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Emergency Contraception for Transgender and Nonbinary patients

Background

Emergency contraception (EC) can reduce the risk for pregnancy after penis-in-vagina sex when contraception failed or was not used, and/or in cases of sexual assault or reproductive coercion. Healthcare providers who offer care for patients of reproductive age should be ready to answer questions about EC for transgender and nonbinary patients.¹

Pregnancy is possible for any individual with a uterus and ovary(ies) who has receptive penis-in-vagina sex with partners who produce sperm, regardless of gender identity. Patients who are amenorrheic due to testosterone use may be surprised that they are at risk for pregnancy. This fact sheet addresses medical and social-emotional aspects of EC for transgender and nonbinary patients.

Notes on language

- Anatomical language will be used throughout this document; however, this is *not* the language that some transgender and nonbinary individuals use to refer to their bodies. For example, some patients may prefer the term “genital opening” rather than “vagina”. Always ask patients what words they would like you to use when referring to their gendered body parts.¹
- Although the term “unprotected sex” can mean many things, here it means any penis-in-vagina sex without use of a barrier method or other type of contraception.

EC Basics

EC is indicated for a range of situations in which contraception is not used, not used correctly (such as missed pills), or does not work correctly (such as a condom slipping or breaking). EC plays an important role in preventing pregnancy for individuals who experience sexual assault and reproductive coercion, which can happen to people of all gender identities.

There are three primary types of EC available in the United States: two dedicated EC pills (ECPs), levonorgestrel and ulipristal acetate, and the copper IUD. ECPs are not the same thing as “the abortion pill;” EC prevents pregnancy before it occurs and will not end an existing pregnancy.

All EC options should be made available to patients who experience unprotected sex which would place them at risk for undesired pregnancy. It is challenging to calculate the precise efficacy of ECPs due to several factors.² For this reason, in this document we discuss EC efficacy in relative terms (which is more effective than the others), rather than providing absolute efficacy rates for ECPs.

- **Levonorgestrel (LNG) ECP (1.5 mg)**
 - Sold as Plan B One-Step, Take Action, AfterPill and other generics
 - Most accessible form of EC: can be purchased over-the-counter (OTC) with no restrictions on the age or perceived gender of the person purchasing it
 - Least effective EC option for all users, and for people [weighing 165 lbs](#) or more or with body mass index (BMI) greater than 26, it may be no more effective than placebo
 - OTC cost is ~\$35-50. LNG EC is typically covered in full by insurance when filled as a prescription
- **Ulipristal acetate (UPA) ECP (30 mg)**
 - Sold as ella
 - Prescription-only
 - More effective for all users³ because it works closer to the time of ovulation
 - Important option for users who weigh 165 lbs or more, as LNG EC may not work for these patients. UPA also appears to have a weight threshold for efficacy: it may be ineffective for those who weigh 196 lbs or more, or have BMI greater than 35⁴
 - UPA can be harder to access: many healthcare providers don't know about it⁵ and many pharmacies may not have it immediately available to fill a prescription the same day⁶
- **Copper intrauterine device (IUD)**
 - Sold as Paragard
 - Must be provided by a trained healthcare professional
 - Nearly 100% effective if placed within 5 days after unprotected sex⁷ (or longer, likely with a different mode of action⁸⁻⁹)
 - If left in place, can prevent pregnancy for at least 12 years¹⁰

Considerations for Transgender and Nonbinary Patients

Medical considerations

Transgender and nonbinary individuals may use a variety of gender-affirming medical and surgical interventions. Testosterone is not a substitute for contraception for people capable of becoming pregnant, regardless of its effect on other characteristics (absent menses, voice changes, clitoral growth, etc.)¹¹ In contrast, people who have undergone hysterectomy (removal of uterus and cervix), salpingectomy (removal of fallopian tubes), bilateral oophorectomy (removal of both ovaries), or any of the combination of these procedures have no risk of pregnancy. The risk of pregnancy is extremely low (<1%) for those who have undergone permanent blockade of the fallopian tubes (tubal ligation, quinacrine, coils).

While some transgender and nonbinary individuals may desire pregnancy and childbirth, preventing pregnancy may be a high priority for others. Healthcare professionals should be aware that individuals may experience gender dysphoria and/or trauma if they become pregnant. In addition, exposure to testosterone in pregnancy can affect the fetus as it is forming, particularly an XX-chromosome fetus prior to 14 weeks. This can include urogenital changes, which may require surgery later in life.¹² It is unclear if there are other long-term effects of testosterone on pregnancy.

Transgender and nonbinary patients at risk for pregnancy should be offered a full range of contraceptive options, including EC when needed.¹³ Some resources for patients and providers are listed at the end of this document. There are no specific studies of EC use among transgender and nonbinary individuals. However, expert consensus and experience with other contraceptive methods indicate no reason to expect drug interactions or loss of efficacy for either ECPs or testosterone when used together.

Social-emotional Considerations

Transgender and nonbinary patients may experience a variety of barriers in acquiring EC. Some may experience increased gender dysphoria due to side effects of EC. Providers should familiarize themselves with effective strategies to help minimize anxiety and negative experiences for their patients.

Encounters at the Pharmacy

At the pharmacy, staff may question a prescription for EC for a patient whose insurance identifies them as male. When prescribing EC, consider documenting on the prescription that this medication is intended for this patient, regardless of the gender listed on insurance or identification. Make sure that a patient can easily contact you for assistance if a pharmacy refuses to fill an EC prescription or if an insurance company refuses to cover it. If you are familiar with pharmacists in your area who are particularly helpful to transgender and nonbinary patients, consider referring patients to them.

