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Parenthood Intentions, Pathways to Parenthood, and Experiences in the Health Services of Trans People: an Exploratory Study in Portugal

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Abstract

Background It has been speculated for several years that trans identity and parenthood could be incompatible. However, studies investigating the parental intentions of trans individuals stress that they have motivations and parental intentions similar to cis people. Fertility preservation is a way for trans people to achieve parenthood; still, information about these procedures is not always provided, and implications on trans people well-being are not always discussed with health professionals.

Methods In this exploratory study, we looked at the parenthood intentions of 14 Portuguese trans and non-binary people and their experiences with health services. We conducted four focus groups and used thematic analysis to analyze the participants' speeches.

Results Half of the participants wanted to be parents, especially through adoption. Most of the remaining were undecided on the subject. Mixed experiences with the health services were reported, and only a few participants were informed by health providers about fertility preservation options.

Conclusions Trans individuals need to receive clear information about parenthood possibilities in order to make informed decisions about their future.

Keywords Trans · Parenthood intentions · Pathways to parenthood · Health service · Fertility preservation

Introduction

Parenthood among trans individuals remains a subject of debate, due to speculation that the trans identity and the process of gender reassignment may predict the absence of parenthood intentions in this community (Riggs, Power, & von Doussa, 2016). However, many studies emphasize that parenting is not necessarily an excluded area for trans individuals, even for those who undergo gender-affirming procedures (e.g., De Sutter, Kira, Verschoor, & Hotimsky, 2002; Riggs et al., 2016; Wierckx et al., 2012). De Sutter et al. (2002) found in their study, with 73 trans women from the Netherlands, Belgium, France, and the UK, that 40% of them would like to become mothers one day. Also, Wierckx, Van Caenegem, et al. (2012) found in Belgium a percentage of 54% trans men who wanted to become parents. The study of Riggs et al. (2016) with trans and gender diverse individuals from Australia showed that most participants looked forward to become parents. Taking into account the previous evidence, several medical and scientific societies pointed out that trans people have parenting desires similar to non-trans people (e.g., ASRM - American Society for Reproductive Medicine, 2015). Even so, studies focusing on parenthood expectations in the trans population are still scarce (Auer et al., 2018; De Sutter et al., 2002; Riggs et al., 2016; Wierckx, Van Caenegem, et al., 2012), and little is known about how health services are facilitating or hindering the parenthood projects of these individuals (James-Abra et al., 2015).

For several years, trans people in Portugal, where the present study was conducted, did not have legal protection of their rights. Only in 2011 was the legality of the recognition of gender identity made official, and since then, the rights of trans individuals have gradually been taken into account. Current legislation includes the possibility of self-determination of gender identity and expression (Law No. 38/2018 of 7, 2018). These legislative changes were a necessary condition but still insufficient to guarantee access to

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health care and equal opportunities in life projects such as parenting.

Trans people are the most discriminated group within the lesbian, gay, bisexual, and trans (LGBT) community (European Union, 2019; Nogueira et al., 2010), including within health services (ILGA Portugal, 2017; Pinto & Moleiro, 2012). However, there is still a lack of knowledge about what resources and practices are available in the National Health System for trans people in Portugal (ILGA Portugal, 2016).

As far as the parenting rights of trans people are concerned, there is a legislative gap regarding the access to assisted reproduction techniques (ART) by trans people (Law No. 6/2016 of 29, 2016). Furthermore, while there is no effective ban on adoption by these individuals, the protection of this right is not legally enforced either. All these impediments make parenthood a daunting project for trans individuals in Portugal.

Pathways and Barriers to Parenthood in Trans People

Parenthood pathways for trans individuals include sexual intercourse (when reproductive capacity is maintained), surrogacy, adoption/fostering, use of a sperm/oocyte donor, and also the conception of a child by the partner (Tornello & Bos, 2017; Wierckx et al., 2012). Looking at the parenthood intentions of 32 trans individuals from EUA, Tornello and Bos (2017) found that adoption was the preferred option to achieve parenthood (31.3%), followed immediately by sexual intercourse (25%). Participants who wanted to become parents through sexual intercourse or artificial insemination justified it based on the desire to have biological offspring; those who wanted to adopt or foster a child wanted to provide children in need with a warm home (Tornello & Bos, 2017). Interestingly, these motivations are not very different of those expressed by the cisgender population (e.g., Guedes, Carvalho, Pires, & Canavarro, 2011).

However, there are several barriers to the parenthood intentions of trans individuals. Anticipating discrimination, especially when directed at future children, is one of these barriers (Downing, 2012). A second obstacle concerns legal impediments. For instance, many European countries have restrictive laws concerning ART, preventing the access of trans individuals (Hangan, Badiu, Vladareanu, & Tampa, 2016). Thirdly, the weight of economic issues must be also stressed. In Tornello and Bos' study (Tornello & Bos, 2017), participants reported that the most affordable method was sexual intercourse; however, this is an option that many trans people cannot access due to the suffering induced by the use of sexual/reproductive organs associated to a gender which they do not identify and/or to the poor performance of the reproductive system. In fact, an important barrier is the loss of reproductive capacity. Gender-affirming interventions create limitations on the performance of the reproductive system, which impairs the attainment of parenthood via penile–vaginal intercourse (Tornello & Bos, 2017; Wierckx, Stuyver, et al., 2012). In Tornello and Bos' (2017) study, infertility was pointed out by 16% of participants as an important condition for the choice of having or not having children.

