Contraceptive Beliefs, Decision Making and Care Experiences Among Transmasculine Young Adults: A Qualitative Analysis

CONTEXT: *Transmasculine people—that is, individuals who were assigned female at birth and have a male or masculine gender identity—can experience unintended pregnancy. Yet research on contraception among transmasculine individuals is extremely limited.*

METHODS: *Participants were recruited online; from community-based organizations, health centers and student groups; and by chain referral. From purposive sampling, 21 transmasculine individuals aged 18–29 who resided in the greater Boston area and had had, in the last five years, a sexual partner who was assigned male at birth were selected for in-depth interviews. All interviews were conducted in person between February and May 2018 in Boston, and transcripts were analyzed using a thematic analysis approach involving inductive and deductive coding to identify themes and subthemes.*

RESULTS: *Most participants believed that contraceptive use was necessary to effectively prevent pregnancy among transmasculine individuals. Their beliefs and decisions regarding contraception occurred in the context of a lack of information about contraception among transmasculine people, especially those using testosterone. Many individuals chose a contraceptive method on the basis of whether it mitigated their gender dysphoria or stopped menstruation, and said they preferred condoms and implants because these methods provided fewer reminders of their natal anatomy and were not perceived as interfering with testosterone use. Gender bias, discrimination and stigma in patient-provider interactions and health care settings negatively influenced participants' contraceptive care experiences.*

CONCLUSIONS: *Health care providers and facilities should provide transmasculine people with tailored contraceptive information and care that address their specific gender-affirmation needs and contraceptive preferences in safe, inclusive and supportive clinical settings.*

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Transmasculine people—that is, individuals who were assigned female at birth and have a male or masculine gender identity—can experience unintended pregnancy.[1–4] Indeed, they engage in a range of sexual behaviors, including penetrative genital sex with cisgender men (i.e., individuals assigned male at birth who identify as men),[5,6] and many retain their natal reproductive organs.[1,4] Some transmasculine individuals use testosterone (i.e., masculinizing hormone therapy) as part of their gender-affirmation process. Clinical expertise[7–9] and limited research[1,4,10] on testosterone and pregnancy indicate that, although testosterone use may result in amenorrhea and decreased fertility, transmasculine individuals can experience pregnancy while or after using testosterone. Contraception is therefore an important concern for transmasculine people seeking to prevent pregnancy—including those who use testosterone. Although no study to date has examined the effect of testosterone on contraceptive use, no contraindications exist for contraceptive use during or after testosterone use. There is no evidence to suggest that contraceptives would be less effective with, as opposed to without, testosterone use.[11]

Research examining contraception in the transmasculine population is extremely scarce. The few published empirical studies investigating this topic have largely focused on ascertaining the prevalence of contraceptive use among transmasculine adults.[3,10,12,13] For example, in a medical chart review of 26 transgender men, Cipres and colleagues found that most reported using condoms (38%) or no contraceptive method (42%).[3] An online survey of 197 transgender men by Light et al. found that 60% reported using contraceptives, especially condoms (49%) and the pill (34%).[10] And in a study of 150 transmasculine adults, Stark et al. found that 37% were currently using a method, including condoms (24%), IUDs (8%) and the pill (3%).[12] Even fewer studies examined the specific and unique aspects of contraceptive use within the transmasculine population, including gender affirmation, lack of provider competency in transgender reproductive health care and gender discrimination in reproductive health care settings.[12–14]

Understanding the patient-, provider- and system-level conditions that shape transmasculine individuals' contraceptive use is essential for developing tailored educational

materials, programs and practices to facilitate high-quality contraceptive care among this marginalized and underserved population. To address this need, we conducted a qualitative study to elicit detailed information about the multilevel barriers to and facilitators of contraceptive use among transmasculine people. Given that youth are at disproportionately elevated risk of unintended pregnancy,[15] we conducted our research among transmasculine young adults. Our findings can inform future qualitative and quantitative research, as well as interventions to help promote the delivery of patient-centered contraceptive care that competently addresses this population's particular needs and concerns.

