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**QUEER  
HEALTH**

## *"Developing queer-focused health justice."*

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The Knowledge Platform on  
Sexual and Reproductive Health & Rights



# Inclusive language

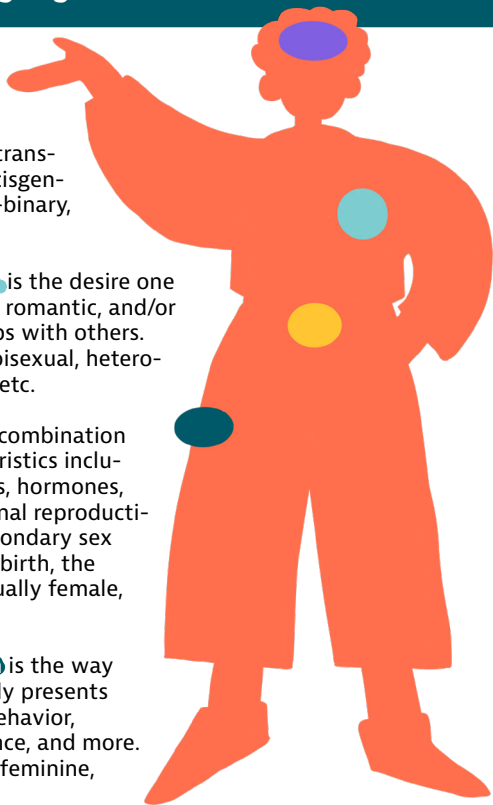
## Gender identity

is the personal self-conception of one's gender. E.g. transgender (wo)man, cisgender (wo)man, non-binary, genderqueer etc.

**Sexual orientation** is the desire one has for emotional, romantic, and/or sexual relationships with others. E.g. homosexual, bisexual, heterosexual, pansexual etc.

**Biological sex** is a combination of bodily characteristics including chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics. At birth, the sex assigned is usually female, male or intersex\*.

**Gender expression** is the way someone externally presents gender, through behavior, clothing, appearance, and more. E.g. androgynous, feminine, masculine etc.



\*A term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't fit the typical definitions of female or male. Common intersex conditions are Turner Syndrome and Klinefelter Syndrome.

# Inclusive language

## GENDER-INCLUSIVE OPTIONS



## GENDERED TERMS

### LANGUAGE

Person who menstruates .....	woman
Pregnant person .....	woman
Person who produces sperm .....	man
High-pitched/low-pitched voice .....	female/male voice
Estrogen .....	female hormone
Testosterone.....	male hormone

### FAMILY AND KINSHIP

Sibling .....	sister or brother
Nibling.....	nephew or niece
Carrying-, gestational-, birthing parent .....	mother
Intended parent.....	the person who will be the child's parent
Chestfeeding, nursing.....	breastfeeding
Pregnancy & parental leave .....	maternity & paternity leave

### BODY PARTS

Germ cells .....	ovaries/testicles
Chest .....	breast
Chest milk, human milk .....	breastmilk
Reproductive organs or internal genital organs .....	uterus/penis
Genital opening, birth canal, internal canal.....	vagina
External genital organs .....	vulva/penis/scrotum

# History taking

## Tips and tricks

Call your patient in by their **last name** instead of "Ms. Smith" or "Mr. Smith"

State your own **pronouns** when you introduce yourself

Ask all necessary questions, and **no unnecessary questions**

Explain the relevance of questions that could be perceived as **invasive**.



## Pronoun Examples

### *Feminine:*

- "Do you know her?  
She is doing well in her follow-up."

### *Masculine:*

- "Do you know him?  
He is doing well in his follow-up."

### *Neutral:*

- "Do you know them?  
They are doing well in their follow-up."

## Physical examination (PE)

- Explain beforehand **what** you are going to do and **why**;
- Consider that your PE can **trigger gender dysphoria** (e.g., to auscultate the lungs a binder needs to be removed);
- Inquire if people are **nervous** and/or have had prior **negative experiences**;
- Ask how to keep these into account during PE;
- Keep in mind which **organs** the patient has regardless of their gender (e.g., pap-smear if someone has a cervix; prostate exam when someone has a prostate);
- Strive for the **least invasive** examination and imaging techniques (e.g., abdominal ultrasound instead of transvaginal).



