Sexual health needs of trans and non-binary people

Overview

This information is for clinicians who work in primary health care services (i.e. first point of contact, non-specialist services). This is to help clinicians to respond to the sexual and reproductive healthcare needs of people who identify as transgender or non-binary in ways which are appropriate, affirming and supportive. This overview covers the following:

- Key concepts including binary gender, transgender, non-binary gender
- The difference between gender and sexuality
- Ways that health services can make trans and non-binary people feel welcome
- The importance of using and recording appropriate pronouns (e.g. he, she, they)
- Asking sexual health questions sensitively without making assumptions about gender, sexuality, anatomy or sexual practice
- Appropriate sexual health advice to trans and non-binary people (including sexually transmitted infection risk; fertility, pregnancy risk and contraception; health promotion and screening)

Definitions

GENDER IDENTITY - An individual's sense of their own gender
NON-BINARY - people whose gender identity does not align with the categories 'male' or 'female'.
INTERSEX – people with sex variation (genetics, hormones and/or sex characteristics which don't fit typical definitions of male and female)
CIS GENDER – where gender identity is congruent with sex assigned at birth
LESBIAN – a woman whose sexual partners are women
THE GENDER BINARY – the assumption that there are only two genders – male and female
GENDER DYSPHORIA - distress that is caused by a discrepancy between gender identity, sex assigned at birth, and primary/secondary sex characteristics
SEXUALITY – the way people express themselves sexually e.g. sexual attraction and sexual practice
GENDER NON-CONFORMITY - behaviours not matching the gender norms of the gender assigned at birth

Gender identity and gender expression

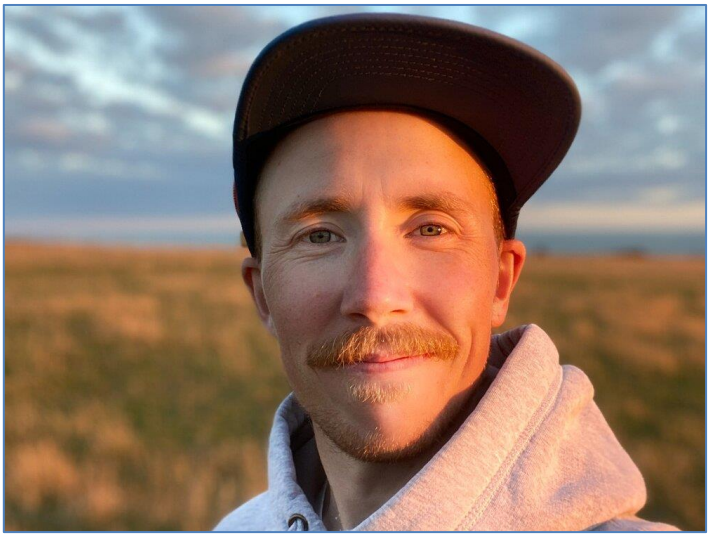
Most societies see people as either 'male' or 'female' (i.e. **binary** categories). These categories are decided (assigned) at birth, usually on the basis of genital appearance. A proportion of the population are **intersex** – i.e. their genetics, genitals and/or hormones do not fit neatly into 'male' or 'female' categorisation, so sex is clearly more complex than two clearly defined categories.

Whilst male and female **sex** and **sex variation** (intersex) are defined by genetics, **gender identity** is someone's internal sense of gender (e.g. masculine, feminine, **non-binary**). **Gender expression** is the way that gender is expressed to others (e.g. through clothes, the body, behaviour…). **Cis gender** means that a person's gender identity is the same as the sex they were assigned at birth (e.g. a woman who was assumed to be female at birth, who 'grew up as a girl', and identifies as a woman). The terms **Assigned Male at Birth** (AMAB) and **Assigned Female at Birth** (AFAB) acknowledge someone's gender history where it is relevant to know this.

Non-binary or **genderqueer** people are those whose gender identity does not align with either 'male' or 'female', and who do not subscribe to conventional gender distinctions. Non-binary and genderqueer identities may be static or fluid. Some people may include aspects of 'male' and 'female' into their identities, and others may reject binary gender categories entirely. Non binary and genderqueer people do not have a typical appearance – they may be **androgynous** (not typically 'male' or 'female' expression), or may also appear typically male or female.

Transgender or trans is a term for people who have a gender identity or gender expression that differs from their assigned sex. For example this could be someone who was assumed to be female at birth who was treated as a girl growing up, but whose gender identity is male.

