Perinatal HIV Prevention for Transgender and Gender-Diverse People Assigned Female at Birth

Updated: January 31, 2023
Reviewed: January 31, 2023

Panel's Recommendations
• The Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission has determined that, in most cases, it is appropriate to extrapolate its recommendations based on data in cisgender women to all people assigned female sex at birth, including transgender and gender-diverse people, with modification when indicated (e.g., drug interactions with gender-affirming hormones) (AIII). • Patient-centered HIV and perinatal services should be provided using gender-affirming and shared decision-making approaches and models of care that address the unique and varied needs of transgender and gender-diverse people and reduce barriers to ongoing engagement in care that can affect adherence to antiretroviral therapy and the likelihood of viral suppression during prepregnancy, antepartum, and postpartum periods (AII). o Patients should be asked about their gender identity, including the pronouns they use and their language preferences, how they want to be referred to as a parent (e.g., the baby's mother, father, or by another name), and terms they prefer to use for sexual and reproductive anatomy and examinations (e.g., breast exams, pelvic exams) (AIII). • Health care providers should assess reproductive and parenting intentions and support access to appropriate reproductive healthcare services for transgender and gender-diverse people (AIII). • Prepregnancy care for transgender and gender-diverse people should incorporate shared decision-making that addresses needs related to gender identity, with consideration of the potential risks and benefits of gender-affirming pharmacologic treatment in relation to pregnancy (AIII). See Prepregnancy Counseling and Care for Persons of Childbearing Age With HIV for more information. • Some transgender and gender-diverse patients may experience the onset or worsening of gender dysphoria and associated symptoms—such as depression—during prepregnancy, antepartum, and postpartum periods; health care providers should regularly assess patients' comfort with their care and provide referrals for mental health or other support services as needed (AIII). For additional information, see Transgender People With HIV in the Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV.
Rating of Recommendations: A = Strong; B = Moderate; C = Optional *Rating of Evidence: I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion*

It is important for health care providers to be aware that not all people who become pregnant identify as women or female. Because many transgender and gender-diverse people retain their reproductive organs, pregnancy can occur, and some may desire and/or experience pregnancy in their lifetime.[1-5] This section provides an overview of recommendations from the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission (the Panel) regarding perinatal HIV prevention and treatment of HIV in pregnancy for transgender and gender-diverse people assigned female at birth. The Panel uses the terms transgender and gender-diverse people assigned female at birth to include people who do not identify as cisgender women while acknowledging individual preferences and ongoing changes in the terminology used to describe this population. The Panel aims to make the guidelines inclusive of transgender and gender-diverse people by incorporating inclusive language,

considering the appropriateness of existing Panel recommendations for the care of transgender and gender-diverse individuals who were assigned female at birth, and adding relevant recommendations and content. Additional information is available in the Adult and Adolescent Antiretroviral Guidelines (see Transgender People With HIV), guidance from the American College of Obstetricians and Gynecologists about health care for transgender and gender-diverse individuals,[6] standards of care developed by the World Professional Association for Transgender Health,[7] and guidelines for primary and gender-affirming care developed by the Center of Excellence for Transgender Health at the University of California, San Francisco.[8]

Perinatal HIV Prevention and Care of Transgender and Gender-Diverse People During Prepregnancy, Antepartum, and Postpartum Periods

Research into the fertility, pregnancy-related, and perinatal HIV prevention needs of transgender and gender-diverse people is in early stages, and descriptions of pregnancy-related care are limited. After careful consideration, the Panel has decided it is often appropriate to extrapolate existing recommendations to transgender and gender-diverse people assigned female at birth and to provide additional content and recommendations, when data are available, to address the unique and varied needs of this population if indicated. This approach is consistent with other guidelines for primary care, family planning,[9] and HIV care[10] for transgender and gender-diverse people.

