Decision Making in Gender Affirming Contraception

Consultation Essentials

Important Principles

- Contraception decision making is centred on informed choice by an individual who has been provided with accurate, evidence-based information on all options. This is no different for trans & gender diverse patients.
- Combine effective listening with a knowledge-driven approach.
- Frame the discussion of choice around advantages and disadvantages of each method, and address potential impact on gender-affirming hormone therapy.
- Language is important; using affirming terms builds trust and puts patients at ease.
- Use a 'parts and practices' approach to explore intentions and life plans in relation to pregnancy. Not all trans and gender diverse people want families, but some do. The goals of trans people and their partners vary, and pregnancy plans should not be presumed based on trans status.
- The type of contraception used is similar to cis populations, except for the use of hormonal IUDs, which were preferred by trans & gender diverse people on testosterone.
- Hormone therapy (masculinising and feminising) is not a reliable form of contraception, even if sperm production or menstruation has reduced/stopped.
- Relevant medical issues require early identification to refine suitable options.
- Discussions may occur in a variety of contexts.

Contexts may include:

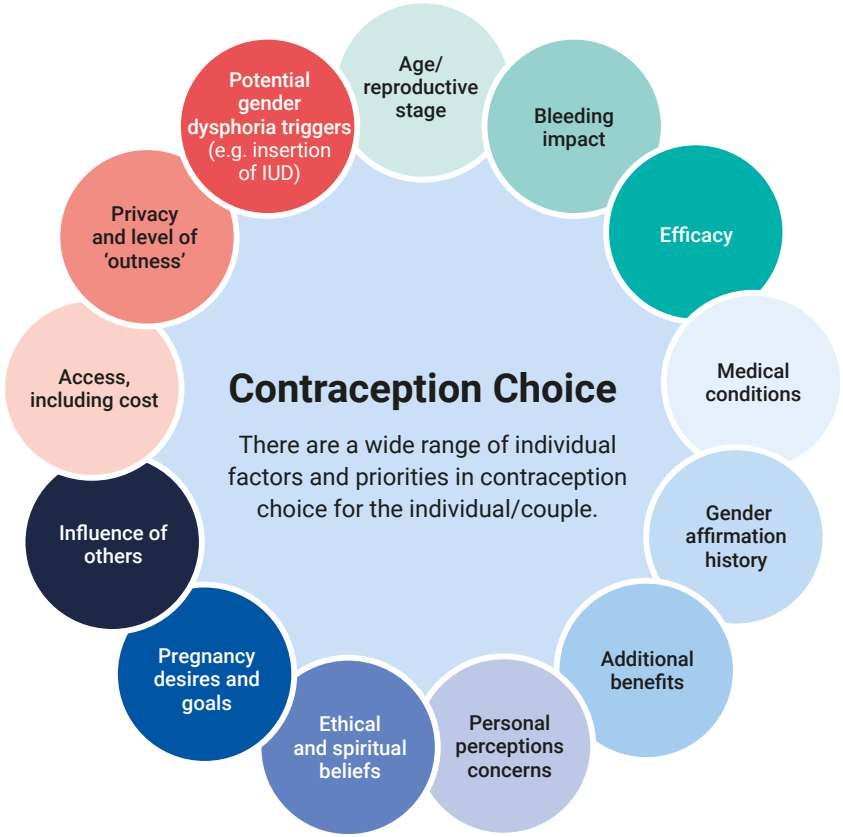
- Planned contraceptive options consultation.
- Annual health checks for First Nations people.
- Opportunistic e.g. sexual health screening, hormone initiation.
- Post partum follow-up.
- Abortion consultation or follow-up.
- Emergency contraception prescription.
- When DFV or sexual violence has been identified.

- Screen for DFV, sexual violence and reproductive coercion.
- Meet contraceptive needs at each visit by providing written information, planning initiation of contraception, or immediate provision of a method. Especially important for patients who want to avoid disclosing their trans history to multiple providers. Adapt language and approach to reflect dignity and respect for trans & gender diverse communities.
- Offer to discuss contraception to all people regardless of gender identity or sexuality.
- Trans and gender diverse people may have varying levels of comfort about methods that involve insertion, due to gender dysphoria and/or an increase in dryness after starting testosterone. Screen for comfort around insertive methods and offer treatments to reduce discomfort (such as topical oestrogen) if appropriate.

