Clinical Education Initiative
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FAMILY PLANNING FOR LGBTQ+ POPULATIONS

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[video transcript]

00:08
Dr. Erica Bostick is board certified and adolescent medicine and internal medicine completing her internal medicine residency at Mount Sinai Morningside Mount Sinai West in New York City, and her adolescent medicine fellowship at the University of Rochester School of Medicine and Dentistry. She specializes in caring for adolescents and young adults, specifically in the fields of transgender medicine, sexual and reproductive health care, as well as eating disorders, and as presented nationally on the topic of LGBTQ TNC care. Part of her clinical time is also spent at the Monroe County STD clinic focusing on treatment prevention and education surrounding STI. Dr. Bostic is passionate about empowering patients with the knowledge and skills they need to make healthy decisions. With that, welcome, Dr. Bostic.

00:54
Thanks, Jessica. And thanks, Maha and everyone from the network to for inviting me to come and speak about a topic I'm pretty passionate about. As Jessica mentioned, I do have no financial disclosures. And also, as Jessica mentioned, America Bostick, I live in pediatrics as like the lone internist here. But I love what I do. I also wear a few different hats, particularly in pediatric patient engagement, so patient portal things and related to adolescent confidentiality within our EHR, which is a topic in itself. Here Today's learning objectives. So by the end of this talk, I hope you're better able to define and discuss the difference between sex assigned at birth, gender identity, and other terminology. We'll also review the origin inventory, review how to be inclusive and affirming when obtaining a sexual history. And we'll talk about various family planning and contraception options. And to achieve those, we'll spend roughly the next hour level setting with key terminology related to gender. We'll talk about why it is so important to get this right. We'll discuss components of an inclusive and affirming sexual history, which will then later guide conversations regarding sexual health and family planning needs. We'll review different contraception and family planning options along with patient centered counseling depending on individualized needs. And if we have time, I'll show you a video of a patient with lived experience. And we'll do some q&a. So let's start with some terminology. Here's a nice graphic describing what each letter in the expanded LGBTQIA plus acronym stands for. And this is evergrowing. I like this one in particular, because it talks about outdated terms like the second tee here to for questioning and adding an A for ally. And Jessica has just uploaded the slides. So lots of information that you can also look at later. This graphic was taken from the CB CDC. And it describes differences between a cisgender person or someone whose identity aligns with their body and a transgender person or someone whose identity is different than the body they were born in. I've also added a few more terms at the bottom. But I think that these are better explained visually. I really liked this graphic, and there are many, many out there like it. That visually describes the differences yet interrelatedness of gender identity, gender expression, sex assigned at birth, and sexual orientation. It's also a nice educational tool that you can use in the

