

Case Report

Global Journal of Medical and Biomedical Case Reports

Pregnancy and Perinatal Inclusive Care for Transgender Men: Addressing Challenges in Brazilian Public Health System

Julia Rossetto Dallanora^{1*}, Victoria Campos Dornelles¹, Nadine de Souza Ziegler¹

¹Hospital Materno Infantil Presidente Vargas (HMIPV), Porto Alegre, RS, Brazil.

Abstract

This study's case report explores the challenges and considerations in providing obstetric care for a transgender man at a public hospital in Brazil, following the Case Report Guidelines (CARE). With an estimated 3 million transgender individuals in Brazil and around 1.4 million in the United States, addressing specific healthcare needs of this community is essential. Despite the increasing prevalence of pregnancies in transgender men, there is a notable lack of adequate data, emphasizing the importance of gender-inclusive approaches in reproductive healthcare.

This case presentation involves a 20-year-old transgender man who experienced an unplanned pregnancy, highlighting the limited fertility counseling provided to transgender patients and stressing the importance of healthcare providers acting on eliminating misconceptions and providing evidence-based information.

The manuscript emphasizes the significance of perinatal mental health approaches for transgender individuals, given the higher rates of perinatal depression within this population. Additionally, it brings attention to systemic barriers, such as electronic systems that may not accommodate diverse gender identities, reinforcing the need for inclusive healthcare environments. Addressing the varied delivery and nursing preferences of transgender individuals, this study encourages discussions based on gender-inclusive terminology.

In conclusion, improving training to achieve inclusive practices within healthcare systems is essential to address the challenges faced by transgender patients during the perinatal period. By doing so, it would be possible to work towards reducing health disparities in society and enhancing the overall experience of transgender individuals in reproductive healthcare.

Keywords: Obstetrics; Pregnancy; Transgender Men; Sexual and Gender Minorities; Perinatal Care.

*Corresponding author: Julia Rossetto Dallanora, Hospital Materno Infantil Presidente Vargas (HMIPV), Porto Alegre, RS, Brazil.

Received: 28 January 2025; **Accepted:** 03 February 2025; **Published:** 05 February

Citation: Rossetto JD, Campos VD, De Souza NZ (2025) Pregnancy and Perinatal Inclusive Care for Transgender Men: Addressing Challenges in Brazilian Public Health System. Glob J Med Biomed Case Rep 1: 005.

Introduction

A transgender person is someone whose gender identity differs from the sex assigned at birth; thus, a transgender man is someone who self-identifies and lives as a man but was labeled female at birth due to physical characteristics. (NCTE, 2016) The transgender men's transition can be social, physical and/or legal, and even the medical aspect does not necessarily include surgical procedures, so they can also retain their female reproductive organs. [1]

The exact size of the transgender population in the world is not

well-known due to discrimination, to the lack of available data and to the differences among transgender definitions. In the United States of America, this population is estimated to be around 1.4 million. [1,2] In Brazil, approximately 3 million individuals self-identify as transgender or non-binary. (UFSB, 2021) However, only 13 out of the country's 27 states have healthcare centers that are inclusive for the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more) community. (The LGBTQ+ center, 2024) Furthermore, while around 66 per cent of those services provide gynecological care, just over 10

per cent have obstetricians available. [2,3] There is still little evidence regarding the prevalence of pregnancy in transgender men; however, studies have been estimating growing numbers of planned and unplanned pregnancies among this population. [1]

Transphobia - being it explicit or in the form of unpreparedness - has been observed as a widespread form of discrimination and is directly responsible for the health inequities when comparing outcomes among cisgender and transgender people. Literature shows a worldwide lack of gender-affirming care, with healthcare services and professionals lacking the skills needed to use inclusive language and to perform a culturally competent and respectful general health and obstetric care. [1,2,4-8] The delivery preferences and experiences of transgender individuals vary; while some perceive vaginal birth as distressing and triggering for gender dysphoria symptoms and prefer elective cesarean sections, others see vaginal birth as empowering and experience it without negative repercussions on their gender identity perception. [9-11]