Health care providers should periodically assess the reproductive and parenting desires and intentions of transgender and gender-diverse patients and support access to reproductive healthcare services.[11] Transgender and gender-diverse people experience multiple barriers to accessing health care, particularly sexual and reproductive health care, which is often delivered in gender-segregated spaces.[12,13]

Some transgender and gender-diverse people assigned female at birth take testosterone to achieve gender-affirming bodily changes. While testosterone may lead to amenorrhea, it does not reliably suppress ovulation. Individuals having condomless sex that can lead to pregnancy and who want to avoid pregnancy should be counseled on the need for contraception. Testosterone is not recommended during pregnancy due to possible irreversible fetal androgenic effects.[13-16] Experts recommend that patients who are pregnant or are trying to conceive should stop taking testosterone.[7,17-19] If a patient taking testosterone desires pregnancy and has concerns about stopping testosterone, they should consult with their gender-affirming hormone prescriber or another transgender care expert about risks and benefits.[20] The optimal time period for stopping testosterone prior to conception is unknown.[2,20] For people wanting to conceive, prepregnancy planning and care provides an opportunity to address HIV prevention—including HIV testing and pre-exposure prophylaxis—for those who are HIV negative. For people with HIV, it provides an opportunity to optimize antiretroviral therapy (ART) and viral suppression before pregnancy. It also enables providers to identify and address transgender and gender-diverse people's concerns about the relationships between pregnancy or parenthood and their gender identity and gender-affirming medical interventions, such as hormones or surgeries. For additional information, see Pre-Exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods; Prepregnancy Counseling and Care for Persons of Childbearing Age With HIV; and Reproductive Options When One or Both Partners Have HIV.

Selection and management of ART for transgender and gender-diverse people with HIV should follow Recommendations for Use of Antiretroviral Drugs During Pregnancy: Overview, Table 6: What to Start: Initial Antiretroviral Regimens During Pregnancy for People Who Antiretroviral-

Naive, and Table 7: Situation-Specific Recommendations for Use of Antiretroviral Drugs in Pregnant People and Nonpregnant People Who Are Trying to Conceive. The potential for drug interactions should be considered and discussed with patients who plan to start or resume hormonal therapy postpartum (see Table 17. Potential Interactions Between the Drugs Used in Gender-Affirming Hormone Therapy and Antiretroviral Drugs in Transgender People With HIV).

Gender-Affirming Care

Health care providers should work to develop patient-centered approaches that assess and address the gender affirmation needs of transgender and gender-diverse individuals in all health care settings.[11,18,20,21] Gender affirmation encompasses processes and interventions that recognize and support a person's gender identity and expression.[22] Gender-affirming care may include psychosocial support, hormone therapy, surgery, and other interventions.[18] Gender affirmation—including such medical interventions as hormonal therapy—has been shown to improve mental health outcomes and quality of life in transgender individuals.[23-26] A prospective evaluation of the effects of medical gender affirmation on HIV-related outcomes—including viral suppression—is currently in process.[27] A national needs assessment found that transgender and gender-diverse people with HIV were more likely to be virally suppressed when they worked with HIV care providers who affirmed their gender (e.g., providers who use their chosen name and pronoun[s]).[10,28] Language is important for inclusivity and for providing respectful, affirming health care.[11,29] Many transgender and gender-diverse people use terms unique to them and their anatomy; therefore, providers should never assume that a patient prefers a certain term and should respect the patient's expressed preferences.[29,30] All patients should be asked about their gender identity, including the pronouns they use and language preferences, including how they (and their partners) want to be referred to as parents (i.e., birth parent, father, mother, or another name). Clinicians should also ask patients about desired terminology for sexual and reproductive anatomy and be aware that terminology is rapidly changing.[30]

Health care providers should be aware that although transgender and gender-diverse patients may adjust well to pregnancy, some patients may experience and require support for the onset or worsening of gender dysphoria and associated symptoms during prepregnancy, antepartum, and postpartum periods. Gender dysphoria and associated symptoms may be precipitated or exacerbated by the body changes that occur in pregnancy and the harmful practices of misgendering pregnant transgender and gender-diverse people in prenatal, labor and delivery, and postpartum care settings.[17,18,20] Gender dysphoria refers to the distress that results from incongruence between a person's sex assigned at birth and their gender identity[31] and is manifested by a range of symptoms, such as depression, anxiety, and a sense of unease.[32] Gender dysphoria can be reduced when a person receives affirmation for their gender identity through various interventions that include interpersonal approaches—such as adaptations made in gender-specific clinic environments and procedures—and medical interventions, such as hormones.[18,32] Health care providers should have individualized discussions with their patients regarding starting or restarting testosterone therapy in the postpartum period, including referral to and/or coordination with a gender-affirming care specialist as needed.