Levonorgestrel EC is approved for OTC sale for anyone of any age, sex, or gender and it should be available on store shelves (often stocked near condoms and pregnancy tests). However, some stores do not stock LNG EC on the shelf, and customers may need to ask for it at the pharmacy counter. There is no need for any pharmacy staff to ask questions about who will be using it because there are no restrictions on its sale, but some staff may not know this. Patients who encounter barriers at the pharmacy and want to advocate for themselves can introduce pharmacy staff to the American Society for Emergency Contraception's [EC Pharmacy Guide](#), which describes current EC regulations.

Advance Provision of EC

Providers can encourage patients who are interested in preventing pregnancy to keep EC on hand in case they need it in the future. The sooner EC is used after unprotected sex, the more likely it is to be effective. If patients have EC on hand, they can avoid emotional and logistical barriers to purchasing it before it becomes time-sensitive.¹³

There are several options for obtaining ECPs online. LNG EC is OTC and several generic brands may be available online at lower prices than in stores. Some brand names of products approved for sale in the United States are Plan B One-Step, Aftera, AfterPill, EContra EZ, My Choice, My Way, New Day, Option 2, React, and Take Action. If purchasing from an online retailer, carefully consider the seller to ensure that the product will be sent by a reputable company, such as [AfterPill](#) or [Option2](#). If purchasing on Amazon, the tag “sold and shipped by Amazon” may provide some additional assurance, but is not a guarantee of quality.

UPA EC cannot be purchased through regular retail outlets because it is still a prescription-only product. However, there are a number of online services (such as [Nurx](#), [Simple Health](#), [Twentyeight Health](#), [Virtuwell](#), [Pandia Health](#) and [Planned Parenthood Direct](#)) that can ship UPA EC after a brief virtual consultation with a prescribing provider (read this [FDA guidance](#) on how to identify legitimate online pharmacies). Insurance may cover the cost of the medication purchased on these sites, but there may be a consultation fee that is not reimbursable.

A note about IUDs

The copper IUD is nearly 100% effective as EC when inserted within 5 days (or more, likely with a different mode of action⁸⁻⁹) after unprotected sex and provides at least 12 years of ongoing contraceptive protection.¹⁰ However, providers should be aware that due to gender dysphoria, genital tissue changes, or other issues (for example, a history of trauma or abuse), a comprehensive trauma-informed approach to IUD placement is essential. Even with the best preparation, some patients may find the insertion process to be difficult, or sometimes intolerable.¹³ For some, the side-effects may be unacceptable; these may include cramping or heavier menstrual flow. The rate of these side-effects in patients who are amenorrheic due to testosterone is unknown. When counseling about EC options, providers' enthusiasm for offering the most effective option must be tempered by prioritizing patients' needs and concerns. See Krempasky et al¹ and Bonnington et al¹³ for helpful guidance on patient-

centered contraceptive counseling for transgender and nonbinary patients, including tips for reducing anxiety and pain associated with IUD insertion.

What to Expect after Using EC

All EC methods (LNG and UPA pills and the copper IUD) can change bleeding patterns. These effects vary by individual and by method. Providers should offer anticipatory guidance that uterine bleeding may change following use of any EC method; menses can come earlier or later than expected, or be longer or shorter than usual. Even for patients who are amenorrheic, bleeding, spotting, and cramping may occur following IUD insertion or use of either ECP. Both anticipatory guidance and non-steroidal anti-inflammatory (NSAID) use (like ibuprofen or naproxen) can reduce distress associated with these side effects.

Most people who use EC as indicated do not become pregnant; however, ECPs are not 100% effective, and pregnancy is a possibility. Efficacy of ECPs is notoriously difficult to establish. Further complicating the equation is that people who use ECPs for one episode of unprotected sex may have had other instances of unprotected sex in that cycle.⁴

Individuals who are amenorrheic or have irregular cycles can't rely on the arrival of their next period to confirm that they're not pregnant. Therefore, checking a urine pregnancy test (widely available OTC) at 2-3 weeks after ECP use may be reassuring. If a transgender or nonbinary patient becomes pregnant, pregnancy options counseling is a crucial next step. (See the "Medical Considerations" section for information about risks of exposure to testosterone in pregnancy.) If the patient does not wish to be pregnant at this time, provide or refer for abortion care, ideally with a provider who is experienced in working with transgender and nonbinary patients.¹⁵ Patients who choose to continue their pregnancy will benefit from provision of, or referral to, culturally appropriate and identity-sensitive prenatal care.

Conclusion

Transgender and nonbinary people deserve patient-centered access to the full range of reproductive healthcare options, including EC. Healthcare providers have an important role to play in offering supportive, non-judgmental, and compassionate care. For more information about healthcare for transgender and nonbinary patients, see the resource list below.

Resources

For patients

- [Birth Control across the Gender Spectrum](#) (Reproductive Health Access Project)
- [I'm trans. Do I need birth control?](#) (Bedsider)
- [7 Things to Know About Birth Control If You Are Transgender or Nonbinary](#) (Teen Vogue)
- [Provider Search](#) (World Professional Association for Transgender Health)

For providers

- [Contraceptive counseling for transgender and gender diverse people who were female sex assigned at birth](#) (Society of Family Planning)
- [Clinical minute: Emergency Contraception for transgender or gender nonbinary patients](#) (Bedsider)
- [Taking a transgender-inclusive sexual health history](#) (Bedsider)
- [Contraceptive Choices and Sexual Health for Transgender and Non-Binary People](#) (UK Faculty of Sexual and Reproductive Healthcare)
- [Improving Ob-Gyn Care for Transgender and Non-Binary Individuals](#) (American College of Obstetricians and Gynecologists)
- [Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People](#) (World Professional Association for Transgender Health - available in 18 languages)

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