office with patients and their families as well. And so you can see here, all of these can be either a spectrum or really off of a spectrum. So gender identity is how someone identifies as a person only they can know. Gender expression is how someone presents to the world. sex assigned at birth, body parts chromosomes, things that we don't have control over and sexual orientation or who one is physically and or emotionally attracted to. So now that we're on the same page with language, let's look at a little bit of data. When we think about family planning in any population, we think about parenthood intention of the people involved. For those with uteruses. The literature typically refers to intended and unintended pregnancies. The latter are further sub classified as Miss timed and unwanted, as defined here. So Miss time does not wanting to become pregnant at the time pregnancy occurred, but wanting to become pregnant in the future. Unwanted is not wanting to become pregnant at this time or really any time in the future. And of course, unintended pregnancy is one that was desired at the time it occurred or had hoped to be sooner. These graphs are from a New England journal article describing trends of unintended pregnancy in the US up to 2011. And includes age, income, race and ethnicities. As shown unintended pregnancy rates are the highest and those who are greater than or equal to 200% of the federal poverty level. Those that are 18 to 24 years old, cohabiting women, so women that are not married, and women of color. It's critical that we understand the demographic differences, disparities to identify where to focus policy and programmatic interventions, and highlight areas of inequalities and take action and accountability. As the Guttmacher Institute says so nicely, these differences do not occur in a vacuum. They reflect differences in social, cultural, structural, economic and political contexts, which influence health behaviors, access to services and outcomes. In my personal opinion, these data provide an opportunity to acknowledge structural racism and take anti racist action. The good mocker Institute put together a nice back sheet describing the trends of unintended pregnancies, pulling data from the previous to the discussed New England journal article, and the link is at the bottom of this slide for later review. Now that we talked about the general population, let's dive deeper into additional populations that are often underrepresented or not examined in General Studies. This study examined disparities in pregnancy intentions in a national representative sample of adults across multiple sexual orientation populations, and had a sample size of almost 10,000 assigned female at birth age 20 to 45 years old, and over 5000 pregnancies. It analyzed data collected from the National Survey of Family Growth. To identify characteristics of the sample population, participants were asked quote, do you think of yourself as heterosexual or straight, homosexual, gay or lesbian, or bisexual. Participants were also asked if they had ever had a sexual experience of any kind with another female. What they found was compared with heterosexual women reporting only male partners. heterosexual women who had sex with women had higher odds of reporting a mistimed pregnancy, and bisexual women had higher odds of reporting an unwanted pregnancy. The authors concluded that adult sexual minority women are at equal or greater risk of reporting an unintended pregnancy, and more research is needed to develop strategies to improve family planning for this population. Of note, in a different study by the same author using a community based sample 24% of sexual minority women reported at least one unintended pregnancy, and 44% of those women reported identifying as lesbian. The study was published in 2021. The aim to collect data on pregnancy intentions and outcomes among transgender non binary and gender expansive people assigned

female or intersex at birth in the US via an online study. This table is small, but you can see the sample characteristics of the respondents separated by total, and those who reported ever having a pregnancy here, as well as the breakdown of different gender identities and sexual orientations. As you can see, it's not just cisgender women who reported having a pregnancy. Let's briefly look at trends, general trends with healthcare engagement within the transgender population. This is from the 2015 Transgender Survey, the largest survey examining the experiences of transgender people with almost 28,000 respondents. It was an anonymous online survey for transgender adults so 18 Plus in the US and territories. In this slide, you can see some key findings as it pertains to the experience of transgender adults when interfacing with the healthcare and insurance systems in this country. A quarter of all respondents experienced problems with their insurance policy related to being trans. Nearly a quarter of respondents avoided seeing a doctor out of fear of being mistreated as a person of trans experience, and 33% reported at least one negative experience with a health care provider. Expanding on the negative experiences, you can see that they vary between the need to educate providers to being asked questions unrelated to the care that they were seeking at the time, to verbal and or physical harassment and assault, or straight up refusal of care. Now this does not testified the type of non transition related care. So you can imagine when we're talking about sexual and reproductive health care, which is sensitive for most, if not all patients, it is critical that we approach the sexual history and related counseling and management of reproductive and family planning needs in an affirming and inclusive way.

10:19

So how do we do that? Well, in order to talk about family planning, we must normalize conversations about sex, build a rapport, and approach the sexual history in a way that facilitates safety and trust. This is deeply personal information regardless of gender. But even more care needs to be taken when having these conversations with gender diverse and LGB. identifying patients, we must tailor our sexual history to be inclusive, yet detail oriented and resist the human urge to make assumptions. This was especially apparent with the data just presented on unintended pregnancies and those who identified as non sis heterosexual women. If we assume that assume that only straight people can get pregnant, and therefore only obtain sexual health information related to pregnancies in that population, we would not be addressing the family planning needs of a very large portion of people. What are the big picture goals of obtaining a sexual history? Well, you want to better understand what role sex may or may not play in that person's life. You want to know the types of contact this removes gender and allows for site specific assessment and screening. If there are risky behaviors happening, that's an opportunity to assess that and perhaps assess the stage of change as well. You want to understand barriers and facilitators to change but overall ticket sex positive approach, goals of sexual health and wellness for the individual? Is it about connection? Is it about parenthood? Is it about pleasure, all of the above. And remember, your role is not to change their mind or tell them what is best, only the patient can know what's best for them, and that may or may not align with what you think. Setting the stage this can be done in many different ways by many different people. Using gender inclusive language, hiring a diverse staff, most of us serve a diverse population. Use last names or the names and pronouns provided by the patient,

