Chosen Family: Contraception for Transgender and Gender Diverse People

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October 29, 2024

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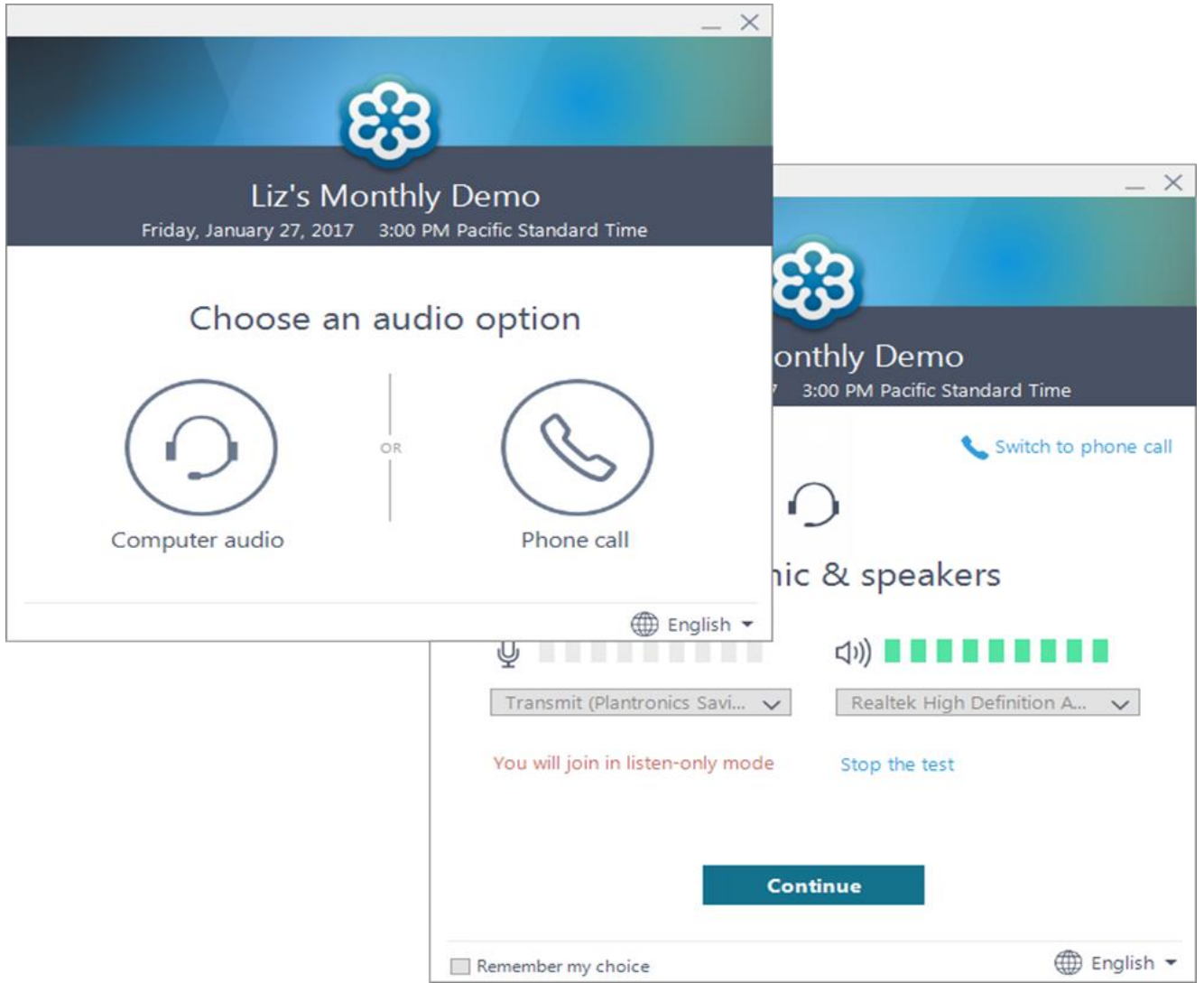

