Transcript of “Family Planning as Gender Affirming Care with Trans and Nonbinary Patients”

Tammy Kremer (00:09):

Coming Together for Sexual Health engages you in shameless conversations about sex positive, identity affirming sexual health care. We keep our attention on those most impacted by STIs, HIV and structural barriers. We're powered by nationally recognized experts in sexual health at the University of California San Francisco and the California Prevention Training Center. All views expressed are those of the person speaking and not of the CAPTC or their employer. My name is Tammy Kremer. Let's come together for sexual health.

(00:49):

Today's episode is the third in our series on family planning and reproductive health. The last two episodes focused on abortion and birth control options. Today we're discussing family planning with transgender and gender diverse people specifically, both for those who want to prevent pregnancy and for those who are looking to preserve their fertility or get pregnant. I'm joined by Miles Harris, FNP-BC. He/him. Miles is a trans and non-binary identified family nurse practitioner and serves as the founding director of gender-affirming care for the University of California at Davis Health. Miles is an assistant clinical professor at the UC Davis Betty Irene Moore School of Nursing.

(01:29):

Miles's research focuses on sexual and reproductive health needs of transgender and gender non-binary people. He's an advocate for the integration of gender-affirming care with primary care and has trained healthcare students and providers across the US. I first met Miles during his presentation on family building and contraception for transgender and gender non-binary patients at the Trans Health Summit in San Francisco earlier this year. A biannual conference that I'd highly recommend if you're interested in serving this community. So welcome Miles. I'm so glad to get to chat with you today.

Miles Harris (02:02):

I'm excited to be here. Thanks for having me.

Tammy Kremer (02:05):

So just to get us started, I'd love to hear from you a bit about your story. Can you tell me about yourself, your training, the work you do and why you chose it?

Miles Harris (02:12):

I've been a family nurse practitioner since 2015 and a nurse since 2012. I didn't go to college for nursing initially. I went to Carleton College, which is a liberal art school in the Midwest where I studied biology and studio art and graduated in 2008, which was not a great moment of the economy to graduate into. I had done EMT training and throughout college I had worked at our college's gender and sexuality center and had done a lot of sexuality education as a part of that, and around the same time had met some nurse practitioners who I really loved and felt like they seemed to love their jobs too. And so that's what led me down this road into nursing. I did not intend, or at least in the beginning, in vision to have a focus in gender-affirming care or trans and non-binary health. I really feel like it picked me, but it is something that I love to do and I love to be able to do so much to advocate and support my community.

Tammy Kremer (03:31):

What a cool space to find yourself in, and it's just really impressive to see how much you've been able to lead in this area in terms of your current work. I'm wondering now that you are involved in gender-affirming care, now that it has chosen you, what are some highlights? Can you share any aha moments or memories early on in this work that you were like, oh, this work, this is for me?

Miles Harris (03:55):

It's really a lot of individual visits, individual patients, what we as healthcare providers do for trans and non-binary patients. It's so straightforward. It's not hard. The medications are generally not complex. It's easier than diabetes, right? It is most of the time pretty straightforward and it's just about creating access. And so I really encourage anybody who's in a healthcare role to know that, whether that's helping someone figure out how to navigate to whatever surgical option they're interested in or get started on hormones or be the person that signs a piece of paper that lets somebody change their identification if you live in a state that requires that. It is often so easy as a healthcare provider to do the thing that someone needs that changes their life.

Tammy Kremer (04:52):

I think that's the first time I've ever heard gender-affirming care be described as easier than diabetes, and I'm going to take that one with me.

Miles Harris (05:00):

Yes, I've gotten to be a part of that for hundreds of people, every single one of those feels special. Getting to be a trans or non-binary person providing healthcare for your own community is really special and magical.

Tammy Kremer (05:19):

The magic of being able to provide care to trans and non-binary folks as a trans non-binary identified person yourself, can you share any stories about a time where that felt particularly true for you or you felt like especially connected with one of your patients?