Also, providers should consistently employ gender-inclusive terminology when discussing lactation, with “chestfeeding” proposed as an alternative to the conventional “breastfeeding”; however, the preferred terms should always be discussed with the specific patient under care. [12] The decision to engage in chestfeeding is a personal one; not all transgender men who become pregnant and give birth opt for this practice, particularly due to the potential exacerbation of feelings of gender dysphoria. [13] Nonetheless, it should always be discussed during perinatal care. Health providers should be well-informed about patients’ potential for nursing, even those who underwent chest masculinization, where typically some mammary tissue is preserved. [1,14]

Hence, the aim of this study is to report a case of a transgender man’s pregnancy and the perinatal care provided at a public hospital in Brazil, sharing experiences and contributing to the improvement of obstetric healthcare for transgender people. This involves drawing parallels between the case and evidence from the existing literature, while following the Case Report Guideline (CARE). [15]

Case Presentation

NTBS, 20 years old, transgender man - identified himself as a transgender man since childhood and had started gender-affirming hormone therapy (GAHT) at 18 years old, bisexual, single, blood type B+, no drugs/alcohol use.

The patient had stopped GAHT for a two-month period and, though never having thought of parenthood before, achieved unplanned pregnancy through vaginal intercourse with a casual cis male partner. The transient partner did not become involved with the pregnancy or with any parenting aspects. The patient received pregnancy diagnoses after usual symptoms (nausea and uterine

cramps) and laboratory testing, as advised by a general practitioner (GP). However, he did not resume GAHT use, as the same GP had instructed against it due to its teratogenic effects.

He was first evaluated at an obstetrical emergency with a gestational age (GA, weeks+days) of 16+0 by ultrasound, presenting antidepressant-induced mania symptoms after starting prescribed Sertraline 50mg and fearing gender dysphoria-associated symptoms relating to the physical and hormonal changes caused by pregnancy. Sertraline was previously prescribed by a GP for this emotional distress presented since the pregnancy discovery. After psychiatric evaluation he was admitted to the psychiatric ward of a maternal and child health public hospital due to identified suicide risk.

At this hospitalization, the institution’s electronic system did not accept the admission of a patient with male gender identity documents. The issue was discussed with the patient and the chosen solution was to use his previous identity card (with female registration). Subsequently, a change was made to the electronic system to permit admissions of patients with mismatched sex and gender.

During the hospitalization period he received obstetric and psychiatric care, being diagnosed with Type II Bipolar disorder and being prescribed Quetiapine 300 mg, Folic Acid 5mg and Ferrous Sulfate 900 mg. The patient was discharged after 18 days in symptom remission, with outpatient psychiatric and multidisciplinary prenatal care follow-up arranged at the same hospital.

In the course of prenatal care, NTBS was diagnosed with gestational hypothyroidism and received a prescription of 50 mcg Levothyroxine a day. At GA 23+6, the morphological ultrasound scan observed cervical insufficiency (cervical length of 1.9cm), and the obstetrician in charge prescribed vaginal micronized progesterone 200mg a day until GA 36+6. Also at GA 36+6, the psychiatrist added Sertraline 50mg to his daily prescription and adjusted the Quetiapine dose to 350mg a day.

At GA 40+2 the patient was admitted at the obstetric unit in spontaneous labor, regularly using the following prescribed medications: Quetiapine 350mg, Sertraline 50mg, Levothyroxine 50mcg and Ferrous Sulfate 900mg. Oxytocin was administered with progression to vaginal delivery on April 24th, 2023, 8:25pm, the male newborn was evaluated by a pediatrician, Apgar score 9/9, birth weight: 3285g, length: 48cm, head circumference: 33cm, pediatric GA 39+2; perineal assessment identified a first degree laceration without need for surgical repair. After 2 days of physiological puerperium they were discharged in exclusive chest feeding, with obstetric and psychiatric follow-up and a GAHT retaking plan for afterward cessation of chest feeding as desired by the patient.

Contraception was later addressed at another specific gynecological appointment (at the Family Planning clinic of the same public hospital). Long acting reversible contraception was advised, and options as etonogestrel subcutaneous implant and levonorgestrel-releasing intrauterine system were disclosed. The patient opted for the subcutaneous implant; however, it was not available at the institution during his admission. Consequently, an appointment was scheduled post-discharge, but unfortunately, he did not attend.

Discussion

Gender identity refers to an individual's intrinsic sense of their gender, encompassing their internal understanding of being male, female, or another gender, which may not align with the sex assigned at birth. In the case of transgender men, these individuals identify as male despite being assigned a female sex at birth. Transgender men may pursue various approaches, such as social, medical, or legal measures, to align their external appearance and daily experiences with their affirmed gender identity as men. Recognizing and respecting the gender identity of transgender men is crucial in providing comprehensive and patient-centered healthcare.

