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Contraceptive Beliefs, Needs, and Care Experiences Among Transgender and Nonbinary Young Adults

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A B S T R A C T

Purpose: This qualitative study explores the contraceptive health-care needs of transgender and nonbinary young adults assigned female sex at birth.
Methods: Qualitative interviews were conducted with 20 transgender and nonbinary young adults assigned female sex at birth (ages 22–29 years), recruited via online platforms and community agencies. Semistructured interviews elicited information on participants' gender and reproductive histories, health-care experiences, sexual practices, and contraceptive use and decision-making processes. Interviews were transcribed and coded using thematic analysis.
Results: Primary thematic domains centered on contraceptive experiences and needs, testosterone as contraception, and experiences with reproductive health care. Participants generally did not use hormonal contraception to prevent pregnancy; in situations where pregnancy was possible, participants relied on condoms. Some participants believed testosterone use would prevent pregnancy and subsequently did not use a contraceptive method. Participants described the lack of knowledge, among themselves and providers, of the impacts of testosterone on pregnancy risk and interactions with hormonal contraception. They described reproductive health-care experiences in which providers were unfamiliar with the needs of transgender and nonbinary patients; made assumptions about bodies, partners, and identities; and lacked adequate knowledge to provide effective contraceptive care.
Conclusions: Patient-centered reproductive care requires that providers be sensitive to the stress of gender-affirming care and engage with contraceptive counseling that addresses patients' behavior, risks, and reproductive functions. In particular, providers should understand and communicate the impacts of testosterone therapy on pregnancy risk.

IMPLICATIONS AND CONTRIBUTION

Transgender and nonbinary young adults assigned female sex at birth face barriers to contraceptive access, including lack of provider knowledge about interactions between contraceptive and testosterone use and discriminatory health-care experiences. High-quality, patient-centered contraceptive care for this population includes respectfully addressing patients' needs based on sexual behavior and pregnancy risk.

Transgender and nonbinary people assigned female sex at birth (AFAB) often experience barriers to and discomfort in accessing reproductive and sexual health care [1–8]. These experiences are consequential, as transgender and nonbinary people AFAB who have not undergone hysterectomy can become pregnant [1,4,9–11], even with testosterone hormone therapy [1,9,12–14]. The literature suggests transgender people AFAB

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participate in sexual practices that could lead to pregnancy [15–19]; despite this, few studies have explored the contraceptive practices of trans people AFAB, with little research focused on the experiences of nonbinary people [10,11,19]. In recent research, 40% of transgender men who did not intend to become pregnant reported contraceptive nonuse while having sex that could result in pregnancy [15,16], and 85% of transgender men at risk of becoming pregnant wished to avoid pregnancy [20]. Transgender men have cited stigma related to family planning and provider hesitancy or avoidance in discussing reproductive health as impeding thorough care [10,20–22]. Medical practice and research with transgender people AFAB has focused on maintaining fertility, neglecting other aspects of reproductive health, including pregnancy prevention [9–11,19,23–25].

Practice guidelines for providers working with transgender people AFAB focus predominantly on hormone and surgical care, with some attention to fertility assistance and pregnancy and little guidance regarding contraceptive care and use [1,9–11,13,14,26–29]. Research exploring transgender men's reproductive health-care experiences is growing [1–6,14,16,29,30]. Yet, the contraceptive needs and care experiences of young trans and nonbinary people AFAB are underexplored [1–6,14,16,29,30]. To address this gap, we conducted qualitative interviews with transgender and nonbinary young adults to understand their experiences accessing typically gendered (i.e., "women's" or reproductive) health services, needs for these services, and suggestions for how health systems and providers could best provide care to their communities.

Methods

The Transgender Reproductive Health Study aimed to qualitatively investigate the knowledge of, experiences accessing, and barriers to accessing reproductive health services among transgender and nonbinary people AFAB. We conducted semi-structured interviews in 2015 with individuals who (1) were AFAB; (2) identified as transgender or nonbinary, men, or another gender identity that was not woman; (3) were between the ages of 18 and 29; (4) resided in Northern California; and (5) had sought reproductive health services in the previous year, or experienced a pregnancy or had sex with a cisgender man in the prior three years. Participants were recruited via social media and flyers in social service agencies serving lesbian, gay, bisexual, transgender, and queer individuals and young people. To ensure racial and socioeconomic diversity in the sample, we set a maximum quota of 12 white participants, as well as 12 college students or graduates.