Miles Harris (05:36):

There's someone who I have provided care to for a few years, who also identifies as a trans and non-binary person. That person's earlier transition really felt like they were just presented with very binary transition options and pursued a lot of masculinizing options and surgical options, because that was the path they were shown. And if you are trans, this is what you do. And when we had established a relationship, I think really in us having conversations about there's no, what are you supposed to do? This is like, what do you want for yourself? What do you want for your own body? There is no right answer. Also you can try something and it cannot fit and then we can pivot, we can do something else.

(06:39):

And so over the course of the past few years, I have supported this person really an exploration of trying to figure out what fits best both in terms of hormones but also in terms of so I can name and gender presentation and this person has told me that getting to see me as another trans and non-binary person with a gender presentation that is not binary, have a mustache, and I'm wearing lipstick today and I have a mustache and wear lipstick almost every day for that person getting to figure out what fits, what feels best for them along with me with another person who has spent a lot of time trying to figure out the world of options, of ways to figure out what gender feels good.

(07:36):

It's been a really beautiful journey with that person and I feel honored to get to have supported them through that. And I think they're in a place that they're pretty happy about. It's really a joy. And I think maybe that's another point that I would like to make about providing gender-affirming care, is that it's special in the way that maybe, I'm going to try this example, it might get weird or it might not fit. But providing care to someone who is pregnant might be, this is not like a disease or a problem that we are fixing. This is supporting someone through a journey perhaps and helping them do something in the way that feels best and most authentic to that person. And really helping someone find their joy, find their gender euphoria, and being a witness and a part of that, it's really special.

(08:43):

It's really an honor and I think because I do it every single day, it's perhaps something that loses a little bit of salience for me honestly. But getting to really reflect on how special that is has been a nice opportunity to do that.

Tammy Kremer (09:04):

Yeah, wow, that does sound really fulfilling to get to just witness people becoming and to support that process. Hearing you say that providing gender-affirming care is actually pretty simple from a medical standpoint, makes me really wonder about what gets in the way of this care. What are some barriers?

Miles Harris (09:34):

I think certainly a lack of training is a major barrier to healthcare providers offering gender-affirming care. A small minority of healthcare professionals get training in gender-affirming care, and it has, I think historically been incorrectly thought of as a specialty. Hopefully in whatever area that person is in, there is a endocrinologist who has some expertise and is willing to do this. I think diabetes is again a good analogy. A lot of diabetes can be managed in primary care. Sometimes it does get more complicated and we want a specialist to assist, but the vast majority of the time it's not needed. And certainly hormones are something that is under the purview of endocrinology, but so much of gender-affirming care is not about hormones.

(10:34):

Certainly for many people, some of it is, but there's a great deal that isn't, and then that person potentially feels at a loss or frustrated when that specialist that is supposed to be their gender-affirming care person doesn't have the expertise perhaps in the other aspects of gender-affirming care. And to their credit, many endocrinologists who have become the go-to person for gender-affirming care in whatever area they're in, do go and figure out all of the rest of it because they have all of these trans and non-binary patients who are asking them for these resources. I think yes, that idea that send people to endo.

(11:19):

And then certainly for some people it does come down to conscious or unconscious bias that they feel some kind of way, some discomfort, some unwillingness to want to engage with trans and non-binary folks on their healthcare. I wasn't trained in this, I don't know how to do this is a really I think easy out for a lot of people.

Tammy Kremer (11:45):

I'm thinking too about the process when people even want to provide this care well and maybe have training but might not have experience of engaging meaningfully or consistently with queer and trans

folks, the amount of fear or unknown internalized stigma that can come out when providing this care, even for those who really have the best intention, so to say. I know you've done trainings for folks working in primary care around gender-affirming care around the US and what are some ideas that you have for people that might be trying their best but also recognize that there's a gap in what they're able to do for their patients?

