also do not have the experience of carrying their child is gender-affirming for the informant since it shows that there are many different ways to being a mother.

6. Discussion on the presented data

In this section I intend to answer research question 2: *How can the experiences during pregnancy and parenting be understood by using the reproductive justice framework?*
To do this I will analyze the results of the primary data and previous research through the theoretical framework.

Drawing from Ross's (2006) definition above on reproductive oppression as the control of people through for example reproduction, sexuality and body, one can make the argument that trans people in Sweden are submitted to reproductive oppression. Much like the historical context that eventually led to women of color having the need to create the reproductive justice framework, trans people in Sweden have also been deemed unfit to reproduce and thus subjected to population control through, for example, involuntary sterilization (Royal Majesty 1972). In 2013, the demand to be sterile or without an ability to reproduce if wanting to change legal sex in the civil register was removed from law and since then we have seen more and more trans people becoming parents. They, like other parents in Sweden, have parental rights that, compared to many other countries, would position Sweden as a country with a satisfying reproductive health and rights situation. However, reports from the trans assessment showing that people have not been informed about the possibility to cryopreserve gametes, as well as not feeling they can ask for it themselves out of fear of not getting a diagnose, i.e., a golden ticket to affordable gender-affirming treatment (Inquiry on Trans People in Sweden 2017) – show that there is more to the picture. To see situations like this, a reproductive justice lens is needed.

6.1 Pregnancy

Research shows that for many trans people, both the path to pregnancy as well as the pregnancy itself are periods of loneliness (Ellis et al 2014; Light et al 2014). This feeling can be explained by the lack of visibility of other trans people that go through the same process and the feelings of discomfort that the discontinuation of gender-affirming treatment may bring about (Charter et al 2018; Ellis et al 2014). The lack of visibility of non-normative people and family constellations is recurrent. Both in the language being used in material (where a non-birthing person is a father and a birthing person is a mother), forms to fill out ('mother' being the only option to choose for the birthing person) and courses to prepare the intended parents. Constantly meeting these normative expectations bring about feelings of

being invisible. Essentially, what this lack of visibility does is to continually remind non-normative people that they do not fit in to the mold that is the heteropatriarchal society. It is a reminder that you are different from other people and the process you are going through is not for you. Given that the problem has such a simple solution (update material, forms and courses to have a more inclusive language and pictures) the lack of willingness to solve it further accentuates how unimportant this problem is to those who are not affected by it. It also perfectly demonstrates that cis- and heteronormativity is dominant in our society and especially in matters regarding reproduction. Cis- and heteronormative notions are so incorporated into the society that it also seeps into the non-normative realm. An example of this is the experience of one informant of being questioned for wanting to be pregnant and having a child from other trans people and the assumptions the informant faced that they would take the role of mother, although not identifying as woman.

Further, from the data gathered in this study as well as previous research (Charter et al 2018; Ellis et al 2014; Light et al 2014) it is evident that the expectations that many trans people have on health care are low. Past experience of ill treatment - such as being misgendered, called by deadname, challenged on personal reproductive decisions or met with preconceptions about reproductive choices, asked irrelevant questions that has nothing to do with the current situation but rather seem to be to still the curiosity of others and being dismissed when correcting any wrongdoing - has this effect on people. Other than the stress and all other possible feelings that can be at play when being or trying to become pregnant, trans people have to face a myriad of hurtful and energy consuming situations. For example, constantly needing to educate other people on your rights, correcting people who misname or misgender, not being respected in your life choices or gender identity. One informant explains that for them it felt extra hard to fend for the right to be called by their preferred pronoun and name since they did not have a diagnosis to back them up. A diagnosis could be a comfort to rely on when dealing with health personnel, something that speaks their language and might help the health personnel understand the severity of the issue. Understandably, the informant felt a need for a proof, something to wave in front of the health personnel that says “Hey, you have to listen to me”. It should go without saying that gender identity is not something that anyone should have to prove. And being treated with respect and dignity is not something that is conditional, it is fundamental. It would be naïve to demand that health personnel could not make mistakes. Mistakes happen because just like the rest of us, health personnel are part of a heteropatriarchal society. However, it is not too much to ask that at the very least when a

patient corrects you and state their wishes you abide because the cost of not doing it is too high. For what is actually being said when ignoring the patients' wishes? That their feelings are not valid and do not deserve to be respected. And this coming from a person that is supposed to be there to help you. How could anyone every feel safe in such an environment? Thus, it is understandable that many trans people have low expectations on health care and enter health care settings with preconceptions that they will be subjected to maltreatment. It could be said to be a coping mechanism tailored to make you prepared for anything that might come your way. Sadly, all of this could easily be avoided with training and guidelines, for example, using inclusive language bring about positive experiences (Light et al 2014). Something to contrast and eventually replace the negative experiences and making trans people feel safe in health care.

