

Reproductive Considerations for the LGBTQ+ Community

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KEYWORDS

- LGBTQ+ • Transgender • Sexual health • Reproduction • Contraception
- Fertility treatment • Pregnancy

KEY POINTS

- Primary care providers are key members of the team for conveying information regarding reproductive health to patients identifying as LGBTQ+.
- Understanding contraception, family building, and gender-affirming care are important reproductive health concerns for LGBTQ+ individuals.
- Working with gender-affirming mental health providers can support patients in their family building journey.

INTRODUCTION

Addressing sexual health is an essential part of all wellness visits. This includes an evaluation of social determinants of health and risk behaviors, and screening for sexually transmitted infections (STIs), intimate partner violence, and pregnancy intentions. The World Health Organization defines sexual health as “a state of physical, emotional, mental, and social well-being in relation to sexuality.”¹ This complex interplay of biologic, cultural, and socioeconomic factors requires that primary care providers adopt a multilayered approach when assessing the sexual health of their LGBTQ+ patients. The reproductive justice movement, constructed and advanced primarily by women of color, applies a helpful intersectional framework to issues of bodily autonomy, the right to have or not have children, and the right to parent children safely.² Developing a foundational understanding of the various factors that place LGBTQ+ individuals at risk for disparities in the health care system improves sexual health outcomes for these patients while furthering a reproductive justice agenda.

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OBTAINING A SEXUAL HISTORY

A comprehensive sexual history is an important first step in incorporating sexual health into practice. Various strategies may be used when creating inclusive and welcoming clinical spaces for conversations about sexuality and gender expression. These include being thoughtful about how patient information is collected and how patients are identified or addressed, providing gender neutral or gender inclusive restrooms, incorporating visual cues of allyship through posters or other printed materials, and completing basic training on sexual orientation and gender identity.³ Within the clinical encounter, open-ended and nonjudgmental questions help lay the groundwork for a comprehensive sexual health evaluation. The Centers for Disease Control and Prevention recommends including questions that address “the 5 Ps” when obtaining a sexual history from any patient: (1) partners, (2) practices, (3) protection from sexually transmitted diseases, (4) past history of sexually transmitted diseases, and (5) prevention of pregnancy (Box 1).⁴ All sexually active patients, regardless of sexual orientation, should be counseled regarding safe sex practices to reduce the risk of STIs. Examples

Box 1

Sexual history questions

1. Questions may be asked in person and/or via intake form
 - Are you currently sexually active?
 - If no, have you ever been sexually active?
 - In the past year, how many sex partners have you had?
 - Are your sex partners men, women, or both?
 - What types of sex do you have, or have you had (oral/anal/vaginal/use of sex toys/other)?
 - Do you have any history of physical, emotional, or sexual abuse?
 - What is your current relationship status?
 - Do you feel safe and supported in this relationship?
 - Do you and your partner(s) use protection from STI?
 - If not, could you tell me the reason?
 - If so, what kind of protection do you use?
 - How often do you use this protection?
 - If “sometimes,” in what situations or with whom do you use protection?
2. Have you ever been tested for STIs, including human immunodeficiency virus? Would you like to be tested?
3. Have you ever been diagnosed with an STI?
 - If so, what was your diagnosis and how were you treated?
4. Has your current partner or have any former partners ever been diagnosed or treated for an STI?
 - If so, what was the diagnosis and how was it treated?
5. Are you currently trying to become pregnant, or thinking you might pursue pregnancy in the next year?
 - If no, are you using contraception or practicing any form of birth control?
 - Do you feel supported in your choice to use (or not use) birth control?
 - Would you like to discuss birth control today?
6. Are there any questions about your sexual health or sexual practices that you would like to address today? Do you have any concerns regarding your sexual health or sexual practices that you would like to discuss?

Adapted from Centers for Disease Control and Prevention. A Guide to taking a sexual history. <https://stacks.cdc.gov/view/cdc/12303>.

of such practices include using condoms during intercourse or on sex toys, use of dental dams, and avoidance of sharing dildos and other sex toys.

