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Addressing Barriers to Healthy Pregnancies Among Transgender Men and Gender Diverse Individuals

Introduction

Transgender men and gender diverse individuals (TGD) assigned female at birth (AFAB) seek parenthood at similar rates as cisgender individuals, however, lack of access to gender-affirming reproductive healthcare leads to negative outcomes and experiences among this population (Besse et al., 2020; Hoffkling et al., 2017; Moseson et al., 2021). Pregnant TGD must navigate a medical setting that "others" trans bodies and shapes reproductive healthcare around the needs and experiences of cisgender women (Besse et al., 2020). Barriers manifest in lack of access to contraception, fertility preservation, prohibitive cost, and lack of gender-affirming reproductive healthcare (Agénor et al., 2021). The literature on pregnancy among TGD individuals is extremely limited, reinforcing their erasure and stigmatization (Besse et al., 2020; Hoffkling et al., 2017). This paper will outline barriers to healthy pregnancies among TGD individuals in the U.S. and propose specific interventions to improve health outcomes.

Understanding the Context

TGD individuals desiring or experiencing pregnancy must navigate the physical and structural violence embedded within U.S. medical institutions (Hoffkling et al., 2017; Reis, 2020). Until 2013, gender-affirming surgeries for individuals AFAB required prior sterilization, laying the framework for intense stigmatization of TGD pregnancies (Reis, 2020). This gender-related stigma manifests as discrimination, victimizaiton, non-affirmation of gender identity,

denial of care, rejection, and more (Besse et al., 2020; Testa et al., 2015). Many care providers are uncomfortable with supporting a man's pregnancy or feel ill-equipped, leading to poor quality care or care refusal that is detrimental to the health and well-being of TGD individuals during such a vulnerable time in their lives (Hoffkling et al., 2017; Obedin-Maliver & Makadon, 2015). Some transgender men describe providers insisting they are not a man if they choose to be pregnant and urging them to get sterilized (Malmquist et al., 2019). In addition to gender minority stress, pregnancy may exacerbate gender dysphoria for TGD individuals as their bodies undergo major changes and some choose to pass as cisgender women or hide their pregnancies to alleviate some stigma (Besse et al., 2020; Hoffkling et al., 2017; Obedin-Maliver & Makadon, 2015).

Scope & Burden

While the overall prevalence of TGD identities is estimated to be between 1 in 500 to 1 in 2000 individuals in the U.S., this population is significant and barriers to care must be addressed (Berger et al., 2015). TGD adults are more likely to be uninsured (19%) and report cost-related barriers to medical care (19%) than their cis counterparts (12% and 13%, respectively) (Koma et al., 2020). TGD adults are also twice as likely as cisgender adults to report being in poor health and experiencing lifetime depression (Koma et al., 2020). Barriers to affirming, quality healthcare for TGD individuals, including stigma, provider incompetence, and legal/structural factors, are associated with disparities in mental health disorders, suicidal ideations or behaviors, and substance abuse (Berger et al., 2015). When seeking medical care, one in three TGD adults report experiencing verbal harassment, refusal of treatment, or having to inform their providers on how to care for them (James et al., 2016). This is especially prevalent for TGD individuals

before, during, and after pregnancy, contributing to gender minority stress and placing pregnancies at higher risk (Hoffkling et al., 2017; Malmquist et al., 2019).

A U.S. online survey of pregnancy prevalence and outcomes among 1,694 TGD adults AFAB reported a pregnancy rate of 16.8 per 1000 respondents capable of becoming pregnant, with 54% of pregnancies unintended (Moseson et al., 2021). One in five respondents capable of becoming pregnant considered themselves "at risk" for unintended pregnancy, underlining the need for improved contraceptive counseling (Moseson et al., 2021). Of all survey respondents, 11% reported that they desired future pregnancy and 16% were unsure (Moseson et al., 2021). These data highlight the need for clinicians to avoid assumptions about TGD healthcare users' reproductive goals (Moseson et al., 2021). Of all pregnancies, 39% resulted in a live birth (23% of which were delivered via cesarean), 33% in miscarriage, and 21% in abortion, though these ratios changed according to race/ethnicity (Moseson et al., 2021).

Among white respondents, for example, the miscarriage rate was 32%, whereas Black and American Indian & Alaskan Native respondents reported rates of 63% and 50%, respectively (Moseson et al., 2021). Researchers cannot draw definitive conclusions due to the small proportion of BIPOC respondents, but preliminary evidence suggests that disparities exist in TGD pregnancy outcomes on the axis of race/ethnicity (Moseson et al., 2021). This finding speaks to the concepts of intersectionality and social determinants of health. TGD individuals at intersecting axes of oppression--not only gender but also race, SES, ability, and/or sexual orientation--experience cumulative adversity which hinders healthy pregnancy. Social determinants of health--the environmental conditions in which one lives, works, learns, and plays that affect health outcomes--are rooted in racism, ableism, classism, and heterosexism, leading to greater disparities among marginalized groups.

Proposed Interventions

On an individual level, clinicians must receive training--or educate themselves--in cultural competency and gender affirming reproductive healthcare (Besse et al., 2020). Providers must understand the unique experiences and potential risks within TGD pregnancies, including effects of gender-affirming hormone therapy, lactation support, and stigmatization (Reis, 2020). In addition, clinicians should be aware of the discomfort TGD individuals may experience during pelvic examination, transvaginal ultrasound, or other procedures and use gender affirming language to reference anatomical features (Besse et al., 2020). Social support was found to be a protective factor in navigating the challenges of pregnancy for TGD individuals (Besse et al., 2020; Hoffkling et al., 2017). The utilisation of midwives or doulas may be beneficial as a source of support throughout this process, but additional training is necessary. Connecting TGD individuals to community organizations and trans-specific support groups for mental health, pregnancy, birth, and parenthood may also bolster support during this period (Hoffkling et al., 2017).

On a structural level, legislation protecting TGD individuals' reproductive health should be prioritized (Hoffkling et al., 2017). Electronic medical records must be adapted to differentiate between sex assigned at birth and gender identity to accomodate procedures TGD individuals undergo throughout pregnancy and aid in insurance billing (Berger et al., 2015). Clinics should consider the ways in which their branding may reinforce cisgenderism (e.g. women's clinic) and foster inclusivity by asking for name and pronouns each visit, creating all-gender restrooms, and enforcing non-discrimination laws (Besse et al., 2020; Hoffkling et al., 2017). Lastly, public health interventions which address intersecting oppressions and social

determinants of health embedded within the environment (e.g. increasing access for TGD BIPOC, providing financial assistance) will be most effective in reducing disparities.

Conclusion

TGD individuals undergoing pregnancy face significant barriers stemming from cisnormative assumptions and violence within the medical institution (Besse et al., 2020). Interventions that promote visibility and normalization of pregnancy among TGD individuals are critical (Besse et al., 2020; Hoffkling et al., 2017). This paper provides an overview of barriers to healthy pregnancies among TGD individuals with specific suggestions. More literature is needed to define best practices in reproductive healthcare for TGD individuals AFAB and combat the erasure and stigmatization TGD individuals experience during pregnancy (Hoffkling et al., 2017).

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