Miles Harris (12:34):

Trans and non-binary people are often really used to training their healthcare providers on how to provide care for them, and that in the long term is something that we want to reduce how much trans and non-binary community is the trainer of their healthcare provider in the context of their health interaction. Being humble and willing to accept the feedback and constructive criticism from patients as it comes in, is a way to continue to learn about working with trans and non-binary people. Every single person is going to be different in terms of what their individual goals and preferences about their health and how you interact with them around their health is.

(13:32):

So really I think asking a lot of questions, what their goals are, how they want to discuss their body. For example, if I am going to do a pelvic exam for someone, I do a lot of prefacing, but one of the things is saying, I usually narrate and say everything that I'm doing the whole time, but if you hate that and you want me to shut up, let me know. We want to do whatever in this context makes you the most comfortable, and that's not going to be the same for every single person.

Tammy Kremer (14:10):

Thanks for that example, Miles, of how you can create more safety during an exam. I'd like to build on that and pivot towards taking a trans-inclusive sexual health history. I'm thinking this can be a foundation for the discussion on family planning with trans folks that we'll get into a bit later. So what are some considerations or ways folks can take a sexual health history that's trans inclusive, both for trans folks and folks who are not trans-identified?

Miles Harris (14:36):

That's a great point in and of itself, that taking a trans and non-binary inclusive sexual health history is for everybody, it's not just for somebody that you think or know to be trans or non-binary. Certainly we know that many trans or non-binary people might not disclose that part of their identity to their healthcare provider due to many different reasons. And it might be in taking an inclusive health history, that you demonstrate that you have competence in working with trans or non-binary people and that person feels safe to disclose that part of their identity to you. And then additionally, cis people have trans and non-binary partners. And so if you are not thinking of that in taking sexual health history really with anybody, you could be missing really important information about that person's sexual health needs by making incorrect assumptions.

(15:38):

And so I guess in taking a sexual health history, one of the questions I like to start out with is when we're talking about your body and your body functions, are there any words that you specifically prefer that I use or are there any terms that you really hate and you want me to make sure I don't say? And say, most of the time folks say medical or anatomical language is okay with me, being asked that question really lets folks know that I want to be attentive to making sure that this conversation is one in which they feel safe and comfortable. I follow up with if I say anything, if I use any words or language that makes you

feel squicky or doesn't feel good, please let me know. My personal beef is with the question, do you have sex with men, women, or both? Which is unfortunate.

(16:38):

If people learned to take sexual health history really at all as part of their training, and if that training was at all inclusive, then the phrase do you have sex with men, women or both was what was taught to you most likely. If we just say, do you have sex with men and women or both? For the most part, the person who hears the answer to that is assuming that the men and the women in question are cis. And this question also negates the idea of non-binary people altogether. So the alternative is something along the lines of could you tell me about the genders and bodies of your partners? If I'm talking with somebody who could potentially get pregnant and that person says, I just have sex with women, I then am going to ask some follow-up questions. Is it just cis women, trans women, something else? Do you have sex with any spermy people?

(17:39):

So if we're specifically thinking about whether someone might need contraception, there could be partners with sperm and that person is still not having any kind of sex that could result in pregnancy. So making sure we're also asking about what kind of sexual activities are taking place. I alluded to the organ inventory a couple moments ago, and so I want to circle back to that. The organ inventory is really important. I wish it had a different name. I think the phrase organ inventory honestly is a little creepy, but that's what we're calling it. But essentially an organ inventory is how you know what sexual reproductive health organs someone has. What someone has currently I think is the most important. Your electronic medical record might also include what sexual reproductive organs this person had or were expected to have at birth, and if they have any organs that are surgically constructed or enhanced or hormonally enhanced.

(18:47):

But current organs I think most, most important, because that's what's going to tell you about whether this person's body has the potential to be pregnant, whether this person maybe needs cervical cancer screening, breast cancer screening and so on. And so some people will have this as a separate section in their EMR, and if you don't, I'd encourage you to just consistently put this in somewhere accessible that you can continue to reference it and keep it up to date so that you are both not missing something important and not wasting your time and your patient's time talking about cervical cancer screening if they don't have a cervix anymore or what have you.