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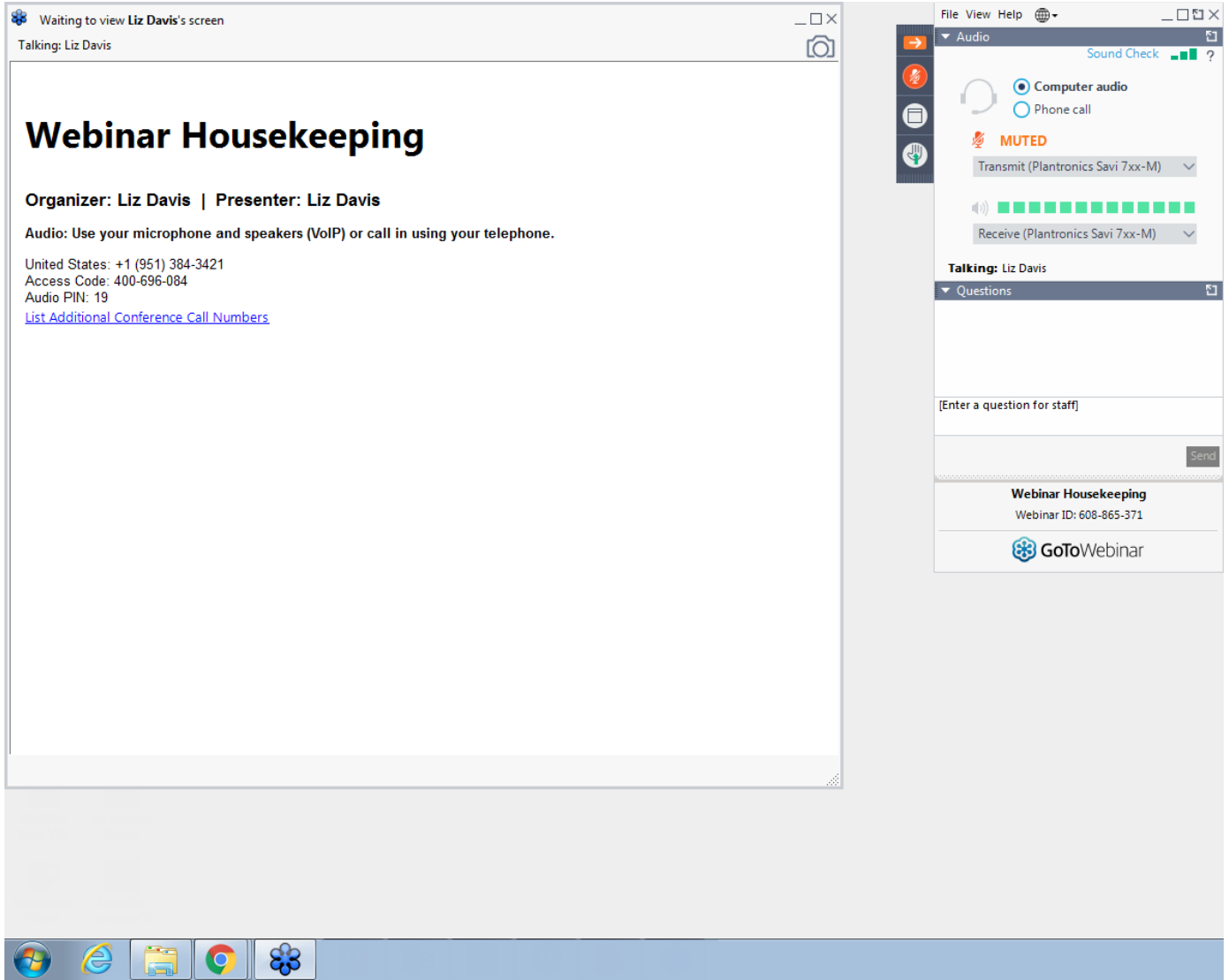