Finally, I want to discuss the situation for some trans people without the ability to become pregnant. In the previously mentioned European study targeting trans women many participants expressed a desire to be pregnant and give birth themselves (De Sutter et al 2002). Within cis- and heteronormative reasoning, being pregnant and giving birth imply that you are a woman. Correspondingly, and according to the same binary and dichotomized logic, a person in a reproductive process who is not pregnant or give birth is a man. Perhaps, for the women in the study, their wish is based on this notion. Meaning, being pregnant and giving birth would be gender-affirming due to its implication of motherhood and going through a reproductive process without being pregnant or giving birth would be gender dissonant because of the association with fatherhood. In the future, it might be possible for trans women to become pregnant and give birth.[15] Until then, we need to renegotiate the meaning of motherhood. For one of the informants in this study, being in a group with other queer mothers (mostly homosexual cis-women) that had not carried their child themselves was a way to make visible other forms of motherhood than what the cis- and heteronormative rational have taught us is the only one. Seeing that cis-women – i.e., the primary shareholders of Motherhood Inq. – have the same experience as themself, a trans woman, was not only gender-affirming but also shattered the cis- and heteronormative regime that dictate motherhood, allowing other forms of motherhood to take its place. Thus, the task of renegotiating motherhood is not only preferable for trans people, but much needed for homo-

[15] In 2014, the first ever child was born in Sweden through a transplanted uterus (Radio Sweden 2014). Since then, a total of 15 babies have been born from transplanted uteruses worldwide (University of Gothenburg 2019). To the authors knowledge, no case involves a trans woman being pregnant and giving birth.

and bisexual cis-women as well as heterosexual women who might find themselves not wanting to abide to the cis- and heteronormative mode of motherhood.

6.2 Childbirth

Despite the scarce research on trans people's experiences in this stage of reproduction a few indicators can be found in the literature. For example, that some prefer caesarean section due to the feeling of distress that having your genitals exposed would induce (Ellis et al 2014). Thus, the reported preference of genital birth by health personnel and succeeding consequence of avoiding caesarean section (Bjurwald 2019) can imply potential problems. Exposing your genitals for strangers can be uncomfortable for many people, but for a trans person who feels that their genitals are incongruent with their gender identity, exposing your genitals can be even more distressing. This added layer should be taken into consideration by health personnel and be a reason for eligibility to caesarean section as long as there are no medical barriers to why the birthing person should not be allowed one.

Further, reports state that there is a culture of paternalism in birthing centers. Resulting in for example, birthing people's pain and worry about being disregarded and birthing people not getting all available information on matters that concern them. It is explained that pain is considered normal and something that a birthing person has to endure (Bjurwald 2019). This is proven to be true also for one of the informants of this study who felt that the information they gave the midwife was disregarded and thus lead to pain that could have been avoided during post-delivery exam. During the heat of the moment, while giving birth, it is possible that a birthing person may disregard this conduct as long as it is not affecting the child or the possibility of a safe delivery. To premier the child and put the birthing person second is not uncommon in reproductive matters[16], and it is also what is expected of a birthing person. Therefore, as long as the childbirth is done medically right and the child is delivered safely, a birthing person should have nothing to complain about. Doing this might invoke feelings of shame for the birthing person since it implies that they prioritize their needs over their child. Still, I can imagine that being treated as a child when you yourself are giving birth to one is traumatic even when it is disregarded by the person experiencing it. Considering many trans

[16] Examples of this are the various bans on abortion - i.e., a pregnant person's right to bodily autonomy and self-determination in matters concerning them and their body – with reference to the fetus (although in these cases often referred to as child) right to life.

people's history with negative experiences and maltreatment in health care, being met with this behaviour risks to exacerbate these people's already scant trust in health care.