Population groups may include:

- Young people, Aboriginal and Torres Strait Islander peoples, trans and gender diverse people, cisgender partners of trans and gender diverse people, culturally and linguistically diverse people.

Patient Considerations



Glossary

COCP	Combined Oral Contraceptive Pill
CVR	Combined Vaginal Ring
DFV	Domestic and Family Violence
DMPA	Depot Medroxyprogesterone Acetate
DSP	Drospirenone
EC	Emergency Contraception
HCG	Human Chorionic Gonadotrophin
HCP	Health Care Practitioner
HMB	Heavy Menstrual Bleeding
IMI	Intramuscular Injection
IUD	Intrauterine Device
LNG	Levonorgestrel
NET	Norethisterone
PCOS	Polycystic Ovarian Syndrome
PID	Pelvic Inflammatory Disease
PMDD	Premenstrual Dysphoric Disorder
PMS	Premenstrual Syndrome
POP	Progestogen Only Pill
STI	Sexually Transmissible Infection
UPA	Ulipristal Acetate
UPSI	Unprotected Sexual Intercourse
VTE	Venous Thromboembolism

Practitioner Considerations

- Factor in all patient considerations. Consider previous interactions with healthcare professionals and the importance of building a welcoming environment.
- Gather medical history to identify contraindications and considerations including:
  - Menstrual disorders, acne, breastfeeding.
  - Other non-contraceptive benefits.
  - Risk factors for venous and arterial vascular disease (relevant to oestrogen containing methods).
  - Use of liver enzyme-inducing medications (relevant to all hormonal methods except DMPA and IUDs).
  - Significant medical risks of a pregnancy.
- Use Medical Eligibility Criteria to guide safe choice.
- Explore and challenge myths and misunderstandings. There may be misconceptions regarding hormone therapy and the impact on contraception or vice-vera.
- Consider the sexual partners of trans and gender diverse people (who can be cisgender or transgender). They will also need to remain informed about contraceptive options and pregnancy risks.
- Consider the cost and availability of affirming services; keep note of local clinics, pharmacies or services that have good knowledge of trans & gender diverse patients and are reputable. Undertake opportunistic activities e.g. cervical and STI screening.
- Provide initiation advice (Quick Start, Bridging, Dual protection). For additional info please see next page.

Medical Eligibility Criteria (MEC)

- Classifies safety of contraceptive methods in individuals with specific medical conditions

MEC 1	No restrictions on method use
MEC 2	Advantages of method outweigh risks
MEC 3	Risks usually outweigh advantages. Seek expert opinion.
MEC 4	Unacceptable health risk (absolute contraindication)

Risk of use is weighed against risk of pregnancy.
For full details see CoSRH website