Fertility Preservation for Trans Individuals

The encouragement of fertility preservation prior to gender-affirming procedures is a practice advised by the Endocrine Society and the World Professional Association for Transgender Health (WPATH) (De Sutter, 2001). A large percentage of the 121 trans women studied by De Sutter et al. (2002) argued that health professionals should address the option of preserving sperm prior to the gender-affirming treatments. Furthermore, many individuals who did not preserve their fertility regretted the impossibility of generating children by biological means (De Sutter et al., 2002).

Fertility preservation procedures have different requirements for trans men and trans women. Although sperm harvesting seems to be a simple process, several trans women admitted that it would be difficult for them to masturbate in a hospital lab (Wierckx, Stuyver, et al., 2012). De Sutter et al. (2002) concluded that one third of their sample of trans women associated sperm preservation with an inability to close their past. Even so, the need for ejaculation to preserve fertility in trans women may not have emotional consequences as painful as menstruation for trans men, possibly due to cultural values that value ejaculation and consider menstruation as taboo (Mitu, 2016). Preserving the reproductive potential of trans men is a challenging process due to the complexity involved in collecting oocytes, and the effectiveness of this technique is still uncertain (Mitu, 2016). Many trans men consider pregnancy undesirable, prioritizing long-sought gender-affirming procedures (Tornello & Bos, 2017; Wierckx, Stuyver, et al., 2012). Furthermore, pregnancy may be seen as incongruent with a male gender identity (Ellis, Wojnar, & Pettinato, 2014). For this reason, it is important that health providers are aware of the emotional difficulties this process entails and understand that trans people may need time to feel emotionally prepared to begin this procedure (Payne & Erbenius, 2018).

Experiences of Trans Individuals with the Health Services

Experiences of trans individuals with health providers have been documented by some studies. Specifically regarding fertility preservation issues, a large part of these studies suggest that trans people are not being properly informed about the preservation of fertility by health professionals, preventing them from making informed decisions about parenthood

(Auer et al., 2018; Kim, Segev, Fung, Jarvi, & Millar, 2017; Riggs & Bartholomaeus, 2019). An investigation by Light, Obedin-Maliver, Sevelius, and Kerns (2014), focusing on the experiences of trans men who had become pregnant after going through gender-affirming procedures, concluded that participants wish they had been better informed of fertility preservation options. Chen, Simons, Johnson, Lockart, and Finlayson (2017) indicated a percentage of only 12.4% formal fertility discussions reported by a sample of trans adolescents. Wakefield, Boguszewski, Cheney, and Taylor (2018) reported a more favorable scenario, showing that 75% of trans adolescents had discussed this with health professionals prior to gender-affirming procedures. An Australian qualitative study by Bartholomaeus and Riggs (2019) found that while over half of the participants in their sample of 295 Australian trans and non-binary people had been provided with very little information by health professionals about fertility preservation, others, on the contrary, felt pressured by them to preserve fertility, even if that was not their wish. This contrast between the data makes it possible to raise the reflection that biological parenting may not be as universal a goal as imagined. For this reason, health professionals must be aware of the specifics of each individual's life projects, considering that they can change over time, and should not impose a pronatalist norm (Bartholomaeus & Riggs, 2019).

Regarding trans people's general experiences with health services, James-Abra et al. (2015) concluded that only two couples in their sample of 66 trans individuals and their partners reported pleasant contact with Canadian ART professionals. The remaining experiences included professionals' refusal to offer treatments, slow bureaucratic processes, and the use of cis terminology. Coleman et al. (2011) also reported a lack of care in the use of gender pronouns, poorer care, and demonstrations of discomfort by some health professionals. Payne and Erbenius (2018) found a slow normalization of the reproductive rights of the trans population in the context of hospital practices in Sweden. In Portugal, Pinto and Moleiro (2012) warned for the existence of some practices of health professionals with trans people who do not comply with the Standards of Care proposed by WPATH. However, studies on the experiences of trans people with health services are still very scarce in this country. It is necessary to close this gap in order to understand how trans people are being supported by health professionals and what needs to be done in this direction in Portugal.

Research Aims

This exploratory study was part of a wider research project aimed at exploring the contextual and psychological determinants of parenthood projects of lesbian, gay, bisexual, and trans and/or non-binary people. In the present study, we aimed to understand the parenthood plans of trans and non-binary people and to explore their experiences with health providers. The following research questions were raised: What are the parenthood intentions of trans and non-binary people? What methods are these people privileged to use to achieve parenthood? How do they describe their experiences with health professionals, namely regarding the provided information about fertility loss and preservation?