Tammy Kremer (19:31):

I'm wondering, when you are taking this sexual health history, I can imagine that for some folks this is the first time they've had a history taken with this much awareness and openness to who they are. Can you talk about how people respond to the way that you ask your questions and what kind of feedback you've gotten?

Miles Harris (19:57):

Light up isn't quite the right word, but I guess the joy of being able to talk about this part of their life in a healthcare context, not feeling like they're being judged or assumptions are being made about them. You're right, is like the first time that's happened for a lot of people and it can be a really important part of me establishing a trusting relationship with someone.

Tammy Kremer (20:23):

Can you tell me about any patient interactions or individuals that you've worked with that stand out to you in thinking about this work?

Miles Harris (20:31):

Absolutely. This is an anecdote which I have written about, this is quite early on when I was a nurse practitioner and relatively new to being a gender-affirming care provider. I got a message and he had written me to say, my friend and I have a bet that we need you to settle. I know that people, auntie who aren't getting periods can't get pregnant and he thinks that they can, so we need you to settle this for us. And I had to pick myself up off the floor and write back and say, oh, no, I'm sorry, you're wrong, and your friend is right. Testosterone is not a substitute for contraception. He wrote back and said, well, I just took 12 at home pregnancy tests, they were all negative, but I would still like to come in and get one done in clinic. And I said, I really found this person.

(21:32):

I did not adequately counsel him regarding testosterone and fertility. And so I think that really sealed in my brain the importance of making sure that I'm providing that counseling both for people who are starting testosterone, but even if somebody's been on for years and then they're transferring their care to me, sometimes I think this person has been on T for potentially a decade, right? I'm not going to tell this person something that they don't know. But it still is very important that we still do all of our testosterone related counseling, including pregnancy and fertility related counseling with everybody because we don't know what sort of information somebody has gotten previously.

(22:25):

So he wasn't pregnant and we talked about contraceptive options. Everything turned out well, but that one always stands out to me. And so that was my lesson learned, which probably led me down this road in the first place.

Tammy Kremer (22:44):

It's funny how our oversights or failures are often the things that redirect us towards where we need to be. I want to apply this specifically to conversations around family planning. How do you approach family planning with transgender diverse folks, and what are some of the key questions that you would ask them?

Miles Harris (23:16):

First off, with family planning for anybody, regardless of their gender identity, we want to avoid making any assumptions about what that person's goals and intentions are as what their reproductive or sexual health history is as well. So in the context of somebody who's thinking about what their reproductive intentions are going forward and how that may or may not interact with their current or planned gender-affirming hormones. It's not an entirely straightforward conversation, right? Because the effects of gender-affirming hormones on fertility is not a particularly clear cut answer. So trying to help folks navigate some of that ambiguity is part of what I do every day.

(24:09):

We want to make sure we're not making any assumptions around the genders and bodies of somebody's sexual partners, not assuming that folks are sexually active, even that we know what the genders and bodies of somebody's partners are not, assuming that we know what sex they're having. Maybe they're not having any sex that could result in pregnancy, and I don't want to waste five minutes

of our precious 15-minute visit talking about contraception when that is completely not relevant to that person's needs.

Tammy Kremer (24:48):

I'm appreciating too what you shared about navigating the spaces of ambiguity. Can you talk a little bit about the kinds of conversations you might have with folks that are interested in fertility preservation or in getting pregnant and what kind of support you might be able to offer them?

Miles Harris (25:05):

With regards to fertility preservation, for someone who is thinking about starting on testosterone, I would counsel them that testosterone may negatively impact their fertility, but it is on the flip side not a guarantee of infertility either. So some people do before starting testosterone elect to do egg retrieval and freeze eggs or embryos to give them that option for using their genetic material in the future. However, many, many people are able to be on testosterone and then stop their testosterone and get pregnant, and for some people they are able to do that through sex or with a turkey baster. Some people requires various kinds of assistive reproductive technology to get pregnant. And there's so many different reasons that somebody might have reduced fertility or need assistive reproductive technology to get pregnant, that it's challenging or impossible to say that necessarily it's because that person was on testosterone.