Decision Making in Gender Affirming Contraception

Consultation Essentials

Choosing a Method: Advantages and Disadvantages

Efficacy†	Method	Advantages ✔	Disadvantages ✘
Long-Acting Reversible Contraception (LARC) *Fit and forget* **>99% efficacy** ✔ Very long action - "fit and forget" for years ✔ Immediate return to fertility ✘ No STI protection ✘ Need HCP to insert & remove, which can be triggering for some trans & gender diverse patients			
99.95%	**Progestogen Implants**	• Simple insertion procedure readily available in most primary care settings • Suitable for Quick Start • Amenorrhoea or infrequent bleeding in ~ 22% of users • Very few contraindications - current breast cancer is the only MEC 4 • MEC 1 immediately post partum, including breastfeeding	• Frequent and/or prolonged bleeding in ~ 20% of users • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals
99.95%	**Intra Uterine Devices (IUDs)** - Levonorgestrel (LNG) - Copper	• Local (intrauterine) mechanism of action • MEC 1 for breast/chest feeding • Few contraindications – MEC 4 include current PID, unexplained abnormal bleeding and, for LNG only, current breast/chest cancer • No medication interactions • Longest acting of reversible methods (5 or 10 years) **LNG IUD only:** • ~ 50% amenorrhoea at 12 months use • Non-contraceptive benefits e.g. from Mx of HMB, dysmenorrhea and endometriosis • Minimal to no hormonal side effects **Copper IUD only:** • Immediately effective • Hormone free • Maintains regular monthly bleed for people who prefer this • Highly effective EC + provides ongoing contraception • 10 year efficacy for some devices	• Insertion requires internal vaginal speculum examination which may be difficult for some trans people, and the insertion procedure may be variably painful • Suitably skilled inserter not always available in primary care settings • Low risk of procedural complications e.g. vasovagal, PID, uterine perforation • Cannot Quick Start due to risk of harm to undetected pregnancy • May require testing for chlamydia and gonorrhoea prior to insertion **Copper IUD only:** • May cause heavier periods • Not on PBS
Other Hormonal Methods *Very effective if used perfectly* **93-99% efficacy** ✔ Can be highly effective ✘ No STI protection ✘ Needs HCP to prescribe ✘ Potential for hormonal side effects			
96-99.8%*	**DMPA Injection**	• Few contraindications - current breast/chest cancer is the only MEC 4 • No daily action required • Use is undetectable by others • ~ 50 - 70% amenorrhea at 12 months use • No medication interactions	• Delay in return of ovulatory cycles/fertility in some users • Unpredictable breakthrough bleeding pattern in some users • HCP administration of IMI • Can cause weight gain and bone density loss in some • Injections are required every 12-14 weeks to remain effective
93-99.5%*	**Combined Hormonal Contraception** - COCP - CVR	• User control of cycle and administration once prescribed • Non-contraceptive benefits e.g. for management of HMB, dysmenorrhoea, endometriosis, PMS, PMDD, acne, perimenopausal symptoms **CVR only:** • Monthly administration • Not affected by vomiting, diarrhoea or malabsorption	• Many more MEC 4 and MEC 3 conditions than LARCs and PO methods • MEC 4 conditions more common e.g. migraine with aura, smokers > 35 yrs, past or current VTE • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals • MEC 4 for 3 weeks post partum or 6 weeks if breast/chest feeding • Estrogen-based contraception may affect the body's uptake of testosterone, and this may be relevant to some trans and gender diverse patients **COCP only:** • Daily action required
	Progestogen Only Pill (POP) - Levonorgestrel and Norethisterone (LNG, NET) - Drospirenone (DSP)	• Very few contraindications - current breast/chest cancer is the only MEC 4 • MEC 1 immediately post partum, including breast/chest feeding **LNG,NET only:** • Effective in 48 hours **DSP only:** • Prevents ovulation –missed pill rules apply if pill >24 hrs late • Beneficial effects on vaginal bleeding over time	• Daily action required • Medication interactions e.g. some anticonvulsants, rifampicin/rifabutin, some antiretrovirals **LNG,NET only:** • Missed pill rules apply if pill >3 hrs late • Unpredictable vaginal bleeding patterns
Barriers and Others *Less effective in use* **76-99% efficacy** ✔ Condoms are the only contraceptive that provides STI protection ✘ Lower efficacy in typical use - not recommended if unintended pregnancy risks medical or psychological harm			
88-98%* 79-99%* 82-86%*	**Condoms** - external, worn on penis during sex **Condoms** - internal, typically inserted into vagina/anus before sex **Diaphragm** - internal, placed in genitals before sex to cover the cervix	• No HCP input required • Hormone free, no side effects or impact on cycles • Can use EC if required e.g. broken condom, barrier not used **External condom only:** • Widely accessible • More effective than diaphragm and internal condom **Condoms only:** • Effective protection against many STIs	**External condom only:** • Not controlled by person at risk of pregnancy **Internal condom and diaphragm:** • More expensive than external condom • Limited access **Diaphragm only:** • May need HCP to teach insertion and limited practitioner knowledge
76-99%*	**Fertility Awareness Based Methods (FABM)**	• Hormone free, no side effects or impact on menstrual cycles • May align with belief systems which restrict contraceptive options	• Significant commitment required to learn and to comply with periods of abstinence or use of barrier methods required for efficacy • Less suitable for people with irregular menstrual cycles (including those who have initiated hormones) because it becomes harder to track fertility cycles.
80-95%*	**Withdrawal**	• User controlled • Can use EC if method not adhered to	• No control for receptive partner • Lower efficacy especially in inexperienced
Vasectomy & Tubal Litigation *Permanent* **>99% efficacy** ✔ ✘ Permanent			
>99%	**Sterilisation** - Male (Vasectomy)	• Can be done under local anaesthetic • Provided in some Primary Health/GP settings	• Needs post-op sperm count at 3 months to confirm effectiveness
	Sterilisation - Female (Tubal ligation)	• Provides control to receptive partner • Potentially undetectable by others • No impact on menstrual cycle	• Surgery and general anaesthesia required • Public hospital access difficulties • No impact on menstrual cycle – periods will remain the same