METHODS

Recruitment and Sampling

We recruited participants in the greater Boston area between January and May 2018 by sharing study flyers with local community-based organizations, health centers, college student groups, electronic mailing lists and Facebook groups that serve transmasculine young adults.[16] We also posted recruitment ads on Craigslist and used a chain-referral sampling strategy in which we asked participants to inform potentially eligible individuals in their social networks about the study.[16–19] Using a purposive sampling strategy,[17,18] we then selected participants who met the following eligibility criteria: were assigned female at birth; identified as male or masculine in terms of gender identity; were aged 18–29; had had, in the last five years, a sexual partner who was assigned male at birth; and resided in the greater Boston area. We used quota sampling to ensure the inclusion of approximately equal numbers of binary and nonbinary transmasculine individuals in our study, as their reproductive health care experiences may differ in notable ways, depending on their differing gender identities and, in turn, gendered lived experiences.[17,18]

Data Collection

We conducted a single one-on-one, in-person, in-depth interview with each of the 21 transmasculine participants to elicit detailed information about their beliefs, attitudes and experiences regarding pregnancy, contraception and abortion. Interviews took place between February and May 2018 in Boston using a semistructured interview guide developed by members of the research team.[20] Several months prior to the interviews, transmasculine young adults, as well as transgender and reproductive health experts from a multi-institution LGBTQ health working group, reviewed and provided feedback on the guide's open-ended questions and probes, which were formulated using the existing scientific literature on contraceptive care among transmasculine individuals. The guide addressed pregnancy intentions and attitudes, perceptions of and attitudes toward contraceptive and abortion care, contraceptive method preferences and experiences, differential treatment by health care providers in reproductive health care settings, patient-provider communication in the context of contraceptive and abortion care, and health systems barriers to and facilitators of reproductive health care.

Two members of the study team—a biracial, young adult cisgender woman and a white, young adult transgender man, neither of whom knew the study participants—conducted all interviews in a private room in a university building or health care facility. Interviews were conducted in English, were audio-recorded upon obtaining written informed consent from participants and lasted, on average, 51 minutes (range, 36–66). After the interview, participants completed a questionnaire used to collect sociodemographic and other characteristics, such as their health insurance status, the gender identity of past sexual partners, and their typical source and site of reproductive health information and care. Participants received a $25 gift card for their time. All research activities were approved by the Office of Human Research Administration at Harvard Longwood Medical Area.

Analysis

A professional transcription company transcribed all audio recordings verbatim, and a member of the research team entered the transcripts into Dedoose 8.1.8 for analysis. The two interviewers analyzed transcripts using a thematic analysis approach,[21,22] which began with immersion in the data[21] and codebook development and refinement.[20,22,23] The interviewers and the first author collaboratively developed the initial codebook, which included both deductive codes based on the interview guide and inductive codes based on four interview transcripts. The two interviewers each independently applied the codebook to these four transcripts to test its fit to the data and to ensure inter-rater reliability. Codes were merged, refined and discarded, as necessary, and coding discrepancies were discussed and resolved by consensus during regular meetings between the interviewers and first author. The interviewers then applied the codebook to all of the transcripts and periodically refined it based on emerging patterns and discussions among themselves and the first author.[20,22,23] The first author organized and collated coded text fragments pertaining to contraception into themes and subthemes,[21,22] and used a matrix to identify and delineate similarities and differences among participants.[24] The two interviewers and first author identified, developed and refined themes and subthemes through memo writing and regular research team meetings.[21,24] Finally, the first author reviewed the transcripts to ensure that all relevant coded excerpts had been included in the analysis, that findings accurately represented the data and that all themes had been identified.[21]

Using this thematic analysis approach, we identified three major themes pertaining to the patient-, provider- and system-level barriers to and facilitators of contraceptive use among transmasculine young adults: testosterone use and perceived contraceptive need; transmasculine gender identity and contraceptive decision making; and gender bias, discrimination and stigma in accessing and using contraceptive care.