introduce yourself with your name and pronouns or have a pronoun button or badge. Show that you are a safe space. Display your inclusive policies have gender neutral bathrooms, the environment that a patient walks into, is really important to use gender neutral language, you may not be sure if a person's gender expression, or remember how they present themselves to the world represents their gender identity, it may not line up with stereotypical gender norms. If you collect this type of data in your work, which is important data to collect, but also it's really important for clinical care. So please be sure that your forms are inclusive. And here's one that I just made up here. This is an example of how Soji information looks in our EHR. So perhaps yours has the option to do this as well. Who should be asked about gender identity? Well, everyone, ideally, you may be the first person asking, you may be the first person that the patient feels safe talking to you about this. And it does go along with other questions that can be part of the sexual history, which we'll talk about in a minute. But something that is always a stumbling block for for a lot of people is how to ask like what words to use. And so it really depends on the developmental and cognitive age of your patient. But here are some examples here. You were born, say a female, do you identify or see yourself as a female? Do you feel more like a girl? Boy? Neither both? Do you identify as a particular gender? If so what term best describes you? At the same time, use your clinical judgment. Sometimes I'm asked if the 83 year old patient that you've been seeing for 20 years needs to be asked these questions, probably not. At the same time. Keep in mind that people can come out as trans or gender diverse at any point in their life. Barring any safety concerns. At worst, you'll be met with a confused, possibly mildly offended look or words. But at best, you may have just opened the door for a person to be their authentic self. We can also recognize how intimidating it may be for providers. One barrier may be the fear of messing up and therefore avoiding it altogether. It's important to ask the questions and make a genuine effort But we're all human and not perfect. So fear of making mistakes should not lead to avoidance. And if you do make a mistake, all you need to do is apologize. Repeat yourself with the correct name, pronoun, or whatever, and move on. But later, be sure that you reflect on what happened there, and how you can prevent it from happening again. With that background, let's dive into the sexual history. Examples of language to use to lead into the sexual history, asking permission and focused yet open ended questions are always a great way to start. So here's some examples from the CDC. So for instance, may ask you a few questions about your sexual health and sexual practices. I understand that these questions are personal, but they're important for your overall health. This is an updated version of previous iterations of the five piece from the CDC, it is much more inclusive and a very useful tool to obtain a sexual history and gather all that information in an organized and inclusive way. So the first key is for partners, so perhaps number of partners and a certain amount of time, the sex assigned at birth of those partners is also important. practices, what body parts are in play, so really, again, removes gender and really gets to what you're looking for. How are people meeting their partners? Are there any substances involved, there are transactional tests going on? Protection from STIs for both the patient and their partners, and it's a nice opportunity to later talk about what strategies for prevention are used, how often are they used, and other tools such as PrEP, an HPV vaccine, past history of STIs and pregnancy or parenthood intention. This table is small on your slide, but the link is at the bottom here. So you can check it out later. But I like this one because it adds even more peas. The

additional piece at the bottom are noted to be pleasure, problems and pride. So again, taking that sex positive approach, nobody's walking into your office, looking to be lectured or judged. But how to say the words and ask the questions. The CDC provides some nice specific language around asking questions related to the five piece, you'll note that gender is removed whenever possible from these questions. My best advice is really to practice, practice, practice, hear the fields from your colleagues and incorporate them into your own. And here are some examples. So partners, practices, and be prepared again, depending on the age both developmentally and chronologically that you serve, to be able to describe the different types of sense.