References

1. Cipres D, Seidman D, Cloniger C, 3rd, Nova C, O'Shea A, Obedin-Maliver J. Contraceptive use and pregnancy intentions among transgender men presenting to a clinic for sex workers and their families in San Francisco. *Contraception*. 2017;95(2):186-189. Available at: https://www.ncbi.nlm.nih.gov/pubmed/27621044.

2. Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014;124(6):1120-1127. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25415163.

3. Light A, Wang LF, Zeymo A, Gomez-Lobo V. Family planning and contraception use in transgender men. *Contraception*. 2018;98(4):266-269. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29944875.

4. Morong JJ, Class QA, Zamah AM, Hinz E. Parenting intentions in transgender and gender-nonconforming adults. *Int J Gynaecol Obstet*. 2022. Available at: https://www.ncbi.nlm.nih.gov/pubmed/35332529.

5. Moseson H, Fix L, Hastings J, et al. Pregnancy intentions and outcomes among transgender, nonbinary, and gender-expansive people assigned female or intersex at birth in the United States: results from a national, quantitative survey. *Int J Transgend Health*. 2021;22(1-2):30-41. Available at: https://www.ncbi.nlm.nih.gov/pubmed/34796363.

6. American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women. Health care for transgender and gender-diverse individuals: ACOG committee opinion, number 823. *Obstet Gynecol*. 2021;137(3):e75-e88. Available at: https://www.ncbi.nlm.nih.gov/pubmed/33595253.

7. World Professional Association for Transgender Health. Standards of care for the health of transsexual, transgender, and gender nonconforming people. 2021;7. Available at: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

8. Deutsch M. Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people. 2016. Available at: https://transcare.ucsf.edu/guidelines.

9. Bonnington A, Dianat S, Kerns J, et al. Society of family planning clinical recommendations: contraceptive counseling for transgender and gender-diverse people who were female sex assigned at birth. *Contraception*. 2020;102(2):70-82. Available at: https://www.ncbi.nlm.nih.gov/pubmed/32304766.

10. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. 2022. Available at: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines.

11. Moseson H, Zazanis N, Goldberg E, et al. The imperative for transgender and gender nonbinary inclusion: beyond women's health. *Obstet Gynecol*. 2020;135(5):1059-1068. Available at: https://www.ncbi.nlm.nih.gov/pubmed/32282602.

12. Schwartz AR, Moravek MB. Reproductive potential and fertility preservation in transgender and nonbinary individuals. *Curr Opin Obstet Gynecol*. 2021;33(4):327-334. Available at: https://www.ncbi.nlm.nih.gov/pubmed/34173770.

13. Moseson H, Fix L, Gerdts C, et al. Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States. *BMJ Sex Reprod Health*. 2022;48(e1):e22-e30. Available at: https://www.ncbi.nlm.nih.gov/pubmed/33674348.

14. Depo-testosterone [package insert]. Food and Drug Adminstration. 2014. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/085635s029lbl.pdf.

15. Patel A, Rivkees SA. Prenatal virilization associated with paternal testosterone gel therapy. *Int J Pediatr Endocrinol*. 2010;2010:867471. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20976267.

16. Wolf CJ, Hotchkiss A, Ostby JS, LeBlanc GA, Gray LE, Jr. Effects of prenatal testosterone propionate on the sexual development of male and female rats: a dose-response study. *Toxicol Sci*. 2002;65(1):71-86. Available at: https://www.ncbi.nlm.nih.gov/pubmed/11752687.

