

**their tobacco use and advise tobacco/nicotine abstinence prior to gender-affirming surgery.**

Tobacco use is a leading contributor to cardiovascular disease, pulmonary disease, and cancer worldwide (World Health Organization, 2020). TGD persons have a higher prevalence of tobacco use compared with cisgender individuals, which varies across the gender spectrum (Azagba et al., 2019; Buchting et al., 2017). This pattern is consistent with other populations experiencing minority stress (Gordon et al., 2021). PCPs can promote protective factors against tobacco use, including reducing exposure to personal or structural discrimination, having gender-affirming identification, and having health insurance (Kidd et al., 2018; Shires & Jafee, 2016).

The health risks of tobacco use affect TGD persons disproportionately, primarily due to decreased access to culturally competent, affordable screening, and treatment of tobacco-related diseases (Shires & Jafee, 2016). Smoking may further increase cardiovascular and VTE risk for TGD individuals taking feminizing GAHT (Hontscharuk, Alba, Manno et al., 2021). Smoking also doubles or triples the risk of general surgery complications, such as wound healing, scarring, and infection (Yoong et al., 2020) and increases these risks for those accessing gender-affirming surgeries. Data in cisgender populations show quitting smoking prior to surgery and maintaining abstinence for six weeks postoperatively significantly reduces complications (Yoong et al., 2020).

There are currently few studies of smoking cessation programs specifically focused on TGD persons (Berger & Mooney-Somers, 2017). However, limited evidence suggests PCPs can enhance smoking cessation efforts by addressing the effects of minority stress (Gamarel et al., 2015) and incorporating gender-affirming interventions, such as GAHT (Myers & Safer, 2016).

HCPs should take into consideration the significant barriers people habituated to nicotine encounter when attempting cessation. Nicotine replacement therapy and/or other cessation adjuncts should be made available, with an emphasis on individual preferences and a recognition of underlying behavioral health factors that contribute to continued nicotine use. Decision-making

regarding approaches to GAHT or surgery should include consideration of the “first do no harm” principle of medical practice, with the realities of an individual patient’s abilities and needs.

Statement 15.5**We recommend health care professionals discuss and address aging-related psychological, medical, and social concerns with transgender and gender diverse people.**

Aging presents specific social, physical, and mental health challenges for TGD persons. While the literature on aging and transgender elders is limited, many older TGD adults have experienced a lifetime of stigma, discrimination, and repression of identified gender (Fabbre & Gaveras, 2020; Witten, 2017). This experience affects TGD elders’ interactions with health care systems (Fredriksen-Goldsen et al., 2014; Kattari & Hasche, 2016; Walker et al., 2017). Transgender elders are more likely than cisgender LGB peers to report poor physical health, even when controlling for socio-demographic factors (Fredriksen-Goldsen 2011; Fredriksen-Goldsen et al., 2014). Reduced access to culturally competent care and the sequelae of minority stress often result in delayed care, potentially exacerbating chronic conditions common with aging (Bakko & Kattari, 2021; Fredriksen-Goldsen et al., 2014).

Although there are few studies on gender-affirming medical interventions among TGD elders, evidence suggests older adults experience a significantly higher quality of life with medical transition even when compared with younger TGD adults (Cai et al., 2019). Although age itself is not an absolute contraindication or limitation to gender-affirming medical or surgical interventions, TGD elders may not be aware of the current range of social, medical or surgical options available that can help them meet their individual needs (Hardacker et al., 2019; Houlberg, 2019).

While studies on mental health among TGD elders are limited, those over age fifty experience significantly higher rates of depressive symptoms and perceived stress compared with cisgender LGB and heterosexual older adults (Fredriksen-Goldsen 2011, Fredriksen-

Goldsen et al., 2014). Risk factors specific to TGD elders include gender- and age-related discrimination, general stress, identity concealment, victimization, and internalized stigma, while social support and community belonging appear protective (Fredriksen-Goldsen et al., 2014; Hoy-Ellis & Fredriksen-Goldsen, 2017; White Hughto & Reisner, 2018). PCPs can assist patients by encouraging spirituality, self-acceptance and self-advocacy, and an active healthy lifestyle, all of which are associated with resilience and successful aging (McFadden et al., 2013; Witten, 2014).

TGD elders often face social isolation, loss of support systems, and disconnection from close friends and children (Fredriksen-Goldsen 2011; Witten, 2017). The most common aging concerns among TGD persons are losing the ability to care for themselves followed by having to go into a nursing home or assisted living facility (Henry et al., 2020). While long-term care settings offer the helpful needed assistance, they also have the potential for physical or emotional abuse, for denial of GAHT and routine care, for being “outed,” and being prevented from living and dressing according to one’s affirmed gender (Auldridge et al., 2012; Pang et al., 2019; Porter et al., 2016). TGD elders identify senior housing, transportation, social events, support groups as being the most needed services (Auldridge et al., 2012; Witten, 2014).

Despite barriers, most TGD persons engage in successful aging strengthened by self-acceptance, caring relationships, and advocacy (Fredriksen-Goldsen 2011; Witten, 2014). PCPs should address core health issues facing TGD elders, including mental health, gender-affirming medical interventions, social support, and end of life/long-term care.

Beyond the independent impact of factors such as minority stress and social determinants of health in later years, data are lacking on specific health issues facing transgender people who use GAHT later in life, individuals who began GAHT at a younger age, and those seeking to continue or begin GAHT in their sixth, seventh, eighth, or later decades. With an increasing proportion of transgender people beginning GAHT at younger ages, including some who begin at the time of puberty, studies to examine the impact of decades of such treatment on long-term health are ever more important.

#### Statement 15.6

**We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration length of time of hormone use, dosing, current age, and the age at which hormones were initiated.**

TGD individuals taking estrogen-based GAHT will develop breasts, and therefore warrant consideration for breast cancer screening. Exogenous estrogen may be one of multiple factors that contribute to breast cancer risk in cisgender people. Two cohort studies have been published evaluating breast cancer prevalence among transgender women in the Netherlands (Gooren et al., 2013) and the US (Brown & Jones, 2015). Both were retrospective cohorts of clinical samples using a diagnosis of breast cancer as the outcome of interest and cisgender controls as a comparison group. Neither study involved prospective screening for breast cancer, and both had significant methodological limitations. Numerous guidelines have been published (Deutsch, 2016a) recommending some combination of “age plus length of estrogen exposure” as the determinant of need to commence screening. These recommendations are based on expert consensus only and are evidentially weak.

BRCA1 and 2 mutations increase the risk of breast cancer, however the role sex hormone exposure plays, if any, in this increased risk is unclear (Rebbeck et al., 2005) The degree of increase in risk, if any, from gender-affirming estrogen therapy is unknown. Patients with a known BRCA1 mutation should be counseled about the unknowns and shared decision-making with informed consent should occur between the patient and provider, recognizing the numerous benefits of GAHT.

Breast cancer screening among transgender women should also take into consideration the likelihood that a transgender woman’s breasts may be denser on mammography. Dense breasts, a history of injecting breasts with fillers such as silicone, and breast implants may complicate the interpretation of mammographic findings (Sonnenblick et al., 2018). Therefore, special

techniques should be used accordingly. People who have injected particles such as silicone or other fillers for breast augmentation may also develop complications, such as sclerosing lipogranulomas, which obscure normal tissue on mammography or ultrasound.