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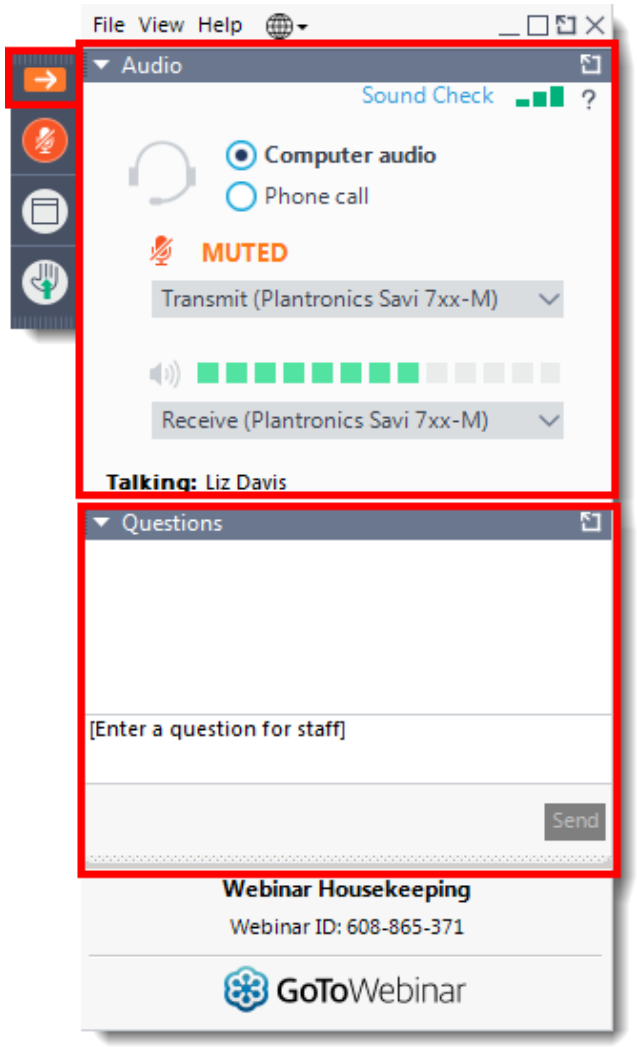

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Presenters

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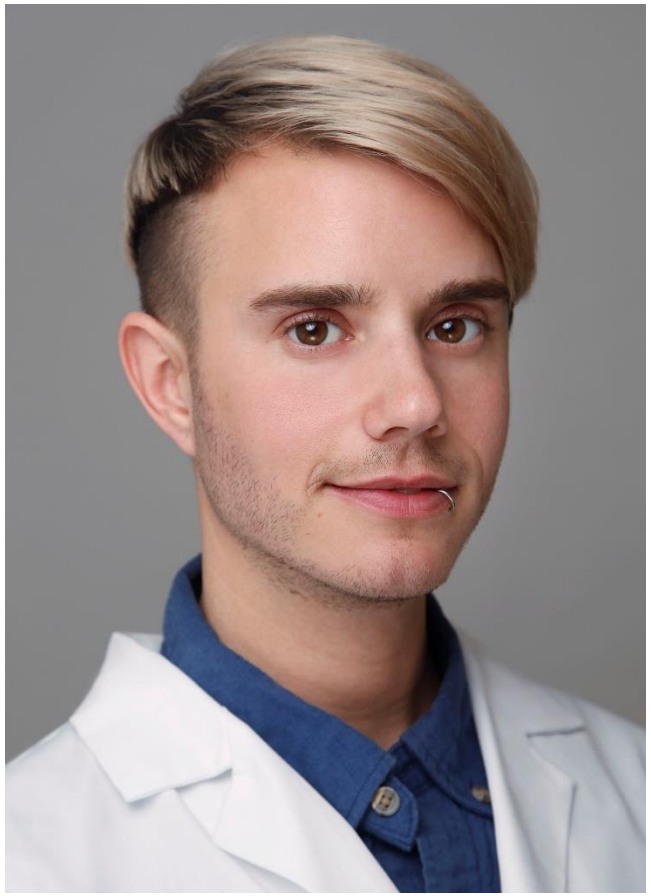
Associate Director of Medicine- Education at Callen Lorde Community Health Center in New York City.