Method

Participants

The sample consisted of 14 participants distributed among four focus groups, with a global mean age of 28.57 (SD = 8.16), ranging from 19 to 43 years. The first group had a mean age of 31.4 years old (SD = 6.8), the second 31.3 years old (SD = 7.5), the third 21.8 years old (SD = 2.5), and finally, the fourth 31 years old (SD = 16.97). Twelve participants had Portuguese nationality, and the remaining had a different nationality. In terms of ethnicity, the majority of the participants identified as European/White/Caucasian, except for one participant. As for educational level, one participant completed elementary school (4 years), four left school after the 9th grade, and five completed secondary education (12 years). Three participants completed or were completing university degrees. Concerning work status, four participants were unemployed, four were students, four were working full time, and one was working part time. Of the total number of participants, seven reported they were trans men, six trans women, and one non-binary (no categories were imposed). Three had already received gender-affirming hormonal and surgical treatments; seven had only undergone hormonal treatment; and the remaining four did not undergo any gender-affirming medical procedure. Heterosexual sexual orientation was predominant ($n = 7$); of the remaining participants, two defined themselves as homosexual, one as lesbian, three as bisexual, and, finally, one person described their sexual orientation as both bisexual and queer.

Procedure

Participants were recruited through two non-governmental organizations that promote equality and inclusion of LGBTI (lesbian, gay, bisexual, trans, and intersex) persons and through a sexology department of a public hospital in Portugal. A leaflet with information about the study, including the main topics to be addressed, was distributed to potential participants by the staff of the three services. The second author also advertised the study in a support group for trans people held in one of the services.

Inclusion criteria were being transgender or non-binary, being over 18 years old, and not having children.

Individuals demonstrated their interest to participate by contacting the services that agreed to collaborate or the authors. Given that we employed convenience sampling techniques, a response rate or the reasons for nonresponse cannot be calculated (Jager, Putnick, & Bornstein, 2017).

Focus group is a very useful and versatile research method, especially in exploratory studies on sensitive topics such as the current one. It has the potential to produce a synergism and a secure setting that makes it more likely to stimulate the reflection and discussion of shared concerns and believes, without pressuring each participant to respond to every topic (Basch, 1987). In the present study, the choice of focus group allowed for the participants to share and compare experiences, opinions, and doubts regarding parenthood plans and the experience with health services. The focus groups were held between November of 2018 and February of 2019, with a duration between 40 min and 2 h; three took place in facilities provided by the collaborating services, and one was conducted in the home institution of the research team. The second author conducted all the focus groups, assisted by one of the two other authors or a research assistant.

All participants were grouped together in focus groups, regardless of their gender identity. At the beginning of each focus group, participants were informed again about the aims of the study and how the discussion would proceed. Interviewers emphasized that different views were valued and that shared information should be kept confidential within the focus group (Breen, 2006). Participants were told that they could leave the interview at any point if they chose to do so (one of the focus group interviewers was prepared to individually debrief a participant in case this happened). Participants were also informed that dropping out from participation would not influence in any way the provision of services by the institutions where the recruitment was made. Anonymity was guaranteed, and participants were asked to choose a fictitious name and give their preferred pronouns. These names are used in the presentation of results (together with the focus group's group number and participant's gender identity and age) to identify the reports. Permission to record the interview for later transcription was also requested. All individuals signed an informed consent form before the data collection took place, formally agreeing to participate in this investigation. All participants gave their informed consent and none withdrew from the study either during an interview session or subsequently. There was no financial compensation for participating.

Two instruments were used in this research. At the beginning of each focus group, participants filled in a short demographic questionnaire that yielded the sample details given above. A semi-structured interview script was also used, covering various topics of discussion: parenthood intentions of the participants, ways considered to achieve it, and experiences in the health system, in particular regarding gender-affirming treatments and preservation of fertility. The study received ethics approval from the Ethics Committee (EC) of the hosting institution.

Data Analysis

After each moment of data collection, recordings were transcribed verbatim in Portuguese by the first author, and each transcription was carefully read. Any information that could identify participants in any way was removed from the transcripts. Then, the transcripts were loaded into the NVivo data analysis software (version 12 PRO). The information processing technique used in this research was thematic analysis (Bardin, 2011; Braun & Clarke, 2006, 2013), a widely used method for identifying and reporting patterns and themes within textual data. We followed Braun and Clarke's (2006, 2013) six-step process for conducting thematic analysis. During the first phase, the first author became familiar with the data by reading each transcript twice. On the second reading, initial ideas for coding were written in the margins, and then initial codes were generated in a second phase using the NVivo data analysis software. The first author systematically coded each unit of meaning across the entire data set and collated data relevant to each code. Phase three entailed sorting the codes into potential themes, while phase four consisted of reviewing and refining the devised set of initial themes by checking whether the data cohered together meaningfully within each theme. In phase five, the specifics of each theme were decided upon, and the overall story of the data emerged. In the sixth and final phase, the report was written, and compelling excerpts from participants were selected to illustrate each theme.