#### Statement 15.7

**We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.**

For TGD people assigned female at birth and who developed breasts via natal puberty, there are theoretical concerns about whether direct exposure to testosterone and exposure to aromatized estrogen resulting from testosterone therapy are risk factors for the development of breast cancer. Limited retrospective data has not demonstrated increased risk for breast cancer among transgender men (Gooren et al., 2013; Grynberg et al., 2010), however prospective and comparison data are lacking. Most people in this group will have some breast tissue remaining, and therefore it is important for providers to be aware breast cancer risk is not zero in this population. The timing and approach to breast cancer screening in this group who have had chest surgery is currently not established, and, similar to cisgender men with significant family history or BRCA gene mutation, screening via MRI or ultrasound may be appropriate. Because the utility and performance of these approaches have not been studied and because self- and HCP-led chest/breast screening exams are not recommended in cisgender women due to potential harms of both false-positive results and over-detection (detection of a cancer which would have regressed on its own with no need for intervention), any approach to screening in this group should occur in the context of shared decision-making between patients and providers regarding the potential harms, benefits, and unknowns of these approaches.

#### Statement 15.8

**We recommend health care professionals apply the same respective local screening guidelines**

**(including the recommendation not to screen) developed for cisgender women at average and elevated risk for developing ovarian or endometrial cancer in their care of transgender and gender diverse people who have the same risks.**

Current consensus guidelines do not recommend routine ovarian cancer screening for cisgender women. Case reports of ovarian cancer among transgender men have been reported (Dizon et al., 2006; Hage et al., 2000). There is currently no evidence testosterone therapy leads to an increased risk of ovarian cancer, although long-term prospective studies are lacking (Joint et al., 2018).

#### Statement 15.9

**We recommend against routine oophorectomy or hysterectomy solely for the purpose of preventing ovarian or uterine cancer for transgender and gender diverse people undergoing testosterone treatment and who have an otherwise average risk of malignancy.**

TGD people with ovaries who are taking testosterone-based GAHT are often in an oligo- or anovulatory state, or otherwise experience shifts in luteal phase function and progesterone production. This condition combined with the possible increased estrogen exposure from aromatization of exogenous testosterone raises the concern for excessive or unopposed endometrial estrogen exposure, although the clinical significance is unknown. Histologic studies of the endometrium in TGD people taking testosterone have found atrophy rather than hyperplasia (Grimstad et al., 2018; Grynberg et al., 2010; Perrone et al., 2009). In a large cohort of trans masculine people who underwent a hysterectomy with oophorectomy, benign ovarian histopathology was noted in all cases (n = 85) (Grimstad et al., 2020). While prospective outcome data are lacking, there is insufficient evidence at this time to support a recommendation transgender men undergo routine hysterectomy or oophorectomy solely to prevent endometrial or ovarian cancer. Certainly, unexplained signs/symptoms of endometrial or ovarian cancer should be evaluated appropriately.

#### Statement 15.10

**We recommend health care professionals offer cervical cancer screening to transgender and**

**gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women.**

Individuals with a cervix should undergo routine cervical cancer screening and prevention according to age-based regional practices and guidelines. This includes vaccination against the human papilloma virus (HPV) and screening according to local guidelines, including cytologic, high-HPV co-testing if available. It is important HCPs be mindful of performing pelvic speculum examinations in a manner that minimizes pain and distress for transgender masculine people.

TGD people with a cervix are less likely to have had conventional cervical cancer screening, either because the exam can cause worsening of dysphoria and/or because general practitioners and patients are misinformed about the need for this screening (Agenor et al., 2016; Potter et al., 2015). In addition, testosterone therapy can result in atrophic changes of the genital tract, and the duration of testosterone use has been associated with a greater likelihood of obtaining an inadequate sample for cytologic screening of cervical cancer (Peitzmeier et al., 2014). Alternatives to speculum exams and cervical cytology, such as provider- or self-collected high-risk HPV swabs, may be of particular benefit for screening people with a cervix. Research underway in the US is investigating the use of self-collected vaginal high-risk HPV testing among transgender masculine populations. HPV swabs were found to be highly acceptable among transgender men with a sensitivity to high-risk HPV of 71.4% (negative predictive value of 94.7%) and a specificity of 98.2% (Reisner et al., 2018). Further study is needed to evaluate the harms of HPV primary screening in transgender men in terms of the potential increased harms associated with invasive examinations and colposcopies.

Statement 15.11

**We recommend health care professionals counsel transgender and gender diverse people that the use of antiretroviral medications is not a contraindication to gender-affirming hormone therapy.**

Human immunodeficiency virus (HIV) prevalence is disproportionately high in TGD

populations. A recent large metanalysis found a global odds ratio for HIV infection of sixty-six for trans feminine individuals and 6.8 for trans masculine individuals (Stutterheim et al., 2021). PCPs have unique opportunities to provide crucial education and implement prevention strategies, especially related to decreasing HIV burden among TGD people. Mistrust of health care providers due to past experiences of discrimination and transphobia impacts HIV prevention and disrupts the linkage to care efforts (Sevelius et al., 2016). Stigma, lack of adequate training, and innate power hierarchies within medical establishments, all contribute to ambivalence and uncertainty among HCPs when caring for TGD people (Poteat et al., 2013). Finally, a lack of inclusiveness and gender-affirming practices in the health care setting may lead to TGD people feeling unsafe discussing sensitive topics, such as HIV diagnosis and avoiding care out of fear (Bauer et al., 2014; Gibson et al., 2016; Seelman et al., 2017).

HCPs should be aware of this broader context within which many TGD people are seeking care for either gender-affirming hormones, HIV pre-exposure chemoprophylaxis/treatment (PrEP), or both. There may be various misconceptions about the safety of taking gender-affirming hormones concurrently with antiretroviral therapy for HIV chemoprophylaxis or treatment.

Direct study of antiretroviral/gender-affirming hormone therapy (ART/GAHT) interactions has been limited. A subanalysis of transgender women and trans feminine persons in the multinational iPrEx trial found poor effectiveness in this group in the intention-to-treat analysis, although effectiveness was similar to that in cisgender gay men among those transgender participants who adhered to the medication as prescribed, suggesting that uptake and adherence to PrEP remain challenging in this population. Two studies of the effects of GAHT on tenofovir diphosphate (Grant et al., 2021) and tenofovir diphosphate and emtricitabine (Shieh et al., 2019) found the significantly lowered ART drug levels were unlikely to be of clinical significance. Overall, data on the interactions between hormonal contraceptives and antiretrovirals are reassuring in terms of the impact of hormones on ART (Nanda

et al., 2017). Because estradiol is partially metabolized by cytochrome P450 (CYP) 3A4 and 1A2 enzymes, potential drug interactions with other medications that induce or inhibit these pathways, such as non-nucleoside reverse transcriptase inhibitors (NNRTIs, e.g., efavirenz (EFV) and nevirapine (NVP)), may exist (Badowski et al., 2021). However, the preferred first-line ART regimens in most countries include integrase inhibitors, which have minimal to no drug interactions with gender-affirming hormones and can be used safely (Badowski, 2021; Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents, 2021). If concerns exist about potential interactions, HCPs should monitor blood hormone levels as needed. Therefore, TGD people living with HIV and taking antiretroviral medications should be counseled that taking antiretrovirals alongside GAHT is safe.

#### Statement 15.12

**We recommend health care professionals obtain a detailed medical history from transgender and gender diverse people that includes past and present use of hormones, gonadal surgeries as well as the presence of traditional osteoporosis risk factors, to assess the optimal age and necessity for osteoporosis screening. For supporting text, see Statement 15.13.**

#### Statement 15.13

**We recommend health care professionals discuss bone health with transgender and gender diverse people including the need for active weight bearing exercise, healthy diet, calcium, and vitamin D supplementation.**

Estrogen and testosterone both support bone formation and turnover. Decreased sex hormone levels are associated with a greater risk of osteoporosis in older age (Almeida et al., 2017). TGD individuals may receive medical and/or surgical interventions that have the potential to influence bone health, such as sex hormone treatment, androgen blockade, and gonadectomy. Therefore, a detailed medical history, including past and present use of hormones along with gonadal surgeries, is necessary to establish the need for osteoporosis screening.

Several observational studies have compared bone mineral density (BMD) of TGD adults before and after gender-affirming hormone therapy along with in TGD individuals compared with sex-at-birth matched cisgender controls.

