

The Right to (Trans) Parent: A Reproductive Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People

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THE RIGHT TO (TRANS) PARENT: A REPRODUCTIVE
JUSTICE APPROACH TO REPRODUCTIVE RIGHTS,
FERTILITY, AND FAMILY-BUILDING ISSUES
FACING TRANSGENDER PEOPLE

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Reproduction is not just a matter of individual choice. Reproductive health policy affects the status of entire groups. It reflects which people are valued in our society; who is deemed worthy to bear children and capable of making decisions for themselves. Reproductive decisions are made within a social context, including inequalities of wealth and power.¹

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1. Dorothy Roberts, Professor, Northwestern Univ. Sch. of Law, Race, Reproduction, and the Meaning of Liberty: Building a Social Justice Vision of Reproductive Freedom, Delivered at a Public Forum Presented by the Othmer Institute (Apr. 18, 2000) (transcript available at <http://www.almondesign.com/websites/othmerinstitute/reports/report1.html>).

INTRODUCTION

In December 2012, I participated in the first convening of a “breakthrough conversation” led by the CoreAlign Initiative.² This new initiative hosts “breakthrough conversations” to generate dialogue around some of the most pressing issues facing the reproductive health, rights, and justice movements.³ This convening posed the question: “[h]ow do we understand gender in today’s world?”⁴ The facilitators led us through a series of exercises to elicit conversations about how gender identity and expression is “operationalized in movement work.”⁵ These conversations ranged from questioning the value of the slogan “war on women”⁶ to the gender inclusiveness of the intake forms of abortion funds and abortion clinics. The conversation was thoughtful and lively, turning on the axis of changing the conversation about gender within work being done on contraception and abortion care. This Article pursues a different, but equally important, direction of inquiry into the eugenics embedded into state statutes affecting transgender people and passive eugenics inherent in the lack of policy supports for their fertility preservation.

In focusing on fertility preservation and the whiff of eugenics in state statutes, this Article aims to make several contributions to issues at the intersection of the LGBT and reproductive health, rights, and justice movements. This Article will show how the reproductive health issues of transgender people remain shadowed in the mainstream LGBT movement and reproductive health and rights movement. This Article will use reproductive justice principles to provide new entry points for LGBT advocates and reproductive health and rights advocates to build alliances around gender, sexuality, and reproduction by highlighting opportunities for reproductive justice advocates to engage on reproductive health and rights issues facing transgender people. Finally, this Article will anticipate and explore areas in which reproductive health, rights, and justice advocates may resist such alliances.

2. The CoreAlign Initiative is a project aimed at bringing the “cores” of the reproductive movements into alignment; these movements include the reproductive *health*, the reproductive *rights*, and the reproductive *justice* movements. See *Our Journey*, COREALIGN, <http://corealign.org/about-corealign/corealigns-journey/> (last visited Nov. 3, 2013).

3. See Whitney Losh, *Breakthrough Conversations*, COREALIGN, <http://corealign.org/breakthrough-conversations/> (last visited Nov. 3, 2013).

4. Whitney Losh, *Breakthrough Conversation: How Do We Understand Gender In Today’s World?*, COREALIGN (Dec. 12, 2012), <http://corealign.org/practice-circle-how-do-we-understand-gender-in-todays-world/>.

5. *Id.*

6. See Meagan Morse, *A War on Whom? The Importance of Inclusive Reproductive Justice Conversations*, NAT’L WOMEN’S HEALTH NETWORK (June 27, 2012), <http://nwhn.org/2012/06/27/war-whom-importance-inclusive-reproductive-justice-conversations>.

I. FINDING A THEORETICAL AND MOVEMENT HOME FOR ISSUES AT
THE INTERSECTION OF REPRODUCTION AND GENDER IDENTITY

*The reproductive needs and concerns of transgender people who choose not to or cannot afford to undergo surgery are rarely, if ever, addressed by either of our movements.*⁷

A. Where are Transgender Reproductive Health Issues in the
LGBT Movement?

“Transgender” is the term ascribed to the group of people whose birth-assigned sex, gender identity, and secondary sex characteristics do not align.⁸ Other scholars have characterized this experience as “a mismatch between the gender that a person is assigned by the world at birth and the gender that the person experiences internally and desires to express outwardly.”⁹ Advocates report that “there are about 700,000 transgender people in the United States, though any estimate depends upon definitional choices regarding who counts as transgender, which are sometimes contested.”¹⁰

There are a range of treatments and surgeries that transgender people may seek as part of aligning their secondary sex characteristics with their gender identity.¹¹ There is no single “sex reassignment surgery” that *all* transgender people undergo.¹² For trans women (assigned “male” at birth), some treatments may include: feminizing hormone therapy (estrogen); breast enhancement; tracheal shave (“Adam’s Apple” reduction); penectomy (removal of penis); orchiectomy (removal of the testicles); and vaginoplasty (creation of a vagina).¹³ For trans men (assigned “female” at birth), some treatments may include: masculinizing hormone therapy (testosterone); bilateral mastectomy and reconstruction (“top surgery”); hysterectomy (removal of uterus

7. LESBIAN, GAY, BISEXUAL & TRANSGENDER CMTY. CENTER, CAUSES IN COMMON: REPRODUCTIVE JUSTICE & LGBT LIBERATION 16 (2006), available at http://www.issuelab.org/resource/causes_in_common_reproductive_justice_and_lgbt_liberation.

8. See Paisley Currah, *Expecting Bodies: The Pregnant Man and Transgender Exclusion from the Employment Non-Discrimination Act*, 36 WOMEN’S STUD. Q. 330, 331 (2008); WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 5 (7th ed. 2011) [hereinafter STANDARDS OF CARE].

9. Tobias Barrington Wolff, *Civil Rights Reform and the Body*, 6 HARV. L. & POL’Y REV. 201, 203 (2012).

10. *Id.*

11. See STANDARDS OF CARE, *supra* note 8, at 54.

12. See, e.g., *id.* at 48–50, 57–58, 64.

13. *Id.* at 48, 57, 64.

and other internal pelvic organs); and phalloplasty (creation of a penis).¹⁴ The clinical guidelines developed by the World Professional Association for Transgender Health (WPATH) stress that treatment for gender dysphoria should be individualized and that not all possible treatments and surgeries are necessary for every individual meeting this diagnosis.¹⁵ Trans activists, advocates, and scholars have echoed the need for respect and support for individual choices in treatment,¹⁶ and have even problematized the medical model of transsexuality/transgenderism.¹⁷

Transgender people “are among the most targeted populations in the United States,”¹⁸ with many facing discrimination in nearly every aspect of life: employment, housing, in public accommodations, and from law enforcement.¹⁹ Reports of violence, harassment, and discrimination remain high despite the success of advocates in enacting non-discrimination policies at the local, state, and federal levels,²⁰ reshaping a number of state and federal policies on gender markers,²¹ and influencing the government to protect transgender adults in employment²² and youth in schools.²³

Disparities in access to healthcare and health outcomes are particularly severe for transgender people.²⁴ According to a report by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, 24 percent of trans women and 20 percent of trans men reported having been refused treatment altogether, and

14. *Id.* at 49–50, 57–58, 64.

15. *Id.* at 5.

16. *See, e.g., id.*

17. For a full discussion, see Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 *BERKELEY WOMEN'S L.J.* 15, 18 (2003) [hereinafter Spade, *Resisting Medicine*].

18. *See* Wolff, *supra* note 9, at 201.

19. For a thorough discussion of the discrimination facing transgender people, see JAIME M. GRANT ET AL., *INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2* (2011).

20. For a complete list of laws and ordinances barring discrimination on the basis of gender identity or expression, see *Non-Discrimination Laws that Include Gender Identity and Expression*, TRANSGENDER LAW & POLICY INST., http://www.transgenderlaw.org/nd_laws/index.htm (last updated Feb. 1, 2012).

21. *See infra* Part I.C.

22. *See, e.g.,* Jesse McKinley, *Ruling Extends Sex-Discrimination Protection to Transgender Woman Denied Federal Job*, *N.Y. TIMES* (Apr. 24, 2012), <http://www.nytimes.com/2012/04/25/us/sex-discrimination-protection-extended-to-transgender-woman.html>.

23. *See, e.g.,* Tom Verdin, *California Governor Signs Transgender-Student Bill*, *ASSOCIATED PRESS* (Aug. 12, 2013), <http://bigstory.ap.org/article/calif-governor-signs-transgender-student-bill>; *Federal Government Resolves Complaint Filed by California Transgender Student*, *NAT'L CTR. FOR LESBIAN RIGHTS* (July 24, 2013), <http://transgenderlawcenter.org/archives/8666>.

24. *See* GRANT ET AL., *supra* note 19, at 73.

trans people of color were even more likely to have been refused treatment.²⁵ A significant number of trans people refrain from seeking preventative or necessary healthcare due to a history or anticipation of mistreatment or discrimination,²⁶ or because they could not afford it,²⁷ particularly if they were trans people of color. According to the report, black trans people “had the worst health insurance coverage of any racial category: 39 [percent] reported private coverage and 30 [percent] public. Thirty-one percent of [b]lack respondents reported being uninsured; by contrast, 66 [percent] of white respondents reported private insurance, 17 [percent] public insurance and 17 [percent] uninsured.”²⁸

Transgender people face reproductive health disparities and barriers to accessing reproductive healthcare that most of the mainstream LGBT movement has failed to incorporate into its advocacy.²⁹ The National Center for Transgender Equality recently highlighted these barriers:

One in three transgender people, and 48 [percent] of transgender men, have delayed or avoided preventive health care such as pelvic exams or STI screening out of fear of discrimination or disrespect. One survey reported that half of transgender men did not receive annual pelvic exams. Reasons included discomfort with the physical exam due to gender issues (40 [percent]), lack of money or insurance (13 [percent]), lack of a medical provider they were comfortable with (13 [percent]), and thinking they did not need pelvic exams (7 [percent]). Another survey found that transgender teens, including those at risk for unintended pregnancy, were reluctant to go to a family planning clinic.³⁰

Reluctance to go to a family planning clinic is particularly concerning because some transgender men who have sex with men become pregnant³¹ and may need access to abortion care or prenatal

25. *Id.* at 72, 73.