LGBTQ and gender nonconforming individuals experience rates of intimate partner violence, homelessness, and sex-trafficking equal to or higher than cisgender heterosexual individuals.⁵⁻⁷ Not only should providers ask questions that address these topics, but they should be familiar with relevant and accessible resources for their patients who have a history of or are currently in any of these high-risk situations. Primary care providers should also be aware of mandatory reporting laws in their state in suspected cases of intimate partner violence, adolescent dating violence, or statutory rape.⁸

CONTRACEPTION

Prevention of unintended pregnancy may be relevant to any patient of reproductive age, and assumptions should not be made regarding desire or need for contraception based on patient sexuality or gender identity. Sexual minority women (people assigned female at birth who identify as anything other than heterosexual or who have sexual relationships with women) have been reported to have higher rates of unintended pregnancy than their heterosexual counterparts.⁹ Additionally, patients who fall within the transmasculine spectrum have unintended pregnancy rates comparable with the general population.¹⁰ Access to contraception therefore remains an important component of caring for LGBTQ+ patients. Provision of contraceptive services should include an assessment of medical comorbidities and the preferences of the patient. Tools, such as the US Selected Practice Recommendations for Contraceptive Use, provided by the Centers for Disease Control and Prevention, are helpful for clinical decision-making and patient education.^{11,12} If unintended pregnancy occurs, LGBTQ+ patients should be counseled on all possible options: continuation of pregnancy, adoption, and termination.

Contraception among transmasculine persons on testosterone is an area of confusion and misunderstanding for providers and patients. Prior studies have found that between 16.4% and 31% of transmasculine patients believe testosterone acts as contraception.^{13,14} Current literature also suggests that between 5.5% and 9% of transgender men have been counseled by a clinician that testosterone is a contraceptive.^{13,15} Although the ability to ovulate is impaired by increased androgens, it is not absent even in the setting of amenorrhea.¹⁶ The teratogenic effects of testosterone, including labial fusion, abnormal vaginal development, and clitoromegaly, further highlight the importance of preventing unintended pregnancy in this patient population. At this time, testosterone is not a contraindication to any form of contraception.

There are several unique considerations involved in counseling transmasculine patients about contraception, many of which relate to gender dysphoria. Transmasculine patients may prefer to avoid contraception involving a pelvic procedure because of discomfort with their pelvic anatomy. Others may find uterine bleeding distressing and thus would prefer methods that suppress menstruation. Another commonly reported patient concern is that hormonal contraception will counteract the masculinizing effects of testosterone.¹⁴ Current research suggests that the amount of estrogen in combined hormonal contraceptives is not likely to significantly prevent masculinization.^{16,17} Appropriate gender-affirming counseling allows providers to engage in supportive, shared decision-making about contraception with their transmasculine patients.

FAMILY BUILDING

The number of LGBTQ+ individuals who wish to start families or grow their existing families has increased substantially over the past decade. The means by which

LGBTQ+ individuals start or grow their families can take a variety of forms. Many LGBTQ+ individuals have children from previous relationships that they may wish to bring into a new relationship; however, greater societal acceptance of LGBTQ+ individuals may be responsible for the rise in LGBTQ+ individuals seeking alternative methods of family building, such as adoption, foster care, and the use of reproductive endocrinology. It is important that LGBTQ+ individuals feel comfortable bringing their family to an LGBTQ+ affirming primary care provider, who is also knowledgeable about the unique needs that LGBTQ+ patients may have during the process of building their families. Both the American Society for Reproductive Medicine and the American College of Obstetrics and Gynecology state that physicians should work to address the challenges that LGBTQ+ individuals face when accessing reproductive care, including family building, and ensure that these communities receive equitable and comprehensive reproductive care.^{15,18–20} Studies demonstrate no difference between LGBTQ+ and heterosexual, cisgender parents in providing safe, healthy, and loving homes for children.¹⁸

In 2010, the US Census found that 19% of same-sex couples were raising children.²¹ A retrospective study conducted in 2016 by the LGBTQ Health Center found that in the preceding decade between 2000 and 2008, there was a 10% increase in same-sex adoptions.²² More recently, a survey conducted by the Family Equality Council in 2019 found that despite structural barriers, LGBTQ+ individuals were increasingly reporting plans to have a family; however, the desire to start and grow families differed by age cohort.²³ LGBTQ+ millennials (ages 18–35) were more likely than LGBTQ+ individuals of older cohorts to envision themselves as parents, with 63% of LGBTQ+ millennials considering growing their families with a first child or by having more children as part of their future family. Nearly half of millennials (48%) were already in the process of growing their family or taking active steps to do so in the future. Notably, there was only a 7% gap in LGBTQ+ millennials who had children (33%) and non-LGBTQ+ identifying individuals who had children (40%). This gap was increasingly pronounced among older cohorts. Among those 36 to 54 years old, there was a gap of 12% between LGBTQ+ (47%) and non-LGBTQ+ (69%) parents. In the 55 and older age group, a 40% difference was noted between LGBTQ+ individuals with children (28%) and non-LGBTQ+ individuals with children (68%). These differences by cohort likely reflect the impact of increased societal acceptance of the LGBTQ+ community over time, reduced barriers to LGBTQ+ family building (eg, sanctioned same-sex adoptions), and developments in reproductive endocrinology.

