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Emergency Contraception for Transgender and Nonbinary patients

Emergency contraception (EC) can prevent pregnancy after penis-in-vagina sex when contraception failed or was not used, 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. While this fact sheet focuses on individuals who were assigned female at birth and intersex individuals capable of becoming pregnant, in general, “transgender and nonbinary” also includes people assigned male at birth.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. Transgender and nonbinary 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.

Please note that 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. Always ask patients what words they would like you to use when referring to their gendered body parts. For example, some patients may prefer “front hole” or “frontal opening” instead of “vagina.”¹

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. EC is an important option for all people who are physiologically capable of becoming pregnant and want to prevent pregnancy.

Note: 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.

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 only 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) EC (LNG 1.5 mg - sold as Plan B One-Step, Take Action, My Way and other generics) is the most accessible form of EC. It can be purchased over-the-counter with no restrictions on the age or perceived gender of the person purchasing it. LNG EC is the 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. The over-the-counter (OTC) cost for LNG EC is about \$35-50. LNG EC is typically covered in full by insurance when filled as a prescription.
- Ulipristal acetate (UPA) EC (UPA 30 mg - sold as ella) is available by prescription only. UPA is more effective for all users³ because it works closer to the time of ovulation, and is a particularly 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: some evidence shows that it may be ineffective for those who weigh 196 lbs or more, or with BMI greater than 35.⁴ UPA can be harder to access as many healthcare providers don’t know about it⁵ and many pharmacies may not have it immediately available to fill a prescription the same day.⁶
- The copper intrauterine device (IUD - sold as Paragard) is nearly 100% effective in preventing pregnancy if placed within 5 days after unprotected sex⁷ (or longer⁸⁻⁹) and, if desired, can be continued to prevent pregnancy for at least 12 years.¹⁰

Considerations for Transgender and Nonbinary Patients

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), or bilateral oophorectomy (removal of both ovaries), or any of the combination of these procedures have no risk of pregnancy; and the risk 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, testosterone use may cause exposure to testosterone in pregnancy

can affect the fetus as it is forming, particularly an XX fetus prior to 14 weeks. This can include changes in the urogenital sinus which forms the urethra and the vagina. People who have these genital differences may need surgery later on in life. virilization of a fetus, especially when used in early pregnancy.¹² It is unclear if there are other long term effects 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 for Getting EC

Transgender and nonbinary patients may experience a variety of barriers in acquiring EC, and *may* experience increased gender dysphoria due to certain side effects. 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 should a pharmacy or health insurance refuse to fill their EC prescription. If you are familiar with specific 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 Having EC on hand in advance of need can help reduce anxiety as well as promote effectiveness.

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 a web 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 more⁸⁻⁹) after unprotected penis-in-vagina sex, and provides at least 12 years of ongoing contraceptive protection.¹⁰ However, some patients may find the insertion process and/or side-effects unacceptable. Some patients experience cramping or heavier menstrual flow; the rate of these side-effects in patients who are amenorrheic due to testosterone is unknown. Even when willing to attempt insertion, patients may find the experience to be difficult, or sometimes intolerable. 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 penis-in-vagina sex may have had other instances of unprotected penis-in-vagina sex earlier in that cycle; or even following ECP use, later in the same cycle - with or without using ECPs on those other occasions.⁴

Because individuals who don't have regular menstrual cycles may not be able to confirm that they're not pregnant by the arrival of their next period, 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 following EC use, pregnancy options counseling is a crucial next step. If the patient does not wish to be pregnant at this time, provide or refer for abortion, ideally with a provider who is experienced in working with transgender and nonbinary populations.¹⁵

Patients using testosterone who are considering continuing a pregnancy should be informed of the risk for virilization of the fetus or other urogenital changes that may require surgery later in life, especially when using testosterone in early pregnancy. The degree of these changes likely depends both on the testosterone dose and the length of exposure, and range from an enlarged clitoris to the merging of the vaginal canal with the urethra. Pregnant patients who wish to continue the pregnancy and avoid this risk should be counseled to discontinue testosterone during their pregnancy. 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)
- [Taking a transgender-inclusive sexual health history](#) (Miles Harris, 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 GenderNonconforming People](#) (World Professional Association for Transgender Health - available in 18 languages)

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