26. *Id.* at 76.

27. *Id.*

28. *Id.* at 76–77. By contrast, “[i]n the general population, 68 [percent] have private insurance and 28 [percent] have public insurance.” *Id.* at 77.

29. *See id.* at 28.

30. NAT’L CTR. FOR TRANSGENDER EQUAL., TRANSGENDER SEXUAL AND REPRODUCTIVE HEALTH: UNMET NEEDS AND BARRIERS TO CARE 1 (2012) [hereinafter UNMET NEEDS], available at http://transequality.org/Resources/Factsheet_TransSexualandReproHealth_April2012.pdf (citations omitted).

31. *See* Ellise Adams, *If Transmen Can Have Babies, How Will Perinatal Nursing Adapt?*, 35 AM. J. MATERNAL CHILD NURSING 26, 27 (2010); Sari Reisner et al., *A Mixed Methods Study of the Sexual Health Needs of New England Transmen Who Have Sex with Nontransgender Men*, 24 AIDS PATIENT CARE AND STDS 501, 510 (2010).

care. More than 90 percent of this same group reports “a lack of adequate information about their sexual health.”³²

The mainstream LGBT movement has mostly overlooked these important reproductive health and rights concerns.³³ No doubt, this is because for many years it was expected—stated or unstated—that transgender people forfeit their ability to reproduce in exchange for gatekeeping professionals to approve their requests for certain medical treatments to transition.³⁴ This may also be because marriage equality has dominated the legal, media, and funding landscape³⁵ or because these issues are seen as being the purview of the reproductive health and rights movements.³⁶

There are, however, a handful of advocates and organizations in the LGBT movement who have attended to some of the issues at the intersection of gender identity and reproduction,³⁷ but these efforts are not coordinated or long-term strategies.³⁸ For example, the National Center for Transgender Equality has recommended, as discussed at length in Part I.C of this Article, that state and local governments permit transgender people to change the gender designation on their identity documents without proof of surgery because “[p]olicies requiring transgender people to undergo sex reassignment surgery before changing their gender marker on government documents violates their reproductive rights and frequently amounts to forced sterilization.”³⁹ The Transgender Law Center squarely took on reproduction in its amicus brief in support of Thomas Beatie’s divorce petition.⁴⁰ Thomas Beatie is a trans man who married a non-trans woman and subsequently gave birth to their three children.⁴¹ When the couple sought a divorce in Arizona, the judge denied the divorce petition, reasoning that because Beatie’s reproductive anatomy was intact and he gave birth to children, he was a woman.⁴² The couple, therefore, was

32. See UNMET NEEDS, *supra* note 30, at 2.

33. See Spade, *Resisting Medicine*, *supra* note 17, at 36.

34. See *id.* at 28.

35. See Dean Spade, *Intersectional Resistance and Law Reform*, 38 SIGNS 1031, 1041 (2013) [hereinafter Spade, *Intersectional Resistance*].

36. See, e.g., *id.*

37. See STANDARDS OF CARE, *supra* note 8, at 1.

38. See, e.g., UNMET NEEDS, *supra* note 30, at 2.

39. *Id.*; see also Harper J. Tobin, *Against the Surgical Requirement for Change of Legal Sex*, 38 CASE W. RES. J. INT’L L. 393, 422–24 (2006–2007) (discussing the compulsory sterilization requirements of some countries).

40. See Brief for Transgender Law Center as Amici Curiae in Support of Petitioner at 14, *Beatie v. Beatie*, No. FC 2012-051183 [hereinafter *Beatie Brief*].

41. See Guy Trebay, *He’s Pregnant. You’re Speechless*, N.Y. TIMES (June 22, 2008), <http://www.nytimes.com/2008/06/22/fashion/22pregnant.html>.

42. See *Thomas Beatie Marriage Case*, TRANSGENDER LAW CTR. (Mar. 29, 2013), <http://transgenderlawcenter.org/archives/3038>.

in a same-sex marriage that Arizona would neither recognize nor divorce.⁴³ In the amicus brief, the Transgender Law Center forcefully responded, “if [the law] is interpreted to require transsexual individuals not only to undergo irreversible medical treatment to physically transition to their new sex, but also to be sterilized and forego forever the opportunity to bear biological children, that would unconstitutionally infringe that most-fundamental of rights.”⁴⁴

B. The Reproductive Justice Approach

Most people in the United States perceive reproductive issues within an abortion-centric framework: whether an advocate, legislator, or story represents a “pro-choice” or “pro-life” position.⁴⁵ This lens is inadequate in three respects. First, it filters conversations about the moral value of fetal life and the ethics of decision-making about that life through the prism of legal rights. Second, it fails to capture the scope of reproductive concerns and decisions that diverse groups of people encounter throughout their lifetimes. Finally, it lumps together many diverse sets of social movement actors who actually work in very different fields, who use different theories of change, may follow different sets of ethics, and who are responsible to different constituencies.⁴⁶

Whereas the American public may think of the pro-choice movement as a singular entity, advocates in the field understand that the contemporary social movement on reproduction is divided into thirds: the reproductive health (focused on service provision, such as women’s health clinics); reproductive rights (focused on legal reform and policy advocacy); and reproductive justice (focused on movement-building with an intersectional analysis).⁴⁷ This Article will focus on the reproductive justice movement as a natural home for advocacy on some issues at the intersection of reproduction and gender identity.

Reproductive justice is a conceptual framework and movement-building tool that captures “an array of phenomena [that] must be analyzed together to understand the complex forces affecting who can access what reproductive possibilities and under what conditions.”⁴⁸ Leading reproductive justice organizations like Asian Communities

43. *See id.*

44. Beatie Brief, *supra* note 40, at 16.

45. *See* Spade, *Intersectional Resistance*, *supra* note 35, at 1036.

46. *See* ASIAN CMTYS. FOR REPROD. JUSTICE, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS, AND REPRODUCTIVE JUSTICE 2 (2005) [hereinafter A NEW VISION], available at <http://forwardtogether.org/assets/docs/ACRJ-A-New-Vision.pdf>.

47. *See id.*

48. Spade, *Intersectional Resistance*, *supra* note 35, at 1036.

for Reproductive Justice (now “Forward Together”) have defined the term as existing “when [all people] 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.”⁴⁹ Other organizations, such as Law Students for Reproductive Justice have provided a shorthand: reproductive justice as a framework that considers all the factors that affect the right to have children, not to have children, and to parent the children we have.⁵⁰ This framework was developed by women of color activists and organizations in the mid-to-late 1990s as an alternative from the pro-choice framework, which was sorely inadequate in addressing some of the most pressing reproductive health issues facing women of color.⁵¹ This inadequacy was due to the pro-choice movement’s reliance on the legal themes of liberty, privacy, and equality to secure rights for individuals as well as general disinterest in exploring how race and class impacted reproductive decision-making. By contrast, the reproductive justice movement embraced an intersectional approach⁵² to analyzing reproductive decision-making. This approach has been well-documented and there has been a flourishing of scholarship⁵³ and activism on the full range of reproductive experiences in the United States. Scholars and activists have drawn the public’s attention to a number of reproductive oppressions, including forced and coerced sterilization;⁵⁴ the requiring of use of long-acting hormonal contraceptives as a condition of receiving cash assistance or food stamps;⁵⁵ the inherent eugenics of welfare family caps;⁵⁶ the trauma enacted upon low-income women of

49. A NEW VISION, *supra* note 46, at 1.

50. See *Orientation: What is Reproductive Justice?*, LAW STUDENTS FOR REPROD. JUSTICE, <http://lsrj.org/orientation/%5C> (last visited Nov. 3, 2013).

51. See Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1296 (1991) (presenting foundational concept of intersectionality).

52. For a complete discussion of intersectionality, see *id.*

53. See, e.g., ELENA R. GUTIERREZ, *FERTILE MATTERS: THE POLITICS OF MEXICAN-ORIGIN WOMEN’S REPRODUCTION* 6 (2008); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 5 (1997); JAE L. SILLIMAN ET AL., *UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE* 1 (2004); ANDREA SMITH, *CONQUEST: SEXUAL VIOLENCE AND AMERICAN INDIAN GENOCIDE* 1 (2005).

54. See Julie Rose, *A Brutal Chapter in North Carolina’s Eugenics Past*, NAT’L PUB. RADIO (Dec. 28, 2011, 4:47 PM), <http://www.npr.org/2011/12/28/144375339/a-brutal-chapter-in-north-carolinas-eugenics-past>.

55. See *Dangerous Contraceptions*, INCITE! WOMEN OF COLOR AGAINST VIOLENCE, <http://www.incite-national.org/index.php?s=124> [hereinafter *Dangerous Contraceptions*] (last visited Nov. 3, 2013).

56. See Diana Romero & Liza Fuentes, *The Welfare Family Cap Policy: Fertility Restriction as Poverty Prevention*, 66 DIFFERENT TAKES 1, 1–2 (2010), available at <http://popdev.hampshire.edu/sites/default/files/uploads/u4763/DT%2066%20-%20Fuentes.pdf>.

color through the child welfare system;⁵⁷ the punitive and unconstitutional punishments of pregnant women struggling with a drug or alcohol addiction;⁵⁸ and the reproductive damage done to women workers at nail salons through exposure to toxic substances common to their work.⁵⁹ This is but a short list of the many reports, campaigns, and actions taken against forms of reproductive oppression that do not occupy the same level of public attention as contraception and abortion, but whose consequences are of equal or greater severity.

The reproductive justice movement has drawn attention to the history and contemporary manifestations of eugenics ideologies against women of color in the United States.⁶⁰ In the United States, eugenics ideologies have been expressed by the state in three forms: immigration restrictions based on the supposed genetic inferiority of a targeted group,⁶¹ antimiscegenation laws,⁶² and laws permitting or requiring sterilization of people convicted of a crime and other people deemed unfit to reproduce,⁶³ overwhelmingly people with disabilities and women of color. Scholars have distinguished between active eugenics—laws and policies that encourage or discourage reproduction among certain populations—and passive eugenics—laws and policies that have the effect of encouraging or discouraging reproduction.⁶⁴

57. See *Racism at the Root of Racial Imbalance in Child Welfare*, OR. DEPT OF HUMAN SERVS., <http://www.oregon.gov/dhs/children/beyondfc/pages/news/2010-0927.aspx> (last visited Nov. 3, 2013).

58. Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL., POL’Y & L. 299, 314 (2013).

59. See A NEW VISION, *supra* note 46, at 8.

60. See, e.g., *Dangerous Contraceptions*, *supra* note 55.

61. U.S. immigration policy restricted foreigners from entering and remaining in the United States to prevent miscegenation, or what was seen as “the biological danger caused by mixing races.” Ana Romero-Bosch, *Lessons in Legal History—Eugenics & Genetics*, 11 MICH. ST. U. J. MED. & L. 89, 97–98 (2007). In 1924, the Federal Immigration Restriction Act was adopted, which implemented national origin quotas that remained in place until 1965. *Id.* at 97.

62. By the early 1900s, twenty-eight states passed antimiscegenation laws. *Id.* at 98 (“While primarily aimed at black-white mixing, the laws also forbade whites from marrying American Indians, Chinese, Ethiopians, Hindus, Koreans, Japanese, and Malaysians.”). In the mid-1960s, the United States Supreme Court found unconstitutional state statutes that banned interracial sexual and marital relations. See *McLaughlin v. Florida*, 379 U.S. 184, 184 (1964) (holding unconstitutional on equal protection grounds a Florida statute that criminalized an unmarried couple composed of one black individual and one white individual sharing the same room at night or committing specified sexual acts); *Loving v. Virginia*, 388 U.S. 1, 2 (1967) (holding unconstitutional on due process grounds a statutory scheme that criminalized interracial marriage because it violated the Due Process Clause of the Fourteenth Amendment).

63. See Romero-Bosch, *supra* note 61, at 97.

64. See, e.g., James E. Bowman, *The Road to Eugenics*, 3 U. CHI. L. SCH. ROUNDTABLE 491, 493 (1996).

There are a number of reproductive justice activists, advocates, and organizations integrating an analysis of reproduction and gender identity in their work, but like the LGBT movement, this work has been in stops and starts, and not part of a larger, coordinated strategy.⁶⁵ For example, a report issued by the Pro-Choice Public Education Project and the Lesbian, Gay, Bisexual & Transgender Community Center focused on sexual and reproductive health needs of trans women and trans men based on New York City–based focus groups.⁶⁶ Recently, the National Latina Institute for Reproductive Health (NLIRH) issued a fact sheet highlighting the reproductive health disparities facing trans Latinas, and providing the reasoning that drove NLIRH to expand the scope of its work:

At its core, the reproductive health and justice movements are about bodily autonomy for all, and particularly those whose gender is marginalized. Though this movement has traditionally been about women’s control over their own bodies, we recognize now that this is not enough. As people whose genders have been marginalized, not just cisgender women, but transgender and gender non-conforming people too are consistently and systemically denied full bodily autonomy.⁶⁷

Social media has played an important role in advancing this conversation in the reproductive justice movement.⁶⁸ Advocacy organizations including Choice USA, NLIRH, and the National Center for Lesbian Rights hosted a “Queering RJ” campaign during Pride Week

65. This is changing: on August 11–14, 2013, with the support of the Civil Liberties and Public Policy Program at Hampshire College, the National Center for Lesbian Rights and the National Latina Institute for Reproductive Health convened a number of local, state, and national advocates with an interest at the intersections of the LGBT movement and the reproductive health, rights, and justice movement. *See 2013 Summer Leadership Institute*, CIVIL LIBERTIES AND PUB. POL’Y, <http://clpp.hampshire.edu/leadership-programs-nlni-network-nlni-summer-leadership-institute/2013-summer-leadership-institute> (last visited Nov. 3, 2013). As the Reproductive Justice Fellow at the National Center for Lesbian Rights, I helped plan this convening, and Eesha Pandit and Verónica Bayetti Flores, long-time leaders, led the discussions. *See id.*

66. *See* PRO-CHOICE PUB. EDUC. PROJECT & LESBIAN, GAY, BISEXUAL & TRANSGENDER CMTY CTR., *SILENCED BODIES: CONVERSATIONS WITH GAY MEN, BISEXUAL & TRANSGENDER PERSONS, AND QUEER WOMEN OF COLOR ON SEXUAL & REPRODUCTIVE HEALTH, RIGHTS & JUSTICE 6*, available at <http://www.gaycenter.org/files/imce/docs/causesSilencedbodies.pdf>.

67. NAT’L LATINA INST. FOR REPROD. HEALTH, *AT THE MARGINS OF CARE: THE NEED FOR INCLUSIVE HEALTH CARE FOR TRANSGENDER & GENDER NON-CONFORMING LATINAS 1* (2013), available at <http://latinainstitute.org/sites/default/files/publications/fact-sheets/NLIRH-FactSheet-GenderedCare-EngR3new.pdf>.

68. *See Women, Health & Our Families in the Media Shifting Culture Through Storytelling & Media Making*, ORG. UPGRADE (June 13, 2013, 2:09 PM), <http://www.organizingupgrade.com/index.php/component/k2/item/992-women-health-our-families-in-the-media-shifting-culture-through-storytelling-media-making>.

in Washington D.C.,⁶⁹ including a blog series that drew attention to difficult conversations about gender identity in the reproductive health, rights, and justice movements: “how do we talk about the fact that there are also gender non-conforming folks seeking abortion? That trans women’s reproductive health care needs differ, often dramatically, from those of cisgender women? That there are trans men looking to get on birth control?”⁷⁰ State and local reproductive justice organizations, such as New Voices Pittsburgh, Spark Reproductive Justice NOW!, and Forward Together have deep-seated commitments to centering transgender people in their theorizing, strategizing, and organizing.⁷¹

C. Reproductive Injustice: The Logic and Residue of Eugenics in State Requirements to Change Gender Markers

1. The Importance of an Accurate Gender Designation in Documents for Everyday Life

In the United States, there are a plethora of different federal, state, and local rules governing the change of gender designation on certain identity documents.⁷² Identity documents include government records such as birth certificates, Social Security cards, passports, and driver’s licenses; they are documents that people must produce to verify their identity and access many public and private services. For example, in his foundational text on documenting gender reclassification practices in federal, state, and local jurisdictions, trans scholar and activist Dean Spade notes: “DMV ID is certainly the most commonly used ID in the United States, essential for driving, applying for employment, dealing with police, entering age-barred venues, traveling on planes, purchasing age-barred products, using checks and credit cards, etc.”⁷³ Birth certificates have become “essential for access

69. See Mari Schimmer & Kimberly Inez McGuire, *Queering Reproductive Justice: Taking PRIDE in Our History, Experiences, and Identities*, FACEBOOK, <https://www.facebook.com/events/374459399341908/permalink/376126552508526/> (last visited Nov. 3, 2013).

70. Verónica Bayetti Flores, *We Make the Road by Walking: Trans-inclusive Language and Reproductive Justice*, CHOICEWORDS (June 12, 2013), <http://www.choiceusablog.org/we-make-the-road-by-walking-trans-inclusive-language-and-reproductive-justice/>.

71. See GROUNDSWELL FUND, *Catalyzing Women of Color-Led Reproductive Justice Nationwide—The First Five Years* 8, 14, 23 (2013), available at [http://www.korwinconsulting.com/pdfs/Catalyst%202012%20Evaluation%20Report%20FINAL%20\(042413\).pdf](http://www.korwinconsulting.com/pdfs/Catalyst%202012%20Evaluation%20Report%20FINAL%20(042413).pdf).

72. See Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 761, 766–67 (2008) [hereinafter Spade, *Documenting Gender*].

73. *Id.* at 773.

to schooling, insurance, pensions, and much more”⁷⁴ and “[i]t has been estimated that federal requirements, such as providing documents to prove identity when applying for a Social Security card, ‘account . . . for about half the demand for birth certificates in the United States.’”⁷⁵ Such documents have become a “ubiquitous and essential currency of contemporary life.”⁷⁶

The difficulty in changing the gender designation on these common documents affects a significant number of transgender people, and contributes to persistent and severe economic and social disparities.⁷⁷ It is estimated that “[n]ationally, the percentage of transgender people who are unable to update identification and official records to reflect their lived gender varies from 41 percent for driver’s licenses and 51 percent for Social Security records to 74 percent for birth certificates.”⁷⁸ Without accurate identity documents, a person’s transgender status is at risk of disclosure in the most ordinary moments of everyday life, as “he or she begins a new job, applies for housing, credit, or public benefits, goes to a bar or club, is subject to a routine traffic stop, or boards an airplane.”⁷⁹

The pace of change remains uneven for modernizing standards for changing the gender designation on identity documents.⁸⁰ As meticulously documented by Tobin, there are a significant number of state and local governments that “rely on outdated policies that require proof of [often unspecified] surgical treatment to update identification and other documents”⁸¹ By contrast, trans advocates have successfully persuaded the U.S. Department of State (passports)⁸² and the Social Security Administration (Social Security cards)⁸³ to revise their requirements so that “sex reassignment surgery” is no longer required of any applicant seeking to change their gender designation on either of these documents.

74. *Id.* at 766.

75. *Id.* (citing James B. Rule et al., *Documentary Identification and Mass Surveillance in the United States*, 31 *SOC. PROBLEMS* 222, 224–25 (1983)).

76. Harper Jean Tobin, *Fair and Accurate Identification for Transgender People*, 1 *HARVARD KENNEDY SCH. LGBTQ POL’Y J.* (2011), available at <http://isites.harvard.edu/icb/icb.do?keyword=k78405&pageid=icb.page414493>.

77. *See id.*

78. *Id.* at 3.

79. *Id.*

80. *See id.*

81. *Id.*

82. *See* U.S. DEP’T OF STATE, *Identification Requirements for Gender Reassignment Applicants*, http://travel.state.gov/passport/get/first/first_5100.html (last visited Nov. 3, 2013).

83. *See* SOCIAL SEC. ADMIN., *RM 10212.200 Changing Numident Data for Reasons Other than Name Change*, <https://secure.ssa.gov/poms.nsf/lnx/0110212200> (last visited Nov. 3, 2013).