FERTILITY TREATMENTS FOR LGBTQ+ PATIENTS

Fertility treatments are one of the main methods through which LGBTQ+ couples can have genetically related offspring. Intrauterine insemination (IUI) and in vitro fertilization (IVF) are common fertility treatments used to help individuals who are struggling to conceive. In IUI, sperm is injected directly into the uterine cavity during ovulation, with or without the use of hormones to stimulate the ovary and induce ovulation. IVF is a much more rigorous process, involving stimulation of the ovaries to mature multiple ovarian follicles, surgical retrieval of oocytes from these follicles, IVF of retrieved oocytes with sperm, and transfer of the fertilized embryo into the uterus for implantation and pregnancy. IVF is more efficacious, but also a more expensive process from start to finish. Appropriate assisted reproduction techniques for LGBTQ+ patients are outlined in [Table 1](#). In general, individuals assigned male sex at birth (AMB) can have genetically related offspring through IUI or IVF with the

Population	AMB	AFB
Fertility treatments	IUI: lower efficacy, lower cost IVF: higher efficacy, more appropriate in cases of oligospermia (low sperm counts) or if performing preimplantation genetic testing	
Genetic material provided	Sperm	Egg
Reproductive components required for reproduction	Surrogate ± donor egg or AFB partner	Donor sperm or AMB partner

Abbreviations: AFB, assigned female sex at birth; AMB, assigned male sex at birth.

assistance of a surrogate or gestational carrier and, in some cases, a donated oocyte. Individuals assigned female sex at birth (AFB) can have genetically related offspring through IUI or IVF with the use of donor sperm. Unique to transgender patients is the need to discontinue gender-affirming therapy in the setting of semen collection or ovarian stimulation, which may induce gender dysphoria.

Unfortunately, stigma and discrimination against LGBTQ+ individuals can prevent them from seeking medical assistance to achieve pregnancy. Single, same-sex, and transgender parents have historically been denied access to assisted reproductive technologies (ART), in part because of concerns from providers that these nontraditional family structures may be harmful to children.^{24,25} Under Section 1557 of the Affordable Care Act, LGBTQ+ individuals were protected against discrimination in health care services, including fertility care. However, in June 2020, these protections were removed through recent regulatory changes by the Trump administration.²⁶ Without these explicit protections, LGBTQ+ patients may be denied access to health care, including infertility services, under religious freedom laws.²⁷

Fortunately, as of 2010, 15 states and Washington, DC had antidiscrimination laws and statutes in place that offer explicit protections for transgender people.²⁰ Still, fertility treatments are associated with high rates of psychological morbidity and LGBTQ+ individuals may especially benefit from mental health support given the additional stressors placed on these patients.^{28,29}

As with many heterosexual couples, assisted reproduction may be cost-prohibitive for many LGBTQ+ couples and individuals. American Society for Reproductive Medicine quotes a single cycle of IVF in the United States at \$12,400, but studies indicate that the out-of-pocket cost is nearly double this figure in some parts of the country.^{30,31} Commercial (compensated) surrogacy can cost anywhere from \$50,000 to more than \$200,000 per pregnancy in the United States.³² Fertility mandates have emerged as one mechanism to reduce the burden of cost for individuals desiring fertility treatment. Although several states have fertility insurance mandates that require insurance companies to pay for IVF and other fertility services, some mandates contain stipulations that could exclude LGBTQ+ patients. Many mandates define infertility based on the duration a couple has been attempting conception, which does not apply to same-sex couples.^{33,34} Arkansas, Hawaii, and Texas all require that the couple's own eggs be fertilized with the husband's sperm, effectively eliminating third-party reproduction and excluding same-sex couples from mandated coverage.³³ Furthermore, heteronormative definitions of disease, such as qualifying infertility based on 6 or more months of unprotected heterosexual intercourse with

failure to conceive, effectively exclude some LGBTQ+ patients from mandates based on these definitions.