17:52
Protection from STIs past history of STIs pregnancy intention, but I strongly prefer parenthood intention because oftentimes it takes two

18:13
and then finishing the session. So a final check in before wrapping up can tie up any loose ends for the patient. And here are some examples again from the CDC. What other things about your sexual history and sexual practices should we discuss to help ensure you're in good health? Now we are all busy and the second sexual history No, the system is working against us at times. But after obtaining a sexual history, particularly from a patient who identifies as LGBT, be sure to take a moment to reflect acknowledge that the information shared may make this person feel highly vulnerable. When talking about body parts, try to check in with and write down specific terms that may make the person feel more comfortable. So for example, chest instead of breast or down below instead of referring to the specific names of genitalia, or simply ask what they refer to their body parts because there's some really creative terms out there. Expanding on that perhaps your EHR has an area for an organ inventory or you can create your own. This is an example from our system. We know that it's important for providers to know what body parts a person has, regardless of gender for many reasons, but one big one is for health maintenance. So if somebody's gender marker may be present day or maybe for example, they present as stereotypically masculine. It's easy to make the assumption that they were assigned male at birth, but if they still have a cervix, then regular health maintenance for people with surfaces needs to be offered. So some key takeaways, right? LGBT and gender diverse patients like all patients should feel welcomed and affirmed when entering the clinical space. Use forms and signage that convey this message. to be mindful of language, the sexual history can be uncomfortable for people of all genders, but particularly those who are LGBTQIA. Plus, the more you practice asking the sexual history questions, the less uncomfortable you will feel. So let's apply what we just learned quickly to a case. Avery is a 27 year old trans male, so assigned female at birth, identifies as male, and his pronouns are he him who presents for a new patient visit. Which of the following is the most affirming example of asking about Avery's sexual history? And you can go ahead and put your answer in the chat. Give it a minute or two. Please don't be shy. This is a safe space. We'll talk about all of them if we.

21:00

I often joke that as an adolescent medicine doc, I'm used to adolescents kind of giving me the silent treatment so I can deal with that awkward silence all day long. All right, thank you so soon says De Soto scenario. Okay. Thank you. You're correct. ANC, you shared that you are currently sexually active when having sex with your partners. What parts of the body? Are you in contact with? You shared that you identify as trans male? Do you find yourself attracted to assigned males? Females? Both? Neither? So now that we've obtained a comprehensive and inclusive sexual history, how do we apply that to the patient's needs? To start, why is talking about family planning important? Well, the concept of reproductive autonomy is critically important. Our patients have the right to make informed decisions about their reproductive health. This inevitably helps prevent unintended pregnancies. But there are so many contraceptive options. Yes, there are. And we'll talk about lots of tools out there and guidelines that can help us counsel patients. But it's uncomfortable to talk about well, we suggest so similar to the sexual history, you want to start family planning counseling by asking permission. Based on parenthood intention, this may lead to discussions about contraceptive options. If a person has medical affirmation goals such as gender affirming hormones, fertility preservation should also be discussed. So let's talk more about the family planning needs particularly for trans and gender diverse individuals. Here's a flowchart calling back to the Oregon inventory. And making recommendations based on family planning goals of the patients and provides next steps for the clinician will talk in more detail about fertility preservation and contraception. With this is a nice sort of big picture view of family planning needs. As we know, there are many ways to make a family when it comes to transgender individuals who may be considering puberty suppression and or gender affirming hormones. There are a few additional considerations and counseling points. This study of 197 Trans males so again, assigned female at birth respondents showed the breakdown of how those who envisioned creating a family for themselves would go about doing so. A significant portion reported the desire to bear children themselves are born by others, which may involve their own genetic material. What do the guidelines say? There are many many out there which essentially say the same thing. This is an excerpt from the 2017 Endocrine Society guidelines which recommend that all clinicians inform and counsel individuals considering gender affirming medical treatment, about fertility preservation prior to initiating puberty suppression and or gender affirming hormones. UCSF elaborates even further, they make recommendations and provide some additional information regarding the knowns and the unknowns when it comes to fertility in a person with a history of gender affirming hormone use. It emphasizes the limited data available as well as how gender affirming hormones themselves are not meant to be viewed as birth control. I've taken the liberty of highlighting several portions of this for your later review. They break down the fertility preservation options and barriers for trans males including Oh site, or embryo criers IO preservation as the most common methods. It also talks about pregnancy in this population. For trans women or assigned male at birth cryopreservation of sperm is the most successful option for fertility preservation. Of note for children and adolescents, we know that the use of GnRH agonists for natal puberty suppression is most often reversible and should not impact future fertility if discontinued and needle puberty progresses. For those who are blocked before completing navel puberty, and then immediately started on cross gender hormones, there currently is no reliable option to preserve fertility for those patients. So this should be heavily