Low BMD may exist before the initiation of hormones. One study showed a lower mean areal BMD at the femoral neck, total hip, and spine in transgender women than in age-matched cisgender male controls (Van Caenegem, Taes et al., 2013). Another study revealed a high prevalence of low BMD scores among TGD youth before starting puberty blockers (Lee, Finlayson et al., 2020). The authors of both studies concluded low rates of physical activity may be an important contributor to these findings.

Acceleration of bone loss can occur after gonadectomy if hormones are stopped or if hormone levels are suboptimal. In one study, thirty percent of transgender women who had undergone gonadectomy had low bone mass, and this correlated with lower 17- $\beta$  estradiol levels and adherence to GAHT (Motta et al., 2020).

Investigation of the effects of GAHT on BMD have revealed TGD women receiving estrogen therapy show improvements in BMD. A systematic review and meta-analysis on the impact of sex hormones on bone health of transgender individuals included 9 eligible studies in transgender women ( $n=392$ ) and 8 eligible studies in transgender men ( $n=247$ ) published between 2008 and 2015. The meta-analysis revealed transgender women showed a statistically significant increase in lumbar spine BMD (but not femoral neck BMD) compared with baseline measures. Among transgender men, there were no statistically significant changes in the lumbar spine, femoral neck, and total hip BMD at 12 and 24 months after starting testosterone compared with baseline measures (Singh-Ospina et al., 2017). Since the publication of this study, the European Network for Investigation of Gender Incongruence (ENIGI) study, a multicenter prospective observational study (Belgium, Norway, Italy, and the Netherlands) published results on BMD outcomes for 231 transgender women and 199 transgender men one year after initiating GAH (Wiepjes et al., 2017). Transgender women had an increase in BMD of the lumbar spine, total hip and

femoral neck, and increased BMD of the total hip occurred in transgender men. One study reported no fractures in transgender individuals at 12 months following initiation of hormones in 53 transgender men and 53 transgender women (Wierckx, van Caenegem et al., 2014). No studies suggest GAHT should be an indication for enhanced osteoporosis screening. Rather, gaps in GAHT in those who have undergone prior gonadectomy would be a consideration for such screening.

Clinical practice guidelines include recommendations for osteoporosis screening in TGD individuals (Deutsch, 2016a; Hembree et al., 2017; Rosen et al., 2019). For TGD people, both the International Society for Clinical Densitometry and the Endocrine Society suggest consideration of baseline BMD screening before initiation of hormones. Further recommendations for BMD screening are based on several factors including sex reported at birth and age along with the presence of traditional risk factors for osteoporosis, such as prior fracture, high risk medication use, conditions associated with bone loss, and low body weight (Rosen et al., 2019). Specifically, the ISCD guidelines state BMD testing is indicated for TGD individuals if they have a history of gonadectomy or therapy that lowers endogenous gonadal steroid levels prior to the initiation of GAHT, hypogonadism with no plan to take GAHT or known indications for BMD testing (Rosen et al., 2019). However, the evidentiary basis for these recommendations is weak.

The recommended screening modality for osteoporosis is dual energy x-ray absorptiometry (DXA) of the lumbar spine, total hip, and femoral neck (Kanis, 1994). However in many low- and middle-income countries, BMD tests using DXA are not available, and routine DXA-based screening is conducted in few countries, the US being an exception.

PCPs should discuss ways to optimize bone health with TGD people. In addition, PCPs should provide information about the importance of nutrition and exercise on maintaining bone health. TGD individuals with (or at risk) for osteoporosis should be informed about the benefits of weight bearing exercise along with strength and resistance exercises in limiting bone loss

(Benedetti et al., 2018). Nutrition is integral to bone health. Nutritional deficiencies, including insufficient calcium intake and low vitamin D, can result in low bone mineralization. Vitamin D and calcium supplementation have been shown to reduce hip as well as total fracture incidence (Weaver et al., 2016). Although relevant to all populations, this discussion is pertinent as a high prevalence of hypovitaminosis D has been observed in TGD populations (Motta et al., 2020; Van Caenegem, Taes et al., 2013).

#### Statement 15.14

**We recommend health care professionals offer transgender and gender diverse people referrals for hair removal from the face, body, and genital areas for gender-affirmation or as part of a preoperative preparation process.**

Hair removal is necessary both for the elimination of facial hair (Marks et al., 2019) as well as in preparation for certain gender-affirming surgeries (GAS) such as vaginoplasty, phalloplasty, and metoidioplasty (Zhang et al., 2016). Preoperative permanent hair removal is required for any skin area that will either be brought into contact with urine (e.g., used to construct a neourethra) or be moved to reside within a partially closed cavity within the body (e.g., used to line the neovagina) (Zhang et al., 2016). Hair removal techniques used in gender-affirming care are electrolysis hair removal (EHR) and laser hair removal (LHR) (Fernandez et al., 2013). EHR is currently the only US Food and Drug Administration–approved method of permanent hair removal, whereas LHR is approved for permanent hair reduction (Thoreson et al., 2020).

EHR involves the use of an electric current with a very fine probe that is manually inserted sequentially into individual hair follicles (Martin et al., 2018). Since this method uses direct mechanical destruction of the blood supply to the hair, it can be used on all hair colors and skin types (Martin et al., 2018). EHR is time consuming and costly as it requires each hair follicle to be treated individually, but is effective for permanent hair removal. For genital permanent hair removal prior to GAS, this treatment needs to be performed by a practitioner competent in genital hair removal as this method differs

from that of the face and body. EHR is more painful than LHR, with possible side effects of erythema, crusting, and swelling (Harris et al., 2014). Postinflammatory hyperpigmentation is a risk for dark-skinned individuals (Richards & Meharg, 1995). Pain can be controlled with topical local anesthetic and cooling techniques, and tolerance to EHR does develop to some degree with many persons able to tolerate longer sessions (Richards & Meharg, 1995).

LHR uses laser energy to target hair follicles. It is beneficial for larger surface areas. The mechanism is photo-thermolysis, whereby light from a laser selectively targets melanin in the hair shaft (Gao et al., 2018). This energy is converted to heat, which damages the follicles within the skin that produce hairs and results in the destruction of hair growth. Further treatments are needed to achieve best results and are typically spaced six weeks apart to allow for hair cycling (Zhang et al., 2016). Because LHR targets melanin, results may be limited for those with grey, blonde, or red hair.

There are specific considerations for using LHR in dark-skinned individuals (Fitzpatrick skin types IV to VI) (Fayne et al., 2018)). The higher melanin content of the epidermis can compete with the target chromophore of the light or laser, which is the melanin in the hair shaft of the hair follicle. For selective thermolysis to occur, heat

diffuses from the hair shaft to the follicular stem cells to cause damage. In darker skin types, rather than reaching the target melanin in the hair shaft, light is absorbed in the epidermis where it is then converted to heat. This may result in poorer clinical outcomes and a higher rate of thermally induced adverse effects, such as hypo- or hyperpigmentation, blistering, and crust formation (Fayne et al., 2018). The selection of laser wavelength is critical in reducing this risk, with longer wavelength recommended to minimize the absorption of light in epidermal melanin and thus maximize efficacy and minimize adverse effects in patients with dark skin (Zhang et al., 2016). Side effects from LHR can include the feeling of sunburnt after treatment, as well as inflammation, redness, hyperpigmentation, and swelling. Flashing lights have been known to induce seizures in susceptible patients, so patients should be screened for this risk. Pain and discomfort during the procedure can also represent a significant barrier, and PCPs should be prepared to prescribe topical or systemic analgesics, such as a eutectic mixture of local anesthetics (EMLA) or a low dose systemic opioid. For genital GAS, some have recommended a 3-month wait after the last planned hair removal treatment before proceeding with surgery to confirm that no further hair regrowth will occur (Zhang et al., 2016).