[NEW_PARAGRAPH]It is possible for folks to get pregnant while they are still on testosterone, even if somebody is amenorrheic, meaning that they are not having any periods not bleeding. And so that's super important, something that I absolutely always counsel folks about when we are starting testosterone to keep that in mind and then if needed, discuss contraception options, which is one of my favorite things to talk about with people. So fertility preservation is for people with eggs, is a pretty invasive process and is often very expensive. Starting about $10,000. For most people, they're not going to find that they get any coverage from their insurance on that. But then if someone has frozen eggs or embryos, then they want to use those down the road. Sometimes people use them in their own uterus. Sometimes somebody might use it in the uterus of a partner or a surrogate.

(27:31):

Fertility preservation for people with sperm similarly is often not covered by insurance, but the price tag I would say is more often, again, this very much ballpark in the 500 to $1000 range, 10 to 20 times less than it might be for somebody trying to preserve eggs. Most of the time semen samples are produced through masturbation if someone is unable to do that because of the dysphoria associated with that or for some other reason, there are other ways to retrieve semen samples. There is an option where folks don't necessarily have to go into a fertility clinic to do that. And for trans and non-binary folks, that's often really helpful option because being in the fertility clinic environment might be particularly uncomfortable or maybe feel unsafe. So being able to do that at home is much better for some folks.

Tammy Kremer (28:32):

I can imagine that kind of environment, there could be unwelcomed confusions or questions on how being able to-

Miles Harris (28:41):

So many things could go wrong.

Tammy Kremer (28:43):

So many things could go wrong. Being able to avoid that sounds very valuable. You mentioned that one of your favorite topics is talking about contraceptive options. Can you talk to me more about that and what you share? You also said specifically that reminding folks that not having your period doesn't mean that you couldn't get pregnant.

Miles Harris (29:01):

Yes, which is counterintuitive, right? There's some data out there that shows that this is even a common misconception among healthcare providers and that a good number of trans non-binary people report that they were misinformed by their healthcare provider about gender-affirming hormones being a substitute for contraception, which it is not. I'll focus more on contraception for people with ovaries in the uterus, but before I go too far down that road, it is also not contraception for folks who make sperm. So while for many people who make sperm they will see decreased viability of their sperm down to no viability of the sperm on feminizing hormones. Some people will still have viable sperm on feminizing hormones.

(29:55):

Unfortunately in the world there just aren't that many options for contraceptions that are driven by the sperm having person other than condoms, although I know there's a lot of other options being researched in the works. But for the ovaries and uterus having person, in my visit I'm going to find out if contraception is even relevant for this person's needs, but providing that it is, any contraceptive method that would be appropriate for that person if they were not on gender-affirming hormones is still appropriate for that person on gender-affirming hormones. Meaning that there is no specific methods that are contraindicated due to testosterone use. We want to remember that this person is a whole person more than just their trans or non-binary identity and their potential use of testosterone.

(30:57):

So remember all of the other things that we need to consider when picking a contraceptive method for someone. So their tobacco or nicotine use, other medications, any other health conditions that might limit what kind of contraceptive methods they can use. But specifically with regards to gender identity and testosterone use, the world is your oyster, all of the options are still there for you. We want to in some part counsel very similarly we would to a cis person. I think a good example might be privacy. So the privacy of a contraceptive method is relevant for all people regardless of gender identity. But for a trans or non-binary person, privacy might take unique importance or significance. So let's say there's a trans man who lives with some roommates who he is not out to as trans.

(32:02):

If he is on oral contraceptive pills and his roommate finds his oral contraceptive pills, he is not just potentially being outed as someone using birth control, he might be being outed as trans. In a paper that I was an author on called contraception across the trans-masculine spectrum. We have a great table that I would encourage folks to check out, which goes through lots of different considerations regarding contraceptive methods, so including privacy and concealability, spotting irregular bleeding, whether you need a clinician to help you discontinue that method and so on. I know there's probably a dozen or more. So if somebody would find having irregular bleeding to be unacceptable, then we're going to cross out those methods.

