towards transformative healthcare

ASIA PACIFIC TRANS HEALTH AND RIGHTS MODULE

ASIA PACIFIC TRANSGENDER NETWORK

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towards transformative healthcare

ASIA PACIFIC TRANS HEALTH AND RIGHTS MODULE

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How to navigate

SECTION OPENERS

The book is divided into 14 sections:
An introduction, 12 topics, and a closing section. Find them as a double spread with a large illustration and a blue background. The right hand side page shows numbered sub-topics within each topic.

LEARNING OBJECTIVES

For each topic find the 'Learning Objectives' after the section opens against a dark blue page.

QUICK REFERENCE GUIDE

Find things easily by locating the following icons

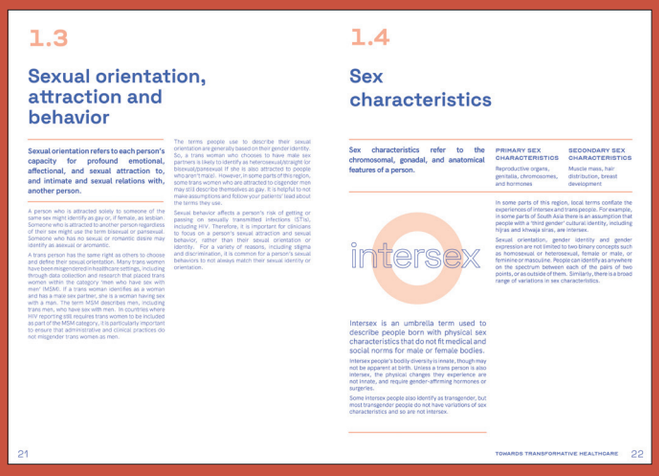
→ **Arrows** indicate references to other relevant topics in this book

✱ **Asterisks** indicate resources for further learning

▶ **Play buttons** indicate exercises, videos and other zresources

Clipboards indicate lists of practice points, helpful tips for real life applications

e this module ↓



1.3

Sexual orientation, attraction and behavior

Sexual orientation refers to each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, another person.

A person who is attracted solely to someone of the same sex might identify as gay or, if female, as lesbian. Someone who is attracted to another person regardless of their sex might use the term bisexual or pansexual. Someone who has no sexual or romantic desire may identify as asexual or aromantic.

A trans person has the same right as others to choose and define their sexual orientation. Many trans women have been misgendered in healthcare settings, including through data collection and research that placed trans women within the category 'men who have sex with men' (MSM). If a trans woman identifies as a woman and has a male sex partner, she is a woman having sex with a man. The term MSM describes men, including trans men, who have sex with men. In countries where HIV reporting still requires trans women to be included as part of the MSM category, it is particularly important to ensure that administrative and clinical practices do not misgender trans women as men.

The terms people use to describe their sexual orientation are generally based on their gender identity. So, a trans woman who chooses to have male sex partners is likely to identify as heterosexual/straight (or bisexual/pansexual if she is also attracted to people who aren't men). However, in some parts of this region, some trans women who are attracted to cisgender men may still describe themselves as gay. It is helpful to not make assumptions and follow your patients' lead about the terms they use.

Sexual behavior affects a person's risk of getting or passing on sexually transmitted infections (STIs), including HIV. Therefore, it is important for clinicians to focus on a person's sexual attraction and sexual behavior, rather than their sexual orientation or identity. For a variety of reasons, including stigma and discrimination, it is common for a person's sexual behaviors to not always match their sexual identity or orientation.

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1.4

Sex characteristics

Sex characteristics refer to the chromosomal, gonadal, and anatomical features of a person.

PRIMARY SEX CHARACTERISTICS	SECONDARY SEX CHARACTERISTICS
Reproductive organs, genitalia, chromosomes, and hormones	Muscle mass, hair distribution, breast development

intersex

Intersex is an umbrella term used to describe people born with physical sex characteristics that do not fit medical and social norms for male or female bodies.

Intersex people's bodily diversity is innate, though may not be apparent at birth. Unless a trans person is also intersex, the physical changes they experience are not innate, and require gender-affirming hormones or surgeries.

Some intersex people also identify as transgender, but most transgender people do not have variations of sex characteristics and so are not intersex.

In some parts of this region, local terms conflate the experiences of intersex and trans people. For example, in some parts of South Asia there is an assumption that people with a 'third gender' cultural identity, including hijras and khwaja siras, are intersex.