Professor of Clinical Nursing at Columbia University School of Nursing, in the Certificate in Professional Achievement in TGNB Health Care Program.

Lead author of "Chapter 22: Contraception for Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Queer/Questioning, Intersex, and Asexual Individuals" in the 22nd Edition of Contraceptive Technology.



Presenters

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Trans and nonbinary-identified family nurse practitioner and the Director of Gender-Affirming Care for UC Davis Health.

Assistant Clinical Professor at the UC Davis Betty Irene Moore School of Nursing.

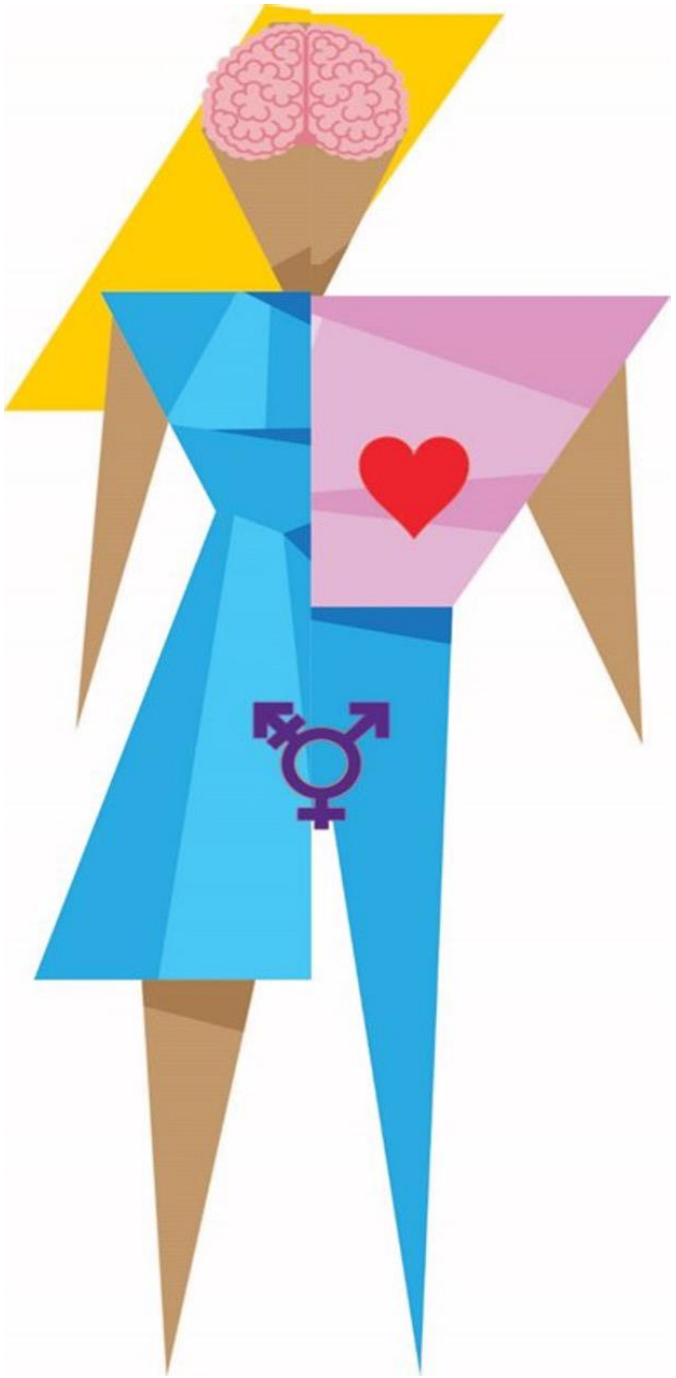
Published in The American Journal of Obstetrics and Gynecology and The Nurse Practitioner, as well as textbooks including Pharmacotherapeutics for Advanced Practice Nurse Prescribers and 22nd Edition of Contraceptive Technology.