## CHAPTER 16 Reproductive Health

All humans, including transgender individuals, have the reproductive right to decide whether or not to have children (United Nations Population Fund, 2014). Medically necessary gender-affirming hormonal treatments (GAHTs) and surgical interventions (see medically necessary statement in Chapter 2—Global Applicability, Statement 2.1) that alter reproductive anatomy or function may limit future reproductive options to varying degrees (Hembree et al., 2017; Nahata et al., 2019). It is thus critical to discuss infertility risk and fertility preservation (FP) options with transgender individuals and their families prior to initiating any of these treatments and to continue these conversations on an ongoing basis thereafter (Hembree et al., 2017). Established FP options, such as embryo, oocyte, and sperm cryopreservation, may be available for postpubertal transgender individuals (Nahata et al., 2019). Research protocols for ovarian and testicular tissue cryopreservation have also been developed and studied (Borgström et al., 2020; Nahata et al., 2019; Rodriguez-Wallberg, et al., 2019). Whereas the use of embryos, mature oocytes, and sperm have all proven to be efficacious when employed within clinical treatments, cryopreserved gonadal tissues would require either future retransplantation aimed at obtaining fully functional gametes or the application of laboratory methods for culture, which are still under development in basic science research settings. Of note, recent American Society for Reproductive Medicine guidelines have lifted the experimental label on ovarian tissue cryopreservation, but evidence remains limited in prepubertal children (Practice Committee of the American Society for Reproductive Medicine, 2019).

Individualized care should be provided in the context of each person's parenthood goals. Some research suggests transgender and gender diverse (TGD) people may be less likely to desire genetically related children or children at all when compared with cisgender peers (Defreyne, van Schuylenbergh et al., 2020; Russell et al., 2016; von Doussa et al., 2015). Yet, several other studies have shown many TGD individuals 1) desire

genetically related children; 2) regret missed opportunities for FP; and 3) are willing to delay or interrupt hormone therapy to preserve fertility and/or conceive (Armund, Dhejne et al., 2017; Auer et al., 2018; De Sutter et al., 2002; Defreyne, van Schuylenbergh et al., 2020; Tornello & Bos, 2017).

Many barriers to FP have been reported, such as cost (which is exacerbated when insurance coverage is lacking), urgency to start treatment, inability to make future-oriented decisions, inadequate provider knowledge/provider biases that affect offering FP, and difficulties accessing FP (Baram et al., 2019; Defreyne, van Schuylenbergh et al., 2020). Additionally, transgender individuals may have worsening dysphoria due to various steps in the FP process that are inseparably connected with the gender assigned at birth (Armund, Dhejne, et al., 2017; Baram et al., 2019). When available, a multidisciplinary team approach, where both medical and mental health providers collaborate with gender-affirming fertility specialists, can help overcome some of these barriers (Tishelman et al., 2019). TGD individuals should be educated about the distinction between fertility (utilizing one's own gametes/reproductive tissues) and pregnancy. In addition to fertility considerations, efforts to ensure equitable high-quality care for all forms of family planning and building throughout the full reproductive continuum must be maintained. This includes procreative options such as perinatal care, pregnancy, delivery, and postpartum care, as well as family planning and contraceptive options to prevent unplanned pregnancies, and pregnancy termination if sanctioned (Bonnington et al., 2020; Cipres et al., 2017; Krempasky et al., 2020; Light et al., 2018; Moseson, Fix et al., 2020). TGD people who wish to carry a pregnancy should undergo standard of care preconception care and prenatal counseling and should receive counseling about breast/chest feeding in environments supportive of people with diverse gender identities and experiences (MacDonald et al., 2016; Obedin-Maliver & Makadon, 2016).

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and

**Statements of Recommendations**

- 16.1- We recommend health care professionals who are treating transgender and gender diverse people and prescribing or referring patients for hormone therapies/surgeries advise their patients about:
- 16.1.a- Known effects of hormone therapies/surgery on future fertility;
  - 16.1.b- Potential effects of therapies that are not well studied and are of unknown reversibility;
  - 16.1.c- Fertility preservation (FP) options (both established and experimental);
  - 16.1.d- Psychosocial implications of infertility.
- 16.2- We recommend health care professionals refer transgender and gender diverse people interested in fertility preservation to providers with expertise in fertility preservation for further discussion.
- 16.3- We recommend transgender care teams partner with local reproductive specialists and facilities to provide specific and timely information and fertility preservation services prior to offering medical and surgical interventions that may impact fertility.
- 16.4- We recommend health care professionals counsel pre- or early-pubertal transgender and gender diverse youth seeking gender-affirming therapy and their families that currently evidence-based/established fertility preservation options are limited.
- 16.5- We recommend transgender and gender diverse people with a uterus who wish to carry a pregnancy undergo preconception care, prenatal counseling regarding use and cessation of gender-affirming hormones, pregnancy care, labor and delivery, chest/breast feeding supportive services, and postpartum support according to local standards of care in a gender-affirming way.
- 16.6. We recommend medical providers discuss contraception methods with transgender and gender diverse people who engage in sexual activity that can result in pregnancy.
- 16.7. We recommend providers who offer pregnancy termination services ensure procedural options are gender-affirming and serve transgender people and those of diverse genders.

harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

**Statement 16.1**

**We recommend health care professionals who are treating transgender and gender diverse people and prescribing or referring patients for hormone therapies/surgeries advise their patients about:**

- a. Known effects of hormone therapies/surgeries on future fertility;**
- b. Potential effects of therapies that are not well studied and are of unknown reversibility;**
- c. Fertility preservation (FP) options (both established and experimental);**
- d. Psychosocial implications of infertility.**

**TGD individuals assigned female at birth**

GAHT may negatively impact future reproductive capacity (Hembree et al., 2017). Based on current evidence in transgender men and gender diverse people assigned female at birth, these risks are as follows:

Gonadotropin-releasing hormone agonists (GnRHAs) may be used for pubertal suppression to prevent further pubertal progression until adolescents are ready for masculinizing treatment. GnRHAs may also be used for menstrual

suppression. GnRHAs impact the maturation of gametes but do not cause permanent damage to gonadal function. Thus, if GnRHAs are discontinued, oocyte maturation would be expected to resume.

There are few studies detailing the effects of testosterone therapy on reproductive function in transgender men (Moravek et al., 2020). Restoration of normal ovarian function with oocyte maturation after testosterone interruption has been demonstrated in transgender men who have achieved natural conception. A retrospective study on oocyte cryopreservation showed no differences in the total number of oocytes retrieved or in the number of mature oocytes between transgender men and age- and BMI-matched cisgender women (Adeleye et al., 2018, 2019). The first results have recently been published evaluating live birth rates after controlled ovarian stimulation in transgender men compared with cisgender women (Leung et al., 2019). Testosterone was discontinued prior to ovarian stimulation. Overall, the results concerning the influence of testosterone on reproductive organs and their function appear to be reassuring. However, there have been no prospective studies to date evaluating the effect of long-term hormone therapy on fertility (i.e., started in adolescence) or in those treated with GnRHAs in early puberty followed by testosterone therapy. It is important to take into consideration that required medications and procedures for cryopreserving oocytes (a

pelvic examination, vaginal ultrasound monitoring, and oocyte retrievals) may lead to increasing gender dysphoria in transgender men (Armuand, Dhejne et al., 2017).

Surgical interventions among transgender men will have obvious implications for reproductive capacity. If patients desire a hysterectomy, the option should be offered of preserving the ovaries to retain the possibility of having a genetically related child. Alternatively, if the ovaries are removed either separately or concurrently with the hysterectomy, egg freezing should be offered prior to surgery and/or ovarian tissue cryopreservation can be done at the time of oophorectomy. Although this procedure is no longer considered experimental, many transgender men may desire *in vitro* maturation of primordial follicles, which is still investigational. Studies evaluating oocyte function have shown oocytes isolated from transgender men with testosterone exposure at the time of oophorectomy can be matured *in vitro* to develop normal metaphase II meiotic spindle structure (De Roo et al., 2017; Lierman et al., 2017).