Also, for those who experience fear of childbirth (FOC), the literature shows that in addition to the regular fear of pain, injuries, complication, death etcetera, they experience another layer of fear that is related to the placement of their identity and/or relationship(s) outside of the norm. This fear is related to previous negative experiences in health care (Malmquist, Jonsson, Wikström & Neiminen 2019). Thus, being constantly reminded that you do not adhere to the norm - for example through lack of visibility of trans people in material, 'mother' being the only option in forms, misgendering etcetera – risk to enhance this additional layer of FOC. Although more research on this matter is needed, this information is important that health personnel keep in mind. Additionally, another fear that is mentioned in the literature is to not be able to advocate for yourself during childbirth (Ellis et al 2014). For this reason, having another person with you in the room who can fend for your rights, correct any misgendering, and so on is important. A birth plan is another way for people to advocate for themselves. The birth plan has been mentioned by several informants to this study. It is described as a safety net where they can inform health personnel in advance about what pronoun to use for them and their child. One informant describes the different in treatment from health personnel that have read their birth plan in advance (gendered the participant correctly) and health personnel who had not yet read the birth plan (repeatedly misgendering them). This experience points out the importance of a birth plan for trans people and the need for health personnel to read it in advance in order to give the patient a positive experience.

6.3 Parenting

A law-change in 2019 made it so that trans non-birthing persons had to get their parenthood recognized by social services, even if their own gametes were used (Mägi, Westerlund, Burman, Ehne & Mire Åsell 2018). This was the reality for one of the informants in this study. Together with their partner, they had to "prove fatherhood", a disturbing term considering the informant identify themself as a mother. Although they did this while the birthing person was pregnant it took weeks after the child was born for the informant to receive the right as legal parent. For the informant, it had consequences regarding the initial connection to the child. It also brought with it a lot of fear and worry of how this could have affected the family if, for example the partner would have been ill. This is especially

troublesome given the result of one study that shows that trans birthing persons (in the study the targeted population was trans men, but I assume that the same would go for non-binary birthing persons) might be of high-risk to experience post-partum depression. A condition that is amplified due to the lack of gender-sensitive resources (Light et al 2014). In the case of the informant, no other consequence than trouble to initially connect with the child, occurred. But what if the birthing person, i.e., the only legal parent to their child for the first couple of weeks, would suffer from post-partum depression? What consequences can this have for the child, with one parent depressed and another without any legal rights, if for example the child is sick and decisions on their treatment have to be made?[17] Although, more studies on trans birthing person's risk of experiencing post-partum depression is needed, in light of the knowledge we already have, it is deplorable for the whole family that the non-birthing person stands without any legal rights to the child.

Although I am not a legal scholar, I am quite familiar with reading law texts and I would say that the Swedish parental law is a struggle to read and understand. In my opinion, the law confuses social roles as mother and father with biological roles as birthing person and non-birthing person. Also, it is highlighted in one study that the participant feel that it is problematic that the law only acknowledges two legal guardians (Inquiry on Trans People in Sweden 2017). For a long time, the general conceptualization of family has been that it is comprised of a mother, a father and children (i.e., a nuclear family). Although, it still might be the normative mode of family formation, more and more people choose to form families in other ways. Families can include one, two, three or more parents of various genders, non-parents, animals, children and the list goes on. Families can be biologically related just as much as they may not be. For the protection of these families, the law has to change accordingly and as long as the Swedish parental law is not gender- and number neutral, I believe that problems will arise in regard to trans people's reproductive rights.

Further, in the literature we can see that many trans people, especially non-binary people, worry about being viewed as bad parents only because they are trans (Abrahamsson & Arinell 2015). For this group, it is also noted to be particularly hard to name their role as parents (Ellis et al 2014). Considering that 'mother' and 'father' are established terms that can be

[17] I am not saying that a person who suffers from post-partum depression lack any ability to make decisions. Only that for this person it might be preferable not having to make any life-altering decisions for the time-being and leave that to the other parent(s).

used by trans women and trans men alike, this might not come as a surprise. The language of cis- and heteronormativity is still being complied with, even though the user might not fit in to the cis- and heteronormative picture of how a user of a specific term should be. But for non-binary people there is no well-recognized language, because the cis- and heteronormative regime does not recognize the existence of people that do not fit into one of these two categories. For that reason, in addition to having to struggle getting your gender recognize, non-binary people also need to establish a new language for their parental roles. Though, this can be a blessing. Using new terms for your parenthood might make it possible to circumvent the demands and expectations that are incorporated in already established roles such as 'mother' and 'father' and thus enables a new form of parenthood to be constructed.