counseled upon before initiating W path who somewhat recently came out with their eighth version of the standards of care. There's lots of opinions and thoughts on that made several statements related to the importance of assessing capacity of youth and adults when discussing the effect of gender affirming treatment on reproduction and fertility, as well as counseling about preservation methods prior to starting these treatments. They summarize their recommendations regarding reproductive health here, which address counseling points pertaining to the impact of gender affirming treatment on future fertility, fertility preservation options, the gaps in data, psychosocial aspects, importance of referring to specialists, specifically specific counseling points for gender diverse youth and their families, as well as family planning details including pregnancy, contraception and pregnancy termination. Again, some highlights from W Pat's 888 version, reproductive health chapter that goes into more details for your later review. And last but not least, I wanted to also share you with you the committee opinion from the American College of Obstetricians and Gynecologists regarding health care for transgender and gender diverse individuals. They made several recommendations. Those emphasized here are from a medical and gender affirming surgical perspective, noting the importance of discussing fertility and parenting desires prior to medical or surgical treatment. They also emphasize that gender affirming hormones are not effective as contraception. And those individuals not desiring a pregnancy but have retained gonads should be counseled on contraception options. They also take a stance on empowering clinicians of many backgrounds and disciplines to consider becoming gender affirming hormone prescribers.

27:51
So let's let's shift gears a little bit to contraception. The approach here is very similar to those who are cisgender. Whenever providing contraceptive counseling, you always want to take an individualized approach. So starting with the most effective option. So let's say you have a trans patient with ovaries and the uterus who does not desire Parenthood in the near future. You know, from your inclusive sexual history that they have sperm producing partners. Perhaps you also know that they experienced worsening of their gender dysphoria with menses, which to make matters worse, or heavy and painful. There are many opportunities to help here. factors that may have an impact on method selection for a person may include the desire for menstrual suppression. So if you're thinking about combined oral contraceptive pills patch brings, you can think about continuous versus monthly use adherence intolerance. So some people are needle phobic and would prefer to avoid needles at all costs. Some people are really good at remembering to take something or do something every single day, versus others are not good at that and would much prefer something that they would have to do maybe once a week or once a month or every few years. And when we think about that, we think about user dependent versus user independent options. So Lark are long acting reversible contraception, IUD, and the contraceptive implant, nothing for the person to do versus a pill, they have to take that pill every day. And if you have a patient who anticipates starting gender affirming hormones, or has estrogen contra indications, there are plenty of progestin only methods of various efficacy that are out there and we'll talk about them. You can also reassure that person that if a combined pill makes the most sense for them, it is very unlikely that it will raise endogenous estrogen levels, which is often concern for those who identify as male but are assigned female at birth. This is