(33:01):

Some jet trans and non-binary people might find taking an estrogen or a progesterone containing method to be unacceptable to them due to feelings of dysphoria or associations with the idea of taking

estrogen or progesterone that don't fit with their gender identity. There is no specific contraindication of combining either a combined oral contraceptive pill or a progesterone only pill or other kinds of, not necessarily pill, but method with testosterone. It's not going to reduce the efficacy significantly of the testosterone and it's not going to interfere with the effectiveness to the best of our knowledge with those contraceptive methods.

Tammy Kremer (33:49):

That's something that really stood out to me from your presentation at the Trans Health Summit with Chance Krempasky about how clear we are that methods of contraception that are available do not interact with someone who's taking testosterone, like getting the benefits that they're looking for and also don't contraindicate in terms of the efficacy of those methods.

Miles Harris (34:12):

Absolutely. And I guess I would clarify that it's not like there's this great wealth of research about studying the efficacy of various contraceptive methods for trans and non-binary people on gender-affirming hormones. I guess it's the flip. There is no evidence to show that there is decreased efficacy for any particular contraceptive method in conjunction with testosterone. People with uterus and ovaries still produce some small amount of testosterone, and so combined contraceptive methods, so estrogen and progesterone methods can slightly decrease the amount of testosterone being produced by somebody's own ovaries, but that decreased amount coming endogenously or from somebody's own ovaries is very small and not enough to be a significant to impact compared to the amount of testosterone that someone is using exogenously or taking in as a gel or a shot.

(35:17):

The other small, but worth mentioning potential interaction is that combined contraceptive methods can increase a protein in your body called sex hormone binding globulin. And so sex hormone binding globulin can bind to some of the testosterone in the bloodstream. It is possible that somebody taking a combined method might have a little bit more of their testosterone bound to this sex hormone binding globulin or SHBG, so that less of it is going into your body's tissues. But this is very small amount in comparison to your overall amount of testosterone that somebody is taking in, again, as a gel or as a shot or whatever method, those are worth mentioning. But the amount of impact that might have is so small that I wouldn't say that it is a reason to not use a combined method with somebody on testosterone.

Tammy Kremer (36:24):

It makes me curious if there are any outstanding questions that you wish there was research on. If you had a wishlist of research questions you could have answered that would support you in your practice, what might be on there?

Miles Harris (36:38):

Oh my goodness, there's so many. I don't even know where to start. There are some methods that are more associated with irregular bleeding, and we don't know if for somebody who is already amenorrheic from testosterone, meaning they're not having any periods, if somebody's starting any of those methods, how likely they might be or might not be to start having irregular bleeding if they were not bleeding before. Or for example, people who are not on testosterone using a copper IUD can sometimes give people heavier bleeding or more intense cramping, and we don't really have any information about

whether if somebody is on testosterone not having periods, is using a copper IUD, are we putting them at risk for having more cramping even if they're not having bleeding or cramping.

(37:42):

We know a hormonal method does this in people not on T. Does it still have those same potential side effects or risks in somebody on T? In general research on gender-affirming care is limited and then especially with regards to thinking about contraception, but I'm excited to be a part of the research that is going on.

Tammy Kremer (38:08):

Can you talk a bit about the research that you're involved with?

Miles Harris (38:11):

One of the projects I'm working on right now is asking trans and non-binary people about their experiences and use of emergency contraception. I'm really excited to see what we find out from that, but I guess I didn't even say anything about emergency contraception yet, any of the available emergency contraception options. So Plan B, Ella, copper IUD are all options for someone who wants to prevent pregnancy.

Tammy Kremer (38:42):

In each of the three episodes on family planning and reproductive justice, we're showcasing relevant projects by our colleagues at the UCSF Bixby Center for Global Reproductive Health. The Bixby Center focuses on advancing reproductive and sexual health worldwide. Here's Bixby Center Director, Dr. Jody Steinauer.