Patients requiring a surrogate must work closely with their health care providers to navigate the complex laws governing surrogacy in the United States, which can differ drastically by state. For example, such states as Indiana and Michigan consider surrogacy contracts to be unenforceable.^{32,35} Some states do not permit prebirth parentage orders (which are court orders that recognize the intended parents as the only legal parents) or limit prebirth parentage orders to individuals who share a genetic relationship to the child.^{35,36} Louisiana, Michigan, and Nebraska explicitly prohibit the compensation of surrogates.^{32,35} As such, it is imperative that physicians aiding LGBTQ+ couples in the family building process be familiar with fertility and gestational surrogacy laws in their state.

ADOPTION

Adoption is a common practice among LGBTQ+ couples hoping to start a family; same-sex couples are four times more likely to adopt a child than their heterosexual counterparts.³⁷ Compared with IUI and IVF, adoption has the benefit of not requiring hormonal therapy or medical care that could be distressing or cost-prohibitive to patients. However, adoption is not without its own hurdles and drawbacks. Most obviously, adopted offspring do not share a genetic relationship with their adoptive parents. Adoption itself can cost upward of tens of thousands of dollars, especially when adopting an infant.³⁸

Although LGBTQ+ couples historically faced significant barriers to adoption, several recent Supreme Court cases have made adoption by same-sex couples legal in all 50 states. From 2015 to 2017, the US Supreme Court struck down bans on same-sex marriage, Mississippi's ban on same-sex couple adoption, and an Arkansas law discriminating against same-sex couples in the issuance of birth certificates. However, several states still permit state-licensed child welfare agencies to refuse placement and services to children and families, including LGBTQ+ individuals and couples, if doing so would conflict with their religious beliefs.³⁹ Given the complexity of state legislation, a general knowledge of state adoption legislation is essential to physicians counseling LGBTQ+ patients on their family building options.

FERTILITY PRESERVATION FOR TRANSGENDER PATIENTS

One of the primary responsibilities for any health care provider who is involved with the medical transition of a transgender patient is to provide thorough informed consent about the impact that these transition steps have on future reproductive abilities, options for future reproduction, options for fertility preservation, and the precedence for fertility practices (eg, the regular use of these services by patients with cancer, including minors).⁴⁰ All individuals considering gender-affirming medical treatment should receive counseling regarding options for fertility preservation before initiation of puberty suppression and gender-affirming hormonal therapy.²⁴ Limited research suggests that many transgender individuals hope to have a genetically related child one day.^{25,41,42} Even if the patient asserts that they are aware of these options, it is important the health care provider ensure that the patient has received accurate information, understands that information, and is aware of the implications. Not only is this best clinical practice, but by having these conversations and documenting them, you can also prevent future ruptures in clinical rapport and any malpractice litigation that a patient (or parent) may bring against you for not informing them of these effects.

According to the Endocrine Society Gender Dysphoria/Gender Incongruence guidelines, puberty suppression is ideally initiated after first physical signs of pubertal onset and coincides with therapy from a mental health care provider (MHP) with expertise in gender care. This provides a “pause” from ongoing development, which could be irreversible, to evaluate the persistence, insistence, consistency, and severity of gender dysphoria and the presence of comorbid psychological conditions that may impair executive functioning (eg, autism spectrum disorder, cognitive impairment, attention-deficit/hyperactivity disorder). In these cases, extra steps are needed to obtain informed assent/consent from the youth/parents. After informed consent is obtained from the patient and parents, a multidisciplinary team of medical and mental health professionals may confirm the persistence of gender dysphoria, and begin ongoing cross-sex hormone treatment, as indicated. Although adequate capacity to give informed consent has been commonly established by age 16 years, a child’s physical development relative to their peers, severity of gender dysphoria, and bone mass density accrual problems are other factors that influence timing of cross-sex hormone initiation.²⁴

