

RESOURCES

For Advocacy, Support, Guidance, or Financial Assistance:

www.kentuckyhealthjusticenetwork.org/trans-health
(502) 694-2227
transhealth@khjn.org

Trans Bodies, Trans Selves (Oxford University Press, 2014)

(Resource guide for transgender, gender expansive, and non-binary populations, covering health, legal issues, cultural and social questions, history, theory, and more. It is a place for transgender, gender expansive, non-binary, and gender questioning people, their partners and families, and others to look for up-to-date information on life under the trans umbrella.)

<https://radremedy.org/>

To locate local trans competent providers

REPRODUCTIVE OPTIONS FOR TRANS PEOPLE

This is mainly a compilation of info from fact sheets out of Rainbow Health Ontario and Fenway Health

COST ESTIMATES

NOTE ABOUT TERMINOLOGY: For the purposes of this fact sheet, we will refer to people according to their reproductive characteristics as opposed to their gender. For example, trans men will be referred to as people with ovaries and uteri or people with internal reproductive organs and trans women will be referred to as people who can produce sperm or people with external reproductive organs. An exception will be made where research explicitly refers to trans men or trans women. Non-binary people, who do not align themselves with binary gender categories (i.e., male or female), may or may not identify as trans but the issues covered in this fact sheet may be relevant to them as well.

- Donor sperm: \$500 per vial
- Sperm banking and FDA testing: \$1000
- Intrauterine insemination: \$400
- In vitro fertilization: \$15,000 per cycle
- In vitro fertilization with egg donation: \$25,000 per cycle
- Oocyte/embryo cryopreservation: \$10,000
- Gestational surrogacy: \$50,000 - \$100,000

REPRODUCTIVE OPTIONS FOR TRANS AND GENDER-VARIANT PREPUBESCENT CHILDREN

The World Professional Association for Transgender Health's Standards of Care recommend that health care providers discuss reproduction with young clients and their parents prior to any treatments that may affect fertility. In some cases, children may be prescribed gonadotropin releasing hormone analogues (GnRH analogues, or "hormone blockers") to temporarily prevent puberty, leaving the patient in a prepubertal hormonal state until they either reach the age of sixteen or are ready to make a decision about which hormone they feel should be dominant.

- No changes in fertility or increase in birth defects have been reported in adults who were formerly treated with hormone blockers. However, initiation of hormone treatment that often accompanies prevents the gonads from maturing. If young people who have had pubertal suppression with hormone blockers wish to retain reproductive options before beginning hormone therapy, they will need to wait for sperm production or ovulation to occur (at least three months) in order to bank sperm, eggs or embryos. This will result in some level of masculinization or feminization as testosterone and estrogen will now be produced.

FERTILITY PRESERVATION FOR TRANS PEOPLE WITH OVARIES AND UTERI

- Research suggests that long-term testosterone use does not deplete the ovary follicles (the part of the ovary which contains an egg) or affect the ability of the eggs to mature.

- For trans people concerned about fertility loss after testosterone use, or for those planning to have hysterectomies (removal of the uterus) there are currently two options for fertility preservation:

1. Oocyte (Egg) banking involves hormone-induced ovulation and the retrieval of the eggs using a needle, guided by ultrasound, inserted through the vaginal wall into the ovary. Many cryogenically frozen eggs do not survive because they are sensitive to the freezing and thawing process.

2. Embryo banking is egg retrieval (as above) followed by immediate fertilization and banking of the embryo. It has a better success rate, but the sperm donor (whether known or anonymous) must be chosen at the time of the egg retrieval. Harvested eggs, previously banked eggs or embryos can be implanted into the original donor, into a partner's

The cryopreservation (freezing) of ovarian tissue is currently offered to people undergoing cancer treatment, on an experimental basis. There is little data regarding its success rate, in terms of resulting live births. In the future, this may be a desirable option for trans people with internal reproductive organs because it does not require hormonal stimulation at the time of preservation.

Decisions concerning fertility preservation should be made as early as possible. After age 30, ovarian tissue rarely has sufficient egg follicles to make cryopreservation practical. Trans people with internal reproductive organs over age 30 should consider freezing embryos or eggs for better results.

HYSTERECTOMY AND TOP SURGERY

- For trans people who wish to become pregnant in the future, retaining the ovaries and uterus is desirable. Evidence regarding medical indications for hysterectomy (removal of the uterus) and oophorectomy (removal of the ovaries) after hormonal transition is limited and conflicting.
- Some trans people undergo hysterectomy for psychological benefits, to prevent gynecological cancers (particularly a concern for individuals who do not receive annual pelvic exams), and, in some jurisdictions, in order to change the sex marker on their identification from female to male.
- Trans people who have had chest surgery should be prepared for a small amount of lactation during and immediately following pregnancy, and should be alert to the symptoms of mastitis (inflammation of breast tissue) (j wallace, personal communication). If desired, drugs to stop lactation are also available.
- For those who want to nurse in the future but do not wish to postpone chest surgery, breast reduction is an option, though any chest surgery may jeopardize the ability to nurse successfully (j wallace, personal communication).

FERTILITY PRESERVATION FOR TRANS PEOPLE WHO PRODUCE SPERM

- A trans person who has testicles and plans to have them removed must bank sperm beforehand to retain the option of having genetically related children.
- Testicular volume is greatly reduced by long-term estrogen use, impacting maturation and motility of sperm. It is preferable to bank sperm before using hormones.
- A trans woman whose partner is unable to carry a child themselves may wish to become a parent with a donor egg and a gestational surrogate.
- For trans people already using hormones, a suspension of hormone treatment is recommended for a few months so that sperm production and quality can recover prior to banking.
- A study examining the effect of high doses of estrogen suggests that testes' function can recover if the dosage is stopped.
- In cases where sufficient sperm cannot be produced through ejaculation, fertility clinics can provide surgical options for sperm extraction.

BREASTFEEDING AFTER HORMONE-INITIATED BREAST DEVELOPMENT

- It has been anecdotally reported that hormone therapy needs to continue for 2 years to develop sufficient breast tissue to lactate (Dr. N. Barwin, personal communication).
- People whose breasts develop as a result of hormone therapy may wish to breastfeed their babies and to do so may be psychologically beneficial to both parent and baby. There is anecdotal evidence that some trans women have successfully produced breast milk using protocols developed for adoptive mothers, including mechanical stimulation and prescribed medications to increase milk production.
- Fenugreek (also called Milk Thistle), a plant native to the mediterranean, contains chemicals which mimic estrogen and has been found to increase breast milk production. A prescription drug, domperidone also stimulates the production of breast milk by increasing the secretion of prolactin by the pituitary gland through the suppression of dopamine.