Two interviewers (the first and second authors) conducted the interviews. At the time, they identified as an Indian American cisgender woman in her 30s with a PhD degree and a Vietnamese American transgender person in their early 20s pursuing an MSW degree. Both interviewers had extensive prior training in qualitative research methods and engaged in conversations throughout data collection regarding their respective positionalities and the ways these may influence interviews, as well as their interpretation of the data. Interviews were conducted in-person at local universities or via videoconference. For in-person interviews, interviewers administered informed consent procedures at the time of the interview. For video interviews, participants completed an online informed consent form in advance. Before the interview, all participants completed a survey that assessed gender identity, sexual orientation, demographic characteristics, and use of women's and reproductive health services. We used a semistructured interview guide that elicited, among other topics, participants' experiences and decision-making processes around accessing services that are typically gendered as "women's" or "reproductive" health care, including pregnancy testing, clinical breast examinations, pap smears, and contraceptive care. Interviews were digitally recorded with participants' permission. One interviewee declined to be audio recorded, as he was undergoing medical transition and was uncomfortable with his voice being captured in its current pitch; in this case, the interviewer took detailed notes to record his responses. Upon completion of the interview, each participant received a $25 gift card. Interviewers wrote field notes after each interview to summarize their initial impressions and emergent themes. The Committee for Protection of Human Subjects at the University of California, Berkeley approved the study protocol.

All interview recordings were transcribed verbatim. To guide this thematic analysis, study staff appraised field notes and transcripts, identified salient themes and topics, and developed a series of deductive codes. The second and third authors coded interviews using Dedoose software, meeting regularly to achieve consensus in coding. For the present analysis, we examined all data regarding contraceptive use, care experience, and needs, as well as recommendations for reproductive health-care provision for transgender and nonbinary people. We created a data matrix to identify themes regarding individuals' contraceptive experiences and needs. Throughout the results, we identify participants by their stated gender identity and pronouns.

Results

The study included 20 participants aged 22–29 years (median age 26.5). More than half of the participants (n = 13) identified as transgender men, while four identified as nonbinary or genderqueer, four as men, and two as another gender identity (Table 1). Our analysis of the qualitative, interview data revealed three primary thematic domains: (1) contraceptive experiences and needs, (2) testosterone as contraception, and (3) experiences with health-care providers and needs for health-care provision in the context of reproductive health.

Contraceptive experiences and needs

The majority of participants did not regularly engage in sexual activity with partners who produced sperm—that is, partners with whom sexual activity could result in pregnancy. Participants concerned with pregnancy prevention used condoms exclusively, while those not concerned suggested they would use condoms if they were at risk of pregnancy. Many participants described using hormonal contraception in the past for pregnancy prevention and other reasons, although none currently used other contraceptive methods for either purpose. For example, one participant described previously using a hormonal intrauterine device (IUD) when they were in a monogamous relationship with a cisgender man. They were satisfied with the IUD and particularly appreciated the resultant menstrual suppression but discontinued use after that relationship ended and based on their expectation that several months of testosterone use would suppress menstruation. Other participants described using hormonal contraception specifically to suppress menstruation before starting testosterone therapy. As one 22-year-old trans man stated, "A lot of people that

Table 1
Transgender reproductive health study, participant characteristics (n = 20)

	N
Gender identity[a]	
Transgender man or trans man	13
Genderqueer or nonbinary	4
Man	4
Another gender identity	2
Sexual orientation	
Straight or heterosexual	1
Gay or lesbian	3
Bisexual	1
Queer	13
Pansexual	1
Asexual	1
Race and ethnicity	
White	12
Black	1
Latinx	1
Asian or Pacific Islander	1
Multiracial	5
Health insurance	
Private	11
Public	7
Uninsured	2
Services ever accessed	
Pap smear	18
Contraception prescription	13
Pregnancy test	9
Emergency contraception	5
Abortion	3

n = 20.
[a] Participants could choose more than one option for gender identity.

I've talked to who are trans masculine or who are born with ovaries said that they had done birth control as a preventative measure for getting their period before they had access to testosterone." Three participants expressed potential future interest in using contraceptive methods other than condoms, for pregnancy prevention, suppressing menstruation, and reducing dysmenorrhea. One of these participants, a 25-year-old trans man, was unsuccessful in a recent attempt to obtain an IUD because the clinic could not bill for the service owing to his male legal gender marker. He said, "The only real barrier as of late is the whole trying to get the proper billing codes for trans men to be able to get on female birth control..."