17. Brandt JS, Patel AJ, Marshall I, Bachmann GA. Transgender men, pregnancy, and the "new" advanced paternal age: a review of the literature. *Maturitas*. 2019;128:17-21. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31561817.

18. Hahn M, Sheran N, Weber S, Cohan D, Obedin-Maliver J. Providing patient-centered perinatal care for transgender men and gender-diverse individuals: a collaborative multidisciplinary team approach. *Obstet Gynecol*. 2019;134(5):959-963. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31599839.

19. Krempasky C, Harris M, Abern L, Grimstad F. Contraception across the transmasculine spectrum. *Am J Obstet Gynecol*. 2020;222(2):134-143. Available at: https://www.ncbi.nlm.nih.gov/pubmed/31394072.

20. McCracken M, DeHaan G, Obedin-Maliver J. Perinatal considerations for care of transgender and nonbinary people: a narrative review. *Curr Opin Obstet Gynecol*. 2022;34(2):62-68. Available at: https://www.ncbi.nlm.nih.gov/pubmed/35102108.

21. Roosevelt LK, Pietzmeier S, Reed R. Clinically and culturally competent care for transgender and nonbinary people: a challenge to providers of perinatal care. *J Perinat Neonatal Nurs*. 2021;35(2):142-149. Available at: https://www.ncbi.nlm.nih.gov/pubmed/33900244.

22. Sevelius JM. Gender affirmation: a framework for conceptualizing risk behavior among transgender women of color. *Sex Roles*. 2013;68(11-12):675-689. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23729971.

23. Bauer GR, Scheim AI, Pyne J, Travers R, Hammond R. Intervenable factors associated with suicide risk in transgender persons: a respondent-driven sampling study in Ontario, Canada. *BMC Public Health*. 2015;15:525. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26032733.

24. White Hughto JM, Reisner SL. A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgend Health*. 2016;1(1):21-31. Available at: https://www.ncbi.nlm.nih.gov/pubmed/27595141.

25. Keo-Meier CL, Herman LI, Reisner SL, Pardo ST, Sharp C, Babcock JC. Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. *J Consult Clin Psychol*. 2015;83(1):143-156. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25111431.

26. Mahfouda S, Moore JK, Siafarikas A, et al. Gender-affirming hormones and surgery in transgender children and adolescents. *Lancet Diabetes Endocrinol*. 2019;7(6):484-498. Available at: https://www.ncbi.nlm.nih.gov/pubmed/30528161.

27. Reisner SL, Deutsch MB, Mayer KH, et al. Longitudinal cohort study of gender affirmation and HIV-related health in transgender and gender diverse adults: the LEGACY project protocol. *JMIR Res Protoc*. 2021;10(3):e24198. Available at: https://www.ncbi.nlm.nih.gov/pubmed/33646126.

28. Chung C, Kalra A, McBride B, Roebuck C, Sprague L. Some kind of strength: findings on health care and economic wellbeing from a national needs assessment of transgender and gender non-conforming people living with HIV. 2016. Available at: http://transgenderlawcenter.org/wp-content/uploads/2017/03/tlc_report_some_kind_of_final_rev3.pdf.

29. Klein A, Golub SA. Enhancing gender-affirming provider communication to increase health care access and utilization among transgender men and trans-masculine non-binary individuals. *LGBT Health*. 2020;7(6):292-304. Available at: https://www.ncbi.nlm.nih.gov/pubmed/32493100.

30. Ragosta S, Obedin-Maliver J, Fix L, et al. From ‘shark-week’ to ‘mangina’: an analysis of words used by people of marginalized sexual orientations and/or gender identities to replace common sexual and reproductive health terms. *Health Equity*. 2021;5(1):707-717. Available at: https://www.ncbi.nlm.nih.gov/pubmed/34909540.

31. American Psychological A. Guidelines for psychological practice with transgender and gender nonconforming people. *Am Psychol*. 2015;70(9):832-864. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26653312.

32. Murad MH, Elamin MB, Garcia MZ, et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin Endocrinol (Oxf)*. 2010;72(2):214-231. Available at: https://www.ncbi.nlm.nih.gov/pubmed/19473181.