Sexual orientation, gender identity and gender expression are not limited to two binary concepts such as homosexual or heterosexual, female or male, or feminine or masculine. People can identify as anywhere on the spectrum between each of the pairs of two points, or as outside of them. Similarly, there is a broad range of variations in sex characteristics.

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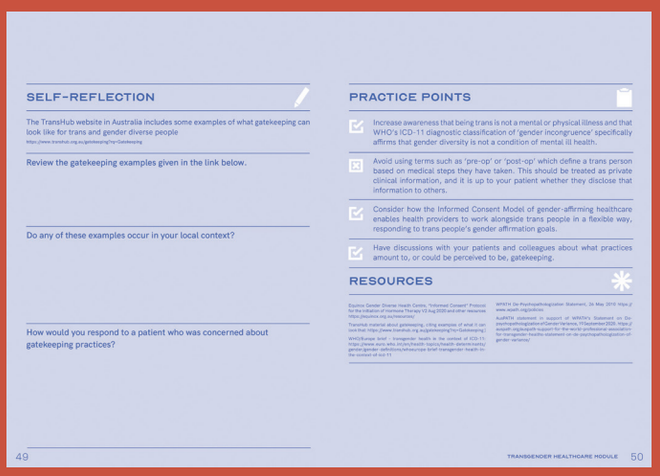

SELF-REFLECTION

The TransHub website in Australia includes some examples of what gatekeeping can look like for trans and gender diverse people
https://www.transhub.org.au/gatekeeping?sq=Gatekeeping

Review the gatekeeping examples given in the link below.

Do any of these examples occur in your local context?

How would you respond to a patient who was concerned about gatekeeping practices?

PRACTICE POINTS

- Increase awareness that being trans is not a mental or physical illness and that WHO's ICD-11 diagnostic classification of 'gender incongruence' specifically affirms that gender diversity is not a condition of mental ill health.
- Avoid using terms such as 'pre-op' or 'post-op' which define a trans person based on medical steps they have taken. This should be treated as private clinical information, and it is up to your patient whether they disclose that information to others.
- Consider how the Informed Consent Model of gender-affirming healthcare enables health providers to work alongside trans people in a flexible way, responding to trans people's gender affirmation goals.
- Have discussions with your patients and colleagues about what practices amount to, or could be perceived to be, gatekeeping.

RESOURCES

Equinox Gender Diverse Health Centre, "Informed Consent" Protocol for the Initiation of Hormone Therapy V3 Aug 2020 and other resources https://equinox.org.nz/resources/

TransHub material about gatekeeping, citing examples of what it can look like: https://www.transhub.org.au/gatekeeping?sq=Gatekeeping

WHO/Europe brief – transgender health in the context of ICD-11: https://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions/who/europe-brief-transgender-health-in-the-context-of-icd-11

WPATH De-Psychopathologization Statement, 26 May 2010 https://www.wpath.org/policies

AusPATH statement in support of WPATH's Statement on De-psychopathologization of Gender Variance, 17 September 2020. https://auspath.org.au/auspath-support-for-the-world-professional-association-for-transgender-health-statement-on-de-psychopathologization-of-gender-variance/

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SUB-SECTIONS/ SUB-TOPICS

Numbered sub-topics can be found at the top of each page at the top left, signified by pink numerals and blue headlines.

FURTHER READING, SELF REFLECTION AND POINTERS

Each topic closes with questions or statements for 'Self Reflection', 'Practice Points' and 'Resources' for implementation in real situations. These can be seen on light blue pages.

To-Do Checks signify do's / **To-Do Crosses** signify don'ts

Links to signify online content

Pencil indicates workbook-like areas for self reflections

Plus sign indicate learning objectives

Welcome

Purpose and human rights framework

Learning objectives

Structure of the module

Development of the resource

Self-reflection

This is an introducto trans-competent he usage of healthcare workers across the

TRANS-COMPETENT HEALTHCARE

Trans-cultural competency refers to the ability to understand, communicate with, and effectively interact with trans people, in a respectful, non-judgmental, compassionate manner, in settings free of stigma and discrimination

Trans-clinical competency refers to demonstrated competency across the specific gender-affirming healthcare needs of trans people and about the application of prevention and screening tools for general healthcare to trans people.