RESULTS

Participant Characteristics

Participants' mean age was 25 years (standard deviation, 3.1). Gender identity categories were not mutually exclusive; participants identified as men or male (five), transgender men or male (nine), transmasculine (five) and nonbinary (23; Table 1). The majority reported current testosterone use (13), identified as white (16), had a bachelor's degree or higher (17) and were enrolled in a private health insurance plan (15). Most identified as queer (14), reported having had sex with cisgender men in the past year (14 of 19 responses), and described their gender expression as masculine or androgynous (12 each). The majority of participants received reproductive health care from a physician (13) and at a community health center (15). The most common sources of reproductive health information were health care providers and the Internet (15 each), followed by friends (13). All but one had used a contraceptive method in their lifetime, with the majority having used condoms (18) or the pill (12).

Testosterone Use and Perceived Contraceptive Need

•***Testosterone is ineffective for contraception.*** The majority of study participants believed that, although testosterone may provide some level of pregnancy prevention (ranging from considerable to negligible), pregnancy was nonetheless possible among individuals using the masculinizing hormone. For example, a white, nonbinary participant noted: "I'd been told that [testosterone] greatly reduces your ability to get pregnant.… For most people, you can't get pregnant at all, but…there's always a chance." Most participants believed that testosterone use was not an effective form of contraception. A white, nonbinary and agender participant said, "If you're on testosterone, it does decrease the chance of pregnancy but…hormones, if you're taking them for transition purposes, are not themselves contraception." Only one participant, a white, nonbinary and transmasculine individual, erroneously believed that testosterone was a contraceptive: "Within six months [of using testosterone], my menstrual cycle did end up stopping. So I felt like…my testosterone was a form of birth control in itself."

•***Contraception is needed for pregnancy prevention.*** Most participants believed that testosterone was less effective at pregnancy prevention than contraceptives, and that contraceptives were therefore necessary to effectively prevent pregnancy, regardless of testosterone use. For example, a white, transgender man said, "My understanding is that you still need a form of birth control because [testosterone] does not guarantee that you can't get pregnant." Similarly, a Native American and white, gender-nonconforming, gender-expansive, gender-fluid and male-identified participant shared this: "Even if you are on [testosterone], even if you don't get your period anymore, if you're having sex with folks that can get you pregnant, then you need some [contraception]."

•***Sources of (mis)information.*** Participants described getting information about using testosterone and using contraceptives to effectively prevent pregnancy from a variety of sources, including health care providers, friends, community and support groups, and the Internet. Several reported receiving information that testosterone is not an effective form of contraception from one or more of these sources, especially health care providers and peers. According to a black, transgender man: "The doctor… told me that [testosterone] will not do anything for you [to prevent pregnancy]. So that's why a lot of trans men either would stay on birth control or just continue to use condoms and safe sex." The doctor of a white, gender-nonconforming and transgender man had also advised that testosterone does not prevent pregnancy. This participant said, "My friends all know that, and they try to spread that information to trans men." And a white, transgender man echoed this: "I've mostly heard—and this is just from people in my circle—that you do need a form of contraception because…there's no guarantee that [testosterone] will stop pregnancy from being able to happen."

In contrast, many participants explained that their beliefs about testosterone and contraception existed in the context of a lack of accurate information—from peers, health care providers and online sources—about testosterone, pregnancy and contraception. A Latinx and biracial, transmasculine participant stated: "The impression I got when I started testosterone was that I couldn't get pregnant.… I don't think [a provider] ever said that to me, but…they did not seem concerned [with a possible pregnancy]." Moreover, a nonbinary and transmasculine participant who identified as Asian, white and multiracial, and who did not personally espouse the belief that testosterone was a form of contraception, observed that "there's a lot of misinformation about the need for contraception, especially once you start testosterone—that [testosterone] is, in and of itself, contraception because your period stops." Similarly, the Native American and white participant quoted earlier explained: "I heard it from some friends and groups, and sometimes even providers who are less informed will say, 'Oh, you're on testosterone, you shouldn't be able to get pregnant.'… It's kind of a myth that's been going around."