Jody Steinauer (39:13):

Thank you for creating this important miniseries of the Coming Together for Sexual Health podcast and for inviting me to share some related resources at the Bixby Center for Global Reproductive Health. We providers need to create a welcoming environment so every patient who walks through our doors feels that they were treated with dignity and respect. I will highlight three resources created by Bixby members to help us provide high quality sexual and reproductive healthcare for our transgender and gender diverse patients. And on a personal note, I want to say that I chose these three because I have personally used them to improve the care I provide. And I also have used these in my clinical settings at San Francisco General Hospital.

(39:54):

The first resource is the Society of Family Planning Contraceptive Counseling guidelines for transgender and gender diverse patients who are assigned female at birth. And this was co-authored by many people, including Bixby member Dr. Jennifer Kerns, and I strongly recommend that you read this if you provide contraceptive care in your practice. The second is a publication created by HIVE, a clinical care program based at San Francisco General Hospital and published in the journal Obstetrics and Gynecology. It is called Providing Patient-Centered Perinatal Care for Transgender Men and Gender-Diverse Individuals. And includes really important system changes and best practices to support these patients in having a positive and gender-affirming experience before, during, and after their pregnancy.

(40:41):

And finally, I want to mention the resource for you that is called Innovating Education and Reproductive Health. This is an online hub of three courses that you can take and it includes a module called Sex and

Gender 101 that describes the basics of creating trans-inclusive care in your clinical setting. I want to close by thanking you for taking the time to learn about how you can improve the care you provide to your trans and gender diverse patient.

Miles Harris (41:16):

I do want to put a plug in for talking about PrEP with trans and non-binary patients, HIV disproportionately affects trans and non-binary people, and I think we think of that much more for trans femme folks, but it certainly also affects trans-masculine folks. With all of my patients who are HIV negative or have perhaps not ever had an HIV test talk about PrEP and how there's no interaction with gender-affirming hormones, that's often a big concern. Likewise, PrEP is not significantly negatively impacted by use of gender-affirming hormones. And even if someone's current sexual practices don't seem like that person might be a candidate for PrEP, I still check and say, I'm like, hey, have you heard of PrEP? Do you know what it is?

(42:17):

And make sure that if in the future that was ever something that was relevant for them, that they know it's available. And then even talking with someone who isn't not necessarily currently a PrEP candidate, like getting more information out to the community that PrEP is accessible, well tolerated, safe, effective. So essential PrEP is so important and so underutilized overall, but especially I think in trans and non-binary communities.

Tammy Kremer (42:49):

Thanks for bringing that in.

Miles Harris (42:51):

And then talking about HIV and HIV testing, the most important part is once somebody has HIV testing, whether it's positive or negative, we have excellent options for treatment or prevention to keep somebody HIV negative or if somebody is positive, getting them on treatment and undetectable, keeping folks engaged in care. And I think that really circles back to what we've been talking about with sexual health history taking and talking with folks about their sexual practices that the most important thing we do is create a safe and welcoming environment in which trans and non-binary folks feel safe, accepted, included, and are willing to continue to engage in healthcare. But if someone has a negative experience and is not willing to engage with healthcare, then we don't have any of those options.

Tammy Kremer (43:53):

I'd love to hear from you if you have any suggestions of resources for providers looking to learn more about the topics we've discussed today.

Miles Harris (44:00):

Absolutely. The National Trans Health Summit from UCSF is a great conference focused on trans and non-binary health, but will include some sexual reproductive health topics focusing on trans and non-binary folks. Online, the National LGBTQIA+ Health Education Center, which is a program out of Fenway in Boston, has amazing resources. They have hundreds of webinars on a wide, wide variety of topics including sexual reproductive health for trans and non-binary folks. You'd have to register to access the webinars, but it is quick and free. Another go-to for me are the UCSF transgender health guidelines. Just

Google that they will pop right up and it's really well organized, so it's typically really easy to find the piece of information that you're looking for on there.