Pronouns (such as he, she, they) are very important in affirming someone's gender identity. Non-binary people may choose the pronoun 'they', as a gender neutral pronoun which is neither male nor female. There are other gender neutral pronouns (e.g. ze, sie, hir, co, per, ey), and terminology concerning gender identity is changing over time. It is important not to guess or assume someone's gender identity and pronouns.



Freddy McConnell (trans man, pronoun 'he')

Monica Roberts (trans woman, pronoun 'she')

Jack Monroe (non-binary, pronoun 'they' or 'she')

The DSM-5 defines **gender dysphoria** as significant distress caused by a discrepancy between a person's gender identity, their sex assigned at birth, and their primary/secondary sex characteristics. People with gender dysphoria experience a distressing incongruence between their sense of their own gender and the gender that society perceives them to be. It is common to experience **gender incongruence** without distress, but gender dysphoria can lead to mental ill health and severely affect quality of life. It is very important that assessment and support is prompt, and that appropriate treatment is available.

Gender dysphoria is not the same as **gender variance**, which refers to behaviour not matching the gender norms or stereotypes of gender assigned at birth. People expressing gender variance (whether they are trans or not) may often experience significant backlash from families, communities and/or wider society.

Transition means expressing a different gender identity through changes to the body, appearance, and/or behaviour. **Social transition** means expressing a different gender through changes like a different appearance, name and pronoun. **Medical transition** can involve hormones and/or surgery, but not everyone who is trans wants to express their gender identity through changes to the body or appearance.