2. The Question of Active and Passive Eugenics in Requirements to Change Gender Designation: Comparative Policies in the United States and Europe

A considerable number of European countries have compulsory sterilization requirements in order for transgender people to change their gender marker on national identity documents. By contrast, in the United States, similar federal and state requirements (past and present) are more ambiguous in this regard and do not facially implicate a transgender person's reproductive potential. There is an important difference between clear compulsory sterilization requirements, like those in Europe, and requirements like those in the United States, where—by how administrative interpretation of their vagaries (which is often inconsistent across and even within jurisdictions)—diminish the reproductive potential of transgender people. Also, while these types of requirements sidestep the spectra of historical forced/coerced sterilization against women of color and people with disabilities in the United States, they have a reproductive impact of no less import. Understanding these requirements, in contrast to the explicit compulsory sterilization laws of some European countries, will be important in building effective alliances and shared advocacy strategies between the LGBT movement and the reproductive justice movement.

According to an index produced by Transgender Europe, there are twenty-four European countries that require transgender people to be sterilized as a prerequisite for changing the gender marker on various identity documents or government records.⁸⁴ These statutes and policies are not relics that have yet to be repealed. For example, in 2007, Belgium enacted new uniform requirements for transgender people seeking to change their first names and gender markers on their birth certificates.⁸⁵ There are different sets of standards for changing their

84. These countries include Belgium, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Georgia, Greece, Italy, Latvia, Luxembourg, Malta, Moldova, Montenegro, The Netherlands, Norway, Romania, Russia, Slovakia, Switzerland, Turkey, and Ukraine. There are fifteen countries who have unknown or vague procedural requirements for changing the gender marker on government records or do not allow it at all; these countries include: Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Ireland, Kosovo, Liechtenstein, Lithuania, Macedonia, Monaco, San Marino, Serbia, and Slovenia. TRANSGENDER EUR., TRANS RIGHTS IN EUROPE INDEX (2013), available at http://www.tgeu.org/sites/default/files/Trans_Rights_Europe_Index_2013.pdf.

85. See JOZ MOTMANS ET AL., INST. FOR THE EQUAL. OF WOMEN AND MEN, BEING TRANSGENDER IN BELGIUM: MAPPING THE SOCIAL AND LEGAL SITUATION OF TRANSGENDER PEOPLE 52–53 (2010), available at http://igvm-iefh.belgium.be/fr/binaries/34%20-%20Transgender_ENG_tcm337-99783.pdf. Prior to 2007, these changes were possible, but were a source of legal uncertainty. First name changes were subject to the discretionary approval of the Minister of Justice. There were two disputed legal avenues to change the gender marker on birth certificates. The 2007 law resolved these uncertainties. See *id.* at 52.

first names and a set of standards for changing the gender markers on their birth certificates.⁸⁶ The standard for changing the first name includes requiring specific certifying statements from their psychiatrist and endocrinologist, and the transgender person must be undergoing hormone replacement therapy.⁸⁷ The standard for changing the gender marker on the birth certificate, however, includes similar certifying statements from healthcare professionals, including that “the individual is no longer capable of producing children in accordance with his/her previous gender.”⁸⁸ Another example is the Czech Republic, where in order for transgender persons to change the gender marker and their national ID number (which is gender-specific), they must undergo a “sex reassignment surgery” that “terminate[s] the reproductive function of the trans person.”⁸⁹ In Finland, legal gender changes require that a transgender person “provide[] a medical statement on the fact . . . he or she is sterilised or for other reasons unable to reproduce.”⁹⁰ As recently as 2013, the Court of Cassation, a court of last resort in France, held that it was legal for France to condition legal gender change on undergoing “irreversible medical reassignment” surgery, which is sterilizing in practice.⁹¹ In Netherlands, legal changes are allowed only if the person requesting the change “is marked on the birth certificate as a male and he is definitely incapable of procreating children or if he is marked on his birth certificate as female, [and is] . . . definitely incapable of giving birth to children.”⁹² The Turkish Civil Code requires that the gender change applicant must document that he or she is “irreversibly devoid of reproductive faculties.”⁹³ Until recently, Sweden conditioned legal gender change on sterilization, a policy strictly enforced even if the applicant had

86. *See id.* Denmark holds a similar policy: that people may change their names without sterilization. *See* TRANSGENDER EUR., *supra* note 84.

87. *See* MOTMANS ET AL., *supra* note 85, at 52.

88. *Id.* at 53.

89. ILGA-EUR., ANNUAL REVIEW OF THE HUMAN RIGHTS SITUATION OF LESBIAN, GAY, BISEXUAL, TRANS AND INTERSEX PEOPLE IN EUROPE 79–80 (2013), *available at* <https://dl.dropboxusercontent.com/u/15245131/2013.pdf>.

90. *2002/563 Act on the Confirmation of Gender of a Transsexual*, (unofficial English translation), TRASEK ASS'N (2010), <http://www.trasek.net/wp-content/uploads/2011/03/TransAct2003.pdf>.

91. *See* ILGA-EUR., *supra* note 89, at 99.

92. *See* Dutch Civ. Code, BW Art. 1:28, *available at* <http://www.dutchcivillaw.com/legislation/dccititle044.htm>. Although Article 1:28 is currently the law in the Netherlands, it is expected to change soon, since the House of Representatives recently passed a bill to amend the law, removing the sterilization requirement. *See* ILGA-EUR., *supra* note 89, at 169. The Senate is expected to vote to pass the bill in the fall of 2013. *See id.*

93. LGBT RIGHTS PLATFORM, DISCRIMINATION AND VIOLENCE AGAINST WOMEN ON BASIS OF SEXUAL ORIENTATION AND GENDER IDENTITY 8 n.19 (2009), *available at* http://www.ighrc.org/sites/default/files/CEDAW_TURKEY_Thematic_LBT_WOMEN.pdf (quoting Turkish Civil Code, Law no. 4721, Art. 40).

undergone some form of gender-confirming surgery abroad.⁹⁴ The policy was overturned in a pair of successive decisions from the country's highest court and its parliament.⁹⁵

In the Ukraine, the government will recognize legal gender change only if transgender people “undergo surgeries to remove all sexual organs, as well as mammary glands for transgender men.”⁹⁶ In addition, transgender people who have children cannot receive medical treatments.⁹⁷ By requiring sterilization while permanently blocking transgender people who are already parents from accessing legal gender change, Ukraine has gone further than these other countries in ensuring that transgender people cannot reproduce and parent.

In the United States, “[t]he connection between personal documentation provided by the federal government and documentation practices taking place in states and local jurisdictions remains decentralized, yet interdependent.”⁹⁸ Passports⁹⁹ and Social Security cards¹⁰⁰ are two common identity documents within the jurisdiction of the federal government, and driver's licenses and birth certificates are two common identity documents within the jurisdiction of state governments.¹⁰¹

With respect to birth certificates, there are three states that will not amend birth certificates for gender reclassification for any reason nor based on any evidence.¹⁰² Arizona requires the doctor to certify that a “sex change operation” has occurred.¹⁰³ There are seven states that require a court order to change the gender designation on a birth certificate.¹⁰⁴

94. *See Sweden to Stop Sex Change Sterilization*, LOCAL (Jan. 11, 2013, 7:18 AM), <http://www.thelocal.se/45550/20130111/#.UPYtTGeUuRN>.

95. *See id.*

96. *Submission on Ukraine to the UN Human Rights Committee*, HUMAN RIGHTS WATCH (June 20, 2013), <http://www.hrw.org/news/2013/06/20/submission-ukraine-un-human-rights-committee>.

97. SERHIY PONOMARYOV, STUDY ON HOMOPHOBIA, TRANSPHOBIA AND DISCRIMINATION ON GROUNDS OF SEXUAL ORIENTATION AND GENDER IDENTITY LEGAL REPORT: UKRAINE 4, available at http://www.coe.int/t/Commissioner/Source/LGBT/UkraineLegal_E.pdf.

98. Spade, *Documenting Gender*, *supra* note 72, at 766.

99. *See* U.S. DEPT OF STATE, *supra* note 82.

100. *See* SOCIAL SEC. ADMIN., *supra* note 83.

101. *See* Spade, *Documenting Gender*, *supra* note 72, at 736.

102. These states are Idaho, Ohio, and Tennessee. *See* TENN. CODE ANN. § 68-3-203 (West 2013); Spade, *Documenting Gender*, *supra* note 72, at 834 n.457, 838 n.481.

103. ARIZ. REV. STAT. ANN. § 36-337(A)(3)(b) (2013).

104. These states include Alabama, Alaska, Arkansas, California, Colorado, Connecticut, and Delaware. *See* ALA. CODE § 22-9A-19(d) (West 2013); Ark. Code Ann. § 20-18-307 (2013); CAL. HEALTH & SAFETY CODE § 103425 (West 2013); COLO. REV. STAT. ANN. § 25-2-115(4) (West 2013); CONN. GEN. STAT. ANN. §§ 19A-42(a)–(b) (West 2013); DEL. CODE ANN. tit. 16, § 3131 (West 2013); 16 DEL. ADMIN. CODE § 4205-10.9.4 (West 2013); *see also Sources of Authority to Amend Sex Designation on Birth Certificates*, LAMBDA LEGAL, <http://www.lambdalegal.org/publications/sources-of-authority-to-amend> (last updated Oct. 23, 2013); Spade, *Documenting Gender*, *supra* note 72, at 832 n.446.