Although the effects of gonadotropin-releasing hormone (GnRH) agonists used to suppress puberty are reversible, the changes that occur with cross-sex hormone treatment can result in impaired fertility.^{40,43} For example, exogenous estrogen has been associated with testicular atrophy and impaired spermatogenesis, but these affects have been observed to be completely reversible in some studies.^{42,44} The long-term effects of testosterone on ovarian function are unclear. A limited number of studies have indicated an increased incidence of polycystic ovary syndrome in transgender men.^{37,45–48} However, more recent studies have not supported this hypothesis.^{49,50} Even when the effects of gender-affirming hormone modalities are believed to be reversible, reversibility may be partially dose dependent, or there may be a delay in restoration of normal reproductive function once hormonal therapy is discontinued.⁴² Surgical management of transgender patients is only recommended after the procedures are deemed beneficial by the patient and medically necessary by the patient’s MHP and/or the clinician responsible for endocrine transition therapy.²⁴ Furthermore, gender-affirming gonadectomy and/or hysterectomy should only be considered after the legal age of majority and at least 1 year of hormone treatment, unless hormonal therapy is not desired or contraindicated.⁴²

Currently approved fertility preservation options include oocyte, embryo, and ovarian tissue cryopreservation (OTC) for individuals AFB, and sperm cryopreservation or embryo cryopreservation with a donor-oocyte for individuals AMB. Fertility preservation options and eligible populations are outlined in **Table 2**. Embryo and oocyte cryopreservation rely on ovarian stimulation to obtain gametes in transgender men. In ovarian stimulation, exogenous gonadotropins are used to stimulate the ovary and enhance oocyte maturation. GnRH analogues or antagonists are used to prevent spontaneous ovulation. Throughout this process, patients undergo frequent monitoring with serum estradiol and progesterone measurement and transvaginal ultrasounds to monitor follicular growth. Once sufficient follicular maturation is achieved, ovulation is triggered using human chorionic gonadotropin or a GnRH analogue (eg, leuprolide). Finally, oocytes are retrieved by follicular aspiration under ultrasound-guidance and cryopreserved. Patients opting for embryo cryopreservation instead fertilize retrieved oocytes using their partner’s or donor sperm.

OTC, which only recently became nonexperimental, consists of surgical extraction followed by freezing of ovarian cortical tissue or the entire ovary. Preserved ovarian tissue is then transplanted back into the patient at a later point. OTC does not involve ovarian stimulation, and is therefore the only fertility preservation option available for

Fertility Preservation		
Method	Procedure	Timing of Intervention⁵¹
Assigned Male at Birth		
Sperm cryopreservation	Sperm is collected from ejaculated semen ± electrical or vibratory stimulation	<ol style="list-style-type: none"> 1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated, consider 3-mo cessation of estrogen
Surgical sperm extraction	Sperm is obtained surgically from the testis (TESE) or epididymis (PESA)	<ol style="list-style-type: none"> 1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated, consider 3-mo cessation of estrogen
Assigned Female at Birth		
Oocyte cryopreservation	Ovarian stimulation followed by surgical egg retrieval and egg freezing	<ol style="list-style-type: none"> 1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated, consider 3-mo cessation of testosterone
Embryo cryopreservation	Ovarian stimulation followed by surgical egg retrieval, IVF, and embryo freezing	<ol style="list-style-type: none"> 1. Before initiation of gender-affirming hormone therapy or surgery 2. If gender-affirming hormone therapy already initiated, consider 3-mo cessation of testosterone
Ovarian tissue cryopreservation	Surgical removal and freezing of ovarian tissue	Before gender-affirming surgery involving removal of ovaries

Abbreviations: PESA, percutaneous epididymal sperm aspiration; TESE, testicular sperm extraction.

prepubertal girls.⁵² Furthermore, this method of fertility preservation may be preferable in the future for transgender men who desire to avoid the potential dysphoric effects associated with the hormones and frequent transvaginal ultrasound used in ovarian stimulation.

Semen cryopreservation obtained through ejaculation is the current standard of care for fertility preservation for transwomen before gender-confirming surgery. Semen samples can later be thawed for use in IUI or IVF. Some patients may be unable to maintain an erection or ejaculate because of testosterone depletion as a result of gender-affirming therapy.²⁴ Electrostimulation or penile vibratory stimulation is an option for difficult cases.⁵³ Sperm can also be obtained via testicular sperm extraction or percutaneous epididymal sperm extraction. Subsequent pregnancy can only be achieved via IVF. Alternatively, a transgender woman could consider embryo cryopreservation if in a relationship with a partner AFB or with the use of donor oocytes.⁵¹ Testicular tissue cryopreservation for prepubertal children is still considered experimental.⁵⁴ As such, there are no options for fertility preservation for prepubertal transwomen.