Among many participants, there were overarching concerns about the interaction between hormonal contraception and testosterone therapy. Participants previously experienced negative effects from using hormonal contraception while also using testosterone or feared that hormonal contraceptive use would counteract their efforts to enhance "male" characteristics through the use of testosterone. A 26-year-old trans man explained, "I tried it out for a month and a half because my partner, a cis guy, wanted me to, but it made me absolutely insane. I felt horrible. My dysphoria was terrible...I felt emotionally unstable, I had panic attacks every day, so I just had to call it quits." A 23-year-old transmasculine participant described hesitation about using hormonal contraception to suppress menstruation while using testosterone ("T"), saying, "I think trans men are worried about possibly feminizing themselves after all the hard work that T does, even though testosterone is very strong." At the same time, a 25-year-old trans man described the positive impact of IUD use while initiating hormone therapy: "When I first started hormones, I was on an IUD, and it made it easier...there was less of a fear that I could still get pregnant if I'm on T."

Testosterone as contraception

The notion that testosterone had contraceptive effects was prevalent among participants. Twelve participants believed that testosterone use reduced their likelihood of becoming pregnant, with some basing this belief on the idea that amenorrhea (a consequence of prolonged testosterone use) significantly decreases chances of pregnancy and that testosterone use causes temporary or permanent sterility. Additionally, in the past, some participants had simultaneously used hormonal contraception or condoms while using testosterone, with the understanding that this combination would prevent pregnancy more effectively.

Some participants described the presumed pregnancy prevention effect of testosterone use as a deciding factor in engaging in unprotected sexual encounters with sperm-producing partners. One 26-year-old trans man stated, "I know [testosterone is] not 100% because very few methods are. But if I wanted to, I could have unprotected sex and be fairly low risk of getting pregnant." A 25-year-old trans man said, "Luckily for me, I'm pretty sure being on testosterone also helped as some form of birth control, because I'm actually surprised that it [pregnancy] didn't happen with the level of [sexual] activity I had." Some participants explicitly expressed that testosterone is not a form of birth control and awareness of the possibility of pregnancy while using testosterone. Many participants were aware that there is little or no research suggesting that testosterone may be used as effective contraception; however, some of these same participants had relied on testosterone for pregnancy prevention based on the assumptions mentioned previously. One 29-year-old man declared, "I have been irresponsible and used testosterone as a contraceptive…and it's worked so far!" One 23-year-old gender fluid participant said, "I know so many folks on T...who think that they won't be able to get pregnant, and they identify as gay men, and so they'll be sleeping with cis men, and I'm like, 'No, you can still get pregnant.'" These descriptions were often paired with an understanding that testosterone has not been studied or may not be effective as a contraceptive. The same 29-year-old trans man later added, "They [providers] told me not to rely on testosterone as birth control, and I have been using it as birth control against medical advice." Among participants who reported receiving counseling family planning options before testosterone therapy, many recalled being told by their providers that pregnancy was unlikely to occur while on a testosterone regimen. One 25-year-old trans man recalled when they started testosterone:

> [The doctor] pretty much just told me, "Oh, well, you may not be able to reproduce while you're on." That was the cut and dry end of it. There was no in-detail of, you know, trying to do in-vitro or trying to have my eggs stored or nothing like that, it was just, simple, you know, "This may hinder your ability to get pregnant." That was it. Which is actually why I agreed to an IUD is because then that's a definite no chance of me getting pregnant.

Overwhelmingly, participants desired better data on the impact of testosterone on fertility potential and reproductive health, particularly more focused and detailed research on the dynamics of testosterone dosage, length of testosterone treatment, and pregnancy potential after cessation of testosterone. One 29-year-old man succinctly reflected on the state of knowledge and medical practice in this area: "The answer is they don't know because there has not been a lot of medical study. Trans men on testosterone have gotten pregnant before. No one

really knows what our bodies are doing when we're on testosterone."