With respect to driver's licenses, there are a considerable number of states whose standard for changing the gender designation on a driver's license relies on a court order or amended birth certificate.¹⁰⁵ There are two states, Kentucky and Montana, where an amended birth certificate is required to change the gender designation on a driver's license,¹⁰⁶ and in Kentucky, the gender designation for a birth certificate may only be amended "[u]pon receipt of a sworn statement by a licensed physician indicating that the gender of an individual . . . has been *changed by surgical procedure*."¹⁰⁷ There are an additional five states where an amended birth certificate is one of several possible documents that will fulfill the evidentiary requirement for changing the gender designation on a driver's license.¹⁰⁸ There are seven states that require a court order to change the gender designation on a driver's license,¹⁰⁹ and an additional nine states where a court order is one of several possible documents that will fulfill the evidentiary requirement for changing the gender designation on a driver's license.¹¹⁰

There are eight states that absolutely require a doctor's letter certifying that an individual has undergone surgery in order to change the gender designation on a driver's license.¹¹¹ Among these states, the statutory requirement provides no definitive guidance on what constitutes such surgery, it is simply referred to as "sex reassignment surgery," "gender reassignment surgery," or "surgery necessary to effect a gender change."¹¹² The statutes' vagueness on this matter leaves

105. *See Driver's License Policies By State*, NAT'L CTR. FOR TRANSGENDER EQUAL., http://transequality.org/Resources/DL/DL_policies_text.html (last updated Jan. 4, 2013) [hereinafter *Driver's License Policies*].

106. *See id.*

107. KY. REV. STAT. ANN. § 213.121(5) (West 2013) (emphasis added).

108. These states are Alaska, Iowa, Texas, Utah, and Virginia. *See Spade, Documenting Gender*, *supra* note 72, at 823 n.405, 824 n.409, 828 nn.437 & 440; *Driver's License Policies*, *supra* note 105.

109. These states include Arkansas, Mississippi, Montana, North Carolina, South Carolina, Texas, and West Virginia. *See Spade, Documenting Gender*, *supra* note 72, at 822 n.397, 825 n.418, 827 n.434, 828 n.438, 829 n.442; *Driver's License Policies*, *supra* note 105.

110. These states include Alaska, Georgia, Idaho, Illinois, Indiana, Iowa, Pennsylvania, Virginia, and Wisconsin. *See Spade, Documenting Gender*, *supra* note 72, at 823 n.404, 824 nn.407 & 409, 827 n.432, 828 n.440, 829 n.443; *Driver's License Policies*, *supra* note 105.

111. These states include Alabama, Louisiana, Missouri, New Hampshire, North Dakota, Oklahoma, Tennessee, and Wyoming. *See Spade, Documenting Gender*, *supra* note 72, at 822 n.394, 824 n.412, 825 n.419, 827 nn.428 & 430, 829 n.444; *Driver's License Policies*, *supra* note 105. By contrast, there are seven states—Connecticut, Georgia, Oregon, Pennsylvania, South Dakota, Vermont, and Virginia—where a doctor's letter certifying that an individual has undergone surgery is one of a set of possible documents that will fulfill the evidentiary requirement for changing the gender designation on an individual's DMV ID. *See Spade, Documenting Gender*, *supra* note 72, at 823 nn.400 & 404, 827 n.431; *Driver's License Policies*, *supra* note 105.

112. *See, e.g., Driver's License Policies*, *supra* note 105.

the interpretation of what surgery is sufficient to be negotiated between a trans person, his or her physician, and agency officials who may differ from each other from how they process these requests.

Notably, since 2008, a considerable number of states have relaxed their evidentiary requirements for gender reclassification on driver's licenses.¹¹³ Three states that formerly required an amended birth certificate to change the gender marker now require completion of a specific form by a healthcare or social services provider.¹¹⁴ By signing the form, the provider certifies that the individual attempting to change his or her gender markers has received medical treatment, that the change is expected to be permanent, and/or that the individual's gender identity is consistent with the requested change.¹¹⁵ Three states that formerly required a court order, either absolutely or as one of a set of possible evidentiary items, now require a specific, certifying form signed by a healthcare or social services provider.¹¹⁶ Fourteen states that used to require a doctor's letter certifying that an individual has undergone some type of "sex reassignment surgery" have lowered their evidentiary requirements.¹¹⁷ In those states, signed statements from licensed physicians without mention of surgery, other identity documents that reflect the requested change, and specific forms issued by the state DMV are now sufficient.¹¹⁸

As demonstrated, unlike a number of European countries,¹¹⁹ the United States federal and state governments do not explicitly require sterilization of transgender individuals in order to change the gender designation on their birth certificates or driver's licenses.¹²⁰ However, a number of states require some variation of "sex reassignment surgery" to change the gender designation on birth certificates or driver's licenses which implicates reproduction, thereby stealthily embedding eugenics ideologies into these states' legal codes.¹²¹ Sterilization requirements may not be made explicit and compulsory, but such an embedding is of significant ethical consequence.

113. *See id.*

114. These states are Hawaii, Massachusetts, and New Jersey. *See id.*

115. *See id.*

116. These states are New Jersey, Ohio, and Vermont. *See id.*

117. These states are Alaska, Arizona, California, Colorado, Delaware, District of Columbia, Florida, Maine, Maryland, Massachusetts, New Jersey, New Mexico, New York, and Rhode Island. *See id.*

118. *See Driver's License Policies*, *supra* note 105.

119. *See TRANSGENDER EUR.*, *supra* note 84.

120. Andrea Ayres-Deets, *Transgender Rights: Why They Matter to Everyone*, POLICYMIC (Jan. 14, 2013), <http://www.policymic.com/articles/22744/transgender-rights-why-they-matter-to-everyone>.

121. *See Driver's License Policies*, *supra* note 105.

Trans advocates have identified a number of reasons to modernize state requirements to change the gender designation on birth certificates and driver's licenses, and proposed several model codes.¹²² This is because (variations of) the phrase "sex reassignment surgery" remain undefined, thereby leaving the judgment of what type of surgeries are sufficient with either state agency officials or local judges (who entertain requests for a court order).¹²³ Surgical requirements to change the gender designation on birth certificates or driver's licenses foist a tremendous expense onto transgender individuals, who are disproportionately low-income.¹²⁴ In fact, many transgender individuals cannot change the gender designation on their identity documents because they cannot meet these requirements.¹²⁵ As discussed *supra*, it is well-documented that failure to obtain and carry accurate identity documents can subject transgender individuals to discrimination, harassment, and violence.¹²⁶

These requirements have an overlooked, but undeniable reproductive impact. They force treating surgeons or physicians to carefully choose the wording of such certifying letters or affidavits for transgender individuals to appeal to these decision-makers, who may be uninformed or biased about what procedures constitute "sex reassignment surgery." For example, bilateral mastectomies—commonly known as "top surgery"—are more common among trans men than "bottom surgery," which may include hysterectomies (removal of the uterus) and/or phalloplasties.¹²⁷ But the number of officials or judges in particular jurisdictions who consider breast reduction or bilateral mastectomy as "sex reassignment surgery" is unclear and likely unknowable. Such vagaries compel trans individuals, and their advocates and doctors, to negotiate a number of unstated assumptions to obtain accurate identity documents.¹²⁸ Moreover, they incentivize

122. See Spade, *Documenting Gender*, *supra* note 72, at 772–74.

123. See *id.* at 773 ("Two individuals living in the same state, having undergone similar medical treatment, may face different results depending upon the DMV worker they are faced with, the rules of the birth certificate issuing agency in their birth state, or the standards for gender applied by the judge from whom they seek a court order.").

124. See Meaghan Winter, *Trans-Formative Change: Meaghan Winter Interviews Dean Spade*, GUERNICA (Mar. 1, 2011), http://www.guernicamag.com/interviews/spade_3_1_11/.

125. See Nolan Feeney, *Identity Crisis: Changing Legal Documents No Easy Task for Transgender Individuals*, TIME (July 10, 2013), <http://healthland.time.com/20130710/identity-crisis-changing-documents-no-easy-task-for-transgender-individuals/>.

126. See Tobin, *supra* note 76.

127. *FTM Chest Reconstruction Surgeries*, HUDSON'S GUIDE: FTM RESOURCE GUIDE, <http://www.ftmguide.org/chest.html> (last visited Nov. 3, 2013).

128. See Feeney, *supra* note 125, at 2; *Transgender People & the Law: Frequently Asked Questions*, AM. CIVIL LIBERTIES UNION, https://www.aclu.org/sites/default/files/images/asset_upload_file781_33764.pdf (last visited Nov. 3, 2013); Zack Ford, *Illinois Relaxes Requirements for Transgender Identity Documentation*, THINKPROGRESS (Oct. 24, 2012, 11:50 AM), <http://www.thinkprogress.org/lgbt/2012/10/24/1080691/illinois-relaxes-requirements-for-transgender-identity-documentation/>.

trans individuals to undergo surgeries that affect their reproductive potential that they may not have otherwise have considered necessary to their transition.¹²⁹

Foremost, these statutes and regulations represent archaic, simplistic understandings of gender dysphoria and possible corresponding treatments. They also, however, constitute eugenical incentives that should alarm reproductive health, rights, and justice advocates. There are two possible categories of resistance by these advocates to form alliances with trans advocates to focus on modernizing these state requirements (thereby removing “sex reassignment surgery” as a standard). The first is that these statutes and regulations are not a eugenics issue because that is not their primary intent. The second is that, because trans individuals, advocates, and treating physicians may be silently and successfully working around these statutes and regulations, there is little urgency to repeal or modernize these requirements.

As for the issue of intent, reproductive rights and justice advocates have welded together ostensible state intent and actual reproductive impact on contemporary issues such as welfare family caps and sterilization abuse in California prisons.¹³⁰ For example, a number of states have the welfare family cap,¹³¹ a rule that denies women receiving public assistance from additional financial assistance to which they would otherwise be entitled, if they give birth to a child.¹³² Reproductive justice scholars and advocates have challenged this rule as unacceptable state surveillance and regulation of low-income women’s fertility.¹³³ They have drawn upon human rights frameworks to draw attention to how “certain women’s reproductive rights are dissolved because they are poor,”¹³⁴ and may incentivize low-income women to choose abortion.¹³⁵ Advocates have stressed that regardless of the

129. See, e.g., Rita Vavra, *How the Legal Regulation of Transgender Bodies Affects Us All*, COLUMBIA UNIV. GENDER & SEXUALITY LAW BLOG (Fall 2012), <http://blogs.law.columbia.edu/genderandsexualitylawblog/files/2013/02/Vavra-Rita-Legal-Regulation-of-Transgender-Bodies.pdf>.