There are numerous barriers to pursuing fertility preservation for transgender individuals, including cost, invasiveness of procedures, and patient experiences of bias or mistreatment.⁵⁵ Despite the American Medical Association statement that physicians may not refuse to accept patients because of their gender or sexual orientation,⁵⁶ historically some ART programs have restricted access to ART and fertility preservation transgender individuals.^{57,58} Without medical insurance, the out-of-pocket cost of a single oocyte retrieval and cryopreservation cycle was \$9253⁵⁹ and \$745 for ejaculatory sperm retrieval.⁶⁰ Furthermore, these sums do not include the cost of long-term storage for frozen eggs or sperm, which averages \$343 per year.⁶⁰ One US study found that nearly half of transmen in their study population reported not pursuing fertility preservation because of the cost of treatment.⁵¹ Ten states in the United States have laws that mandate coverage of fertility preservation for patients with iatrogenic infertility.³⁴ Although these laws were written with patients with cancer specifically in mind, some states including Connecticut, Delaware, Illinois, New Hampshire, New York, Maryland, and Rhode Island use broad language that could extend these benefits to transgender patients.⁴⁴

The process of ovarian stimulation for transgender men and sperm collection for transgender women can act as a strong reminder of their sex assigned at birth.^{51,61} Mental health professionals should be available to provide support during treatment of fertility preservation, including counseling on the impact of discontinuing gender-affirming hormone therapy, the need for frequent gynecologic evaluation, and the impact of fertility treatments on underlying gender dysphoria.^{40,62,63}

PREGNANCY AND CHILDBIRTH FOR THE LGBTQ+ COMMUNITY

Recognizing that gender is a spectrum, the experience of being pregnant can also create gender dysphoria for people AFB who identify as transmasculine. For transgender men, achieving pregnancy is complicated given the immediate and long-term impacts of testosterone therapy. Transmasculine patients on testosterone are at risk of pregnancy if they are exposed to sperm and not concomitantly using contraception. Comprehensive pregnancy care should include options counseling and access to abortion services. For transgender men on testosterone therapy who wish to continue pregnancy, the current recommendation is to discontinue therapy throughout the duration of pregnancy. Testosterone can impact milk production and supply. Patients wishing to chest (breast) feed may want to discontinue use for that reason, as well. The decision to discontinue gender-affirming hormones should be made using a shared decision-making model that takes into account the patient's values and goals for therapy. There is no evidence that testosterone passage through breast milk has deleterious impacts on the neonate. Given increased risks of depression and suicidality in this patient population, a focus on postpartum depression should be part of comprehensive postpartum care.⁶⁴

For patients without any additional comorbidities, prenatal care is attained through community obstetric providers. Referral to maternal fetal medicine would only be necessary should the patient also have other high-risk conditions. For some patients, being seen in a traditional obstetrics and gynecology office can increase gender dysphoria and increased microaggressions related to gendered spaces (eg, "women's clinics").⁶⁵ Should there be distress that arises at any point during the process, it would likely be prudent to make sure that the patient has access to gender-affirming mental health resources before, during, and after the pregnancy. For those who have mood lability related to hormonal shifts, the significant perinatal hormone changes from pregnancy in combination with resumption of gender-affirming hormones may also make

the postnatal period a time when connection to an MHP is indicated. An MHP can also be helpful to a couple who is planning their pregnancy by facilitating preemptive conversations about the details mentioned previously, thus allowing for the formulation of plans regarding parenting roles and when to seek out help.

Having family physicians or midwives who provide gender-affirming care is invaluable for patients vulnerable to gender dysphoria. Having an office with a nongendered waiting area and providers experienced in the care of gender and sexual minority patients is important for patients seeking care. For LGBTQ+ patients seeking prenatal care, having providers who offer inclusive, affirming care increases patient satisfaction and prenatal care visit attendance. It cannot be emphasized enough the impact of using correct terminology, pronouns, and person-centered language on increasing trust in the medical system and decreasing stigma. This extends to intrapartum and postpartum nursing care, social work support, and lactation consultants.⁶⁶ Some patients seek prenatal and childbirth care outside of the traditional medical system because of previous negative experiences within health care institutions.⁶⁵ Patients who identify as lesbian, bisexual, and transgender voice concerns about fear during the childbirth process related to previous experiences where they were treated prejudicially based on their gender and sexual identity.⁶⁷