from www dot bed cyber.org and is an excellent evidence based page Should friendly resource depending on the individualized goals of the patient, always trying to start with the most effective method that matches those goals. First, you and or the patient can click on each of these methods to get more information. I recently found this resource that provides a really nice overview of sexual and reproductive health needs across the gender spectrum. So you can see here it talks about if one can even get pregnant. How can someone else get someone pregnant? Birth control options for people taking testosterone and estradiol a little bit about the permanent options and upload to not forget about sexually transmitted infections which no contraceptive method short of a barrier method can really prevent. in isolation, they choose to break down the different contraceptive methods by hormones or lack thereof, how to use the method impact on leading and important things for the patient to know along with efficacy. Here you can see info about the progestin only methods including emergency contraception. You can also see that they are starting with the most effective options first. So in this case, the hormonal IUD and contraceptive implant or again Lark. Here are the non hormonal methods, you can see the copper IUD being most effective, and I suspect the other percentages reflect perfect to use, which we should counsel about realistic expectations related to perfect to use. Few of us are perfect methods with estrogen. It says here that it's safe to use if you are taking testosterone. In our practice, we do not typically prescribe estrogen containing methods and those who are taking testosterone, especially since there are plenty of Highly Effective progestin only methods. But like so many things related to contraception, it really needs to be viewed through the lens of the alternative being an unintended pregnancy. And so if you have someone who is next I just had a patient the other day is gearing up to start gender affirming testosterone is already on a combined contraceptive pill has definite risk of pregnancy. And we did not have time to talk about all these other options, we made a plan to have a follow up appointment or review all of these options, I did not recommend stopping their combined oral contraceptive pill until that appointment. So really, you need to kind of weigh and it should be shared decision making like so many things, the risks and benefits of you know, pregnancy prevention, and its impact or minimal impact. In this situation, I'm starting a low dose testosterone.

32:55

Here's another handy table from the article cited in the slide. This one is likely more geared towards providers with counseling points for the patient. And so it's busy and small but again, you can have it and look at it later. Somewhat combining the two previous resources. This table from Boddingtons group talks about each method along with pertinent patient and provider information for trans individuals. For the next several slides again included for your leader reference of note efficacy is extrapolated from data and cisgender women. So this slide shows some non hormonal methods got the copper IUD and the diaphragm here. And you can see that it talks about this in the hormonal IUD as well. When you're thinking about placing an IUD with someone who has been on or for someone who's been on testosterone. Some of the side effects of testosterone can lead to vaginal atrophy and dryness. You're essentially inducing a menopause. And so taking care with counseling sort of expectation management, and also using the smallest speculum that you can and fully lubricated. Sometimes if it's just really atrophied. We can do some topical,

34:14
extra dial just you know, vaginally so these little pearls can really come in handy. Here's some more non hormonal methods. So external and internal condoms.

Tara 34:30
Even more, so withdrawal method sponge. Lots of non hormonal, not super efficacious methods.

34:43
Here the progestin only methods, with pertinent pearls, again, such as vaginal atrophy, and steps to improve comfort when placing an IUD and even more Here are the combined methods very small. And then there are the general resources out there for contraception. This is a great one by the CDC that lists several different medical conditions, along with color and numerically coded safety recommendations. And so you can see the condition on the left, and it's even further broken down, you can see at the top and blue. Here, they even start with the most effective methods. And as you go towards the right, less effective ones, though, the progesterone only pill and combined one really shouldn't be stuck. But it's easier to really use the app from the CDC. And hopefully you have this. But if not, you just go to your app store and type in US MEC. And this is really cool, because you can search by condition or method, as you can see screenshots here. And it'll take you through that same chart just more visually pleasing way, I think. It also includes the selected practice recommendations, or sP r, that's on the far right here. And I find the one that is called How to reasonably be certain or how to be reasonably certain that a woman or really a person with a uterus is not pregnant. And so that really draws attention to the fact that, you know, especially I work with adolescents, and so it is unlikely that that adolescent has had no sex for the last two weeks. So the urine pregnancy test that I do in the office is not going to be reflective of a very early pregnancy. And so, you know, former recommendations have said, Okay, send them back. US barrier methods, abstain for two weeks and come on back in and we'll, we'll start something then. And really short of placing an IUD, which can just anatomically, perhaps disrupt an early pregnancy. But there there has been a New England Journal paper on the hormonal IUD specifically branded Mirena that can that's very efficacious as emergency contraception, though it hasn't been labeled as that by the FDA. But really, any of the progestin and or combined methods are not going to harm a pregnancy. And so the risk of not starting a method or Quickstart method is really high for again, particularly an adolescent, but really anyone to really not start a method if pregnancy is not a goal of theirs. So there's some really useful information in the SPR. And so, lastly, I'd like to share this video from bedside er.org of a trans patient who describes his lived experience in getting an IUD there are some parts that are clearly his opinion or perspective and medically not totally accurate and could be clarified a bit. But again, I think it's really powerful and it's really powerful for patients to hear the voice of someone who's lived through it. So I'm just gonna swap my screen for a second bear with me