### **TGD individuals assigned male at birth**

Based on current evidence in transgender women and gender diverse people assigned male at birth (AMAB), the influence of medical treatment is as follows:

GnRHs inhibit spermatogenesis. Data suggest discontinuation of treatment results in a re-initiation of spermatogenesis, although this may take at least 3 months and most likely longer (Bertelloni et al., 2000). Furthermore, the psychological burden of re-exposure to testosterone should be considered.

Anti-androgens and estrogens result in an impaired sperm production (de Nie et al., 2020; Jindarak et al., 2018; Kent et al., 2018). Spermatogenesis might resume after discontinuation of prolonged treatment with anti-androgens and estrogens, but data are limited (Adeleye et al., 2019; Alford et al., 2020; Schneider et al., 2017). Testicular volumes diminish under the influence of gender-affirming hormone treatment (Matoso et al., 2018). Semen quality in transgender women may also be negatively affected by specific life-style factors, such as a low frequency

of masturbation, wearing the genitals tight against the body (e.g., with use of tight undergarments for tucking) (Jung & Schuppe, 2007; Mieuisset et al., 1985, 1987; Rodriguez-Wallberg, Häljestig et al., 2021).

### Statement 16.2

**We recommend health care professionals refer transgender and gender diverse people interested in fertility preservation to providers with expertise in fertility preservation for further discussion.**

Research shows many transgender adults desire biological children (De Sutter et al., 2002; Defreyne, van Schuylenbergh et al., 2020; Wierckx, Van Caenegem et al., 2012), yet FP rates remain widely variable, particularly in youth (< 5%–40%) (Brik et al., 2019; Chen et al., 2017; Chiniara et al., 2019; Nahata et al., 2017; Segev-Becker et al., 2020). In a recent survey, many youth acknowledged their feelings about having a biological child might change in the future (Strang, Jarin et al., 2018). Non-elective sterilization is a violation of human rights (Ethics Committee of the American Society for Reproductive Medicine, 2015; Equality and Human Rights Commission, 2021; Meyer III et al., 2001) and due to advances in social attitudes, fertility medicine, and affirmative transgender health care, opportunities for biological parenthood during transition should be supported for transgender people. Due to the influence clinical opinion may have on transgender or nonbinary people's FP and on parenting decisions, FP options should be explored by health care providers alongside options such as fostering, adoption, coparenting, and other parenting alternatives (Bartholomaeus & Riggs, 2019). Transgender patients who have been offered this type of discussion and have been given the choice to undergo procedures for FP have reported the experience to be an overall positive one (Armuand, Dhejne et al., 2017; De Sutter et al., 2002; James-Abra et al., 2015).

In other patient populations, fertility referrals and formal fertility programs have been shown to increase FP rates and improve patient satisfaction (Kelvin et al., 2016; Klosky, Anderson et al., 2017; Klosky, Wang et al., 2017;

Shnorhavorian et al., 2012) Physician attitudes have been investigated, and recent studies indicate both an awareness and a desire to provide fertility-related information to children and their families (Armund et al., 2020). However, barriers have also been identified, including lack of knowledge, comfort, and resources (Armund, Nilsson et al., 2017; Frederick et al., 2018). Thus, the need for appropriate training of health care providers has been highlighted, with emphasis placed on fertility counseling and offering FP options to all at-risk individuals in an unbiased way (Armund, Nilsson et al., 2017). Parents' recommendations have also been shown to significantly influence FP rates in adolescent and young adult males with cancer (Klosky, Flynn et al., 2017). While there are clear clinical differences in these populations, these findings can help inform best practices for fertility counseling and FP referrals for transgender individuals.

#### Statement 16.3

**We recommend transgender care teams partner with local reproductive specialists and facilities to provide specific and timely information and fertility preservation services prior to offering medical and surgical interventions that may impact fertility.**

Cryopreservation of sperm and oocytes are established FP techniques and can be offered to pubertal, late pubertal, and adult birth assigned males and birth assigned females, respectively, preferably prior to the initiation of GAHT (Hembree et al., 2017; Practice Committee of the American Society for Reproductive Medicine, 2019). Cryopreservation of embryos can be offered to adult (post-pubertal) TGD people who wish to have a child and have an available partner. The future use of cryopreserved gametes is also dependent on the gametes and reproductive organs of the future partner (Fischer, 2021; Maxwell et al., 2017)

Although semen parameters have been shown to be compromised when FP is performed after initiation of GAH medication (Adeleye et al., 2019), one small study showed when the treatment was discontinued, semen parameters were comparable to those in TGD patients who had

never undergone GAH treatment. With regard to ovarian stimulation, oocyte vitrification yield and subsequent use of the oocytes in in-vitro fertilization (IVF), there is no reason to anticipate a different outcome in assisted reproductive technology (ART) treatments for TGD patients than that obtained in cisgender patients undergoing ART—other than individual confounding factors related to (in)fertility—when gametes are banked prior to any medical treatment (Adeleye et al., 2019). The use of oocytes in ART treatment resulted in similarly successful outcomes in TGD compared with controlled, matched cisgender patients (Adeleye et al., 2019; Leung et al., 2019; Maxwell et al., 2017).

Although these are established options, few pubertal, late pubertal or adult TGD people undergo FP (Nahata et al., 2017), and many experience challenges while undergoing FP interventions. Not only is access and cost of these methods a barrier (particularly in regions without insurance coverage), but these procedures are often physically and emotionally uncomfortable, and many express concerns about postponing the transitioning process (Chen et al., 2017; De Sutter et al., 2002; Nahata et al., 2017; Wierckx, Stuyver et al., 2012). Especially for the birth assigned females, the invasiveness of endovaginal ultrasound follow-up of the ovarian stimulation and oocyte retrieval procedures (and associated psychological distress) have been cited as a barrier (Armund, Dhejne et al., 2017; Chen et al., 2017). There is also the concern young adults going through transitioning may not have a clear vision of parenting and are therefore likely to decline the opportunity to use FP at that time—while as adults, they may have different opinions about parenthood (Cauffman & Steinberg, 2000). The reduction of gender dysphoria during transitioning could also influence the decision-making process surrounding FP (Nahata et al., 2017). Based on research showing TGD youths' fertility perspectives may change over time (Nahata et al., 2019; Strang, Jarin et al., 2018), FP options should be discussed on an ongoing basis.

#### Statement 16.4

**We recommend health care professionals counsel pre- or early-pubertal transgender and**

**gender diverse youth seeking gender-affirming therapy and their families that currently evidence-based/established fertility preservation options are limited.**

For prepubertal and early-pubertal children, FP options are limited to the storage of gonadal tissue. Although this option is available for TGD children in the same way that it is available for cisgender prepubertal and early-pubertal oncological patients, there is no literature describing the utilization of this approach in the transgender population. Ovarian tissue autotransplantation has resulted in over 130 live births in cisgender women. Most of these patients conceived naturally without ART (Donnez & Dolmans, 2015; Jadoul et al., 2017), and the majority stored their ovarian tissue either as adults or during puberty. Although the recent American Society for Reproductive Medicine guideline has lifted the experimental label from ovarian tissue cryopreservation (Practice Committee of the American Society for Reproductive Medicine, 2019), there are very few case reports describing a successful pregnancy in a woman following the transplantation of ovarian tissue cryopreserved before puberty. Demeestere et al. (2015) and Rodriguez-Wallberg, Milenkovic et al. (2021) described cases of successful pregnancies following transplantation of tissue procured at the age of 14, and recently Matthews et al. (2018) described the case of a girl diagnosed with thalassemia who had ovarian tissue stored at the age of 9 and transplantation 14 years later. She subsequently conceived through IVF and delivered a healthy baby.