There are several special considerations for lesbian patients seeking prenatal and obstetric care. Screening for health conditions that disproportionately impact lesbian patients should be part of the initial prenatal visit. This includes tobacco use, obesity, diabetes, alcohol use, and intimate partner violence. During labor and birth, providing culturally competent care and referencing patients and their co-mother correctly is impactful for the patient's experience. Considerations of the nonpregnant partner include making sure they feel engaged in the birth process and potentially becoming involved via induction of lactation.⁶⁸

GENDER-CONFIRMATION HYSTERECTOMY FOR TRANSMASCULINE PATIENTS

Referral to a gynecologist or plastic surgeon who provides gender-confirming care is an important part of the reproductive health journey for many transgender and nonbinary patients. Before initiation of gender-confirming surgery, patients must be at the age of majority (typically 18 and older), have undergone a social transition for a period of 18 months, and have taken gender-affirming hormones for a period of 12 months or longer. Patients must also seek consultation with an MHP with experience caring for sexual and gender minority patients regarding plans to pursue gender-confirming surgery. Presurgical consultation with a reproductive endocrinologist should be a standard offering for patients seeking gender-confirmation surgery to explore their long-term parenting goals. Not all patients want to explore this option, but a discussion about regret after surgery should at least be explored using a shared decision-making model. Barriers to timely care include comprehensive insurance coverage of gender-confirming procedures and availability of providers trained in providing inclusive gender-affirming care. Timing of surgery often depends on patient's age, child-bearing goals, insurance status, ability to take time away from work or school for recovery, and family support.⁶⁹

Gender-affirming hysterectomy is often achieved through a minimally invasive approach, either laparoscopic hysterectomy or vaginal hysterectomy.⁷⁰ Complication rates from hysterectomy are comparable with those seen in cisgender women.⁷¹ This is often the first step that precedes "bottom" surgery, which is much more invasive and is associated with a longer postoperative recovery and increased complications.⁷² This surgery is typically performed by a plastic surgeon with subspecialty

training and is often carried out at a center for excellence in transgender care. This may require the patient to travel out of state for care, which is a costly barrier. This highlights the need for a greater number of surgeons with this particular skillset.

Discussion surrounding impacts of ovary removal or retention is part of the preoperative consultation. For patients currently on testosterone therapy, the impact on the hormonal milieu and side effect profile is likely minimal. For young patients, ovarian removal may have long-term impacts that are not completely understood.⁷³ For patients who may not be able to continue testosterone therapy because of side effects or cost, cessation of testosterone could lead to significant menopausal symptoms.

SUMMARY

Providing reproductive health care to LGBTQ+ patients is a privilege. Clinicians have an ethical obligation to not only become versed in the distinct medical challenges of caring for this population, but also serve as advocates to eliminate socioeconomic disparities and biases uniquely impacting the sexual health and autonomy of LGBTQ+ individuals. Primary care physicians are on the frontlines, often serving as gatekeepers and facilitators of therapeutic relationships between the health care system and their LGBTQ+ patients. There are numerous areas of active research that will help address knowledge gaps and further inform future clinical practice; however, delivering empathetic, evidence-based care while supporting policies that facilitate this care are immediately actionable imperatives that protect and further reproductive justice for the LGBTQ+ community.

CLINICS CARE POINTS

- All sexually active patients, regardless of sexual orientation, should be counseled regarding safe sex practices to reduce the risk of sexually transmitted infections.
- Prevention of unintended pregnancy may be relevant to any patient of reproductive age, and assumptions should not be made regarding desire or need for contraception based on patient sexuality or gender identity.
- Testosterone therapy is not a substitute for contraception, even when amenorrhea is achieved.
- Fertility treatments, such as intrauterine insemination and in vitro fertilization, are one of the main methods through which LGBTQ+ couples can have genetically related offspring. Other methods of family building include adoption and foster care.
- All individuals considering gender-affirming medical treatment should receive counseling regarding options for fertility preservation before initiation of puberty suppression and gender-affirming hormonal therapy.

CONFLICTS OF INTEREST

Dr B. Gray is a site PI for Veracept IUD trial sponsored by Sebela.

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