Transmasculine Gender Identity and Decision Making

•***Gender dysphoria and method choice.*** Participants reported using a range of contraceptive methods since identifying as transmasculine—namely, condoms, the pill, the implant, and hormonal and copper IUDs—for various reasons, especially pregnancy prevention and menstrual period management. Many participants described choosing a method on the basis of whether it increased or decreased their gender dysphoria. Explaining the decision to use an implant, as opposed to the pill, a white, gender-nonconforming and transgender man explained: "There's certainly dysphoria. I didn't want to be on the pill because I didn't want that experience of taking a birth control pill…because it's a daily reminder. It's a thing that's associated with women." Referring to the implant, this participant also noted, "That's really something that helps with

TABLE 1. Selected characteristics of transmasculine individuals aged 18–29 who participated in a study of barriers to and facilitators of contraceptive use in the greater Boston area, 2018

Characteristic	Number (N=21)
Gender identity*	
Man/male	5
Transgender man/male	9
Transmasculine	5
Nonbinary†	23
Another identity	2
Currently using testosterone	
Yes	13
No	8
Race/ethnicity*	
White	16
Black/African American	2
Latinx/Hispanic	2
Asian/Asian American/Pacific Islander	1
Native American/indigenous	1
Multiracial	2
Another race/ethnicity	2
Educational attainment	
Some high school	1
High school/GED	0
Some college/associate's degree	3
Bachelor's degree	11
Some graduate school	2
Graduate degree	4
Health insurance	
Private	15
MassHealth (Medicaid)	3
None/other	3
Sexual orientation*	
Heterosexual	0
Queer	14
Lesbian	1
Bisexual	7
Gay	6
Another orientation	3
Gender of sexual partners in past year*	
Cisgender women	8
Transgender women	3
Cisgender men	14
Transgender men	4
Nonbinary AFAB individuals	5
Nonbinary AMAB individuals	0
None	1
Gender expression*	
Masculine	12
Androgynous	12
Genderqueer	1
Gender fluid	1
Another expression	1
Usual health care provider*	
Physician	13
Nurse (registered nurse/nurse practitioner)	9
Physician assistant	2
Not sure	1
Other	1
Usual site of reproductive health care*	
Private doctor's office	3
Community health center	15
Hospital clinic	3
Planned Parenthood clinic	3
Other	2
Usual source of reproductive health information*	
Health care provider	15
Family member	6
Friend	13
Partner	6
Internet	15
Other	1
Lifetime contraceptive method use*	
Condom	18
Pill	12
IUD	8
Ring	3
Emergency contraception	3
Injectable	1
Implant	1
Diaphragm	1
None	1

*Participants could select multiple categories. †Includes nonbinary, genderqueer, gender nonconforming, gender fluid, agender and bigender. *Notes:* For race and ethnicity, one participant did not respond; two did not respond regarding gender of sexual partners in the past year. AFAB=assigned female at birth. AMAB=assigned male at birth.

Table continues

dysphoria.… Because I don't have to be reminded of [my body] every day."

Some participants expressed a preference for condoms, which they described as not female-gendered, over hormonal contraception. A white, nonbinary and agender participant said, "I just use condoms.… That's worked so far.… It avoids pregnancy and is a method that doesn't make me feel more dysphoric." Several individuals reported choosing a method on the basis of its perceived ability to stop menstruation, which they identified as a notable source of gender dysphoria. For example, according to a white, nonbinary participant, "I was having a desire to get off of hormonal birth control to something [with which] I ideally did not have to menstruate, because menstruation is something I had a lot of dysphoria around."

•Perceived feminizing effects of hormonal contraceptives. Many individuals expressed concern about using hormonal contraceptives out of fear that doing so would increase the feminizing hormones in their body or undermine the masculinizing effects of testosterone. When a white, nonbinary and agender participant was asked why using hormonal contraceptives was not an option, this person responded: "Honestly, part of the reason why I wouldn't want to go on hormonal birth control is because I don't want to take estrogen [considered a "female" hormone]. And I think that's related to dysphoria, and I just wouldn't feel great, as somebody who doesn't identify as a woman, taking estrogen." In a similar vein, a white, gender-nonconforming and transgender man expressed concerns about using a hormonal method: "I was very apprehensive because there are some cases where people have said birth control messes with their [testosterone]. It can diminish the masculinizing effects or it can slow them down." One white, nonbinary individual even described intentionally halting the use of hormonal contraceptives prior to starting testosterone in order to avoid undermining its effects.