Currently, the only future clinical application for storing ovarian tissue is autotransplantation, which might be undesirable in a transgender man (due to the potentially undesirable effects of estrogen). A laboratory procedure that would make it possible to mature oocytes *in vitro* starting with ovarian tissue would be the ideal future application of stored ovarian tissue for transgender people, but this technique is currently only being investigated and optimized in basic science research settings (Ladanyi et al., 2017; Oktay et al., 2010).

Prepubertal procurement of testicular tissue has been documented as a low-risk procedure (Borgström et al., 2020; Ming et al., 2018). Some

authors have also described this approach as a theoretical option in transgender people (De Roo et al., 2016; Martinez et al., 2017; Nahata, Curci et al., 2018). However, there are no reports in the literature describing the clinical or investigational utilization of this FP option for TGD patients. Moreover, the viability of the clinical application of autotransplantation of testicular tissue remains unknown in humans, and *in vitro* maturation techniques are still in the realm of basic science research. Thus, specialists currently consider this technique experimental (Picton et al., 2015). The possibility of storing gonadal tissue should be discussed prior to any genital surgery that would result in sterilization, although the probability of being able to use this tissue must be clearly addressed.

Statement 16.5

**We recommend transgender and gender diverse people with a uterus who wish to carry a pregnancy undergo preconception care and prenatal counseling regarding the use and cessation of gender-affirming hormones, pregnancy care, labor and delivery, chest/breast feeding supportive services, and postpartum support according to local standards of care in a gender-affirming way.**

Most transgender men and gender diverse people (AFAB) retain their uterus and ovaries and thus can conceive and carry a pregnancy even after long-term testosterone use (Light et al., 2014). Many transgender men desire children (Light et al., 2018; Wierckx, van Caenegem et al., 2012) and are willing to carry a pregnancy (Moseson, Fix, Hastings et al., 2021; Moseson, Fix, Ragosta et al., 2021). ART has expanded the opportunity for many transgender men to conceive and fulfill their family planning wishes (De Roo et al., 2017; Ellis et al., 2015; Maxwell et al., 2017). Some transgender men report psychological isolation, dysphoria related to the gravid uterus and chest changes, and depression (Charter, 2018; Ellis et al., 2015; Hoffkling et al., 2017; Obedin-Maliver & Makadon, 2016). Conversely, other studies have reported some positive experiences during pregnancy as well (Fischer, 2021; Light et al., 2014). Mental health providers should be involved to provide support, and counseling should be

provided addressing when to stop and when to resume gender-affirming hormones, what options are available for the mode of delivery and for chest/breast feeding (Hoffkling et al., 2017). Finally, system-level and interpersonal-level interventions should be implemented to ensure person-centered reproductive health care for all people (Hahn et al., 2019; Hoffkling et al., 2017; Moseson, Zazanis et al., 2020; Snowden et al., 2018).

Given the potential harmful effects of testosterone on the developing embryo, discontinuing testosterone or masculinizing hormone therapy prior to conception and during the entire pregnancy is recommended. However, the optimal time for both the discontinuation of testosterone prior to pregnancy and its resumption after pregnancy is unknown. Since stopping gender-affirming hormones may cause distress and exacerbate dysphoria in transgender men, when and how to stop this therapy should be discussed during prenatal counseling (Hahn et al., 2019). Because information about the duration of testosterone exposure and the risk of teratogenicity is lacking, testosterone use should be discontinued prior to attempting pregnancy and before stopping contraception. Moreover, there is limited information regarding health outcomes of infants born to transgender men. Small case series attempting to evaluate this question have revealed no adverse physical or psychosocial differences between infants born to transgender men and infants in the general population (Chiland et al., 2013).

### **Chest/Breast feeding**

In the limited studies evaluating lactation and chest/breast feeding, the majority of transgender men and TGD individuals AFAB who chose to chest/breast feed postpartum were successful, with research suggesting induction of lactation is in part dependent on preconception counseling and experienced lactation nursing support (MacDonald et al., 2016; Wolfe-Roubatis & Spatz, 2015). Specifically, transgender men and TGD people who use testosterone should be informed 1) although quantities are small, testosterone does pass through chest/breast milk; and 2) the impact on the developing neonate/child is unknown, and therefore gender-affirming testosterone use is not recommended during lactation but may be resumed after discontinuation of

chest/breast feeding (Glaser et al., 2009). Transgender men and other TGD individuals AFAB should be made aware some patients who carry a pregnancy may experience undesired chest growth and/or lactation even after chest reconstruction and should therefore be supported if they desire to suppress lactation (MacDonald et al., 2016).

There is limited information concerning lactation in transgender women as well as other TGD AMAB but many also express the desire to chest/breast feed. While there is a case report of a transgender woman successfully lactating and chest/breast feeding her infant after hormonal support using a combination of estrogen, progesterone, domperidone, and breast pumping (Reisman & Goldstein, 2018), the nutritional and immunological profile of chest/breast milk under these conditions has not been studied. Therefore, patients need to be informed about the risks and benefits of this approach to child feeding (Reisman & Goldstein, 2018).

### Statement 16.6

**We recommend medical providers discuss contraception methods with transgender and gender diverse people who engage in sexual activity that can result in pregnancy.**

Many TGD individuals may retain reproductive capacity, and they (if they retain a uterus, ovaries, and tubes) or their sexual partners (for sperm producing individuals) may experience unplanned pregnancies (James et al., 2016; Light et al., 2014; Moseson, Fix et al., 2020). Therefore, intentional family planning counseling, including contraception and abortion conducted in gender-expansive ways is needed (Klein, Berry-Bibee et al., 2018; Obedin-Maliver, 2015; Stroumsa & Wu, 2018). TGD people AFAB may not use contraception due to an erroneous assumption that testosterone is a reliable form of contraception (Abern & Maguire, 2018; Ingraham et al., 2018; Jones, Wood et al., 2017; Potter et al., 2015). However, based on current understanding, testosterone should not be considered a reliable form of contraception because of its incomplete suppression of the hypothalamic-pituitary-adrenal axis (Krempasky et al., 2020). Furthermore, pregnancies have occurred while individuals are amenorrheic due

to testosterone use, which may outlast active periods of administration (Light et al., 2014). Pregnancy can also occur in TGD people after long-term testosterone use (at least up to 10 years), although the effect on oocytes and baseline fertility is still unknown (Light et al., 2014).

TGD people AFAB may use a variety of contraceptive methods (Abern & Maguire, 2018; Bentsianov et al., 2018; Bonnington et al., 2020; Chrisler et al., 2016; Cipres et al., 2017; Jones, Wood et al., 2017; Krempasky et al., 2020; Light et al., 2018). These methods may be used explicitly for pregnancy prevention, menstrual suppression, abnormal bleeding, or other gynecological needs (Bonnington et al., 2020; Chrisler et al., 2016; Krempasky et al., 2020; Schwartz et al., 2019). Contraceptive research gaps within this population are profound. No studies have examined how the use of exogenous androgens (e.g., testosterone) may modify the efficacy or safety profile of hormonal contraceptive methods (e.g., combined estrogen and progestin hormonal contraceptives, progestin-only based contraceptives) or non-hormonal and barrier contraceptive methods (e.g., internal and external condoms, non-hormonal intrauterine devices, diaphragms, sponges, etc.).

Gender diverse individuals who currently have a penis and testicles may engage in sexual activity with individuals who have a uterus, ovaries, and tubes of any gender. Gender diverse people who have a penis and testicles can produce sperm even while on gender-affirming hormones (i.e., estrogen), and although semen parameters are diminished among those who are currently using or who have previously used gender-affirming hormones, azoospermia is not complete and sperm activity is not totally suppressed (Adeleye et al., 2019; Jindarak et al., 2018; Kent et al.,

2018). Therefore, contraception needs to be considered if pregnancy is to be avoided in penis-in-vagina sexual activity between a person with a uterus, ovaries, and tubes and one with a penis and testicles, irrespective of the use of gender-affirming hormones by either partner. Currently, contraceptive methods available for use by the sperm-producing partner are primarily mechanical barriers (i.e., external condoms, internal condoms), permanent sterilization (i.e., vasectomy), and gender-affirming surgery (e.g., orchiectomy, which also results in sterilization). Contraceptive counseling that considers sperm producing, egg producing, and gestating partners (as relevant) is recommended.