Credibility checks used were two qualitative analysts and two additional auditors for a verification step. Specifically, inspired in the consensual qualitative research paradigm (Hill, 2012; Hill, Thompson, & Williams, 1997), a masters' student worked together with the first author during all the phases of the thematic analysis, and the second and the third authors played the important role of auditors, reviewing the data in order to affirm and to expand on the primary team's findings (Hill, 2012). This was a dynamic process, and a progressive regrouping of categories was carried out through discussions first between the first author and a masters' student and then by three authors of this article and the masters' student, in order to guarantee the mutual exclusivity between each theme and subtheme, the validity, exhaustiveness, and homogeneity of each of them (Bardin, 2011; Braun & Clarke, 2006, 2013). The three main categories resulted from the objectives of the study, while the subcategories emerged inductively from the data found. These themes are discussed further in the following section.

Results

Thematic analysis of interview data yielded three major themes across all four focus group discussions: "Parenthood intentions", "Pathways to parenthood", and "Healthcare experiences".

Parenthood Intentions

This theme reflected the prospective intentions of participants regarding parenthood and their arguments for such intentions. It encompassed subcategories "Positive Parenthood Intentions", "Undefined Parenthood Intentions", and "Negative Parenthood Intention", reflecting a sustained continuum in the participants' aspirations.

Positive Intentions

The explicit desire to become a parent was mentioned by half of the participants and was similarly distributed across all focus groups. Four main motivations for having children were given: family offspring/continuity, personal achievement, the agreeableness of the gestation process, and children as a source of emotional support.

"Offspring" and the possibility of continuing the family line emerged as one of the reasons given for parenting. Two participants verbalized, "*I want to have a piece of me,* […] *someone that is my legacy* […]" (Miguel, FG2, FtM, 31) and "[…] *it is to know that the story goes on with the next generation* […]" (Joaquim, FG2, FtM, 24). A second motivation refers to "Personal achievement" and included a set of assumptions related to (i) the accomplishment of a life project—"*And after you can have that complement in your life, it seems that everything fits in*" (Sílvia, FG1, MtF, 33), (ii) sharing personal interests with the future child—"[…] *I also really like the idea of being able to share this with my child later, not only my interests, but also try to see what his/her interests are*" (Joaquim, FG2, FtM, 24), and (iii) caring for a child—"*The possibility of having a child [...] it is merely associated with one thing: your desire to have a child, your desire to take care of someone* […]" (Silvia, FG1, MtF, 33). Even though other motivations emerged, the family offspring/continuity and personal achievement were the most common motives addressed by participants. The "agreeableness of the gestation process" were related to a positive appreciation of the physiological changes associated to a pregnancy. This motivation was addressed only by one participant—"*I think it's fascinating to feel a human being growing inside of us*" (Yara, FG1, MtF, 31). Finally, "Children as a source of emotional support" was related to how participants saw the future role of children in their lives, identifying them as facilitators of positive emotions and greater psycho-emotional stability: "*(S)he is going to help me clear my head whenever I am more psychologically and emotionally disturbed* […]" (Yara, FG1, MtF, 31).

Undefined Intentions

A considerable number of participants were uncertain about their parenthood intentions. Although they did not integrate parenting into their current life projects, they left the option open for the future: "*I do not plan either, it is an open thing* […]" (John, FG3, FtM, 25). Many of them said that their current indecision about future parenthood could be changed or resolved, depending on various factors, such as age, lack of preparation to have children, partners' perspectives, and the current prioritization of the gender-affirming procedures.

Some participants said they had no current intention to become parents due to their age. Even those who highlighted parenthood as a valued area at present reflected that their young age still did not allow them to have the necessary conditions to fulfill the responsibilities it entails, "*I'm not even 20, I think I am a little too young to think about having a family. I have no conditions or maturity for such a thing*" (Toothless, FG4, FtM, 19). The quotes in this subtheme mirror the speeches of participants who were between 19 and 25 years old. For participants in this age range, other categories emerged; participants pointed out that the lack of preparation for having children weakened their intent to parent. One participant said, "[…] *I see parenting as a responsibility that lasts for all of our lives* […], *it has to be something that has to be given a lot of consideration before taking a step like this*" (Roxanne, FG3, MtF, 21). Economic conditions played an important role in the participants' indecision regarding future parenthood. Many mentioned that they were experiencing periods of great economic and professional instability and, therefore, were unable to raise a child. The costs of gender-affirming procedures together with the costs of raising a child were also mentioned. Lastly, emotional instability was also pointed as a factor that contributes for this indecision.