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HEALTHCARE PROFESSIONALS

- Healthcare providers, nurses, doctors, and administrators in all specialities
- Community-Based services and peer-providers
- Trans Health Advocates

ASIA-PACIFIC REGION

The Asia-Pacific region covers a large, diverse geographic area with significant cultural and linguistic differences. This is conveyed throughout the Module, though less research and data are available from the Pacific.

Purpose and human rights framework

The trans health module has been created as an introductory resource for healthcare professionals and other healthcare workers in Asia and the Pacific, particularly those in primary care including community-based health services.

There are significant differences across this region in societal attitudes towards transgender people, and the extent to which trans people are treated with dignity and respect when accessing healthcare and the number of health professionals, working across various disciplines, who support trans people's health and wellbeing.

The term 'gender-affirming healthcare' is used more specifically in this document to refer to any form of healthcare that trans and gender diverse people receive to align their body with their gender. There is also significant variation in the range of available gender-affirming healthcare and its cost, with no access to specialists, including surgeons, in some countries.

However, there are also common overarching regional themes, as previous research undertaken by the Asia Pacific Transgender Network (APTN) has shown. Trans people face barriers to accessing healthcare services in all countries in this region and across a range of healthcare issues, including general care; HIV prevention, testing and treatment; and gender-affirming healthcare.

Human rights standards require that healthcare and the underlying determinants of health must be available, accessible, and acceptable to all people and of quality (UN CESCR, 2000).[1] This is referred to as the AAAQ framework for the right to health.

The Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific (Asia Pacific Trans Health Blueprint) published in 2015 highlighted the human rights issues and trans health needs in this region.[2] Two years later, in 2017, the From Barriers to Bridges (FB2B) Conference brought together trans people, health professionals, community organizations and government officials to identify country-level road maps for improving access to trans-competent HIV and healthcare services.[3]

APTN's recently completed community-led Key Populations Research and Advocacy (KPRA) project (2020) looked at the health of trans people in Nepal, Indonesia, Thailand and Vietnam.[4] It concludes that trans people's right to health is compromised across all four countries. This most recent report has highlighted:

- Gaps in the availability of services, particularly gender-affirming healthcare
- Discrimination and cost barriers that undermine accessibility
- Acceptability issues due to lack of guidance about providing services in ways that are culturally competent for trans people
- In interviews and focus groups, participants also identified quality issues when there was limited information about using unregulated gender-affirming hormones safely.

AAAQ FRAMEWORK

requires health services to be

A **AVAILABLE** Enough functioning public health services and programmes are available.

A **ACCEPTABLE** Services must respect medical ethics, be culturally appropriate, and respect confidentiality.

A **ACCESSIBLE** Services and facilities do not discriminate, are physically accessible, affordable, and people are aware of them.

Q **QUALITY** Services must be scientifically and medically appropriate and of good quality.

Who is this resource for?

One of the persistent requests emerging from APTN's work is the need for practical resources that health care providers, including community-based services, can use to improve the trans-competency of their day to day work. This module is one response to that need.

This resource echoes the approach taken in the Standards of Care (SOC) developed by the World Professional Association for Transgender Health (WPATH) by emphasizing core principles that can be applied in by health professionals even in areas with limited resources and training opportunities (Coleman et al, 2012). It also notes that ensuring trans people have access to acceptable and quality healthcare services, including gender-affirming healthcare, is vital in order to achieve HIV epidemic control for this key population.

[1]The AAAQ framework draws extensively on General Comment 14 from the United Nations Committee on Economic, Social and Cultural Rights. United Nations (2000). The right to the highest attainable standard of health: general comment 14, UN. E/C 12/2000/4.

[2]Health Policy Project, Asia Pacific Transgender Network, United Nations Development Project. 2015. Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities. Washington, DC: Futures Group, Health Policy Project. https://weareaptn.org/wp-content/uploads/2017/10/blueprint-comprehensive.pdf

[3]https://weareaptn.org/wp-content/uploads/2018/12/FBTB-Report-D3-Screen.pdf

[4]https://weareaptn.org/wp-content/uploads/2021/02/KPRA-Regional_Darkgrey2pdf1.pdf

Learning objectives

Specific learning outcomes are linked to each of the topics. The overall learning objectives are to understand:

DIVERSITY

The diversity of trans people and the concept of gender-affirming healthcare

DE-PATHOLOGIZATION

The legacy of pathologization of gender diversity on attitudes towards trans people, and how informed consent models of care counter such pathologization

MENTAL HEALTH+WELL BEING

Minority stress and its impacts on transgender people's mental health and wellbeing