# Masculinizing Gender Affirming Care (GAC)

E.g. for assigned-female-at-birth people (AFAB)

Some transgender and gender diverse people (TGD) seek gender affirming care (GAC) to affirm their gender. GAC includes **non-medical practices**, **hormone therapy** and/or **surgical procedures**. TGD adults often choose one or more GAC options.

- Hair growth
- Baldness
- Acne
- Lower voice
- Square jaw line

- Increased muscle mass

- Binding
- Mastectomy/  
chest surgery

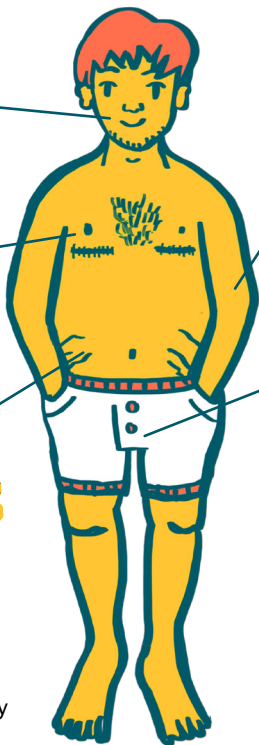
- Increased libido
- Clitoromegaly
- Genital dryness/  
atrophy

- Apple-shaped fat redistribution

- Hysterectomy
- Oophorectomy
- Metoidioplasty
- Phalloplasty
- Scrotoplasty
- Colpectomy

- Packing

Testosterone (transdermal, intramuscular) is the most commonly used masculinizing hormone therapy.



# Feminizing Gender Affirming Care (GAC)

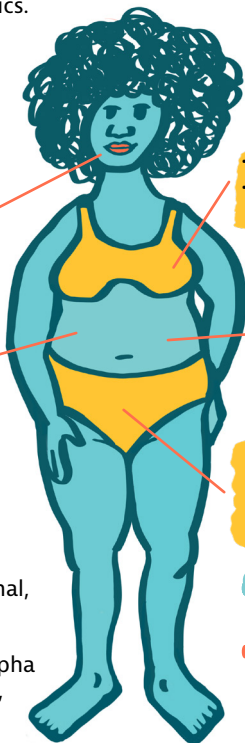
E.g. for assigned-male-at-birth people (AMAB)

Some transgender and gender diverse people (TGD) seek gender affirming care (GAC) to affirm their gender. GAC includes **non-medical practices**, **hormone therapy** and/or **surgical procedures**. GAC-related changes, especially of hormone therapy, have a great individual variation and show in different ways based on personal characteristics.

- Softer skin
- Arrest/reversal of scalp hair loss
- Lasering facial hair
- Tracheal cartilage shave
- Facial feminization surgeries
- Phonosurgery

- Decreased muscle mass

Frequently used feminizing hormone therapies include estrogens (transdermal, oral or sublingual) and antiandrogens (spironolactone, 5-alpha reductase inhibitors), and less commonly progesterone.



- Breast augmentation

- Breast growth
- Reduction of body hair (lighter, thinner)

- Stuffing

- Pear-shaped fat redistribution

- Decreased genital size
- Erectile dysfunction
- Decreased libido

- Orchidectomy
- Vaginoplasty

- Tucking
- Padding



## Fertility preservation options: for people born with ovaries

STAGE	METHOD	FUTURE USE
Pre-puberty and pre-GAC	Immature ovarian tissue cryopreservation (OTC)*	No established protocol. In vitro maturation of ovarian cortex tissue currently not possible.
Post-puberty and pre-GAC	Mature oocytes cryopreservation	
Post-puberty and pre-GAC+ active child desire with current partner	Embryo cryopreservation	Partner with sperm cells: IVF/ICSI Partner with egg cells: sperm donor, (reciprocal) IVF/ICSI
Post-puberty and pre-GAC	Ovarian tissue cryopreservation*	No protocol established
Post-GAC	After 3-6 months HT discontinuation, same options as pre-GAC	After 3-6 months HT discontinuation, same options as pre-GAC

*\*experimental*

**HT:** hormonal therapy; **GAC:** gender-affirming care; **IVF:** in vitro fertilization; **ICSI:** Intracytoplasmic Sperm Injection.