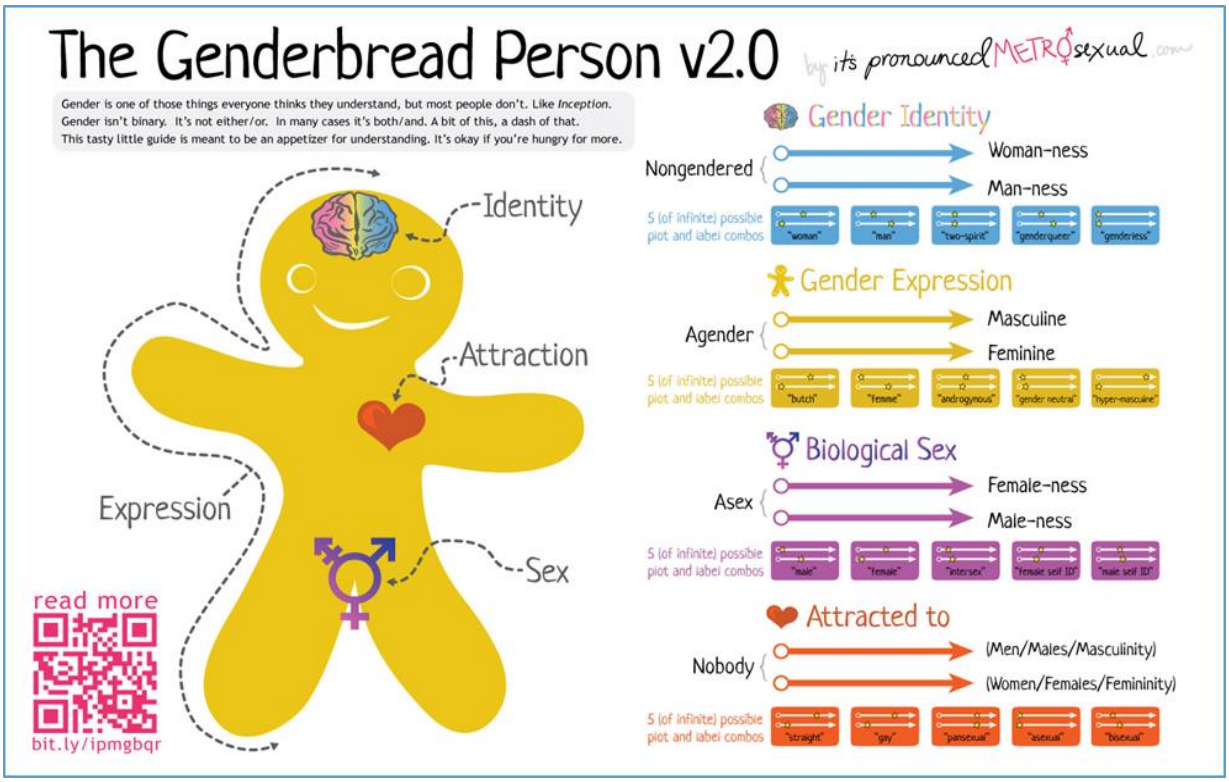
Medical transition

Medical transition is a process that may include the use of hormone therapy, and/or surgery. Not all trans people will pursue a medical transition, while others may pursue hormone therapy without surgery, or surgery without hormones. Surgeries can include breast augmentation, Adam's apple reduction (tracheal shave), orchidectomy (removal of testicles), vaginoplasty (creation of vagina often from scrotal and penile tissue), mastectomy, metoidioplasty (release of clitoris and use of local tissue to create a penis), scrotoplasty (testicular implants), phalloplasty (creation of penis from donor site, often abdominal or forearm flap).

It is important to realise that anatomy does not dictate gender – for example, a transwoman may have a penis, and a transman may have uterus and menstruate. Trans people may feel dysphoric (distressed) about their bodies, or they may not.
It is important to ask what terms someone uses for their anatomy – for example, a transman may refer to his vagina as a 'front'. Mastectomy is commonly known as 'top surgery' and genital surgery is commonly referred to as 'bottom surgery'. Be guided by the terms that people use, and if you are not sure, ask.

Gender is distinct from **sexuality**. For example, '**gay'**, '**lesbian'** or '**bisexual'** are sexualities (sexual orientations), i.e. expressions of sexual attraction. Gay men are typically attracted to male sexual

partners; lesbians to female sexual partners; bisexual people are attracted to people of the same or different genders to them. **LGBTQIA** stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual/Aromantic. There are many, many other ways of expressing sexuality.
For more information, see [Gender, Sexual, and Relationship Diversity].



***Videos*:**

[Trans 101 - The Basics]

[The Origin of Gender]

Welcoming trans and non-binary people in health services

People have a strong sense of their gender identity, but it can be very difficult to express this if those around them do not accept their gender. Trans and non-binary people often have poor experiences within healthcare settings, and may avoid or delay seeking care because of this.

A report by Stonewall in 2018 found that 41% of trans and non-binary people experienced a lack of understanding of their health needs, while 7% had been refused care because of their gender identity. A negative experience in a clinic can have a lasting effect on mental and physical health, whilst a good experience can be very affirming.

It is important that *all* staff in a clinic respond appropriately to trans and non-binary people, and that the clinic has policies and procedures that are appropriate for all patients. People working in health services play a key role in welcoming people, listening, respecting what people say and taking it seriously, and accepting without judgement.

Equality Act 2010

Under the Equality Act (2010), health and social care services in the UK are required to provide equal treatment and tackle discrimination. 'Gender reassignment' is a protected category, and includes those 'who are proposing to undergo, are in the process of or have completed a process to change sex'. Individuals are not required to show that they are under any medical supervision nor have undergone any particular medical/surgical procedures to qualify.

How can health services provide a welcoming environment?

- Avoid gendered language on signs and paperwork. For example, choose a name like "Sexual & Reproductive Health Clinic" instead of "Women's Health Clinic"
- Have a single waiting room for everyone, and do not divide waiting areas into 'male' and 'female'.
- Posters for LGBTQIA people to show people that they are welcome
- Inclusive registration forms and other paperwork –ask and record preferred name (instead of legal name), pronouns (e.g. he, she, they), sex assigned at birth and gender identity.
- Gender-neutral toilet facilities are very important – ideally provide individual toilets which people of any gender can use
- Health promotion materials should use gender-neutral/inclusive language and have images of gender diverse people.
- Fail-safe clinic systems in place for gender-specific screening programmes – for example, cervical screening recall for people with a cervix who are registered as Male

- Make sure that all staff are trained on LGBTQIA issues in healthcare (clinical and non-clinical, junior and senior, part-time and full time)
- Seek accreditation for services e.g. LGBT Foundation's Pride in Practice scheme and the British Association of Sexual Health and HIV Service standards for transgender and non-binary people.

Asking sexual history questions

It is important to avoid assumptions about gender identity, anatomy and sexual practice when asking questions about sexual and reproductive history – this applies equally to cisgender, transgender and non-binary people.