Experiences and needs with reproductive health-care providers

Participants articulated broad needs from health-care providers, in general and in the context of their reproductive health. Primarily, participants referred to a broad lack of an informed and inclusive environment for transgender patients. They described the need for clinics to ask about and use the pronouns and genders with which patients identify. Further, they noted the lack of and need for gender-neutral restrooms and other signs, messaging, materials, and staff that signal clinics and providers are welcoming to transgender and nonbinary people. Participants expressed frustration at the lack of basic knowledge on transgender identity, embodiment, and health issues. One 29-year-old trans guy described an interaction with his provider in which she asked questions that assumed cisgender, heterosexual sexual behavior, explaining:

> She [the provider] didn't even think to rephrase them [the questions], which again comes back to if you're around trans people or queer people, you know to ask, "When is the last time you came in contact with sperm?" Because that may or may not have been through sex. "Do you know when you conceived?" is a really great question! Why don't we just start there?

Another 29-year-old trans man described the desire "to have care providers be thorough when they ask me questions but not invasive. So when they ask if you're sexually active, ask more questions, but make sure it's only medically relevant. Like, am I having sex with people where I could get pregnant? Am I having sex with people, what's the word, that have the same junk?"

Participants noted the particular need for a more sensitive and informed approach to patient care with transgender people. They described invasive and unnecessary questions from clinic staff and providers in the course of reproductive care, specifically questions about transgender identity, relationship status and formation, sexuality, and the genders or bodies of sexual partners. A 29-year-old trans guy explained:

> They asked how I got pregnant, how it works, how do other lesbians do it, where do you find sperm, and I was like, "Well, don't you work with pregnant people all day?" She was well-meaning in the questions she was asking because she wanted to be a better provider but, at the same time, that's not my job to teach her.

Participants expressed frustration at provider assumptions about any correlation between transmasculine identity, gender expression, embodiment, the desire for type of health care, and/or the desire for body modification. When asked to comment on what he would like reproductive health-care providers to know about caring for transgender people, the same participant stated:

> That everyone's desires and needs are different, and just because they're trans doesn't mean they have the same needs and services. I know another guy that's pregnant, and he has Kaiser, and the Kaiser provider was like, "So let's talk about delivery." And she was like, "I can totally set you up with a C-section and hysterectomy if you want." And, you know, the assumption [is] that because he's trans he automatically wants his delivery to be a hysterectomy…rather than being like, "What do you want to get out of your labor and delivery?" You know? I think it's good that she's like, "I'm willing to advocate for you to have these surgeries at the same time," but I think she should wait until somebody says, "Well, I want to have a hysterectomy and C-section at the same time." And then say, "Great! I'm happy to advocate for that for you!"

Participants further described specific needs from health-care providers in reproductive health settings. In addition to a gender-neutral environment, they highlighted the need for gender expansive language beyond "women's health," which emphasizes the assumption that only women have uteruses or can get pregnant. Participants suggested the need for spaces, such as waiting rooms, welcoming to people of different gender presentations and that do not assume the only patients are women, which inevitably "out" transgender and nonbinary patients.

The need for providers to understand that health-care interactions not inclusive of transgender and nonbinary patients caused stress and anxiety was repeatedly mentioned by participants. For example, one 23-year-old trans masculine participant described a situation in which their usual provider at a specialized transgender health clinic directed them to a gynecologist for a contraceptive prescription: "It makes me nervous to go to different doctors who I'm sure aren't going to be very knowledgeable about trans things. I'm not sure about that, maybe they have a very trans-friendly gynecologist, but my gut says, 'No.' That's why I also haven't had a Pap, even though I'm 23." Participants identified the need for providers to accurately assess the reproductive health needs of transgender and nonbinary patients, and not make assumptions about gender identity, embodiment, sexuality, partners' bodies, and desires for pregnancy prevention. A 23-year-old gender fluid participant who was in a relationship with a trans man explained, "I've had so many doctors say, 'Oh, so you have a boyfriend,' and I'm like, 'Yeah, I have a boyfriend,' and then they'll insist that I be on birth control, and I know I don't need to be on birth control. It's acknowledging that there are so many more ways that queers and trans folks have sex and interact with each other."

In describing the lack of clarity on interactions between testosterone and hormonal contraception, participants emphasized that providers should be prepared to honestly answer questions in this realm. In addition to the earlier mentioned topics of best practices for contraceptive use for people using testosterone and the impact of testosterone on bodies and fertility, participants desired information on timelines for starting or stopping testosterone use in relation to pregnancy and the impact of testosterone on a potential fetus. A few participants desired information about pregnancy risk when having sex with transgender and nonbinary partners assigned male sex at birth who are undergoing hormonal treatment (e.g., testosterone-suppressing and/or estrogen-enhancing regimes). Finally, participants requested that providers be transparent about the current, scant research on reproductive health among transgender and nonbinary people and their knowledge of it (or lack thereof) and take the initiative to learn that information in advance rather than in response to interactions with patients.