Gender diversity is acknowledged as a natural variation in individuals and is not inherently pathological. (APA, 2015) Qualified health practitioners, not limited to those from the mental health field, should conduct proper assessments of gender incongruence and/or gender dysphoria. Although gender dysphoria is still considered a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 and its Text Revision - DSM-5-TR) (APA, 2013; APA, 2022), gender incongruence is no longer seen as pathological or a mental disorder in the global health community. The International Classification of Diseases and Related Health Problems, 11th Version (ICD-11), recognizes gender incongruence as a condition (and not a pathology). (WHO, 2019) Due to historical and current stigma, transgender individuals may experience dysphoria that can be addressed with gender-affirming treatment options and minimized through the implementation of proper inclusive care. While nomenclature is subject to change and fluctuation within the various health organizations, the medical necessity of treatment and inclusive care is clearly recognized for all transgender individuals. The current ICD-11 criteria for gender incongruence involve marked and persistent incongruence between experienced gender and assigned sex, necessitating a requirement for gender transition. (WHO, 2019) Slightly divergent, the DSM-5 criteria for gender dysphoria emphasize marked incongruence between experienced/expressed gender and assigned gender, lasting at least six months. (APA, 2013; APA, 2022; WPATH, 2022)

In light of the rise in the pregnancy rates among the transgender population, this case report highlights the importance of addressing

reproductive health with patient-centered and gender affirming approaches. Also, it is important to emphasize both the training of providers and their access to adequate information.

In this case specifically the pregnancy was not planned, which brings to light the fact that most transgender patients do not receive adequate fertility counseling. [1] There is still professional misunderstanding regarding GAHT and contraception or loss of fertility, and while reduction of fertility caused by testosterone therapy should always be addressed, including recommendation on fertility-preserving options, patients should also be advised that testosterone and other gender-affirming medications are neither definitive nor totally reliable as contraception. [16-18] Researchers have observed that certain transgender men express apprehension about using contraceptives containing estrogen due to concerns about potentially hindering the desired masculinization effects of GAHT. Healthcare professionals should actively dispel this myth, providing patients with evidence-based information stating that the masculinization effects are not significantly affected by hormonal and non-hormonal contraceptives. [1,12,18,19]

Another worth underlining aspect in this case report is the mental health approach provided to this patient in association to the obstetric care, which is essential considering the higher rates of perinatal depression among this population. This pattern can be attributed to exacerbation of gender dysphoria, higher social vulnerability and lack of appropriate mental health assessment since the tools routinely used to assess perinatal depression do not evaluate gender dysphoria. [11,20,21] All that, on its turn, reinforces one of this report's goals: educating healthcare staff on providing gender-affirming care since a positive psychological outcome depends on an inclusive perinatal care experience. [20]

Recognizing and employing affirming and sensitive communication is crucial, not only in delivering care to transgender patients but also in ensuring respectful care for any individual undergoing the birthing process. [22] In accordance with the recommendations of [23] providers are advised to inquire about each new patient's preferred name and pronouns. Also, recognizing that some transgender individuals may be uncomfortable with gendered terminology during the anamnesis or physical examination is essential to ascertain their preferred anatomical terms; for instance, this may involve substituting 'vulva' for 'external pelvic area' or using 'frontal pelvic opening' and/or 'genital opening' instead of 'vagina'. [23] Notably, at the present case, there was no documented specific training for clinical staff, and fundamental aspects like employing gender-neutral language and using patient-preferred anatomical terminology were not addressed, which was an important limitation in this case management.