130. See Jim Sanders, *Los Angeles Lawmaker Pushing to Repeal ‘Family Cap’ for Welfare Benefits*, SACRAMENTO BEE (Feb. 13, 2013, 5:25 PM), <http://www.sacbee.com/2013/02/12/5185534/los-angeles-lawmaker-pushing-to.html>; see also Alex Stern & Tony Platt, *Sterilization Abuse in State Prisons: Time to Break with California’s Long Eugenic Patterns*, HUFFINGTON POST (July 23, 2013, 6:12 PM), http://www.huffingtonpost.com/alex-stern/sterilization-california-prisons_b_3631287.html.

131. See Romero & Fuentes, *supra* note 56.

132. See *id.*

133. See *id.* at 3.

134. *Id.*

135. See Sanders, *supra* note 130 (“Many supporters of AB 271 fear that California’s family cap can spark decisions to abort a child rather than be pressed further into poverty, though no conclusive statistics exist on the impact of such laws on abortion.”).

intent of welfare family caps, which are often framed as a cost-benefit issue to the state, their reproductive impact is that low-income women, who are overwhelmingly women of color, are constrained in their reproductive decision-making.¹³⁶ Reproductive health, rights, and justice advocates should recognize the parallel logic in state codes requiring “sex reassignment surgery” to obtain accurate identity documents. Like women receiving public assistance, these state codes constrain the reproductive decision-making of transgender individuals. For transgender individuals, the logic is that if you want to obtain accurate identity documents, you must undergo treatment that has a reproductive impact (infertility).¹³⁷ For women receiving public assistance, the logic is that if you become pregnant, your choices are to have an abortion or risk the health and well-being of your child(ren)¹³⁸—either choice represents significant reproductive impact. Both sets of rules—for transgender individuals and for women on public assistance—press directly upon the right to parent because they discourage reproduction. The right to parent is a core tenet of reproductive justice,¹³⁹ and the tenet that most directly descends from the history of eugenics against women of color and people with disabilities in this country.¹⁴⁰ Under a reproductive justice framework, the arguments against such practices have coextensive principles, whether these rules are considered active or passive eugenics.¹⁴¹

D. Reproductive Justice: Fertility Preservation and Family Building

*Longing is a powerful feeling. It aches. It pangs. It rolls. It roils. It changes us. This longing is where I want to start because all of us have felt longing for something; longing that feels deeply personal. Some longing that we feel is for intangibles like love, freedom, justice, and safety. Many of us experience more concrete and specific longing, including the powerful desire for a child.*¹⁴²

136. See Romero & Fuentes, *supra* note 56, at 2–3; see also *Bill to Overturn “Family Cap” Option Introduced*, NAT’L ASSOC. OF SOC. WORKERS (July 23, 1998), <http://www.socialworkers.org/archives/advocacy/alerts/1998/familycap.htm>.

137. See Vavra, *supra* note 129, at 7.

138. Because the state will deny your family a proportionate increase to which you would already be entitled if you had that number of children at the time you applied.

139. See A NEW VISION, *supra* note 46, at 1.

140. See, e.g., ROBERTS, *supra* note 53, at 59–62; SMITH, *supra* note 53, at 75–76.

141. See, e.g., Loretta Ross, *Understanding Reproductive Justice*, TRUST BLACK WOMEN (Nov. 2006), <http://www.trustblackwomen.org/our-work/what-is-reproductive-justice>.

142. Miriam W. Yeung, *A New Queer Agenda: Reproductive and Genetic Justice*, SCHOLAR & FEMINIST ONLINE (Spring 2012), <http://sfonline.barnard.edu/a-new-queer-agenda/reproductive-and-genetic-justice/>.

Policy supports for fertility preservation for transgender people has been an oft-neglected area of inquiry and advocacy for the LGBT and reproductive health, rights, and justice movements. This may be due to a lack of strong and long-standing collaborations between advocates and scholars in the fields of (1) reproductive health and rights; (2) fertility preservation and reproductive technologies; and (3) sexual orientation and gender identity. The reproductive justice movement has an opportunity to unite advocates across these fields to take seriously the reproductive desire and potential of transgender people and to advocate for policies that support their fertility preservation.

1. Establishing Reproductive Desire

In October 2008, Dean Spade wrote a commentary for the *Los Angeles Lawyer* about three myths regarding transgender identity that adversely affect transgender people.¹⁴³ The first myth: “transgender people do not exist.”¹⁴⁴ This section establishes a similar, predicate assertion: transgender people may desire to have children.¹⁴⁵ In fact, as Dutch researchers noted in a study of reproductive wishes of transsexual men: “[p]articipants with children did not differ in the desire to have (more) children from participants without children. This is in accordance with [a study of the reproductive wishes of transsexual women, which] found no differences in the desire to have children between transsexual women with or without children.”¹⁴⁶ Like all people, transgender people may value having children that are genetically related to them.¹⁴⁷ But transgender people’s reproductive wish or potential is severely impacted by pervading myths about their desire to reproduce, the residue of eugenics embedded in state requirements to change gender markers on identity documents discussed *supra*, the lack of laws and policies to support their fertility preservation and family-building, and the disproportionate number of transgender people who live in poverty or are incarcerated.¹⁴⁸

143. See Dean Spade, *Transformation: Three Myths Regarding Transgender Identity Have Led to Conflicting Laws and Policies that Adversely Affect Transgender People*, L.A. LAWYER, Oct. 2008, at 35 [hereinafter Spade, Transformation], available at <http://srlp.org/files/Trans%20Formation%20Article.pdf>.

144. See *id.* at 36.

145. See *id.*

146. Katrien Wierckx et al., *Reproductive Wish in Transsexual Men*, 27 HUMAN REPROD. 483, 486 (2012), available at <http://humrep.oxfordjournals.org/content/27/2/483.full.pdf>.

147. See, e.g., Joanne Herman, *Can Transgender People Bear Children?*, HUFFINGTON POST (Mar. 28, 2011, 9:40 AM), http://www.huffingtonpost.com/joanne-herman/can-transgender-people-be_b_839703.html.

148. See Spade, *Transformation*, *supra* note 143, at 38.

According to the WPATH Standards of Care, “very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria.”¹⁴⁹ The lack of research may reflect (1) a common, but changing belief among gatekeeping healthcare professionals that a transgender person’s expressed reproductive desire meant that he or she had insufficiently embraced his or her “new” gender identity;¹⁵⁰ (2) transgender people needing to triage their survival by income, housing, and health care, with fertility preservation and child-bearing being a lesser priority;¹⁵¹ (3) a realization that with people transitioning at younger ages, reproductive counseling and fertility preservation should be more of a forefront issue.¹⁵²

Given this the lack of research, WPATH states, “it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs.”¹⁵³ It is unstated, but clear that removing or altering reproductive organs would impact fertility, and WPATH also stresses that “feminizing/masculinizing hormone therapy limits fertility.”¹⁵⁴ Researchers have noted “the majority of transsexual men are of reproductive age at the moment of transition and have relationships following transition.”¹⁵⁵

In a Dutch study of transgender men who had undergone “sex reassignment surgery” (SRS), 54 percent expressed a desire to have children.¹⁵⁶ Researchers acknowledge one shortcoming of the study is

149. See STANDARDS OF CARE, *supra* note 8, at 51.

150. See Marcus Jurema, *Fertility Preservation Options for the LGBT Community*, N.J. FERTILITY CTR. (June 29, 2012), <http://www.ivfnj.com/fertility-preservation-options-for-the-lgbt-community-by-dr-marcus-jurema/> (“Old school thinking preached the notion that for a complete transsexual transition one should absolutely part with the old and embrace the new. For example, that storing frozen sperm prior to a male to female change would be a sign of doubt or might interfere with the psychological commitment to the process.”); see also P. De Sutter et al., *The Desire to Have Children and the Preservation of Fertility in Transsexual Women: A Survey* 6, INT’L J. TRANSGENDERISM (2002), http://www.iiav.nl/ezines/web/ijt/97-03/numbers/symposion/ijtvo06no03_02.htm (“This has been considered a ‘price to pay’, and was sometimes thought to be beneficial for the transitioning process. Breaking completely with the past as a male and losing the possibility to ‘father’ a child, often was, and still is, considered a psychological prerequisite for a successful transition into the female role.”).

151. See, e.g., NAT’L COAL. FOR LGBT HEALTH, AN OVERVIEW OF U.S. TRANS HEALTH PRIORITIES: A REPORT BY THE ELIMINATING DISPARITIES WORKING GROUP (Aug. 2004), available at <http://transequality.org/PDFs/HealthPriorities.pdf> (discussing the major goals of transgender health priorities, without listing reproduction or child bearing).

152. See Jurema, *supra* note 150.

153. STANDARDS OF CARE, *supra* note 8, at 50.

154. *Id.*

155. Wierckx et al., *supra* note 146, at 484 (citations omitted).

156. See *id.* at 485.

that they made no inquiry if this desire was a specific desire for genetically related children or just parenthood.¹⁵⁷ Regardless, the overwhelming majority of study participants had not considered freezing their eggs at the time of hormone therapy (HRT).¹⁵⁸ The study found that a smaller number had considered it, but “never talked to a health-care provider about this subject.”¹⁵⁹ Notably, some of the study participants were already parents: eight transgender men had female partners who were inseminated with donor sperm and three transgender men gave birth before HRT and SRS.¹⁶⁰ The study found that “[t]wo of those three participants who gave birth themselves experienced this as (very) problematic, while one participant found this experience very pleasant.”¹⁶¹

In a 2002 internet survey of 121 trans women in four European countries, “48 had biological children either from the present relationship, or, more often, a previous relationship, while 73 women had no biological children.”¹⁶² A considerable number of these trans women—with or without children—expressed a desire to have children in the future.¹⁶³ Notably, approximately half of these respondents “would prefer to have their own biological child” with “a future (female) partner from their own sperm” (the other half “would not care”).¹⁶⁴ An overwhelming majority expressed that sperm freezing should be available to trans women before they transition (i.e., begin certain hormone treatments or gender-confirming surgeries).¹⁶⁵

2. Fertility Preservation for Transgender People Within the Ambit of Reproductive Justice

For transgender people, the possibilities of fertility preservation are controlled by the direction of the transition, the gender of current or future partners, and cost.¹⁶⁶ The clinical guidelines for discussing fertility preservation with cancer patients are a reference point for possible policy supports for trans people.¹⁶⁷ However, resistance to this

157. *See id.* at 486.