Discussion

This study elucidates transgender and nonbinary young people AFAB's contraceptive decision-making processes, barriers to fulfilling contraceptive preferences, and gaps in quality of reproductive care. Specifically, participants described mixed messages from providers about the impact of testosterone on the likelihood of pregnancy, the ways that the gendered nature of reproductive health care caused them to avoid seeking care, and a desire for transparency and honesty from reproductive health-care providers, particularly around the fertility impacts of testosterone use. Results highlight clinic- and provider-level barriers to contraceptive care and affirm the need for reproductive health practice guidelines organized around individual bodies and sexual behavior that address contraceptive and fertility options for transgender and nonbinary patients [11,23].

This study illuminates how transgender and nonbinary young people understand testosterone's impact on menstruation and ovulation: some participants believed testosterone therapy prevented pregnancy and, as a result, did not contracept when having sex with sperm-producing partners. Others acknowledged that testosterone was not effective as contraception but presumed that it would reduce their likelihood of pregnancy. As described in this study and by other research [7,10,24], health-care providers generally lacked requisite knowledge to support transgender and nonbinary patients, were not transparent about that lack of knowledge, and made assumptions about their pregnancy risk, partners, bodies, and identities, which did not facilitate effective and appropriate contraceptive counseling. Considered in the broader context of discrimination in health-care settings and the desire to avoid gendered health-care settings where contraception is often provided, participants' actions may reflect the best option for pregnancy prevention—one that allows them to avoid harmful and stigmatizing encounters, even when they knew that testosterone was not recommended as contraception.

Patient-centered contraceptive care research thus far has not focused on transgender and nonbinary patients. Gender-affirming tools tailored to the needs of transgender and nonbinary patients can support patients and providers in this process [7,13,14,31,32]. To effectively serve all patients, providers must use language that is specific to behavior, risk, and current bodily functions [10,13,14]. Sensitivity to the unique stressors of accessing gender-affirming care and addressing patient needs and desires is fundamental [11,14]. The informed consent process for gender-affirming hormones, which requires a discussion of impacts of hormones on fertility [1,33], can be stressful: at the time of initiating hormones, some patients may feel urgency to access hormones and not have an interest in future fertility. Providers must be patient centered in presenting this information and be attentive to the possibility that a patient's partners, sexual practices, and fertility desires can change over time.

Strengths of this study include the use of qualitative methods, which allowed for the organic emergence of participants' contraceptive needs and care experiences. While additional research including other age groups and in settings other than Northern California is important to expand understanding of experiences of and barriers to contraceptive use and care, these data provide actionable insights to improve quality of care for a population at high risk of discrimination and inadequate access and quality of care. Even with the application of quotas to ensure that participants of color and without college degrees were represented in the sample, our study population underrepresents the experiences of transgender and nonbinary people of color and of lower socioeconomic status, who face greater barriers accessing health care and elevated discrimination [34,35].

This study underscores the importance of creating inclusive clinical environments for transgender and nonbinary patients, particularly for "gendered" services like contraceptive care, as well as abortion and prenatal care [7,13,14]. As efforts grow to expand contraceptive access through pharmacy prescribing [36], online services [37], and over-the-counter access [38], it is critical to consider how young transgender and nonbinary people can be best served, particularly as these modes of contraceptive delivery may not require interaction with conventional health-care settings. These data suggest there are aspects of the provider-patient encounter that can be feasibly improved without delay. Health-care providers can practice language that respectfully elicits a patient's risk for pregnancy rather than providing care informed by assumptions. Health systems can modify the physical clinical environment toward gender neutrality and (re) design health records to include name, gender identity, and pronouns that may differ from legal and insurance documents. Providers and staff should receive ongoing resources and training on supporting reproductive health care for transgender and nonbinary people, promoting a practice of respectful engagement so patients feel safe returning for additional care. This is all the more crucial, given that negative experiences with contraceptive care early in life can impact future contraceptive use and healthcare-seeking behavior [39]. Ensuring quality contraceptive care for young transgender and nonbinary people is critical for advancing health equity for a population disproportionately at risk for health and health-care inequities [14,34,35,40].

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