Staff working at Clinic Q, a specialist sexual health service for transgender and non-binary people, use the "7 Ps" approach to history taking:

- **Pronouns** – which pronoun does an individual prefer (He/She/They)? This allows for accurate documentation, as well as showing sensitivity to the individual's gender identity
- **Partners** – what is the gender of their sexual partners? Important to not presume a transgender person's sexual orientation. A trans person can be heterosexual, bisexual or lesbian/gay, just as a cis person can.
- **Parts** – has the person had any genital ('bottom') surgery? This enables the practitioner to establish pregnancy risk and if STI screening is needed, which samples are required. It is important to approach this sensitively and explain why you are asking – many trans people are asked inappropriate questions related to their genitals which have had no relevance to their care.
- **Practice**– what kind of sex do they engage in? Oral, vaginal, anal sex? Are they insertive/receptive, both or neither? Do they use and/or share sex toys?
- **Past history** of STIs – relevant for interpreting some tests, such as syphilis screening, Hepatitis B testing and vaccination
- **Prevention** strategies – how do they protect themselves from STIs? This includes condom use, pre-exposure prophylaxis (PrEP) for HIV prevention and vaccinations such as Hepatitis A&B and HPV. Condom/dam use for different genital shapes/sizes
- **Pregnancy** prevention – for AFAB people with a uterus having sex with someone who is AMAB who can produce sperm, how do they prevent unwanted pregnancy? Important to know that hormone replacement therapy is not a reliable contraceptive method.

Fertility, contraception and pregnancy

Trans and non-binary people may want to have children and become parents, and not all transgender or non-binary people wish to have genital surgery as part of their gender affirmation.
It is important check -

Is pregnancy a possibility for this person and their partner/s? Do they want a pregnancy?
Do they want to avoid pregnancy?

Fertility preservation and fertility treatment
People who have had testes or ovaries removed will no longer be fertile, but people taking gender-affirming hormones such estrogen or testosterone may still be fertile, possibly without realising it.

Fertility should be discussed with all trans and non-binary people before starting gender affirming interventions.

Pregnancy in transmen and non-binary people assigned female at birth

Some transmen and non-binary people assigned female at birth (AFAB) may wish to carry a pregnancy regardless of their gender identity. For AFAB people who have a uterus and ovaries, the use of testosterone does not necessarily preclude future pregnancy, although pregnancy may induce gender dysphoria for some. It is important that testosterone is stopped if pregnancy is desired, since testosterone is absolutely contraindicated in pregnancy, due to the risk of teratogenicity.

Video: NHS Choices – *Being a trans man: Jay's story*

Contraception methods for trans and non-binary people with a uterus and ovaries

For transmen and non-binary people assigned female at birth (AFAB) who have a uterus and ovaries, there are no restrictions on the use of any particular method of contraception on the basis of gender identity. As with anyone, an individual's personal characteristics (e.g. smoking, BMI), medical history, family history, and use of medications need to be considered when assessing the suitability of contraception.

A reliable form of contraception should be offered to any AFAB person who:

- has not undergone hysterectomy or bilateral oophorectomy
- is having receptive vaginal sex with a risk of pregnancy
- does not wish to conceive

Combined hormonal contraception (pill, patch and ring)

Combined hormonal methods are not recommended for people using masculinising hormones because the estrogen component can counteract the effects of the therapy.

For those not using hormones for gender affirmation, CHC methods can be considered but some potential side effects such as breast tenderness may contribute to feelings of gender dysphoria. The combined pill, patch or ring can be used continuously to control menstruation.

Progestogen-only methods (mini-pill, injection, implant)

Progestogen-only pills, injection and implant are not thought to interfere with masculinising hormone therapy and can be safely used. They may also provide the additional benefit of reducing menstrual bleeding or inducing amenorrhea. Androgenic side effects of progestogen-only methods may also be desirable for some trans masculine people.

Intrauterine contraception (IUS, IUD)

Both the non-hormonal IUD and the progestogen-releasing IUS are suitable for AFAB people, with no impact on masculinising hormonal therapy. The IUS has the additional benefit of inducing amenorrhea in most individuals, although irregular bleeding with an IUS or heavier periods with an IUD may be unacceptable.

Vaginal atrophy can occur in people using masculinising hormones, which may make speculum examination painful. A small speculum or a proctoscope can be considered, and topical estrogen gel can be useful, although this may not be acceptable to some trans masculine people.

Internal and external condoms, diaphragms and cervical caps

External or internal condoms protect against both pregnancy and STIs, and will not interfere with hormonal therapy.

Diaphragms and the cervical cap require the individual to be comfortable with inserting into the vagina, which may be difficult for those experiencing dysphoria. In addition, vaginal atrophy due to masculinising hormones can make insertion of a diaphragm or cervical cap difficult.