† *Efficacy figures based on data from the Therapeutic Guidelines and UK College of Sexual and Reproductive Healthcare (CoSRH)*

* *Efficacy rate variations in non LARC methods reflect difference in typical use and perfect use*

Commencing Contraception Methods

Key considerations:
- Exclude pregnancy/ recent conception risk
- Will the method be immediately effective?

A NEGATIVE pregnancy test (urine or serum HCG):
- *May not reliably exclude early pregnancy. To exclude undiagnosable early pregnancy including very recent conception, a careful menstrual, sexual and contraceptive history is required.*
- *Excludes early pregnancy ONLY if there has been NO UPSI in the 3 weeks preceding the test.*

Pregnancy risk can be excluded when a method is commenced in the following settings:

If	• Day 1 to 5 of a NORMAL menstrual period** • Within 21 days postpartum • Within 5 days of an abortion	Then: No additional contraception required
If	• No UPSI since Day 1 of last NORMAL menstrual period** • No UPSI in past 3 weeks and a urine HCG is negative	Then: 7 days additional contraception/abstinence is required
If	Currently reliably using an effective contraceptive method	Then: See Therapeutic Guidelines for more detail on switching between methods

See Therapeutic Guidelines for further information on initiating contraception methods and Quick Starting

*** A careful history is important to ensure that "a period" is normal menses, not an implantation bleed or other*

Quick Start

Quick starting contraception:
- Consider "Quick Start" of a hormonal contraceptive at initial consultation, even if it is later than day 5 of the menstrual cycle. Balance the small risk of starting contraception in very early, undetectable pregnancy against the higher risk of unintended pregnancy.
- Suitable for all methods of contraception other than IUDs (hormonal and copper).
- Strongly encouraged when:
  - menstrual cycle is long or irregular e.g. PCOS
  - unintended pregnancy carries specific medical or psychosocial risks
  - access to health services (e.g. for insertion of an implant) is challenging.

Share the "Quick Start" decision with the patient and discuss that:
- A follow up pregnancy test in 4 weeks is required (a formal recall is recommended).
- There are no known teratogenic effects from hormonal contraceptives (other than cyproterone acetate).
- 7 days of additional contraception/abstinence are required after starting.

Decision Making in Gender Affirming Contraception

Consultation Essentials

Young People and Contraception Consultations

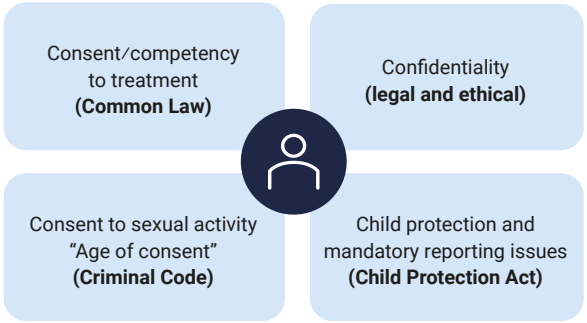
- Aim to see a young person on their own but encourage the involvement of significant adults, where appropriate, in decision making.
- Discuss confidentiality explicitly.
- Establish rapport and take a general history guided by a HEADSSS Assessment Framework.
- Use the HEADSSS discussion to assist in assessing the competence of the young person to give consent/make informed decisions as a "mature minor".
- Seek support and advice from colleagues in assessing any child safety concerns in minors; be aware of specific State-based child protection reporting requirements.
- Offer information on STIs; encourage condom use and STI testing.
- Educate on EC and where it can be accessed.