Language and Terminology

- Contraceptive and family-building needs of lesbian, gay, bisexual, transgender, gender diverse, queer/questioning, intersex, and asexual (LGBTQIA) people are frequently overlooked by health care providers.
- Language for contraception and fertility counseling should be **AFFIRMING** and **ACCURATE**.

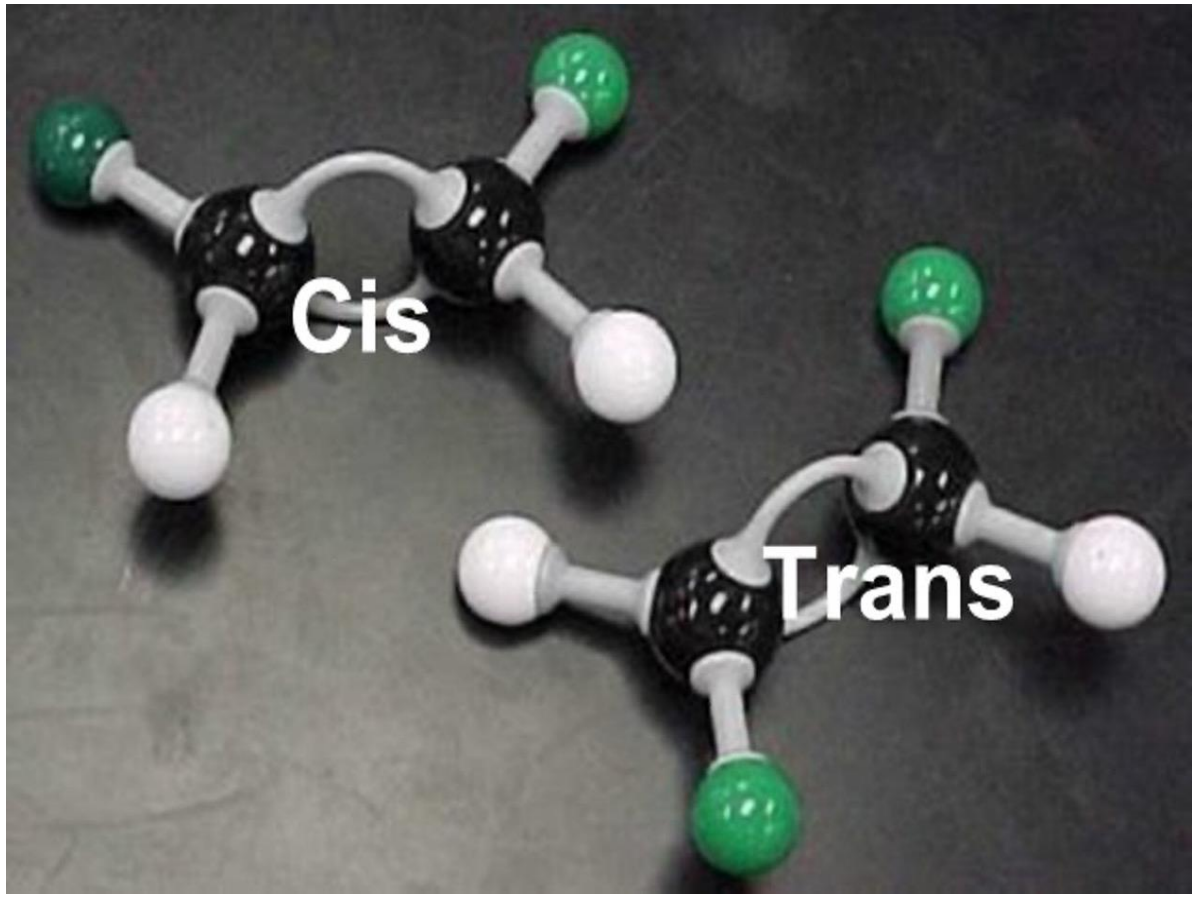
Key Concepts

- Sex assigned at birth
- Sexual orientation
- Gender expression
- Gender identity



Gender Identity

- Agender
- Genderqueer/gender-fluid
- Nonbinary
- Binary
  - Trans man
  - Trans woman
- "Gender diverse"



Why Transition?