38:45

I don't think this is right

39:00
I find my technical difficulties for a minute, I think Do you

39:12
think this is correct. Now there might be a little bit of a lag. I just can put in the chat the link to the YouTube video but I think it'll

39:20
suffice. My name is Michelle. I'm 30 and I have a Mirena IUD. I work as a paramedic. I work at University of Colorado hospital and emergency room. I've been a paramedic for 10 years now, in my free time I like to watch documentaries. I'm a pretty big activist here in the Denver Metro area for transgender inclusive inclusivity. Yeah, I've never really used any birth control method prior to getting rained out in 2013. I've historically been in relationships with cisgender women so it's never pregnancy has never been a worry as far as that goes prior to in my last relationship it was any sort of anything that we used when we had sex, we use protection if there was no condoms, dental dams, that kind of thing. I originally found the Marina basically, through talking with friends and stuff like that, at first being gender queer and kind of presenting masculine ly, I had a hard time getting the courage up enough to go to a health center and say, like, Hey, I'd really like to learn more about the IUD because going into doctors offices have been, it's not been the most comfortable thing for me with how I am perceived by healthcare staff. So it took me about a year and a half. And finally, with the help of my ex partner, got the courage up enough to go into clinic and asked to get an IUD getting an IUD. For me, it was painful, maybe for about 10 seconds. But then I think it was more proud of myself with the stories that I've heard from other people as far as pain goes. But it was a very simple, quick process, I'd say it took probably about 10 minutes for the whole kind of start to finish. What I like about the IUD is I no longer get periods with the help of testosterone. I like that it's good for five years. So I don't really have to go through the process of getting one taken out back in like a year, three months or what have you. The only thing I didn't like about the IUD when I had at first place was about, you know, the first three months, there was some cramping and just getting used to that. And dealing with that was really worth it. But that was probably the only thing that I didn't like about it. I think when I first wanted to get the IUD it was because I was having heavy periods. And although it bothered me at work and made that pretty inconvenient. As far as my gender identity goes, I didn't feel like I was supposed to have a period in the first place. So it's kind of a double whammy, they have really heavy ones and feel like I never should have had one to begin with. So the Marina really helped in my self confidence enough to be like, you know, this is who I am and feeling this way coming out to my partner at the time and then my friends and being very supported. Originally when I started my transition, I didn't feel like I could continue having the Mirena because of the hormones that are involved with the Mirena. I really had to step up and talk to my physician about that. And what I found out was it actually helps your vaginal health with your every part of your reproductive system to have an IND when you are on testosterone. The main advice that I'd like to share as specifically with trans men is

don't fall into gender roles. As far as you know, if you do sleep with cisgender men or you know, really anyone and pregnancy is a concern for you. Don't be scared to talk to your doctor about possibly getting an IUD place, take care of your vaginal health as much as you can, because there are a lot of side effects from other hormones that we we take or that we're interested in. And you know, I think that your body is your temple and there's nothing wrong with having a conversation with your physician about the possibility of staying safe and staying healthy.