158. *See id.*

159. *Id.*

160. *See id.* at 485–86 (“[T]he age of SRS is significantly lower in transsexual men (mean age 28) compared with transsexual women (mean age 35.5). This could explain why few transsexual men had children before SRS.”).

161. *Id.* at 485.

162. *See* De Sutter et al., *supra* note 150.

163. *See id.*

164. *See id.*

165. *See id.*

166. *See* Jurema, *supra* note 150.

167. *See* Alison Loren et al., *Fertility Preservation for Patients with Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500, 2501 (2013), available at <http://jco.ascopubs.org/content/31/19/2500.full.pdf+html>.

comparison may reveal some underlying biases about gender identity in the reproductive health, rights, and justice movements.

Approaches toward fertility preservation for transgender individuals should be informed by current clinical guidelines and new public policy measures for fertility preservation for cancer patients. Currently, fertility preservation undertaken as a result of a cancer diagnosis is typically not covered by health insurance companies.¹⁶⁸ However, in June 2013, the American Medical Association (AMA) adopted a measure to support legislation that would require health insurers to cover fertility preservation when cancer treatments could result in infertility.¹⁶⁹ The AMA called such fertility preservation measures, “an *essential* part of the management of their cancer.”¹⁷⁰

There are minor differences but significant parallels between the fertility considerations facing adolescents and young adults facing cancer treatments and transgender individuals seeking HRT or certain gender-confirming surgeries.¹⁷¹ In fact, the WPATH Guidelines state, “[l]essons learned from [cancer patients] can be applied to people treated for gender dysphoria.”¹⁷² Clinical guidelines for oncologists treating adolescents or young adults with cancer stress that fertility preservation may be important to people with cancer, but they may hesitate to bring it up for three reasons.¹⁷³ First, they may be “overwhelmed by and focused exclusively on the cancer diagnosis.”¹⁷⁴ Second, “they may be unaware that potential fertility loss may occur.”¹⁷⁵ Third, they may be concerned that fertility preservation may delay treatments or increase the risk of death.¹⁷⁶ Transgender individuals expressed comparable anxieties in the reproductive wish study.¹⁷⁷ For example, among the trans women surveyed, “[m]ore than 90 [percent] of the respondents stated that loss of fertility was *not* an important reason to delay their transition.”¹⁷⁸ This finding suggests an urgency among trans women to obtain appropriate medical treatment that may offset fertility concerns—just as many cancer patients are concerned about delaying treatment. In the study of trans men on the

168. See, e.g., *Insurance Coverage*, FERTILEHOPE, <http://www.fertilehope.org/financial-assistance/insurance-coverage.cfm> (last visited Nov. 3, 2013).

169. See *AMA Adopts New Policies on First Day of Voting at Annual Meeting*, AM. MED. ASS'N (June 17, 2013), <http://www.ama-assn.org/ama/pub/news/news/2013/2013-06-17-new-ama-policies-annual-meeting.page>.

170. See *id.* (emphasis added).

171. See STANDARDS OF CARE, *supra* note 8, at 51.

172. See *id.*

173. See Loren et al., *supra* note 167, at 2504–05.

174. *Id.* at 2504.

175. *Id.*

176. See *id.* at 2504–05.

177. See De Sutter et al., *supra* note 150, at 4.

178. *Id.* at 4 (emphasis added).

same subject, researchers found that 77 percent had not considered freezing their eggs at the time of HRT and that nine respondents “had considered it, but had never talked to a health-care provider about this subject.”¹⁷⁹ The researchers did not explore why these trans men had not considered it or raised it with their healthcare provider.¹⁸⁰ However, 54 percent of respondents still expressed a desire to have children,¹⁸¹ which may indicate their lack of action on fertility preservation prior to HRT and certain gender-confirming surgeries did not align with their underlying reproductive desire.

Even the most common fertility preservation measures are quite costly, and this cost is a primary driver of fertility preservation decisions.¹⁸² For men and trans women, sperm cryopreservation (“freezing sperm”) has an upfront cost of several hundred dollars, depending on the clinic’s recommended number of sperm deposits.¹⁸³ Annual storage fees ranging from \$200–\$400 will apply until the time the deposits are retrieved to begin artificial insemination with a female partner or surrogate—another expensive process.¹⁸⁴ For women and trans men, possible fertility preservation options include embryo cryopreservation (“freezing embryos”), which would necessitate a male partner or donor,¹⁸⁵ or cryopreservation of unfertilized oocytes (“freezing eggs”), which is no longer considered experimental by the American Society for Reproductive Medicine.¹⁸⁶ These processes are significantly more expensive than freezing sperm; they range from \$6,500 to \$15,000 upfront, not including annual storage fees.¹⁸⁷ In addition, the process requires two to four weeks of a hormonal stimulation before egg retrieval.¹⁸⁸

179. Wierckx et al., *supra* note 146, at 485.

180. *See id.* at 486.

181. *See id.* at 485.

182. *See* De Sutter et al., *supra* note 150, at 9.

183. *See, e.g., Parenthood Options: Men*, FERTILE HOPE, <http://www.fertilehope.org/learn-more/cancer-and-fertility-info/parenthood-options-men.cfm> (last visited Nov. 3, 2013); *Sperm Freezing: Preserving Sperm for Future Use*, REPROD. CARE CTR., <http://www.fertilitydr.com/sperm-freezing.html> (last visited Nov. 3, 2013).

184. *See, e.g., Sperm Storage Fees*, SPERM BANK OF CAL., <http://www.thespermbankofca.org/content/sperm-storage-fees> (last visited Nov. 3, 2013).

185. *See, e.g., Parenthood Options: Women*, FERTILE HOPE, <http://www.fertilehope.org/learn-more/cancer-and-fertility-info/parenthood-options-women.cfm> (last visited Nov. 3, 2013).

186. *Fertility Experts Issue New Report on Egg Freezing; ASRM Lifts Experimental Label from Technique*, AM. SOC’Y FOR REPROD. MED. (Oct. 22, 2012), http://www.asrm.org/Fertility_Experts_Issue_New_Report_on_Egg_Freezing_ASRM_Lifts_Experimental_Label_from_Technique/.

187. *See* Elizabeth Cohen, *Freezing Your Eggs—the Costs and Other Realities*, CNN HEALTH (Oct. 6, 2011, 12:54 PM), <http://www.cnn.com/2011/10/06/health/fertility-eggs-embryos-empowered-patient>.

188. *See* Loren et al., *supra* note 167, at 2507–08. This is a special concern for trans men, because their process requires additional dosages of estrogen-like substances, complicating

The costs of fertility preservation measures as it intersects with race and class disparities in the United States is weakly addressed in the existing clinical guidelines for cancer patients and transgender individuals.¹⁸⁹ The clinical guidelines for cancer patients has a short section on “health disparities,” which notes that “[m]inority racial/ethnic patients with cancer . . . can experience substantial obstacles to receiving care, are more likely to be un-insured, and . . . [may] live at a [prohibitive] distance from appropriate . . . reproductive specialty facilities.”¹⁹⁰ The guidelines also state: “all patients including parents or guardians of children and adolescents should be encouraged to consider fertility preservation, even though there may be financial or insurance barriers.”¹⁹¹ The WPATH Guidelines statement is equally well-intentioned, but ultimately toothless: “Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.”¹⁹²

The accessibility of fertility preservation for transgender individuals is about the right to have children, one of the central tenets of the reproductive justice movement.¹⁹³ The WPATH Guidelines suggesting cancer patients as a comparative group for fertility preservation recommendations is a useful starting point to peel back the reproductive stigma that even staunch advocates for reproductive health, rights, and justice may attach to transgender individuals. I anticipate two categories of resistance to putting the reproductive potential of transgender individuals on par with that of cancer patients: (1) that a gender dysphoria diagnosis is not equivalent to a cancer diagnosis and therefore treatments for gender dysphoria are somewhat elective; and (2) that the relative, numerical smallness of transgender individuals compared to cancer patients does not raise this to a significant reproductive health injustice. Both of these objections cannot be squared with reproductive justice principles.

First, the objection that a gender dysphoria diagnosis is not equivalent to a cancer diagnosis is grounded in general belief that a mental

the desire to preserve more masculine features. See *Egg Freezing FAQ's*, USC FERTILITY, http://www.uscfertility.org/fertility_options/egg_freezing/egg_freezing_faqs.php (last visited Nov. 3, 2013).

189. See Loren et al., *supra* note 167, at 2507–08.

190. *Id.* at 2507.

191. *Id.* at 2508.

192. See STANDARDS OF CARE, *supra* note 8, at 51.

193. See *If You Really Care About Intimate Partner Violence, You Should Care About Reproductive Justice*, LAW STUDENTS FOR REPROD. JUSTICE & NAT'L WOMEN'S LAW CTR. 17 CONNECTIONS 2, 5 (2013), available at http://www.wcsap.org/sites/wcsap.huang.radical.designs.org/files/uploads/resources_and_pubs/reproductive_justice_2013/Connections_2013_06.pdf; Loretta Ross, *What is Reproductive Justice?*, PRO-CHOICE PUB. EDUC. PROJECT, <http://www.protectchoice.org/section.php?id=28> (last visited Nov. 3, 2013).

health diagnosis is less legitimate than a physical health diagnosis,¹⁹⁴ and a more specific belief that gender dysphoria is not existent or simply decisional.¹⁹⁵ One advocate and scholar has called this one of the “cultural myths about trans healthcare.”¹⁹⁶ He characterizes these beliefs as myths that:

trans people are people who wake up one morning, decide we want to change our sex, go to the nearest doctor’s office, get “the operation,” and become “the opposite sex” at that time. So there’s this one “the surgery” that makes us our gender that every trans person either wants to get or has already had, but there’s no real “need” for it, it’s more of a luxury or a whim.¹⁹⁷

These cultural beliefs are pervasive, despite the overwhelming evidence accepted by a number of major medical associations that gender dysphoria is a real condition with safe and effective treatments.¹⁹⁸ (In fact, advocates are confident enough of the evidence supporting gender dysphoria as a real and treatable condition that they recently filed an administrative challenge to the Medicare spending ban on sex reassignment surgery).¹⁹⁹ Moreover, reproductive health, rights, and justice advocates continue to defend claims in their own field about the “realness” of mental health diagnoses. For example, anti-choice advocates and legislators have sought to disallow mental health diagnoses as qualifying life and health exceptions in legislation restricting abortion access.²⁰⁰ Reproductive health, rights, and justice advocates

194. See, e.g., R.E. Kendell, *The Distinction Between Mental and Physical Illness*, 178 BRIT. J. PSYCHIATRY 490, 492 (2001), available at <http://bjp.rcpsych.org/content/178/6/490.full.pdf+html>.