(45:01):

And then of course, the article that I mentioned, contraception across the transmasculine spectrum is I think if I may say so myself, an excellent resource. Another resource that you can look forward to is that the newest edition of Contraceptive Technology, which is a widely used textbook reference regarding contraception, will for the first time have a chapter specifically on LGBTQ+ communities and contraception. And that is authored by myself as well as Chance Krempasky, Frances Grimstad and Lola Pellegrino.

Tammy Kremer (45:43):

That's very exciting. Definitely sounds like a way to get this to more folks who might not even know that they're missing this information.

Miles Harris (45:50):

Indeed.

Tammy Kremer (45:52):

And what about some resources for trans and gender diverse folks looking for providers? Do you have any recommendations for that?

Miles Harris (46:00):

There's a couple of different directories that are out there. GLMA is a professional organization for advancing LGBTQ+ equality. The acronym is GLMA. They have this new directory, which is called the LGBTQ+ Healthcare Directory, and the URL is just lgbtqhealthcaredirectory.org. Often your local queer Facebook group, maybe I am aging myself by recommending Facebook as an option, but community resources, community members are often going to be really the best resource, the folks who know who in your area are the trustworthy safe providers to see. And your area may or may not have an LGBTQ health center and community center, and often that is a place that you can go to to ask for that resource. There are some telehealth, gender-affirming care providers. So those include Folx, Plume, QueerDoc, I'm probably missing somebody.

(47:18):

Oh, and then certainly Planned Parenthood is in many places an excellent option to go to for accessing gender-affirming care. I wouldn't say it is every Planned Parenthood affiliate that does gender-affirming care, but many, many, many of them do. But if you have a PCP who you otherwise like and want to keep, and that person says, I don't know how to do it, pointing that person toward any of these resources that I mentioned, you might be the person who nudges that provider into realizing that this is something that they can do and that it's not so hard. I don't want anyone to be the person who has to teach or has to do that. But if you have the emotional energy to do that and otherwise have a provider who you feel comfortable with and is open to learning new things, I would not rule that out as an option.

Tammy Kremer (48:20):

Thanks for all those really excellent resources. Where can our listeners find you?

Miles Harris (48:25):

My Instagram is mostly craft and baking focused, but if you want to see my craft projects, it's homostitchual on Instagram. And other than that, my LinkedIn page is a place to find me.

Tammy Kremer (48:46):

I'm going to check it out, look for some good new recipes. So for the last question of the interview, I like to ask folks to connect with their vision and their dreams, and this is based on thinking about how movement building and social change is so often based on being able to envision a different reality than the one that we live in. What is one thing that you would hope or envision we could create by Coming Together for Sexual Health?

Miles Harris (49:13):

I am excited about more and more trans and non-binary people seeing careers in health as something that could be in their future. A world in which trans and non-binary people regularly get to get healthcare from other trans and non-binary people would be a wonderful world. Not to say that we don't need cis providers to be learning and be competent and skilled in providing trans and non-binary health, but a world in which I'm not the exception. If you are thinking about a career in nursing, that is something that I love, love to talk about. I'm always excited to talk with trans and non-binary folks about nursing careers. So please reach out.

Tammy Kremer (50:09):

Beautiful. Thanks for sharing that vision and a world where people can get care from folks that reflect their identities, especially around issues that directly relate to those identities. That's a world I want to join you in. So thank you so much, Miles, for everything that you've shared today.

Miles Harris (50:26):

Thank you for having me. It's been fun to talk about it.

Tammy Kremer (50:32):

Thanks for listening, and please follow and rate us wherever you get your podcasts. This will help more people find us. Check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show. Connect with us on Instagram @ComingTogetherPod, on Twitter @CaliforniaPTC, and at comingtogetherpod.com. This podcast is produced by me, Tammy Kremer, and is edited by Isaiah Ashburn. Thank you for Coming Together for Sexual Health.