Some participants noted that even if they did not currently intend to become parents, this position could be revised if the partner intended to have children, "[…] *but if in the future I'm with someone who wants to have children, I can reconsider*" (Noah, FG3, FtM, 22). On the contrary, other participants expressed concern that their partner could assume a will that would be incompatible with their own, and therefore would be unable to reach a consensus. Finally, several individuals mentioned that the gender-affirming procedures were a priority over their parenting projects—"*The transition is necessary to be well* [...] *and if this is affected, I will not be able to give the child what I have to give, because I'm not making the transition*" (Lili, FG1, MtF, 32).

Negative Intentions

Only one participant, who was non-binary, firmly assumed that they did not want to become a parent in the future, underlying that parenthood was not an important area in their life. One justification was related to the absence of viable

economic conditions for parenting and its associated costs—"[…] *I have a very unstable life in financial terms, I do not have a stable job* […]" (William, FG2, NB, 39). Another reason was related to their sexual orientation. They pointed out that the option of having biological children with their partner was discarded because they have the same sex, which led to their disregarding other possibilities of becoming a parent.

Pathways to Parenthood

Participants highlighted four ways to achieve parenthood: adoption, artificial insemination, surrogacy, and rejection of sexual intercourse as a reproduction method. Adoption was the subtheme with the highest representativeness among the four mentioned parenthood ways. Those who reported that they did not wish to have children assumed that if this intention arose in the future, they would choose adoption. Among the reasons for choosing this method, participants indicated the presence of positive examples of adoption cases in the family and their own personal history: "*Why not be somebody's non-biological father? It wasn't important to me, it will not be important to the child*" (Miguel, FG2, FtM, 31). Another reason relates to an altruistic motivation associated with the possibility of providing a home for a child without a family. Artificial insemination was addressed by four participants. However, this was seen as a difficult way of accessing parenthood—"*This is something we are thinking about and it will be by artificial insemination, which here in Portugal is a very complicated thing*" (Miguel, FG2, FtM, 31). Surrogacy emerged only in the discourse of three participants. One participant expressed his moral indecision about the possible achievement of the surrogacy gestation—"[…] *if I found a surrogate, but this I philosophically, morally, I do not know yet if I agree with these ideas very much for myself*" (Joaquim, FG2, FtM, 24).

All quotes about this issue disregarded sexual intercourse as a means to achieve parenthood. Several participants highlighted that parenting is a complex phenomenon that transcends biology. It was assumed that the central focus of being a parent is centered on the care and affection for the child—"[…] *for me the word father is much more than being biological. I think this biological part is what makes less sense*" (Miguel, FG2, FtM, 31). Among the arguments used, some participants highlighted the influence of their gender identity as inhibitors of their intention to become parents through sexual intercourse. Sexual orientation was also a factor considered by one of the participants, noting that because they are lesbians, penile-vaginal intercourse was immediately excluded as an option. Another reason was the problematic relationship between gender identity and pregnancy—"*Everything, the growing belly, having the child growing up, then the whole process of childbirth* […] *it is something that causes me a certain disgust* […]" (Toothless, FG4, FtM, 19).

Experiences with the Health Services

The subthemes included in this theme referred to two types of experiences within health services, one regarding gender-affirming interventions and the other fertility aspects.

Gender-Affirming Interventions

One negative aspect unanimously highlighted about the gender-affirming procedures was the slowness of medical procedures. Participants criticized the need for a wide range of exams and a small number of professionals available in the field, which inevitably delays the gender-affirming process. Two participants stressed that health professionals were not prepared to respond to the needs of trans people—"*I had to do an x-ray on this part here. I had to take off my bra* [...] *the technician told me to take everything off* [...] *And I said I could not take everything off because I needed a robe and I had to explain to her that I have breasts.* […] *Training is also one of the problems*" (Daniel, FG3, FtM, 19). Another negative point highlighted by participants was the use of pronouns based on the sex assigned at birth. However, one participant talked about his positive experience regarding this aspect—"[…] *they asked if I wanted to be called by my birth name or* [currently chosen name]*, and when they saw my indecision and confusion, they said,* '*then I'll call by your arrival number, do not worry*'." (Toothless, FG4, FtM, 19). A minority reported a number of situations in which ethical standards have not been complied with, such as refusing to perform gender-affirming surgery due to moral and religious values or assessing an individuals' gender identity according to the tasks he/she performed at home. Despite the pointed-out shortcomings, five participants emphasized that, in general, the experience with the Portuguese national health service had been positive, reporting that they have never felt any kind of discrimination.

Only one of the participants carried out hormonal and surgical procedures for sexual reassignment outside Portugal, in two different countries. The experience was predominantly negative in these countries, marked by disrespectful behavior by health professionals, slow gender-affirming medical procedures, intentional postponement of surgical procedures, carelessness about the individual's needs, poorer care, and biased speech based on gender binary. But the participant had no negative comments to make about the Portuguese national health service.

Fertility

This subtheme related to (1) the information participants received from health professionals regarding fertility loss or fertility preservation, (2) timing and approaches in

transmitting this information, and (3) weighing and/or carrying out fertility preservation.