#### Statement 16.7

**We recommend providers who offer pregnancy termination services ensure procedural approaches are gender-affirming and serve transgender people and those of diverse genders.**

Unplanned pregnancies and abortions have been reported among TGD individuals with a uterus (Abern & Maguire, 2018; Light et al., 2014; Light et al., 2018; Moseson, Fix et al., 2020) and documented through surveys of abortion-providing facilities (Jones et al., 2020). However, the population-based epidemiology of abortion provision and the experiences and preferences of TGD individuals AFAB undergoing abortion still represents a critical gap in research (Fix et al., 2020; Moseson, Fix et al., 2020; Moseson, Lunn et al., 2020). Nonetheless, given that pregnancy capacity exists among many TGD people and pregnancies may not always be planned or desired, access to safe, legal, and gender-affirming pregnancy medical and surgical termination services is necessary.

## CHAPTER 17 Sexual Health

Sexual health has a profound impact on physical and psychological well-being, regardless of one's sex, gender, or sexual orientation. However, stigma about sex, gender and sexual orientation influences individual's opportunities to live out their sexuality and to receive appropriate sexual health care. Specifically, in most societies, cisnormativity and heteronormativity lead to the assumption that all people are cisgender and heterosexual (Bauer et al., 2009), and that this combination is superior to all other genders and sexual orientations (Nieder, Gldenring et al., 2020; Rider, Vencill et al., 2019). Hetero-cisnormativity negates the complexity of gender, sexual orientation, and sexuality and disregards diversity and fluidity. This is all the more important since sexual identities, orientations, and practices of transgender and gender diverse (TGD) people are characterized by an enormous diversity (Galupo et al., 2016; Jessen et al., 2021; Thurston & Allan, 2018; T'Sjoen et al., 2020). Likewise, a strong cross-cultural tendency toward allonormativity—the assumption that all people experience sexual attraction or interest in sexual activity—negates the diverse experiences of TGD people, especially those who locate themselves on the asexual spectrum (McInroy et al., 2021; Mollet, 2021; Rothblum et al., 2020).

The World Health Organization (WHO, 2010) emphasizes sexual health depends on respect for the sexual rights of all people, including the right to express diverse sexualities and to be treated respectfully, safely, and with freedom from discrimination and violence. Sexual health discourses have focused on agency and body autonomy, which include consent, sexual pleasure, sexual satisfaction, partnerships, and family life (Cornwall & Jolly, 2006; Lindley et al., 2021). In light of this, the WHO defines sexual health as “a state of physical, emotional, mental, and social well-being in relation to sexuality and not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be

attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled” (WHO, 2006, p. 5). This includes individuals on the asexual spectrum, who may not experience sexual attraction to others but may still choose to be sexual at times (e.g., via self-stimulation) and/or experience interest in forming and building romantic relationships (de Oliveira et al., 2021).

Scientific attention to the sexual experiences and behaviors of TGD people has grown in recent years (Gieles et al., 2022; Holmberg et al., 2019; Klein & Gorzalka, 2009; Kloer et al., 2021; Mattawanon et al., 2021; Stephenson et al., 2017; Tirapegui et al., 2020; Thurston & Allan, 2018). This expansion within the literature reflects a sex-positive framework (Harden, 2014), a framework that recognizes both the positive aspects such as sexual pleasure (Laan et al., 2021) and potential risks associated with sexuality (Goldhammer et al., 2022; Mujugira et al., 2021). Studies of TGD people's sexuality, however, often lack validated measures, an appropriate control group, or a prospective design (Holmberg et al., 2019). Additionally, most focus exclusively on sexual functioning (Kennis et al., 2022), and thus neglecting sexual satisfaction and broader operationalizations of sexual pleasure beyond functioning. The effects of current TGD-related medical treatments on sexuality are heterogeneous (zer et al., 2022; T'Sjoen et al., 2020), and there has been little research on the sexuality of TGD adolescents (Bungener et al., 2017; Maheux et al., 2021; Ristori et al., 2021; Stbler & Becker-Hebly, 2019; Warwick et al., 2022). While sex-positive approaches to counseling and treatment for sexual difficulties experienced by TGD individuals have been proposed (Fielding, 2021; Jacobson et al., 2019; Richards, 2021), to date there is insufficient research on the effectiveness of such interventions. Focusing on the promotion of sexual health, the World Association for Sexual Health (WAS) asserts the importance of sexual pleasure and considers self-determination, consent, safety, privacy, confidence, and the ability to communicate and negotiate sexual relations as major facilitators (Kismdi et al., 2017). WAS asserts sexual pleasure is integral to sexual rights and human rights (Kismdi et al., 2017). To contribute to

**Statements of Recommendations**

- 17.1- We recommend health care professionals who provide care to transgender and gender diverse people acquire the knowledge and skills needed to address sexual health issues (relevant to their care provision).
- 17.2- We recommend health care professionals who provide care to transgender and gender diverse people discuss the impact of gender-affirming treatments on sexual function, pleasure, and satisfaction.
- 17.3- We recommend health care professionals who provide care to transgender and gender diverse people offer the possibility of including the partner(s) in sexuality-related care, if appropriate.
- 17.4- We recommend health care professionals counsel transgender and gender diverse people about the potential impact of stigma and trauma on sexual risk behavior, sexual avoidance, and sexual functioning.
- 17.5- We recommend any health care professional who offers care that may impact sexual health provide information, ask about the expectations of the transgender and gender diverse individual and assess their level of understanding of possible changes.
- 17.6- We recommend health care professionals who provide care to transgender and gender diverse people counsel adolescents and adults regarding prevention of sexually transmitted infections.
- 17.7- We recommend health care professionals who provide care to transgender and gender diverse people follow local and World Health Organization guidelines for human immunodeficiency virus/sexual transmitted infections (HIV/STIs) screening, prevention, and treatment.
- 17.8- We recommend health care professionals who provide care to transgender and gender diverse people address concerns about potential interactions between antiretroviral medications and hormones.

the sexual health of TGD people, health care professionals (HCPs) need both transgender-related expertise and sensitivity (Nieder, Gldenring et al., 2020). With the goal of improving sexual health care for TGD people to an ethically-sound, evidence-based and high-quality level, HCPs must provide their health services with the same care (i.e., with transgender-related expertise), respect (i.e., with transgender-related sensitivity), and investment in sexual pleasure and sexual satisfaction as they provide for cisgender people (Holmberg et al., 2019).