# Reproductive health: for people born with ovaries

Effects of hormone therapy (HT) on reproductive system:

## **Testosterone:**

- Anovulation
- Secondary amenorrhea (80% chance)
- Hypertrophic/atrophic endometrium
- Unchanged ovarian reserve/  
AMH (Anti-Müllerian hormone)

### **REMINDER:**

***TESTOSTERONE IS NOT A  
CONTRACEPTIVE METHOD!***

## **Chest feeding:**

Inquiry about the patient's wish to chestfeed or not. Chest enlargement can occur after giving birth also for patients who have undergone mastectomy. Consider lactation suppression hormones for those who do not wish to chestfeed.



# Fertility preservation options: for people born with testicles

STAGE	METHOD	FUTURE USE
Pre-puberty and pre-GAC	SSC cryopreservation*	No established protocol
	Testicular Tissue cryopreservation*	
Post-puberty and pre-GAC	Semen cryopreservation	Partner with sperm cells: egg donor and gestational surrogate
Post-puberty and pre-GAC	Surgical sperm extraction (TESE or PESA)	Partner with egg cells: IUI or IVF/ ICSI (with partner's oocytes)
Post-GAC	After 3-12 months HT discontinua- tion, evaluate semen quality for semen/embryo cryopreservation or TESE/PESA	Depending on method used



\*experimental

**HT:** hormonal therapy; **GAC:** gender-affirming care; **SSC:** spermatogonium stem cell; **IUI:** intrauterine insemination; **IVF:** in vitro fertilization; **ICSI:** Intracytoplasmic Sperm Injection; **TESE:** Percutaneous extraction of sperm from testis; **PESA:** Percutaneous aspiration of sperm from epididymis.

## Fertility preservation options: for people born with testicles

Effects of hormone therapy (HT) on reproductive system:

### **Estrogens+antiandrogens:**

- Severe impairment of spermatogenesis
  - Lower sperm count
    - + decreased sperm motility
    - + abnormal sperm morphology
- = Oligoasthenoteratozoospermia (OAT)

### **REMINDER:**

***HT IS NOT A CONTRACEPTIVE METHOD!***

### **Chest feeding:**

Lactation can be induced in patients with advanced Tanner stadia of chest development through hormonal stimulation similarly to cisgender women.



# Gender Dysphoria

(DSM-5)

Also: "Gender Incongruence" (ICD-11)

**Dysphoria is, at its core, feelings of discomfort and negativity associated with a person's sex assigned at birth, and the way it relates (or doesn't!) to their gender identity and expression.**

Persons can internalize ideas of what their bodies "should" look like, and dysphoria then stems from **societal expectations** based on sex assigned at birth, and if the person's gender identity does not fit within them.

Gender dysphoria typically begins in childhood, but some individuals may experience dysphoria around puberty, or even much later in life. **External factors** influence feelings of dysphoria, positively or negatively.

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## People with gender dysphoria:

- often feel their identity is not validated or legitimate;
- may feel the need to "prove" their trans identity and that "**they are trans enough**";
- find it harder to seek help and professional care;
- are at higher risk of **depression, anxiety, substance abuse,** and **suicide.**

*A majority of transgender and gender diverse (TGD) people have reported feelings of dysphoria at least once in their lives.*

# Gender Euphoria

Gender Euphoria can be described as positive, enjoyable, and affirming feelings associated with one's gender identity and performance.

Talking about gender euphoria allows attention to be given on **what feels good** and validating, rather than on what does not.

Positivity and an attunement to one's own body can play important roles in the improvement of **mental health outcomes**.

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## "How can I help foster gender euphoria in my patients?"

- Update patient's gender and pronouns in their **medical file**;
- Make your work environment as inclusive as possible (e.g., by having gender-neutral toilets next to the waiting room);
- Display a **rainbow-patterned** ornament in your workplace or on yourself (e.g., a sticker at the front desk, wearing a rainbow lanyard, etc.);
- Adopt gender-inclusive **language** and practices;
- Display your own **pronouns** on your name badge, and in your email signature;
- **Register yourself** in your local database of queer friendly care providers.