Information Provided on Fertility Loss and Fertility Preservation The six participants who spoke about the issue of *fertility loss* were informed, prior to the gender-affirming procedures, of the risks related to deprivation of reproductive capacity following surgical and hormonal reassignment procedures. Some of these reported that this clarification was made at the beginning of the hormonal treatments and only one stressed that he was informed only prior to the hysterectomy. Younger participants reported that this information was provided to them and reinforced on multiple occasions—"*When I had an appointment with the Doctor [name omitted], she spoke of this question of whether hormone therapy would make me infertile* […]. *When I went to the endocrinologist for the first time, she explained it all to me, stressed that I was going to be infertile*" (Roxanne, FG3, MtF, 21). On the contrary, older participants received this information only once, in the context of the endocrinology or psychology consultation. In this consultation, the gender-affirming medical procedures and their future implications were explained. Two participants reported having conducted complementary research prior to the hormonal and surgical process in order to be informed about its implications.

This subtheme also included the participants' experiences with the information received regarding the *preservation of fertility*. Of the ten participants who shared their experience on this topic, four were questioned by health professionals about their intention to preserve fertility. Five participants pointed out that they were not informed of this possibility, but were informed about the risk of fertility loss. Among these, a participant highlighted, "[…] *I think that if one does not ask the question* […]*, the medical entities do not tell us*" (Silvia, FG3, MtF, 33). Finally, one participant pointed out that he received this information outside health services, prior to the gender-affirming procedures, given his intention to donate his eggs.

Two participants who were questioned about their intention to preserve fertility and who immediately refused this option did not obtain additional information about the ways in which they could reach it and the places indicated for it. Another participant was informed of this possibility during the hormonal treatments, but he was also informed after some medical examinations that it was impossible to preserve his reproductive potential, as his ovaries would not be in a good condition. Finally, a fourth participant whose gender-affirming surgical procedures were performed in a foreign country was informed prior to the surgery and clarified about the method in which preservation would be performed. Participants who received no information about fertility preservation before/during the sexual reassignment procedures tended to be older. Again, younger participants were more often informed about options for coping with future fertility loss.

Timing and Approaches for Transmitting Information on Fertility Preservation Most participants considered that the ideal timing to talk about fertility preservation should depend on the professional's assessment of the emotional state of the patient—"*Professionals have to be sensitive and understand how the person is, before approaching a specific subject*" (Silvia, FG1, MtF, 33). Many participants (especially the younger ones) reported that the problem with the information provided on fertility loss and preservation lied more in its excess than in its scarcity. They suggested that this may have happened because biological reproduction is overvalued, and it is not taken into account that there may be other priorities such as gender transition—"*This is not a really important issue when compared to the size of all the other things*" (Roxanne, FG3, MtF, 21). Furthermore, participants warned that fertility loss is a sensitive issue that can affect the emotional state of trans people, contributing to an accentuation of the feeling of inadequacy between biological sex and self-identified gender. However, many participants recognized that other trans people may want to become biological parents, and therefore, it is necessary to inform this population about the risks of loss of fertility and the possibilities of preserving it before gender-affirming procedures take place. Some individuals argued that detailed information about the existence of this possibility should only be given when a clear interest in doing so is expressed—"[…] *say things simply, if the person is curious, she will find out more*" (Toothless, FG4, FtM, 19). Others recommended that this subject may or may not be further explored later in therapy, depending on whether or not parenthood is a priority in the life of the person. One participant suggested introducing this theme in the context of psychoeducational consultations on hormonal and surgical procedures—"[…] *talking only to you about your surgeries, what do you want to do, what do you feel, prioritize your things, talk of the risks*" (Miguel, FG2, FtM, 31).

Weighing and/or Carrying out Fertility Preservation Only one participant performed any kind of fertility preservation procedure, and this was done in a foreign country. In most cases, fertility preservation turned out to be an undervalued option because, as previously mentioned, most participants did not value biological parenting. The existence of other avenues for having children was highlighted as a reason why they would not have chosen to preserve fertility. Moreover, for our participants, preserving the reproductive potential was a lower priority when compared to starting the gender-affirming procedures—"*I also think that the most important thing was to start my transition, start as soon as possible for the dysphoria to calm down*" (Miguel, FG2, FtM, 31). Only one participant pointed out that he had not considered the possibility of cryopreserving its fertility, but stated that he left the option open for the future.

Discussion

To our knowledge, this is the first study conducted in Portugal that aims to understand the parenthood intentions of trans people and their experiences in the health system. At an international level, it is also a recent field of research, as it has often been assumed that trans people do not want to have children (Mitu, 2016).