Still in terms of inclusive language usage, [12]. highlighted difficulties in updating the patient's Electronic Medical Record

(EMR) to align with their gender identity, citing technical limitations. These challenges included the system’s inability to differentiate between sex and gender and accommodate the admission of a nonfemale patient to the labor and delivery floor. In this present case, the patient’s previous identity card with female registration had to be utilized during the initial admission to a maternal hospital. Such situations hold the potential for harm from a transphobic perspective. As per Brazil’s government publication in 2020, all health centers must allow the admission of transgender patients while respecting their gender identity, irrespective of documentation. (SES, 2020)

There is no predetermined route of delivery for transgender patients. Certain studies have highlighted an increased preference for elective cesarean sections, particularly among patients who had prior GAHT use and perceived vaginal delivery as distressing. [10] This poses a complex challenge for specialized obstetric care, given the notable gap in knowledge regarding perinatal approaches. [13,20,24,25] For some transgender individuals, the prospect of a vaginal birth was found to be traumatic, with specific concerns revolving around the prolonged exposure of their genitals. In these same studies, contrasting experiences were noted, as some patients regarded a vaginal birth as significant, expressing a lack of inhibition during labor and birth that transcended their usual concerns about gender identity and revealing their bodies to others. This observation is consistent with the illustrated case, wherein the patient experienced a vaginal birth with no registered adverse repercussions on his self-image or mental health. [9,11]

In several research studies, transgender participants have expressed a lack of awareness among healthcare professionals regarding their right to nurse or even their potential for nursing, especially in cases where a patient has undergone chest masculinization surgery. [14] It is important to remind healthcare staff that the presence and quantity of mammary tissue vary among individuals, particularly those who have undergone any form of chest masculinization surgery. [1] For patients choosing to breastfeed, resuming hormonal therapy with testosterone might interfere with the essential hormones required for lactation. Although its use appears to be safe, as it is not significantly excreted through milk and does not affect the newborn, it can disrupt the necessary hormonal balance for adequate milk production. [13,20] On the contrary, it was also reported that healthcare staff often invalidate the suffering caused by gender dysphoria when patients do not desire to engage on nursing – here it is highlighted that scientific evidence supports the fact that nursing (together with pregnancy and birth) are aspects linked with worsening of mental health outcomes, sometimes even leading to perinatal depression. For patients who are not inclined to chestfeed, the option of chest binding—using a compressive band to flatten the chest area, often employed as a coping strategy for gender dysphoria associated with mammary tissue enlargement

during pregnancy—should also be considered along with, or alternatively, a single oral dosage of 1 mg cabergoline may be administered. (Contreiras, 2021) Binding can be employed before, during, and after pregnancy, but healthcare providers should be aware of potential complications during lactation, including reduced milk supply, blocked milk ducts, or mastitis. It is crucial for providers to understand that transgender men may desire binding and should possess knowledge about the associated risks and benefits to facilitate informed decision-making. [1,26,27]

As a direct consequence of discrimination and the insufficient preparation of medical professionals in delivering comprehensive and inclusive care, the transgender population often reports delays or avoidance in seeking health services. This, in turn, leads to health disparities, with the transgender population experiencing poorer health outcomes. When interactions between healthcare teams and transgender patients are appropriately handled, they present an opportunity to mitigate the consequences of widespread discrimination and transphobia, ultimately improving the health outcomes and quality of life for transgender individuals. [4-8,12]

For quick-consultation protocol and suggestions on initial measures to improve provided services please refer to (Figure 1)

SUMMARIZING PERINATAL HEALTHCARE ASPECTS FOR TRANSGENDER MEN

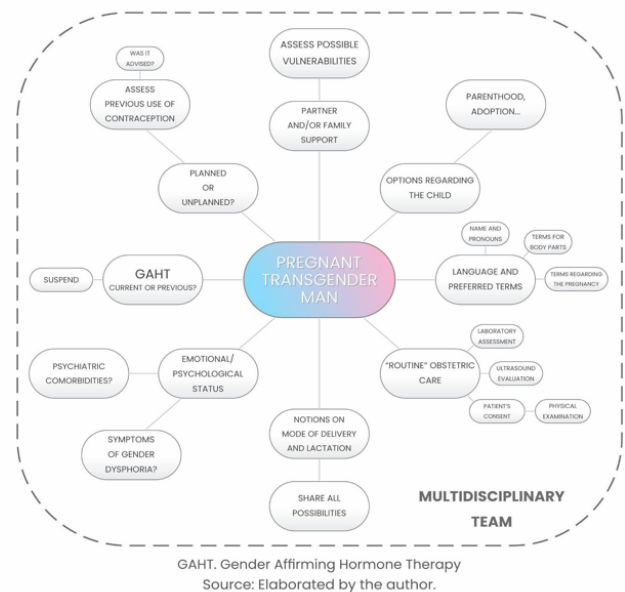


Figure 1: Quick-consultation protocol suggestions.