In correspondence with the previous stages of reproduction, misgendering continues to be a large issue for the informants of the study. Although the difference now is that it is not only the informant that is being misgendered, but also their child. The informants chose to use a gender-neutral pronoun for their child until the child itself can choose. They believe that this enables the child to grow up without expectations connected to a certain gender and thus become whoever they want to. The choice to use gender-neutral pronoun has not always been met with ease. One informant, for example, explained that they have had to change child health care center four times due to being constantly misgendered. The informant explained that they dread going to these meetings, but of course still did it since it is important to monitor the child's development and health. Constantly being on the alert makes it hard for the informant to fully grasp all the information they receive. Another informant explained that they have been in situations where people demand to know the child's gender as well as having relatives claiming that they are unable to connect with the child if they do not know their gender. For the informant this creates a lot of stress and makes it harder to connect to new people since they cannot be sure when and if this person will behave hurtful. Connecting to the fact that many trans people worry about being viewed as bad parents (Abrahamsson & Arinell 2015), and the stress that is induced from having to be constantly on the alert in both health care settings as well as with unsympathetic relatives – having a safe space where you are able to let down your guard and relax is of utmost importance. One study highlights the wish from its participant to have more non-normative meeting places and to meet other people who looked similar to their own family (Inquiry on Trans People in Sweden 2017). This view is also shared by one of the informants who explain how important it is for them to have a group of other mothers who have not carried their child. Having a safe space and being

surrounded with people who share your experiences and can support you can be a remedy for the loneliness, invisibility and mistreatment that many trans people experience during their reproductive process.

7. Conclusion

Less than a decade ago, forced sterilization of trans people came to a halt in Sweden. This opened doors for many to become parents. But a change in the law needs to be accompanied with a change in society. A point we have not yet arrived at.

This study shows that cis- and heteronormativity has a negative impact on trans people throughout the reproductive process. We see that being continuously misgendered by health personnel and having their objections disregarded creates a situation in which the patient does not feel respected nor safe and an already fragile trust for health care may become even worse. It is evident that the reproductive care needs to undergo a change in culture. For example, trans people and other non-normative people need to be represented in material, courses and other forms of information. Health personnel must refrain from assuming gender, respect their patients wishes and refrain from asking questions that are irrelevant to still their own curiosity (or if relevant, explain why to the patient). Further, the laws in Sweden that govern and give rights to parents need to be amended to better reflect the Swedish society and be removed of barriers that hinders trans people and other non-normative people to fully benefit from the rights already won and the rights yet to come. Fighting for this change of culture and inclusion in law is a perfect task for a Swedish reproductive justice movement! On paper, trans people in Sweden now have many possibilities to reproduce. Being able to stay home on parental leave with pay, day-care and universal health care makes Sweden an excellent country to raise your child in. Although, what this study shows is that albeit these benefits there are still barriers to reproduction for trans people in Sweden. These barriers constitute reproductive injustice and are residue that lingers from the previous sterilization demand. Reproductive injustice can only be challenged with the reproductive justice framework since it - unlike a reproductive health and rights framework – aims to look at the actual execution of law and health care and to catch potential segments of injustice.

Further, it is also evident in the study that trans people are resourceful in finding ways to deal with the situation they are in. The informants of this study, for example, used their birth plan as a safety net to inform health personnel of their preferred pronoun and what pronoun they wished to be used for their child. Although the compliance from health personnel varied, it created a sense of security for the informants. Also, the importance of a safe space, with others who experience a similar situation as you, is highlighted and asked for by many trans

people. A meeting place for trans people during the reproductive process could possibly be a remedy for the feelings of loneliness, isolation and invisibility that many endure during this time and should be prioritized to put in place. Moreover, being able to bring someone (friend, family, non-birthing partner, etcetera) to health care visits and during childbirth is crucial. Not only so the birthing person has someone to support them during a time of need but also so that the accompanying person can correct misgendering and signal the right pronoun and name to health personnel. Having another person with you that can do this, offers relief to the birthing person who can put their focus on the task at hand.

Lastly, I want to highlight the need for more research regarding trans people's reproductive circumstances. For example, the indication that trans men are at high-risk of developing post-partum depression as well as the additional layer of fear of childbirth that LBT people face need to be explored further in order to allocate the resources needed to give people their rightful support. Overall, there is a lack of studies regarding conditions that trans people face that has an intersectional lens. This is especially true in relation to reproductive issues. Future studies should focus on how reproductive experiences differ within the group of trans people and the power structures involved. How, for example, does socio-economic status and ethnicity affect trans people's reproductive lives? I am certain that the answer to this question will lead to more eye-opening information on the barriers to achieve reproductive justice that trans people face. Until then, I am hopeful that this study will be a first step for further development of the reproductive justice framework and give guidance and a point of departure for studies yet to come.