The first research question sought to understand the parenthood intentions of trans and non-binary persons. Half of the participants wanted to be parents in the future, which is in accordance with previous research conducted in other countries that points to a significant percentage of trans people wanting to parent a child (De Sutter et al., 2002; Riggs et al., 2016; Wierckx, Van Caenegem, et al., 2012). Participants justified their desire mostly based on the personal fulfillment that parenthood would bring them and the satisfaction with the possibility of ensuring family continuity. In the Tornello and Bos (2017) study, this last motivation arose as an intention of biological connection with future children. In our study, however, participants mentioned mostly the transmission of their interests, values, and knowledge to the offspring. This motivation was also found in a study conducted by Guedes et al. (2011) with a Portuguese sample of cis individuals, pointing to a possible cultural effect in individuals' parenthood motivations, independently of their gender identity. Two other motivations for parenthood arose in two reports: the agreeableness of the gestation process and the perspective of seeing children as a source of emotional support. The first one was mentioned by a trans woman. We may speculate that this participant only highlighted this motivation at the level of fantasy, reinforcing her female gender identity. This is a speech that can be understood in the context of cultural representation that associates the gestational function to the female body (Moura & Araújo, 2004). Regarding the second motivation, various studies emphasized that seeing children as a source of emotional support is a strong motivation mentioned both by cisgender individuals, no matter their sexual orientation: lesbian and gay (Baiocco & Laghi, 2013; Bos, van Balen, & van den Boom, 2003; Goldberg, Downing, & Moyer, 2012; Leal, Gato, & Tasker, 2018; Siegenthaler & Bigner, 2000) and also heterosexual individuals (Miller, 1995; van Balen, & Trimbos-Kemper, 1995).

Several participants were in an undefined position regarding future parenthood plans. Stacey (2006) also noted in her study of gay men's parenting plans that their intentions could be placed along a continuum. Between the positive extreme and the negative extreme, there was an intermediate position, representing those whose parenthood intentions remained ambivalent and could be influenced by several factors (Stacey, 2006). In our study, some of the factors related to changes in life circumstances and the influence of the partners' parenting motivation. A study with a population of cis men considered this intermediate position as a postponement of parenting associated with the lack of conditions to be a parent at the moment (Sousa, n.d.). Studies about prospective parenting among lesbian and gay individuals also highlighted the influence of partner's parenthood intentions in one's own decisions to parent or not (Gato, Santos, & Fontaine, 2016; Goldberg, 2010; Goldberg et al., 2012; Mallon, 2004; Stacey, 2006). Furthermore, several participants mentioned that, at the moment, their priority was to make the gender-affirming procedures and only then they would think about parenthood. Wierckx, Stuyver, et al. (2012) highlighted that many trans women end up postponing or setting aside their fertility concerns, motivated by the desire to make the hormonal and sexual reassignment procedures as soon as possible. This dilemma between prioritizing parenthood or the gender-affirming procedures is specific of trans people and is therefore an added challenge to the many that have been addressed in the literature with regard to trans parenthood (Tornello & Bos, 2017; Wierckx, Stuyver, et al., 2012). An interesting result regarding parenthood intentions is that the vast majority of the motivations supporting positive, undefined, and negative parenthood intentions are quite similar to those enunciated by cisgender persons (Guedes et al., 2011). The only argument that is specific to trans people is the prioritization of gender-affirming procedures, as only trans people are faced with the dilemma between choosing to prioritize gender-affirming procedures or preserving fertility.

The second research question related to the pathways that our participants favored to achieve parenthood. Adoption was the most chosen method, motivated by altruistic reasons, similarly to what Tornello and Bos (2017) observed. Sexual intercourse was totally disregarded by our participants. These data differ from those found by Tornello and Bos (2017), which showed that one in four trans individuals were interested in achieving parenting through sexual intercourse. In fact, the biological connection with the child was a more valued aspect in Tornello and Bos' study (Tornello & Bos, 2017) than in the present one. One of the arguments used to dismiss this biological connection was the aversion to the biological process of pregnancy. As previously mentioned, this obstacle is related to the way in which body changes during pregnancy can further impact the feeling of inadequacy between the gender and the anatomic sex (Mitu, 2016), posing the emotional challenge to dealing with the antagonism between male gender identity and femininity conventionally associated with pregnancy (Ellis et al., 2014). Although they were addressed by fewer participants, artificial insemination and surrogacy were also methods contemplated to achieve parenthood. In Portugal, publicly funded artificial insemination requires that its beneficiaries are married, of different sexes, or both female, or are single women (Decree-Law No. 58/2017 of 2, 2017). Therefore, this path may not be available to transgender men who have a homosexual sexual orientation. The legislation, in

its current format, requires trans men to remain registered as female even after the gender-affirming procedures, in order to take advantage of this possibility (Decree-Law No. 58/2017 of 2, 2017). With regard to surrogacy, Law No. 6/2017 of 31, 2017 states that surrogacy in Portugal can only be granted to persons who are in a situation of absence/injury/uterine disease that prevents the woman's pregnancy, or in clinical situations that justify it, which brings some uncertainty as to the possibility of integrating trans persons in any of these conditions. However, recently, the Constitutional Court recently declared as unconstitutional two regulations of the decree that amends the law on medically assisted procreation (Judgment of the Constitutional Court no. 465/2019), rendering surrogacy illegal in Portugal, in all its forms.