Conclusion

In conclusion, this case report sheds light on challenges and essential considerations in providing obstetric care for transgender

patients at a public hospital in Brazil. The lack of clear data on pregnancy in transgender men highlights the importance of gender-affirming approaches to reproductive health. Disparities in healthcare access, stemming from systemic barriers and widespread transphobia, contribute to health inequities and delays in seeking medical services. To address these challenges, training healthcare professionals for inclusive care is crucial. The case report also stresses the significance of addressing mental health in perinatal care for transgender individuals, emphasizing the need for inclusive support during pregnancy and postpartum. This highlights the necessity of targeted training for respectful and affirming care. Additionally, complexities in fertility counseling and contraception for transgender individual call for healthcare providers to eliminate misconceptions, provide evidence-based information, and encourage open discussions on gender-inclusive terminology.

This case report contributes to the knowledge on transgender reproductive health, urging improved training, awareness, and inclusive practices in global healthcare systems. By addressing these challenges, we can reduce health disparities and enhance the overall experience of transgender individuals during the perinatal period and beyond.

Acknowledgments

We express our gratitude to the patient for granting permission to use his data for research, thereby contributing to the improvement in the management of similar cases in the future. Our appreciation extends to all the assisting professionals involved in the case management for their commitment to providing the best possible perinatal care in their context.

Special thanks to Dr. Nadine de Souza Ziegler for her guidance and support in this work, and for providing the opportunity to study and discuss this topic, with the hope of improving perinatal care for transgender patients in our institution.

Ethics and Consent Informed Signed Term

The patient involved in the study signed the Informed Consent Form (ICF), allowing the development of this manuscript.

The study was submitted and approved by the Research Ethics Committee of Hospital Materno Infantil Presidente Vargas, Porto Alegre, Brazil (CAAE 74383123.8.0000.5329, Parecer 6.504.728, approved in November 2023).

Conflicts of Interest

The authors declare no conflicts of interest to disclose.

Authors Contribution

J.R.D. performed the study design, collection of data, consent term signatures and was the major manuscript and critical discussion

writer; V.C.D. performed manuscript contributions with critical discussion; N.S.Z. performed critical discussion and the final manuscript approval. All authors have read and approved the final version of this manuscript.

References

1. MacLean LR. (2021). Preconception, Pregnancy, Birthing, and Lactation Needs of Transgender Men. *Nurs Womens Health*. 1: 129-138.
2. Chu H, Kirby L, Booth A, Klepper M, Sherman AD, et al. (2023). Providing gender affirming and inclusive care to transgender men experiencing pregnancy. *Midwifery*. 116: 103550.
3. Spizzirri G, Eufrásio R, Lima MCP. (2021). Proportion of people identified as transgender and non-binary gender in Brazil. *Sci Rep*. 11: 2240.
4. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, et al. (2011). Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.
5. White-Hughto JM, Reisner SL, Pachankis JE. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Soc Sci Med*. 147: 222-231.
6. Jaffee KD, Shires DA, Stroumsa D. (2016). Discrimination and Delayed Health Care Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery. *Med Care*. 54: 1010-1016.
7. Echezona-Johnson C. (2017). Evaluation of Lesbian, Gay, Bisexual, and Transgender Knowledge in Basic Obstetrical Nursing Education. *Nurs Educ Perspect*. 38: 138-142.
8. Sherman ADF, Clark KD, Robinson K, Noorani T, Poteat T. (2020). Trans* Community Connection, Health, and Wellbeing: A Systematic Review. *LGBT Health*. 7: 1-14.
9. Andersen LB, Melvaer LB, Videbech P, Lamont RF, Joergensen JS. (2012). Risk factors for developing post-traumatic stress disorder following childbirth: A systematic review. *Acta Obstetrica et Gynecologica Scandinavica*. 91: 1261-1272.
10. Light AD, Obedin-Maliver J, Sevelius JM, Kerns JL. (2014). Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 124: 1120-1127.
11. Greenfield M, Darwin Z. (2021). Trans and non-binary pregnancy, traumatic birth, and perinatal mental health: a scoping review. *Int J Transgend Health*. 22: 203-216
12. Hahn M, Sheran N, Weber S, Cohan D, Obedin-Maliver J. (2019). Providing Patient-Centered Perinatal Care for Transgender Men and Gender-Diverse Individuals: A Collaborative Multidisciplinary Team Approach. *Obstet Gynecol*. 134: 959-963.
13. García-Acosta JM, San Juan-Valdivia RM, Fernández-Martínez AD, Lorenzo-Rocha ND, Castro-Peraza ME. (2019). Trans* Pregnancy and Lactation: A Literature Review from a Nursing Perspective. *Int J Environ Res Public Health*. 17: 44.
14. Falck F, Frisén L, Dhejne C, Armuand G. (2021). Undergoing pregnancy and childbirth as trans masculine in Sweden: experiencing and dealing with structural discrimination, gender norms and microaggressions in antenatal care, delivery and gender clinics. *Int J Transgend Health*. 22: 42-53.
15. Gagnier JJ, et al. (2013). The CARE guidelines: consensus-based clinical