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Attachment 1: Flyer about participation in the study

PARTICIPATE IN STUDY ABOUT REPRODUCTIVE JUSTICE FOR TRANS PEOPLE!

My name is Nadine Dawod and I am writing my master thesis at the Department for Gender Studies at Lund University. The study I am working on examines trans peoples' experiences of 1) pregnancy, 2) childbirth, 3) parenting. The experiences will be analyzed through the theoretical frameworks of reproductive justice and obstetric violence. The aim is that the thesis will contribute to new perspectives in the research field of trans peoples' reproductive options which hopefully will lead to a more just situation from trans people in Sweden. For this study, the definition of trans person is a person whose gender identity and/or gender expression is/was in incongruence with the legal sex that was assigned at birth.

There are two ways to participate in the study:

1. Online interview

2. Write your own text regarding the following:

1. Write about your experience with pregnancy
It does not matter if it is you or your partner(s) that have been pregnant. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?

2. Write about your experience with childbirth
It does not matter if it is you or your partner(s) that have delivered the child. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?

3. Write about your experience with parenting
It does not matter if you have legal custody of the child/children. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?

You can write in Swedish or English. Send your text in a Word-document, PDF or directly in the e-mail. You send the e-mail to **na4170da-s@student.lu.se.** If you do not want to send your file with your own e-mail address there are different anonymous ways to send it, for example through delafil.se or sprend.com.

Would you rather do an interview online? Send an e-mail to the address above and we will book a time that is suitable for you.

The study follows the Swedish Research Council's recommendations for good research practice and all answers will be made unidentifiable and anonymous. Within 24 hours of receiving your e-mail I will download the file and delete the e-mail from the inbox as well as the e-mail program's trash bin. The downloaded file will be renamed to a random number combination to avoid that I will remember which person sent which file. The file will then be saved on a USB-drive and processed in offline mode. When the text is processed the file will be deleted.

If you have any questions you are more than welcome to contact me (na4170da-s@student.lu.se) or my supervisor Prof. Diana Mulinari (diana.mulinari@genus.lu.se).

Your knowledge is important! Thank you so much for wanting to share your experiences and contribute to research.

About me

My academical background consists of a bachelor's degree in human rights and the master's program in gender, migration and social justice. I have worked in civil society for the past 4 years in organizations such as RFSL Youth with the project Newcomers Youth and at the Swedish Red Cross with asylum and social sustainability. I have also been active in RFSU with a focus on abortion rights and sexual politics. I live in Malmö, am queer and love playing board games.

Attachment 2: Handling of data during online interviews

Information on how data will be handled and interview guide– for online interviews

- Interviews will be conducted through the video meeting platform Zoom. Participants will receive a link to the meeting prior to the interview. The interview will be semi-structured, meaning that I will ask open ended questions that allows for a discussion.
- The meeting will be recorded if you have agreed to it in advance.
- The interview will concern the questions in the interview guide below (experiences of pregnancy, childbirth and parenting). If you do not want to share/have experience of all three parts you can still participate but please let me know in the beginning of the interview.
- When the interview is finished, I will save the recorded file on an external hard drive and delete from the computer. Once I have transcribed the recorded file (with my computer in offline mode), I will delete the recording. The transcribed text will be deleted as soon as I have processed it in the text.
- I will have my camera turned on during the interview. I prefer if you also have your camera switched on, but you may choose either way that makes you most comfortable.
- You can, at any time, break the interview without explanation.
- If you want to withdraw your participation in the study, you can contact me at na4170da-s@student.lu.se

  If you have any questions you may contact me (na4170da-s@student.lu.se) or my supervisor Diana Mulinari (diana.mulinari@genus.lu.se) at any time.

INTERVIEW GUIDE

1. Your experience with pregnancy
It does not matter if it is you or your partner(s) that have been pregnant. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?

2. Your experience with childbirth
It does not matter if it is you or your partner(s) that have delivered the child. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?

3. Your experience with parenting
It does not matter if you have legal custody of the child/children. It is your experience that matters. Reflect on whether you think your experience is different from how a cis person would experience the same situation, and if so, how?