We also tried to explore participants' experiences during their gender-affirming process in the health context. The slowness of procedures, the lack of training of professionals to work with trans people, and the use of cis nomenclature and inappropriate pronouns were common aspects to the negative experiences pointed out by them. James-Abra et al. (2015) also point to these limitations, highlighting that some health professionals are not adequately trained to interact with trans people. According to Payne and Erbenius (2018) and James-Abra et al. (2015), the trans-affirmative practices, like using neutral terminology or asking patients about the names they would like to be treated, will only be achieved through the training of health professionals. Other participants denoted that they never felt discriminated by health professionals, having received quality care. This seems to show a positive trend in trans-affirmative practices. Another possible explanation is that this result may be a reflection of a positive bias due to an involuntary self-selection of the sample of this study.

Finally, we further sought to understand what kind of information was provided to participants about the loss and preservation of fertility. All participants were informed about the reproductive consequences associated with the gender-affirming process in endocrinology and/or psychology consultations. This is in line with the literature, which stresses that this information is usually made available within the scope of a multidisciplinary team that includes gynecologists, andrologists, embryologists, and psychologists (Wakefield et al., 2018). However, only four participants were informed about fertility preservation, similarly to what was reported in the study by Bartholomaeus and Riggs (2019). This is a more significant percentage than the one found by Chen et al. (2017), being, but, lower than that of Wakefield et al. (2018). Although these possibilities may be available, often trans people are unaware of them because this information is not clearly provided (Auer et al., 2018; Condat et al., 2018; Kim et al., 2017; Riggs & Bartholomaeus, 2019). Mitu (2016) refers that the difficulty in accessing this type of information may come from the preconceived ideas by health professionals that trans people do not want children or are not suitable to have them.

In our sample, younger participants were more often informed by health professionals about the risks associated with gender-affirming procedures and about the possibility of preserving fertility than older participants. This data is in line with the study of Wakefield et al. (2018), in which around 28.8% of trans adolescents had more than one dialog on the topic of fertility in the clinical context. The similarity with the study of Wakefield et al. (2018) can be explained by the proximity of age groups between both studies. This result may suggest that currently in Portugal, there is a greater concern about reproductive rights of (younger) trans people. It may be speculated that the presence of more trans-affirmative laws (Law No. 19/2013 of 21, 2013; Law No. 38/2018 of 7, 2018) may be moving health services towards valuing of the parenthood rights of the trans individuals.

An interesting result of this study was related to the fact that some participants were not bothered by the lack of information provided by health professionals about fertility, but rather by its excess. This coincides with the speeches of some participants in the study by Bartholomaeus and Riggs (2019), who appreciated that health professionals talked to them about fertility preservation, but felt that this should not be a central point of their conversations. Payne and Erbenius (2018) also warned about the need for sensitivity by health professionals when exploring this topic with their patients, as emotional availability is required to reflect on these options.

Only one participant carried out fertility preservation, and he did it outside of Portugal. The remaining participants did not consider this option because they did not seem to favor biological parenthood, nor did they want to postpone the gender-affirming process (Wierckx, Van Caenegem, et al., 2012. In line with Wierckx, Stuyver, et al. (2012), this demonstrates a prioritization of the gender-affirming process over reproductive concerns.

Limitations, Directions for Future Research, and Implications

Some limitations of the current study should be taken into account. Two of them are related to sample characteristics: one is the existence of only one non-binary individual in the sample. This may be justified by the fact that part of the sample was recruited through institutions that accompany individuals in gender-affirming procedures, in which there is a greater influx of trans people. The other limitation related to the sample is that this is a qualitative study with a small sample of individuals who are already being supported in their transition; therefore, results are not generalizable to the Portuguese trans population. All these points should be taken into consideration in forthcoming investigations. Future studies should also seek to understand these topics with trans and non-binary people who are less protected, for example, residents in non-urban areas or even in cities in which there are no support services. This research provides relevant information for professionals who intervene with trans individuals. First, there is a considerable number of trans people

who wish to have children in the future, so it is necessary to discuss the reproductive implications of the gender-affirming process, the pathways to parenting, and the possibilities of preserving fertility. Second, the way this information is conveyed must be adapted to the specificities of each patient. Third, quality care for trans people requires that health professionals have specialized training focused on the medical and psychological needs of the trans population and adopt trans-affirmative practices (Payne & Erbenius, 2018). Based on the high levels of discrimination that trans people regularly encounter in health services, professional organizations have introduced a group of anti-discriminatory items into their ethical and political records, to guarantee quality of care (ASRM - American Society for Reproductive Medicine, 2015). Although this is an exploratory study, it is important to underline its pioneering character in Portugal and its contribution to a better understanding of the parenthood interests of trans people and the still-existing needs regarding their reproductive health rights and care.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval The study received ethics approval from the Ethics Committee (EC) of the hosting institution.

Informed Consent All individuals signed an informed consent form before the data collection took place, formally agreeing to participate in this investigation.

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