- case reporting guideline development. *J Med Case Rep.* 7: 223.
16. Porsch LM, Dayananda I, Dean G. (2016) An exploratory study of transgender New Yorkers' use of sexual health services and interest in receiving services at Planned Parenthood of New York City. *Transgender Health.* 1: 231-237.
 17. Cipres D, Seidman D, Cloniger C, Nova C, O'Shea A, et al. (2017) Contraceptive use and pregnancy intentions among transgender men presenting to a clinic for sex workers and their families in San Francisco. *Contraception.* 95: 186-189.
 18. Light A, Wang LF, Zeymo A, Gomez-Lobo V. (2018) Family planning and contraception use in transgender men. *Contraception.* 98: 266-269.
 19. Krempasky C, Harris M, Abern L, Grimstad F. (2020) Contraception across the transmasculine spectrum. *Am J Obstet Gynecol.* 222: 134-143.
 20. Obedin-Maliver J, Makadon HJ. (2016) Transgender men and pregnancy. *Obstet Med.* 9: 4-8.
 21. Brandt JS, Patel AJ, Marshall I, Bachmann GA (2019) Transgender men, pregnancy, and the "new" advanced paternal age: A review of the literature. *Maturitas.* 128: 17-21.
 22. Bohren MA, Tunçalp Ö, Miller S. (2020) Transforming intrapartum care: Respectful maternity care. *Best Pract Res Clin Obstet Gynaecol.* 67: 113-126.
 23. Potter J, Peitzmeier SM, Bernstein I, Reisner SL, Alizaga NM, et al. (2015) Cervical Cancer Screening for Patients on the Female-to-Male Spectrum: a Narrative Review and Guide for Clinicians. *J Gen Intern Med.* 30: 1857-1864.
 24. De Roo C, Tilleman K, T'Sjoen G, De Sutter P. (2016) Fertility options in transgender people. *Int Rev Psychiatry.* 28: 112-119.
 25. Charter JM, Ussher JP, Robinson K. (2018) The transgender parent: Experiences and constructions of pregnancy and parenthood for transgender men in Australia. *Int J Transgenderism.* 19: 64-77.
 26. MacDonald TK. (2019) Lactation Care for Transgender and Non-Binary Patients: Empowering Clients and Avoiding Aversives. *J Hum Lact.* 35: 223-226.
 27. Castro-Peraza ME, García-Acosta JM, Delgado N, Perdomo-Hernández AM, Sosa-Alvarez MI, et al. (2019) Gender Identity: The Human Right of Depathologization. *Int J Environ Res Public Health.* 16: 978.
 28. American Psychiatric Association (2013) Diagnostic and statistical manual of mental disorders. American Psychiatric Association.
 29. American Psychiatric Association (2022) Diagnostic and statistical manual of mental disorders. American Psychiatric Association.
 30. American Psychological Association (2015) Guidelines for professional practice with transgender and gender non-conforming people. *American Psychologist.* 70: 832-864.
 31. Contreiras C, Centro de Referência e Treinamento DST/Aids. (2021) Homem trans: sexualidade e aspectos obstétricos. São Paulo.
 32. National Center for Transgender Equality (NCTE). (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
 33. Secretaria do Estado do Rio Grande do Sul. (2020). Portaria SES No 512/2020. Aprova a Política Estadual de Promoção da Equidade em Saúde.
 34. The Lesbian, Gay, Bisexual & Transgender Community Center. (2024). Defining LGBTQ+.
 35. Universidade Federal do Sul da Bahia (UFSB). (2021). Cartilha Nacional de Serviços Públicos de Saúde para a Pessoa Trans.