WELCOMING SPACES

Ways to create an affirming and inclusive environment for transgender patients

GENDER-AFFIRMING CARE

The key issues in hormone management and surgical options for gender affirmation, and any potential health issues linked to other non-surgical interventions

TRANS YOUTH

Ways to support gender diverse children and young people and their families

STANDARDS OF CARE

Current good practice standards of care for transgender patients based on an informed consent approach to gender-affirming healthcare

SEXUAL+REPRODUCTIVE HEALTH

How to take a sexual history in a way that affirms a trans person's gender and some specific sexual and reproductive health issues trans people may face

GENERAL HEALTHCARE

How general prevention and screening guidelines apply to transgender people and how to take a gender history

HIV & TRANS PEOPLE

The HIV burden for trans women in this region; prep and pep guidance for trans people, and interactions between HIV medications and gender-affirming hormones

TRANS RIGHTS

Advocacy by health professionals and their health professional bodies on the health and human rights of transgender people

Development of the resource

Before starting to create this resource, APTN reached out to health professionals and trans community leaders across the region who advocate for trans people's access to healthcare.

They were sent a short survey to identify the topics that should be included in the resource and to suggest possible material to incorporate into this module. They were also asked whether they would be available to peer review the content.

The draft module went through two rounds of peer review. APTN is immensely grateful to all the peer reviewers, including those named below who provided a significant amount of feedback:

Health professionals and health academics Dr Asa Radix (USA), Dr Nittaya Phanuphak (Thailand), Dr Alegra Wolter (Indonesia), Dr Melissa Kelly (Australia), Dr Sam Winter (Australia), Teddy Cook (Australia), Dr Rachel Johnson (Aotearoa / New Zealand), Dr Sue Bagshaw (Aotearoa / New Zealand), Mo Harte (Aotearoa / New Zealand)

FHI 360 Matt Avery, Sanya Umasa, Nicha Rongram

The development of the module was coordinated by Cole Young, Program Officer. Internal review was done by Joe Wong, Cole Young and Raine Cortes.

Many of the peer reviewers recommended citing the same core documents or generously shared information from resources they have created. Therefore, APTN would like to specifically acknowledge that this resource has drawn heavily from the documents cited.

It was important to APTN that the material was accessible as possible. Therefore, APTN is particularly grateful to those organizations that have made learning resources available online that we could link to this module.

Specifically, we would like to thank Teddy Cook and ACON's Trans Health Equity team for the extensive amount of material we incorporated and/or linked to from their digital information and resource platform, TransHub. TransHub was created by and for trans and gender diverse people from New South Wales (NSW), Australia, working closely with healthcare providers and allies. ACON specializes in community health, inclusion, and HIV responses for people of diverse sexualities and genders.

This resource was developed with support from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID) through the Meeting Targets and Maintaining Epidemic Control (EpiC) Project, and from the Global Equality Fund (GEF).

Design, lay-out and illustrations were supported by Robert Carr Fund for Civil Society Networks (RCF) and Global Equality Fund (GEF)

SELF-REFLECTION

The following 19 statements are an opportunity for you to reflect on your current knowledge and views about transgender health and gender-affirming healthcare. Select how much you agree with each statement.

Please print off or save these answers. At the end of the module, we will ask you the same questions. It is a chance to reflect on any information or insights gained that may inform your care for trans and gender diverse people.

Understanding a client's experience of their gender identity will help me provide better care as a clinician. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know enough terms to be comfortable talking with a trans client about their gender identity and gender-affirming healthcare needs. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am competent in discussing mental health issues as part of a holistic psychosocial assessment.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand that gender diversity is not a mental illness, and the role I can play in supporting trans patients around any mental health challenges they experience so that these are not a barrier to accessing gender-affirming healthcare.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand the principles of gender-affirming healthcare and informed consent.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand how to create an affirming and inclusive clinical environment for trans and gender diverse people. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of how to apply cancer screening guidelines to trans clients.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

SELF-REFLECTION

I know how to ask a trans patient about their sexual history using language that is affirming and gives me enough information to know what screenings they may need.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know how to talk with trans women, trans men, and gender diverse people about HIV prevention, care and treatment including any concerns about interactions between gender-affirming hormones and PEP, PrEP or HIV medications.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand key issues in gender-affirming hormone management.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of how binding, tucking and use of prosthetics such as packers and breast forms can be gender-affirming for many trans people, and I can advise on how to use these safely.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of the range of gender-affirming surgeries and the type of general medical support that may be required before, around, and after surgery.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand the roles a general health practitioner can play in supporting a young person's gender journey such as providing psychosocial support and developmentally appropriate information to young people and their family as well as specialist referrals, where indicated and available.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of the options available if my patients wish to access gender-affirming healthcare, including where to refer trans and gender diverse people if they need specialist care.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know where to refer trans and gender diverse people if they need peer support.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