- ICD-11: gender incongruence
- Types of transition

Less Gendered Language

Use (less gendered language) [1]	*Instead of (gendered language)*
People who menstruate, people who are pregnant	Female, women; pregnant women
People who produce sperm	Male, men
Not trans, non-trans, cisgender	Biologically male/female

- Suggested sexual history questions

(Krempasky et al, 2020)

Bodily Autonomy

We should be making connections in regard to the policing of bodies:

- Abortion bans / forced birth
- Anti-TGD legislation: bathroom access, sports, youth TGD healthcare bans (ex. Ohio - prohibit certain procedures to alter a minor child's sex and to designate this act as the Save Adolescents from Experimentation (SAFE) Act), conscience clause
- Marriage equality
- How people have sex

Contraception for TGD Individuals AFAB
Who needs contraception?

TGNB people *may*…

- Utilize testosterone as part of gender-affirming therapy
- Have a uterus and ovaries, and be capable of achieving pregnancy
- Engage in sexual activity which can result in pregnancy

(Krempasky et al, 2020)

Contraception for TGD Individuals AFAB
How does GAHT affect fertility?

- Use of GAHT does not guarantee infertility
- TGD AFAB people can still get pregnant, *even* if they are on testosterone and haven't had a recent period
- GAHT's long-term effects on fertility are unclear and may reduce future fertility or result in infertility
- All patients considering starting GAHT should be counseled about options for fertility preservation

(WPATH SOC 8; Krempasky et al, 2020)

Contraception for TGD Individuals AFAB
What methods are appropriate?

- No methods are contraindicated specifically due to TGNB identity or gender-affirming hormone use
- Comparative efficacy is the same as in use by cisgender women (LARCs > others)
- Various aspects (insertion, side effects) of contraceptive methods may uniquely affect TGNB AFAB patients

(Krempasky et al, 2020)

FIGURE 6

Overview of contraceptive methods with transmasculine-specific considerations[80,83]

	Invasive/pelvic procedure	Contains estrogen	Contains progesterone	Risk for spotting/bleeding	Reduces/ceases bleeding	Effect on cramping	Chest/breast tenderness	Privacy/ concealability	Requires frequent dosing [1]	Clinician needed to discontinue	Efficacy (perfect/typical)
Combined Oral Contraceptives	N	Y	Y	low	If continuous	↓	+ at start	moderate	N	N	99/91
Progesterone Only Contraceptive Pill	N	Y	Y	low	Y	↓		moderate	N	N	99/91
Patch	N	Y	Y	low	If continuous	↓	+ at start	moderate	Y	N	99/91
Ring	frontal insertion	Y	Y	low	If continuous	↓	+ at start	moderate	Y	N	99/91
Depot medroxyprogesterone acetate	N	N	Y	high	Y	↓	infrequent	very	Y	N	99/94
Implant	subdermal insertion	N	Y	high	Y	↓	possible	very	N	Y	99/99 [2]
Intrauterine Device (IUD): Copper	Y	N	N	low	Heavier bleeding	↑	N	very	N	Y	99/99
IUD: Progesterone	Y	N	Y	high	Y	↑ at insertion, then ↓	possible	very	N	Y	99/99
Sterilization	requires surgery	N	N	N	N	none	N	very	N	n/a	99/99
Diaphragm	frontal insertion	N	N	N	N	none	N	moderate	N	N	94/88
Condom: Internal	frontal insertion	N	N	N	N	none	N	low	n/a	N	95/79
Condom: External	N	N	N	N	N	none	N	low	n/a	N	98/82
Emergency Contraception (EC): Ulipristal acetate [3]	N	N	N	Y	N	↑, self-limiting	possible	one dose (prescription)	n/a	N	85/85 [4]
EC: Levonorgestrel	N	N	Y	Y	N	↑, self-limiting	possible	one dose (over the counter)	n/a	N	75-89 [5]