Further, some participants expressed a preference for condoms over hormonal contraceptives because they would not interfere with the masculinizing effects of testosterone. Another white, nonbinary participant said, "I use condoms with my partner. I've considered some other things, but…I can't think of anything that I would feel cool about because we're already using condoms, and I don't want anything implanted in me. And why would I take estradiol if I want testosterone?" However, a few individuals noted that testosterone could thin the vaginal lining, rendering the use of condoms uncomfortable or painful.

•Lack of contraceptive information and support. Participants' contraceptive decision making tended to occur in the context of a lack of information and support regarding contraception, especially in relation to testosterone use. One white, transgender man noted:

"I would love to see it laid out where you have the pill, you have the IUD, and information about how it works. But also how might this interact with masculinizing hormones. I would love to see that tied in. I feel like that's a stopping point for so many people; like, how is it going to affect my transition?"

Referring to using contraceptives while taking testosterone, a white, nonbinary participant said, "I don't have anybody to ask right now.… I have no idea if birth control is even doable. I literally have no idea." Similarly, a Latinx and biracial, transmasculine participant noted:

"I don't really understand how [an IUD] would work with testosterone…so I stopped thinking about it once I didn't feel like it was an option.… I feel like if I had somebody who would actually talk to me about it or could support me if I tried it and it didn't work or if I didn't like it, then I might be more inclined to even think about trying it."

Gender Identity Bias, Discrimination and Stigma

•Health care provider assumptions. Although many participants reported that they had not discussed contraception with a health care provider, several who had engaged in these conversations described how providers' gender identity bias, including cis- and heteronormative assumptions, undermined their contraceptive care. Specifically, a few individuals noted that providers incorrectly assumed that they engaged in sexual activity only with cisgender women and thus erroneously concluded that they were not at risk for pregnancy. For example, a white, nonbinary participant shared this experience: "I think people assume I don't have sex with men.… Like, they haven't done this verbatim, but at a couple of places they've been like, 'No chance you're pregnant.' I'm like, 'Well, no, but not for the reasons you think.'" These assumptions also extended to STI testing, as described by another white, nonbinary participant: "I was once denied an STI panel because of the way that they perceived me and the way they assumed that my partners must be [female], that I must not have been exposed to any STIs." Similarly, some participants described how providers emphasized hormonal contraceptives without considering patients' testosterone use and preference for nonhormonal methods, such as condoms, copper IUDs and hysterectomy, which they perceived as not interfering with the masculinizing hormone. As a white, transgender man explained: "If I was talking about, 'Well, I don't want anything hormonal,' it [was] like, 'Well, that's what you're going to get'—you know, not necessarily validating my discomfort around hormonal contraceptives."

•Experiences and fears of gender identity discrimination in contraceptive care. Several participants explained how experiences and fear of gender identity discrimination during clinical encounters negatively affected their contraceptive care. For example, an Asian, white and multiracial participant who identified as nonbinary and transmasculine reported:

"With most people who I've talked to about birth control options, I've decided to table any sort of conversation about my gender because it just opens up a whole other can of worms that's not worthwhile to me and doesn't actually benefit me in getting the birth control. So I'm forced to look at my own gender identity as a barrier to me getting my health care."

Similarly, a white, nonbinary and agender participant described how the fear of experiencing gender identity discrimination may deter transmasculine people from seeking contraceptive care altogether:

"We fear discrimination. And especially if one is very masculine-presenting or identifies as a man, then one might feel like…providers and staff might treat them strangely if they're pursuing certain kinds of contraception that are popularly associated with women."

In contrast, a few participants described positive patient-provider contraceptive care interactions in which they felt that they and their gender identity were respected. According to a nonbinary and transmasculine participant who identified as Asian, white and multiracial:

"I went to get an IUD put in, and the doctor was really nice. The entire staff was very understanding. They listened to everything I had to say. They were very calm with their doctorly bedside manner, so it wasn't a very nervous experience. And they also listened to my pronouns. And although they didn't get it right every time, they understood how to correct themselves in a reasonable way without making it about themselves."