43:36
I'm Lindsay I'm 30 years

43:40
lots of videos on bedside er.org. I'll

43:50
share my last slide.

44:04
Okay, so I'll just quickly go through some resources again, mostly for your later review. Some general ones about sexual and reproductive health and those specific for LGBTQIA plus populations with some overlap. But Guttmacher Institute are referred to before they're really also a good resource for abortion related care in your state. Bed sider a cool article that I stumbled upon called breaking the binary how clinicians can ensure everyone receives high quality reproductive health services included there and don't forget some of the studies. The articles are on the bottom of the slide. Ci in the AIDS Institute have some videos one with yours truly related to trans help and it's on YouTube and the CEI website which offers more see if you're interested So, for those of you who work with minors like I do some resources regarding sexual health and adolescent confidentiality, and those laws vary between states as well, the five Ps from the CDC, and that expanded one from the National Coalition for sexual health provider guide. Again, insider.org. And just a reminder to consider downloading the CDC MEC app, and really, really handy and there's also an now it's available, the STI treatment guidelines. So there's another app with the updated STI treatment guidelines. Similar setup. Cei has some cool things going on. And so there's a podcast, I did one in November with a family planning expert, you can check that out. And if you'd like to order STI clinic cards, we've got plenty of those. And so you can use this QR code here, or you can email Jess, or the general email address. And we can connect you with those. So we'll leave the last 14 ish minutes for any discussion or questions that you may have. Scott asks a really good question. I don't have any particularly great resources regarding fertility treatment or surrogacy for same sex couples. I will say I mean, in part because I work with a younger crowd mostly. But I can speak from experience regarding fertility preservation. And so we work closely with a reproductive endocrinologist at the U of R called her name is Dr. Wendy BTech. And so she works with a lot of our patients, and patients that are not ours. You know, we know even with patients who are receiving chemotherapy for cancer, having fertility preservation covered is really hard. And so more often than not, my patients, at least don't choose to those who are assigned female at

birth mostly do not choose to go through with Oh, site preservation. Faso is, as you may know, for anyone who has experience with IVF, and that sort of thing. It can be really invasive, and really difficult and very triggering to dysphoria. And so right now, for aside females at birth, we don't really have great options in terms of minimizing dysphoria, though, we have some people who do it. And actually Dr. VTech shared with our group somewhat recently, that newer data has come out where they can actually stimulate when someone's on low dose testosterone, don't do it for everybody. But you know, worth the conversation. If you have someone who's very whose dysphoria is just very, very high, but does want to move forward with fertility preservation. We also work with a urologist at your bar, who is very experienced in sort of the family planning aspect for urology, especially for the younger assigned male at birth, who again, their genitals are really dysphoria inducing, and so to provide a sperm specimen can be really hard. And so he's been really great. And his name is Dr. Gabriel sin. So that only sort of 10 Gently addresses your question. And Marjorie's sharing some information in the chat too, which is great.

48:41
Yeah, I don't think everyone can see the chat pod was mentioned what Marjorie shared that NYU transgender clinic has resources, and that in the mid Hudson Valley, they're sending patients to see in life fertility and Albany has a nearby resource, but she believes it's expensive.

48:56
Yeah, I don't think there's any great way around it. It's particularly with surrogacy, I mean, that is very, very expensive. But for assigned males at birth to do sperm cryopreservation in the scheme of expensiveness, for things related to fertility preservation, that is certainly much cheaper than Oh site or embryo preservation. It's an imperfect system, for sure. Other questions or thoughts or experiences? We can all learn from each other? No, it's nearly sighs So. Okay.

49:40
There's no more comments or questions today. We'll wrap up. Thank you again to Maha and Dr. Scott Hartman to you. I know you were on thank you for inviting CEI to present today to the implicit network. So thank you all.

49:52
Thank you so much, Dr. Bostic for all the effort that you put in for taking the time out and presenting to the network here.

[End Transcript]