Sterilisation
If permanent contraception is desired, this can be achieved with tubal occlusion or vasectomy.

For transgender or non-binary people who undergo genital surgery, sterility will be achieved if the testes/ovaries are removed. However, not all transgender or non-binary people wish to have genital surgery as part of their gender affirmation.

Emergency contraception

AFAB people who have had unprotected vaginal intercourse and do not wish to become pregnant should be offered emergency contraception. There is little evidence, but it is not thought that testosterone interferes with hormonal EC. The most effective method of emergency contraception is the copper IUD.

Contraception choices website

Physical examination and cervical screening

Genital examination

Genital examination can be a difficult experience for anyone, and it can be a source of great anxiety for people with dysphoria about their bodies or gender identity. Fear of negative experiences puts people off seeking healthcare, but a sensitively conducted genital examination can be a very positive experience.

The following points are good practice for all genital examinations:

- Ask what terms someone uses for their genitals, and use their terms where possible
- Explain the purpose of a genital examination, and what is involved
- Seek active consent for an examination (*Don't say* "Pop up on the couch and I'll have a look" *Do say* "Would you like me to look, and do some tests for infections?")
- Give someone time to get changed, and check whether it's okay for you to come behind a curtain
- Explain what you are doing as you are examining, and check consent as you go - someone may consent to part of an examination, but not all of it
- Make sure that you don't accidentally equate anatomy with gender (e.g. *Don't say* "Women need cervical smear tests every 3 years…" *Do say* "Since you have a cervix, you need a cervical smear test every 3 years)
- If you make a mistake with what you say, apologise, but don't dwell on it

Screening Programmes
Currently, cervical and breast cancer screening invitations are based on the gender registered on GP records. As a result, transgender and non-binary people could be inappropriately excluded from screening programmes, or invited when it is not appropriate for them.

Cervical screening

Anyone with a cervix is eligible for cervical screening: every three years from age 25 to 49, and every 5 years from age 50 to 64. Invitations are automatically sent to those registered as female on GP records.

Trans men who are registered with their GP as male will not receive invitations, but still need cervical screening if they have not had a total hysterectomy and still have a cervix. Trans women who are registered with their GP as female will receive an invitation, but do not require cervical screening.

Public Health England have produced an information leaflet for transgender and non-binary people, explaining the NHS Screening programmes (link) NHS Screening Programmes – Information for trans people

Sexual health promotion

Many health risks are heightened for trans and non-binary people, because of lack of acknowledgement and acceptance in society. For example:

- **'Coming out'/disclosing trans or non-binary status to potential sexual partners** - gender variant people face a lot of verbal and physical violence in society, and this can be heightened in sexual situations

- **Sex and identity**. It may be difficult for trans and non-binary people to appreciate risks which do not 'fit' with their gender identity – for example, transmen who are not menstruating may not feel that they are at risk of pregnancy

- **Sexual exploration.** Coming out can be a time of sexual exploration (a 'second adolescence', with different hormones), and may include different patterns of sexual partnerships and sexual practice.

- **Safer sex.** Safer sex can be complex for trans and non-binary people, because internal and external condoms may be the wrong shape or uncomfortable (e.g. with vaginal atrophy and soreness). Vaccination for HPV, Hepatitis A and B may be appropriate, depending on sexual history. It is important to check whether PrEP is appropriate, and to that people are informed about PEP for HIV prevention. 'Safer sex' also includes physical and emotional safety, online and offline.

- **Sex work.** As for all patients, it is important to ask about sex work. People who are gender variant face discrimination in the workplace, and for some, sex work may be one opportunity to earn an income

- **Mental health, drug and alcohol use.** Trans and non-binary people often experience poor mental health linked with dysphoria, and linked with lack of support from people around them. There is a high rate of suicide and self-harm, and trans and non-binary people may self-medicate with drugs and alcohol.

- **Accessing services.** Trans and non-binary people face ignorance and prejudice (including from health and social care providers), which means that they may not access support for their sexual health, intimate partner abuse, general health, or mental health.

Healthcare providers can make a huge difference to people – making people feel welcome, listening and respecting what people say, taking it seriously, and accepting people without judgement. Respectful relationships build trust, and facilitate better physical and mental health.

Resources

Contraception choices website

What's right for me?

Effectiveness

Videos

Trans 101 – the basics

The Origin of Gender

Being a trans man: Jay's story

Why was Pink for Boys and Blue for Girls?

Muxes – Mexico's third gender

Dispelling Beauty Myths: Gender Norms | Allure

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