These participants explained how being affirmed and respected as transmasculine encouraged them to seek reproductive health care. For instance, a black, transgender man said, "I get treated as a human. So whatever reproductive stuff needs to get checked,…I get that checked out."

•Gender identity stigma in health care settings. A few participants explained how gender identity stigma in health care settings negatively influenced their contraceptive care experiences. Referring to the experience of refilling a prescription for the pill, a white, transgender man described the following interaction: "I would go to refill my prescription and…get stares from people. Like, 'Why are

you refilling this prescription? Because we're reading you as male.'" A similar situation was related by a white, nonbinary participant, who had called to schedule an appointment with an obstetrician-gynecologist: "Based on the pitch of my voice, someone will say, 'You know which office you're calling, right?'…or, 'Oh, were you calling for your wife?'" And another participant—who was Native American and white and identified as gender-nonconforming, gender-expansive, gender-fluid and male—said:

"As soon as you walk into some reproductive health care clinics, it's like everything is pink…and then [you have to deal with] going to the front desk staff and being like, 'Oh, are you in the right place?' and being misgendered by staff and by doctors when they know you have a uterus or see your genitalia, and then you're already in this place where you're feeling so vulnerable and freaked out."

These biased, discriminatory and stigmatizing experiences can discourage transmasculine people from seeking or returning for contraceptive care, which in turn undermines their ability to prevent unintended pregnancies.

DISCUSSION

This study contributes to the limited empirical literature on contraception among transmasculine individuals, which has primarily focused on ascertaining the prevalence of contraceptive method use,[3,10,12,13] by elucidating the patient-, provider- and system-level circumstances that shape access to and use of contraceptive care. Similar to Light and colleagues,[10] we found that most participants believed that, although testosterone may provide some level of pregnancy prevention, contraception was necessary for effective prevention. Our findings also showed that many participants chose a contraceptive method on the basis of how it affected their gender dysphoria. And as seen in other studies,[3,10,12,13] most participants reported primarily relying on condoms to prevent pregnancy; our analysis suggests that transmasculine individuals may prefer condoms to hormonal methods because they think of condoms as less female-gendered or less likely to interfere with the masculinizing effects of testosterone. We also found that several participants preferred the implant to the pill because it did not provide daily reminders of their natal anatomy (namely, their genitalia) and could stop menstruation, which was described as a source of gender dysphoria.

Our study demonstrates that participants' beliefs and decisions related to contraception tended to occur in the context of a lack of tailored and accurate information and support regarding contraception among transmasculine individuals, especially in relation to testosterone use. As did other studies,[12–14] we found that gender identity bias, discrimination and stigma in patient-provider interactions—and health care settings, more broadly—negatively influenced participants' contraceptive care experiences. Previous research has suggested that transmasculine individuals' contraceptive experiences may be shaped by barriers to high-quality general health information and care among transgender individuals, including cost;[25] lack of access to a regular health care provider;[26–28] exclusion from and stigmatization in health information resources;[29] lack of provider knowledge and training in transgender health;[25,30–32] and gender identity bias, stigma, discrimination and harassment in health care settings[28,29] and during clinical encounters.[25,28,30] Other studies have indicated that contraceptive use and care among transmasculine people may also be influenced by barriers to high-quality reproductive health information and services, in particular, including a lack of transgender health knowledge and training among obstetrician-gynecologists;[33,34] limited sexual and reproductive health information tailored to the needs of transmasculine individuals;[29,35] patients, providers and staff associating reproductive health with cisgender women;[3,14] and heteronormative assumptions among providers regarding transmasculine individuals' sexual behavior and need (or lack thereof) for reproductive health care.[14,35]

Our findings suggest that public health institutions, health care facilities, and community-based LGBTQ and reproductive health organizations should develop gender-affirming educational resources and programs that specifically and accurately address transmasculine individuals' contraception needs and concerns, using gender-inclusive language and taking into account gender dysphoria and testosterone use. In particular, educational resources should note that testosterone is not contraception and specify that there are no contraindications for either nonhormonal or hormonal contraceptive use among transmasculine individuals using testosterone. These resources should explain the side effects of each contraceptive method, such as amenorrhea and chest tenderness, and clarify that hormonal contraceptives do not meaningfully undermine the masculinizing effects of testosterone.[9,11] Resources must also recognize that some methods may be perceived as "female" and that these and related procedures (e.g., speculum use, insertion of IUDs) might cause or increase gender dysphoria.