195. See, e.g., Dale O’ Leary, *The “Transsexual” Delusion*, WHAT DOES THE RESEARCH REALLY SAY? (Jan. 9, 2011), <http://daleoleary.wordpress.com/2011/01/09/the-%E2%80%9Ctranssexual%E2%80%9D-delusion/>.

196. See Gabriel Arkles, *Prisons as a Tool for Reproductive Oppression: Cross-Movement Strategies for Gender Justice*, SYLVIA RIVERA LAW PROJECT (Sept. 27, 2008), available at <http://srlp.org/prisons-as-a-tool-for-reproductive-oppression-cross-movement-strategies-for-gender-justice/>.

197. *Id.*

198. See Norman P. Spack et al., *Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center*, 129 PEDIATRICS 418, 419 (2012), available at <http://pediatrics.aappublications.org/content/early/2012/02/15/peds.2011-0907>; AM. MED. ASS’N, *Resolution 122 (A-08)*, available at http://www.tgender.net/taw/ama_resolutions.pdf; STANDARDS OF CARE, *supra* note 8, at 5, 8. *But see* Spade, *Resisting Medicine*, *supra* note 17.

199. NAT’L CTR. FOR LESBIAN RIGHTS, *LGBT Groups Challenge Medicare’s Refusal to Provide Healthcare to Transgender Patients* (Mar. 29, 2013), <http://www.nclrights.dreamhosters.com/press-room/press-release/lgbt-groups-challenge-medicare-refusal-to-provide-healthcare-to-transgender-patients/>.

200. See, e.g., Cynthia Dailard, *Abortion Restrictions and the Drive for Mental Health Parity: A Conflict in Values?*, 2 GUTTMACHER REPORT ON PUB. POL’Y 4–6 (1999), available at <http://www.guttmacher.org/pubs/tgr/02/3/gr020304.pdf>.

have stressed that they be considered just as serious as a physical health threat.²⁰¹ It would appear a hypocritical posture for these advocates to stress mental health diagnoses as “real” for the purposes of health exceptions to abortion restrictions, but deny or diminish their import in advocating for parity in fertility preservation for transgender individuals.

Secondly, there is a possible objection that the relative, numerical smallness of gender dysphoria diagnoses and the corresponding number of transgender individuals who seek HRT or certain gender-confirming surgeries do not make this a compelling issue for the reproductive health, rights, and justice movement. Certainly, on a yearly basis, there are more people seeking contraception,²⁰² choosing abortion,²⁰³ giving birth,²⁰⁴ and fighting for their parental rights in the child welfare system than the number of transgender individuals seeking treatments that would diminish or cause their infertility. However, such a calculus would be inconsistent with zealous advocacy for other comparatively small populations to obtain abortion care;²⁰⁵ these populations include minors who need a judicial bypass; people who need abortion care at twenty weeks and beyond; and people in the military and Peace Corps forced to navigate a maze of financial and geographic restrictions due to the federal government’s spending bans on abortion care. Moreover, if reproductive health, rights, and justice advocates ranked their priorities based on the number of individuals affected by particular policies, transgender people would face reproductive health disparities and injustices without aid for the indefinite future. Finally, this type of advocacy triage bumps up against a more radical theory of social change that posits when advocates put the needs of the most marginalized people at the center of their theorizing and strategizing, it is more likely that everyone’s needs will ultimately be met.

There may be an intra-movement argument against centering fertility preservation as a locus of policy advocacy. There are some

201. See Robin Marty, *Kansas House Votes to Eliminate Mental Health from Abortion Ban Exemption*, RH REALITY CHECK (Mar. 24, 2010, 9:44 AM), <http://rhrealitycheck.org/article/2010/03/24/kansas-house-votes-eliminate-mental-health-abortion-exemptions/>.

202. See, e.g., Liz Neporent, *7 Facts About Condoms*, ABC NEWS (Feb. 14, 2011), <http://abcnews.go.com/Health/condom-facts-things/story?id=12869404> (noting that 5 billion condoms are sold worldwide each year).

203. See *Facts on Induced Abortion in the United States*, GUTTMACHER INST. (Oct. 2013), http://www.guttmacher.org/pubs/fb_induced_abortion.html.

204. See *Births and Natality*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/births.htm> (last visited Nov. 3, 2013).

205. Thank you to Lindsey O’Pries of the National Network of Abortion Funds for verbalizing this point at the December 2012 Breakthrough Conversation on Gender in Oakland, CA.

scholars and advocates who might argue that fertility preservation is not among the most urgent and constraining reproductive health issues facing transgender people. Gabriel Arkles, a legal scholar formerly associated with the Sylvia Rivera Law Project, has provided another possible point of alliance between the reproductive justice movement and the trans movement by locating prisons as a primary site of reproductive oppression for trans people.²⁰⁶ He described how prisons diminish transgender peoples' reproductive potential by incarcerating large numbers of them in the years they could bear children, setting the threshold for housing placement consistent with their gender identity contingent on "sex reassignment surgery," refusing to provide any treatment which has led some trans women to attempt self-surgery,²⁰⁷ interfering with trans people raising children by the very nature of their incarceration, and how prison conditions and the collateral consequences of conviction and imprisonment diminish their life chances.²⁰⁸ Moreover, other scholars and activists have raised broader questions about racial disparities inherent in access to fertility preservation and attendant reproductive technologies. For example, in her seminal work on the reproductive oppression that black women in the United States have resisted over centuries, Dorothy Roberts describes how reproductive technologies have overwhelmingly benefited white women, given their considerable, comparative wealth (a powerful juxtaposition to the disproportionate number of black and Latino children in foster homes and available for adoption).²⁰⁹ Given these disparities, Roberts challenges the happy promises of reproductive technologies: "Racism is embedded in unjust political, economic, and social structures. Without an ongoing and vigilant effort to dismantle these structures, perfecting genetic technology will only tighten

206. See Arkles, *supra* note 196 ("A few years ago, a colleague of mine was working with two people in the same men's prison in New York. One of them was a transgender woman and one of them was a man with an intersex condition. The man with the intersex condition was given permission to shower privately, but the transgender woman was only allowed to shower in groups, where she felt extremely unsafe. When my colleague called the facility to advocate for the transgender woman, he asked what the justification was for the difference in their treatment. The prison official responded that their policy was to prevent pregnancy. In other words, he was aware that both of these people were highly likely to be raped if forced to shower in a group with non-trans non-intersex men, but he was fine with rape so long as no pregnancies could result.").

207. See, e.g., Denise Lavoie, *Michelle Kosilek, Transgender Murder Convict, Granted Gender Reassignment Surgery*, HUFFINGTON POST (Sept. 4, 2012, 6:23 PM), http://www.huffingtonpost.com/2012/09/04/michelle-kosilek-transgender-murder-convict-surgery-approved_n_1855192.html.

208. See Arkles, *supra* note 196, at 3–5; Winter, *supra* note 124 ("I think that to me 'life chances' is a phrase that captures the many, many vectors of harm and well-being that are being distributed in ways that I'm concerned about.").

209. See ROBERTS, *supra* note 53, at 250–51, 253.

racism's hold."²¹⁰ Indeed, choosing fertility preservation as a locus for policy advocacy risks preserving the existing race and class disparities that Roberts described, given the number of transgender people, particularly those of color, who have no health insurance. In this time of rapidly shifting healthcare policy and reproductive health policy, every starting point may be inadequate in some respects.

However, the moment is now for the LGBT movement and the reproductive justice movement to share leadership on advocating for policy supports for fertility preservation for transgender people. While significant injustices and disparities remain, American society is increasingly more hospitable to transgender people, providing an environment in which more people can "come out" about their gender identity and transition—and many are doing so at younger ages, when they have many child-bearing years fully before them. Young people should not have to make decisions about treatment for gender dysphoria in the absence of affordable and accessible fertility preservation options. Just like people who decide to have an abortion because they cannot afford to have a child (despite existing desire for that child), young transgender people should not have to forego the prospect of future children in order to obtain certain hormone therapies and gender-confirming surgeries to alleviate their gender dysphoria.

CONCLUSION

With the advent of new visibility, organizing, and advocacy around social, economic, and health disparities facing transgender people, the reproductive justice movement has a unique opportunity to turn its lens on—and moreover, build alliances for change on—the oft-neglected reproductive health issues facing transgender people. These issues include the passive eugenics inherent in state statutes that require certain fertility-diminishing procedures in order to change the gender marker on their identity documents, and the lack of policy supports for transgender people to preserve their fertility before certain hormone therapies and gender-confirming surgeries. Any resistance from the reproductive justice movement to adopting these issues into their policy agenda based on a comparatively small number of people affected, or that these state statutes are of lesser priority because they lack the malice of compulsory sterilization requirements, is misguided. By acknowledging and centralizing the reproductive

210. See Dorothy Roberts, *Racial Disparity In Reproductive Technologies*, CHI. TRIB. (Jan. 29, 1998), available at http://articles.chicagotribune.com/1998-01-29/news/9801290086_1_fertility-clinic-white-women-black-children.

potential of transgender people in reproductive justice advocacy, the movement can better capture the full scope of human reproductive experience and create entry points for advocates in the LGBT movement and the reproductive health, rights, and justice movements to work together against a current, cultural moment where these movements are seen as separate. Moreover, shared leadership across movements on these reproductive health issues facing transgender people would greatly benefit the number of these people who experience, as Yeung describes, that “longing that feels deeply personal . . . the powerful desire for a child.”²¹¹

211. Yeung, *supra* note 142.