Superscript number 1 indicates the transmasculine individuals may find daily-, weekly-, or monthly-use contraceptive methods to be periodic reminders of anatomy or previous gender experience that is not aligned with their current identity. *Superscript number 2* indicates the copper intrauterine device is the most effective method of emergency contraception and can be used for up to 5 days after unprotected intercourse.[83] *Superscript number 3* indicates that because ulipristal acetate is a progesterone antagonist, it does not work as well for persons already using a progesterone-containing contraceptive (ie, if someone is taking emergency contraception after having missed combined hormonal contraceptives, levonorgestrel would be a better choice).[83] *Superscript number 4* indicates that ulipristal acetate EC reduces the risk of pregnancy up to 85% and works just as well on any day you take it up to 5 days after unprotected sex.[83] *Superscript number 5* indicates that levonorgestrel EC reduces the risk of pregnancy by 75-89% if you take it within the first 3 days after sex. It is less effective the more time that passes and may not work 4 or 5 days after sex.[83]

downward arrow, decreases *N*, no; *upward arrow*, increases; *Y*, yes.

Krempasky. Contraception for transmasculine persons. Am J Obstet Gynecol 2020.

Contraception for Lesbian, Gay, and Bisexual Cisgender Women

- Sexual orientation is not synonymous with sexual behavior
- A lesbian-identified cis woman may be at risk for pregnancy due to having transfeminine partners AMAB
- A lesbian-identified cis woman may also be at risk for pregnancy due to having cis male partners

Fertility Counseling for TGD individuals

- In one study, 31% of transmasculine persons, and 67% of transfeminine persons believed or were unsure if gender-affirming hormone therapy (GAHT) prevents pregnancy
- Retrospective case studies, usually from fertility clinics, have shown many individual cases of fertility resumption after discontinuation of GAHT
- Key term there “fertility clinics:” very little evidence for guidelines regarding optimal practices for non-assisted reproduction, even though ART is out of reach for many
- Review options even if they may not be feasible. It's important to counsel people with consciousness of what may be accessible to them and balance conversations of what is possible vs. what is achievable

“Am I Even Fertile?” Ovary/Eggs

- In a retrospective study of transmasculine individuals who had conceived on T, 4 in 5 reported they were still bleeding regularly when conception occurred (Abern, 2018)
- A more recent prospective study showed T quickly induced ovulation dysfunction; breakthrough ovulation still occurred, even in those on T for >6mo, and was often (although not always) preceded by bleeding events (Taub, 2020)

“Am I Even Fertile?” Testes/Sperm

- No studies on progression to oligospermia with GAHT initiation
- Schneider et al. reviewed 11 studies, showing a wide variation of the effect of GAHT on spermatogenesis, from intact spermatogenesis to complete atrophy, irrespective of sex hormone levels
- One study showed that 24% of GAHT-experienced transfeminine patients had intact spermatogenesis from post-operative examination of testes
- Jiang et al. found the duration of hormonal therapy did not affect the degree of preservation of germ cells or spermatogenesis, but starting hormonal treatment at a younger age may be associated with decreased germ cells in the testicle

“What Else can I do?”

- The same stuff we always say (moderate exercise, minimize intake of alcohol and other substances, minimize environmental exposures, how about some vaccines, Folic Acid benefits up to 2y before conception, some evidence for CO-Q10)
- For egg-producing individuals who plan supported/assisted fertility measures, consider the role of early AMH to help ballpark
- Use of T severely impairs the accuracy of BBT and cervix checks
- The washout period for discontinuing T prior to pregnancy is still recommended but getting shorter
- For sperm-producing individuals, at-home sperm testing is possible
  - Recommend going off GAHT for at least 90 days
  - Motile sperm count can help ballpark what methods would be successful (>15mil any method, 10-15mil consider IUI, <10mil likely need IVF intervention)

Thank you.
Questions?

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