# SPILL THE T: MISINFORMATION ABOUT TRANSMASCULINE CONTRACEPTION

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## Background

- Transmasculine individuals are people assigned female sex at birth who do not identify as women; rather, gender identity is male, masculine, or nonbinary
  - Some transmasculine individuals may pursue medical transition, which can include masculinizing hormone treatment with testosterone, and/or gender confirmation surgeries (Obedin-Maliver & Makadon, 2014)
  - Transmasculine individuals who retain reproductive organs can become pregnant
  - Those who do not wish to become pregnant or wish to avoid pregnancy temporarily must use safe and effective methods of contraception

## Purpose

The purpose of this research is to determine the methods and efficacy of contraception in the transmasculine population, as well as the quality of patient-provider communication surrounding transmasculine fertility.

## Relevance

Providers should not assume that transmasculine clients wish to avoid pregnancy—130 of 197 surveyed by Light et al. (2018) stated they did not fear pregnancy. Some explicitly wished to achieve pregnancy: 53 (28.3%) reported fear of not achieving a desired pregnancy—most predating testosterone use (n=31, 58.5%), but about one-third (n=18, 34%) reported that the fears began after initiating testosterone hormone therapy (p. 267).
About 51% (67/130) reported that their providers did not ask about reproductive wishes (Light et al., 2018, p. 267).
In a previous study by Light et al. (2014) of 41 men who had previously given birth, 16 of the participants reported receiving prenatal care from an obstetrician, and 11 from a certified nurse midwife; the remaining 35% received prenatal care from a lay midwife (n=7), saw a primary care provider (n=4) , or received no care (n=2) (p. 1125).

Participants in several studies reported a range of experiences while receiving healthcare, ranging from positive to adverse (Light et al., 2014; Hoffkling et al., 2017).

Pregnancy and parenting support organizations for gay, lesbian, and bisexual people were reportedly ill-equipped to support transgender parents. Participants cited a Facebook group Birthing and Breast or Chestfeeding Trans People and Allies as a primary source of support and information (Hoffkling et al., 2017).

## Results

Forms of contraception used

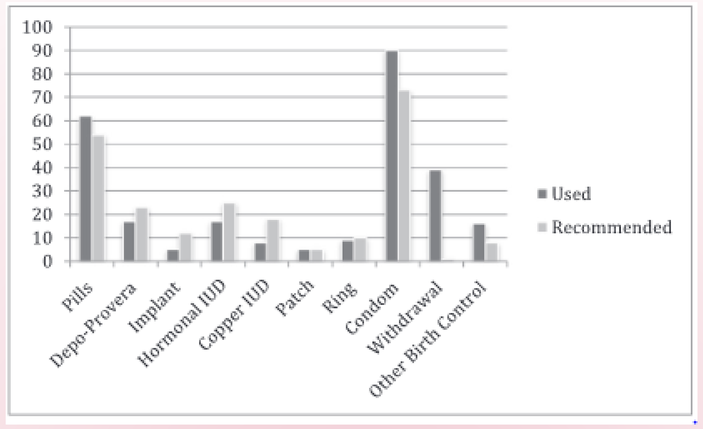


Figure 4 from Light et al., 2018.
Type of contraception ever reported as used by participants versus what participants reported was recommended by their healthcare providers. 110 of 183 respondents (60.1%) reported using contraception (Light et al., 2018, p. 268).
Thirty participants (16%) reported using testosterone as a contraceptive method, and 10 (5.5%) reported that healthcare providers had advised them to do so (Light et al., 2018, p. 268).

The reason for stopping any method was usually reported as an 'other' reason (n=37; 41.1%), particularly that contraception was no longer relevant due to hysterectomy (n=21) or due to no longer engaging in intercourse that could lead to pregnancy (Light et al., 2018, p. 267).

## Analysis

Testosterone is not an adequate form of contraception. According to Taub et al. (2020), median time to amenorrhea was 3 months with a range of 0-20 months (p. 229.e4). Light et al. (2018) noted one man reported conception while taking testosterone. Testosterone is teratogenic and is most likely to affect a fetus when androgens are used during the first trimester of pregnancy (Burchum & Rosenthal, 2019).

Ovulation events during testosterone therapy

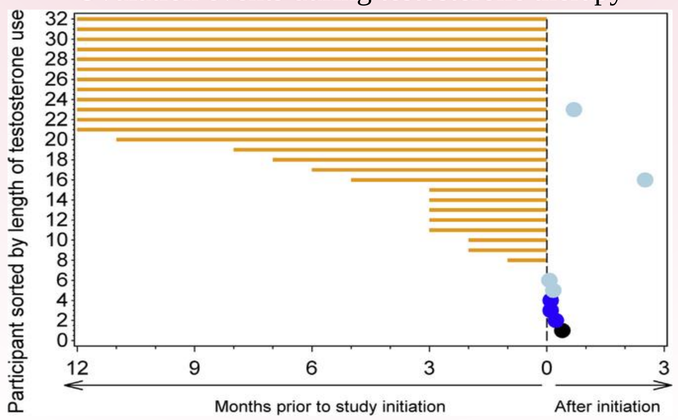


Figure 3 from Taub et al., 2020

Dots show ovulation activity: light blue indicates ≥2 consecutive PdG measures greater than 3 μg/mL; blue indicates ≥3 consecutive PdG measures greater than 4 μg/mL; and black indicates ≥3 consecutive PdG measures greater than 5 μg/mL (Taub, 2020).

Daily measurement of urinary pregnanediol-3-glucoronide (PdG) specifically for evidence of luteal activity has shown excellent utility for retrospective confirmation of ovulation. PdG measures in urine >5 μg/mL has been shown to have a sensitivity of 81% and specificity of 100% when compared to transvaginal ultrasound confirmation of ovulation (Taub et al., 2020, p. 229.e3).

## Conclusions

Gaps in scientific literature present serious limitations to addressing patient concerns related to fertility. Small sample sizes in the studies found present limitations to assessing the scope of the issue and generalizability of the data.

Transmasculine clients may or may not desire to become pregnant. Conversations about contraception and fertility should be held with all patients, including transgender individuals.

Further studies focused on the fertility of the transmasculine population, including those using testosterone therapy, should be performed in order to develop evidence-based guidelines for effective contraception, fertility preservation, and safe conception.

Emphasize cultural competency amongst providers and take steps to break down stigma that may hinder providing quality care for transgender patients.

## Resources

Trans 101 Modules by University of California San Francisco

World Professional Association for Trans Health Standards of Care

The Pride Study: Longitudinal study of LGBT+ health outcomes

Howard Brown Health: Affirming healthcare & services
- Midwest LGBTQ Health Symposium

Visit this website for links to these resources: linktr.ee/shuston

## References

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