HEADSSS

- **H**ome
- **E**ducation, employment
- **A**ctivities
- **D**rugs and Alcohol
- **S**exuality and Gender
- **S**uicide, mental health
- **S**afety

Consider various legal responsibilities

These are often intertwined but should be considered separately – especially in complex cases



ISBN: 978-1-921850-76-9

Emergency Contraception

- Can be used within 5 days of unprotected sex - after contraception failure (broken condom, missed pills) or when contraception has not been used at all, and after sexual assault.
- Is very safe, has very few contraindications
- Is underutilised, possibly due to lack of community awareness of its availability.

Health practitioners have a key role in raising awareness about EC and can provide an advance supply or advance prescription in some circumstances.

Methods of EC are:

- Oral hormonal EC [stat dose of either ulipristal acetate (UPA) 30mg within 120 hours or levonorgestrel (LNG) 1.5mg within 96 hours]: available from pharmacies without a prescription.
- Copper IUD insertion: the **most** effective method of EC. It must be inserted by a trained clinician within 120 hours of unprotected sex – this act of insertion can trigger gender dysphoria in some trans & gender diverse patients.

It is important that those not consistently using contraception, or using condoms and other less reliable methods, know how and where to access EC should they require it.

Choosing between EC methods

	Advantages ✔	Disadvantages ✕
Insertion of Copper IUD	• Most effective EC • Provides ongoing contraception • Efficacy unaffected by body weight or medication	• Requires trained provider with appointment availability • May be costly
EC pill - UPA 30mg - LNG 1.5mg	• Available from pharmacies **UPA only** • Most effective oral EC • Efficacy up to 120 hours **LNG only** • Not contraindicated during breastfeeding	• Efficacy may be reduced if BMI >30 or wt >85kg • Not suitable for patients who want to avoid methods that involve insertion **UPA only** • Efficacy lowered by hormonal contraception in previous 7 or following 5 days

Additional Resources

Patient Education

- SRHA Efficacy Card
- Young people
- Sexual and Reproductive Health Australia
- TransHub – *Contraception*
- Emen8 – *Sexual Health Advice for Gay, Bi+, Queer men (cis and trans)*
- Word on the Sheets – *Sexual Health Advice for queer, bi+, lesbian women (cis and trans)*
- ACT – Sexual Health and Family Planning ACT (SHFPACT)
- NSW – Family Planning NSW
- QLD – True Relationships and Reproductive Health
- SA – SHINE SA
- VIC – Sexual Health Victoria
- WA – Sexual Health Quarters
- TAS – Family Planning Tasmania
- NT – Family Planning Welfare Association of NT Inc

Health Practitioner Guidance

- Fertility and Reproductive Health – *TransHub*
- Trans-Affirming Clinical Language Guide – *TransHub*
- Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy – *AusPATH*
- Contraception chapters of Australian Therapeutic Guidelines *(including detailed information on all methods and many specific topics e.g. MEC categories, missed pill rules, switching contraception methods, side effects management, contraception in patient populations and specific circumstances)*
- Medical Eligibility Criteria Summary Tables – *UK CoSRH*
- Contraception Guidelines – *UK CoSRH*
- Emergency Contraception Wheel
- Reproductive Coercion Information – *Children by Choice*
- HEADSSS assessment
  - Engaging with and assessing the adolescent patient
  - Conducting a Psychosocial Assessment
- Mandatory Reporting
- 1800 My Options
- QLD Abortion & Contraception Services Map – *Children by Choice*

This tool is supported by funding from the Australian Government Department of Health, Disability, and Ageing under the Quality Use of Diagnostics, Therapeutics and Pathology program. ***Disclaimer:*** *Guidance provided on this resource is based on guidelines and best-practices at the time of publication.*