In many societies, nonconforming gender expressions can elicit strong (emotional) reactions, including in HCPs. Thus, when initiating a health-related contact or establishing a therapeutic relationship, a nonjudgmental, open and welcoming manner is most likely ensured when HCPs reflect on their emotional, cognitive, and interactional reactions to the person (Nieder, Gldenring et al., 2020). In addition, transgender-related expertise refers to identifying the impact the TGD person's intersectional identities and experiences of marginalization and stigma may have had on their whole self (Rider, Vencill et al., 2019). To adequately address the specific physical, psychological, and social conditions of TGD people, HCPs must be aware these conditions are generally overlooked due to hetero-cis-normativity, lack of knowledge, and lack of skills (Rees et al., 2021). It is also important to consider cultural norms in relation to sexuality. For example, in some African cultures, the

idea of sex as taboo restricts the number of acceptable terms to be used when taking a sexual history (Netshandama et al., 2017). Culturally respectful language can facilitate talking openly about one's sexual history and reduce ambiguity or shame (Duby et al., 2016). In addition, HCPs must be sensitive to the history of (mis)use of sexual identity and orientation as a gatekeeping function to exclude transgender people from gender-affirming health care (Nieder & Richter-Appelt, 2011; Richards et al., 2014). The following recommendations aim to improve sexual health care for TGD people.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

**Statement 17.1**

**We recommend health care professionals who provide care to transgender and gender diverse people acquire the knowledge and skills to address sexual health issues (relevant to their care provision).**

It is important HCPs addressing the sexual health of TGD people be familiar with commonly used terminology (see Chapter 1—Terminology) and invite those seeking care to explain terms with which the provider may not be familiar. In this context, it is also important HCPs (are

prepared to) take a sexual history and offer treatment (according to their competencies) in a gender-affirming way with a sex-positive approach (Centers for Disease Control, 2020; Tomson et al., 2021). However, HCP's should apply greater importance to the terminology that the TGD person uses for their own body over more traditionally accepted or used medical terminology (Wesp, 2016). When talking about sexual practices, it is advisable to focus on body parts (e.g., "Do you have sex with people with a penis, people with a vagina, or both?"; ACON, 2022) and what role they play in their sexuality (e.g., "During Sex, do any parts of your body enter your partners body, such as their genitals, anus, or mouth?"; ACON, 2022).

#### Statement 17.2

**We recommend health care professionals who provide care to transgender and gender diverse people discuss the impact of gender-affirming treatments on sexual function, pleasure, and satisfaction.**

To achieve gender-affirming care, it is crucial HCPs providing transition-related medical interventions be sufficiently informed about the possible effects on sexual function, pleasure, and satisfaction (T'Sjoen et al., 2020). Since clinical data indicate that TGD people score significantly lower in sexual pleasure compared to cisgender individuals, this is even more important (Gieles et al., 2022). If the HCP cannot provide information about the effects of their treatment on sexual function, pleasure, and satisfaction, they are at least expected to refer the individual to someone qualified to do so. If the sexuality-related effects of their treatment are unknown, HCPs should inform their patients accordingly. As introduced above, the sexuality of TGD people often challenges heteronormative views. Nevertheless, there is a large amount of literature (e.g., Bauer, 2018; Laube et al., 2020; Hamm & Nieder, 2021; Stephenson et al., 2017) highlighting the spectrum character of sexuality that does not fit into expectations of what male and female sexuality entails (neither cis- nor transgender), let alone that of gender diverse people (e.g., non-binary, agender, genderqueer). Thus, these aspects should be carefully considered by HCPs as

cisnormativity, heteronormativity, and transition-related medical interventions, all have a strong impact on sexual health.

Sexual pleasure has been well documented as a factor in improving sexual, mental, and physical health outcomes (Anderson, 2013). Next to sexual function, HCPs providing sexual health care must address sexual pleasure and satisfaction as a key factor within sexual health. Historically sexual health care has been disease focused, and this is particularly true for research and clinical practice in working with TGD patients. Although competent sexual health care regarding HIV and STIs is necessary, integration of valuing sexual pleasure of TGD patients is also necessary. Calls for integrating sexual pleasure as a focal point in STI prevention education and interventions rest on the understanding that pleasure is a motivator of behavior (Philpott et al., 2006). TGD people are concerned about their sexual pleasure and need HCPs who are knowledgeable about the diversity of sexual practices and anatomical functioning particular to TGD health care.

#### Statement 17.3

**We recommend health care professionals who provide care to transgender and gender diverse people offer the possibility of including the partner(s) in sexuality-related care, if appropriate.**

When appropriate and relevant to clinical concerns, inclusion of a sexual and/or romantic partner(s) in sexual health care decision-making can increase TGD patients' sexual well-being and satisfaction outcomes (Kleinplatz, 2012). TGD people may choose a range of transition-related medical interventions, and these interventions may have mixed results in shifting experiences of anatomical dysphoria (Bauer & Hammond, 2015). When discussing the impact of medical interventions on sexual functioning, pleasure, and satisfaction, inclusion of partner(s) can increase knowledge of potential changes and encourage communication between partners (Dierckx et al., 2019). Because the process of transitioning is often not a completely solitary endeavor, the inclusion of sexual and/or romantic partners in transition-related health care can facilitate the process of "co-transitioning" (Lindley et al., 2020;

Siboni et al., 2022; Theron & Collier, 2013) and can also support sexual growth and adjustment both in the individual as well as in the relationship. Social and psychological barriers to sexual functioning and pleasure, including experiences of gender dysphoria, stigmatization, lack of sexual and relationship role models, and limited skills, can have negative impacts on overall sexual health (Kerckhof et al., 2019). Supportive, gender-affirming sexual communication between partners improves sexual satisfaction outcomes for TGD people (Stephenson et al., 2017; Wierckx, Elaut et al., 2011).

Inclusion of sexual and/or romantic partners offers an additional opportunity to set realistic expectations, disseminate helpful and accurate information, and facilitate gender-affirming positive communication related to sexual health. Ultimately, however, it is important to recognize individual choices related to gender health and transition are the patients to make, not a partner's decision. It is important the inclusion of partners in sexual health-related care occur only when appropriate and as desired by patients. Contraindications might include interpersonal dynamics that are abusive or violent, in which case patient safety overrides partner involvement. Finally, it is critical HCPs treat all people in an affirming and inclusive manner, including sexual and romantic partners. This means, for example, monitoring and addressing assumptions and potential biases about the gender or sexual orientation of a patient's partner(s) or a patient's relationship structure.

#### Statement 17.4

**We recommend health care professionals counsel transgender and gender diverse people about the potential impact of stigma and trauma on sexual risk behavior, sexual avoidance, and sexual functioning.**

The TGD community is disproportionately impacted by stigma, discrimination, and violence (de Vries et al., 2020; European Union Agency for Fundamental Rights, 2020; McLachlan, 2019). These experiences are often traumatic in nature (Burnes et al., 2016; Mizock & Lewis, 2008) and can create barriers to sexual health, functioning, and pleasure (Bauer & Hammond, 2015). For example, stigmatizing narratives about

transgender sexualities can increase dysphoria and sexual shame, increasing potential avoidance of the sexual communication needed for safety and optimizing pleasure (Stephenson et al., 2017). Research demonstrates stigma, a history of sexual violence, and body image concerns can negatively impact sexual self-esteem and agency, for example the ability to assert what is pleasurable or to negotiate condom use (Clements-Nolle et al., 2008; Dharma et al., 2019). Additionally, gender dysphoria can be exacerbated by past trauma experiences and ongoing trauma-related symptoms (Giovanardi et al., 2018). It may be difficult for some TGD individuals to engage sexually using the genitals with which they were born, and they may choose to avoid such stimulation altogether, disrupting arousal and/or orgasmic processes (Anzani et al., 2021; Bauer & Hammond, 2015; Iantaffi & Bockting, 2011) or result in complex feelings about orgasm (Chadwick et al., 2019). HCPs providing gender-affirming counseling and interventions must be knowledgeable about the spectrum of sexual orientations and identities (including asexual identities and practices) to avoid assumptions based in heteronormative, cisnormative, allonormative modes of behavior or satisfaction while also affirming the potential impacts of stigma and trauma on sexual health and pleasure (Nieder, Gldenring et al., 2020). Some level of disconnect or dissociation may at times be present, particularly in the case of acute trauma symptoms (Colizzi et al., 2015). It is important HCPs be aware of these potential impacts on sexual health, functioning, pleasure, and satisfaction, so they may refer patients as needed to trauma-informed sexual counselors, mental health providers, or both, who may be of further assistance and may also normalize and validate TGD patients exploring multiple diverse pathways of healing and accessing sexual pleasure.

#### Statement 17.5

**We recommend any health care professional who offers care that may impact sexual health provide information, ask about the expectation of the transgender and gender diverse individual, and assess their level of understanding of possible changes.**