Notably, participants identified providers as an important source of information about contraception, so providers should receive training in transgender reproductive health during undergraduate, professional and continuing education. They should inform all transmasculine patients that testosterone is not contraception and offer the full range of hormonal and nonhormonal methods. Moreover, providers should give patients tailored and accurate information about each method—including procedures and potential side effects—and offer support in making patient-centered contraceptive decisions that consider patients' gender dysphoria. In explaining the relationship between testosterone, pregnancy and contraception, providers should also address concerns about the perceived feminizing effects of hormonal contraceptives and respect patients' contraceptive preferences and pregnancy intentions. In addition, health care providers should use gender-affirming language, including regarding patients' names (which may differ from their legal name on insurance documents), pronouns and anatomy (e.g., "genital" or "frontal opening" vs. "vagina"), and should take comprehensive,

gender-affirming sexual histories that avoid making cis- and heteronormative assumptions about patients and the gender of their past and current sexual partners. Health care facilities can be welcoming to transmasculine people by offering reproductive health services and settings that are not branded as "women's health care" and by displaying markers of inclusivity, such as rainbow or transgender pride flags or signage. Facilities can also ensure that education materials are inclusive of transgender individuals, intake forms have gender-affirming language and response options, and front desk and health care staff are trained to use patients' correct names and pronouns.[9,25,36–39]

Limitations

Our findings should be interpreted in the context of some limitations. First, our sample primarily consisted of white, college-educated individuals enrolled in a private health plan; thus, our findings may not reflect the experiences of transmasculine people of color, individuals with less than a college-level education, or those enrolled in a public health plan or lacking health insurance. Second, interviews took place in the greater Boston area, so our findings may not be transferrable to those who reside in geographic areas with other social, political and health policy climates. Third, we were unable to systematically identify differences between transgender men and nonbinary transmasculine individuals. Thus, future research should examine differences in contraceptive beliefs, decision making and care experiences among transmasculine people—who represent a heterogeneous population—in relation to not only gender identity but also gender expression, race and ethnicity, socioeconomic position, sexual orientation and geographic location, among other sociodemographic characteristics. Finally, we did not collect other types of qualitative or quantitative data, which would have facilitated triangulation and may have strengthened our inferences. Despite these limitations, our results offer new, detailed information on how patient-, provider- and system-level circumstances relate to contraceptive use among a marginalized and understudied population, grounded in their own lived experiences.

Conclusions

Transmasculine young adults have unique contraceptive concerns and needs, including method choice that accounts for gender dysphoria. Educational resources should provide these individuals with tailored and accurate information about both hormonal and nonhormonal methods in the context of gender affirmation. Health care providers can play a critical role in delivering high-quality contraceptive information and care to transmasculine people by offering them the full range of contraceptive methods, while addressing concerns about gender dysphoria and the perceived feminizing effects of hormonal methods; discussing pregnancy intentions and desires; and engaging in patient-centered communication that uses gender-affirming language and avoids making cis- and heteronormative assumptions. Health care facilities should ensure that providers receive training in patient-centered contraceptive care for people from diverse gender identity and other social backgrounds; they should also create environments, procedures and practices that are inclusive of patients whose gender and other social identities are marginalized, and proactively address gender identity and other forms of bias, discrimination and stigma in clinical settings. These patient-, provider- and system-level interventions may facilitate the delivery of high-quality, individualized contraceptive care to transmasculine young adults and address the specific and unique contraceptive concerns and needs of this marginalized and underserved population.[9,25,36–39]

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