SELF-REFLECTION

I know where to find resources to gain a deeper understanding of HIV prevention, testing and treatment, general healthcare, and gender-affirming healthcare for trans and gender diverse people.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am comfortable discussing gender-affirming healthcare with my colleagues and friends.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I feel comfortable educating and speaking with a colleague who makes derogatory remarks towards or about trans and gender diverse individuals.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I can deliver appropriate and effective healthcare to trans and gender diverse clients.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

1

Terminology

Learning objectives

1. Understand the diversity of trans people and some terms people use to describe their gender identity and expression

2. Understand some of the terms used to describe gender-affirming healthcare steps

1.1

Gender identity and expression

This module focuses on the health of transgender people – anyone whose gender identity differs from what was presumed, and therefore assigned, to them at birth. A person's gender includes both their internal gender identity and their external gender expression.

A person's gender includes ↓

GENDER IDENTITY (internal)

A person's deeply felt internal and individual experience of their gender, seeing themself as male, female, a blend of both or neither.

Gender identity can be the same as, or different from, a person's sex assigned at birth.

GENDER EXPRESSION (external)

A person's presentation of their gender through physical appearance – including dress, hairstyles, accessories, cosmetics — and mannerisms, speech, behavioral patterns, names, and personal references.

Gender expression may or may not conform to a person's gender identity.

As gender expression is visible, it is often an element in discrimination against transgender people, and others who are considered to be stepping outside gender-based norms.

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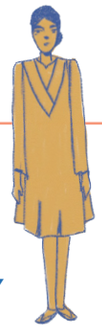
Transgender / trans are two umbrella terms used in this module to describe people whose gender identity does not match the sex they were assigned at birth. These terms encompass a wide diversity of gender identities and expressions in Asia and the Pacific.



TRANSGENDER PERSON / TRANS PERSON

This term is used to describe someone who identifies as a gender that is different from the sex assigned to them at birth. Some trans people identify within the binary, as men or women, and others have a non-binary identity.

ASSIGNED FEMALE AT BIRTH (AFAB)

This term is used to describe a person who was presumed to be female when born and at least initially raised as a girl.

ASSIGNED MALE AT BIRTH (AMAB)

This term is used to describe a person who was presumed to be male when born, and at least initially raised as a boy.

NON-BINARY PERSON

This term is used to describe someone who doesn't identify exclusively as a man or a woman (or as a boy or a girl) and may identify as neither.

nology

Languages across the world, including in this region, do not always distinguish between the terms sex, gender, gender identity and/or sexual identity. For example, some culturally specific, including indigenous, terms may describe a person's gender identity, gender expression and/or sexual attraction.

GENDER DIVERSE

This term is used to describe people who do not conform to their society or culture's expectations for males and females. Being transgender can be one way of being gender diverse, but not all gender diverse people identify as being transgender and vice versa.

TRANS MAN

This term is used to describe someone who identifies as a man or a boy, who was assigned female at birth.

TRANS MASCULINE PERSON

This term is used to describe someone who was AFAB, and identifies to some extent as a man or a boy.

TRANS WOMAN

This term is used to describe someone who identifies as a woman or a girl, and who was assigned male at birth.

TRANS FEMININE PERSON

This term is used to describe someone who was AMAB, and identifies to some extent as a woman or a girl.

CIS OR CISGENDER PERSON

Someone whose gender identity aligns with their sex assigned at birth.

1.2

Terms that describe a person's gender

In Asia and the Pacific, there is a long history of culturally specific terms for diverse gender identities or expressions. This module frequently uses the broader umbrella term 'trans and gender diverse' to encompass these culturally specific terms too.

TRANS MEN / TRANS MASCULINE PEOPLE

Some culturally specific, local language terms for trans men in this region include *thirunambi* and *kua xing* (Malaysia), *fa'atama* (Samoa) and *viaviatagane* (Fiji), though the common slang term used by trans masculine people in Fiji is *brastos*, which is an acronym from English language words.

TRANS WOMEN / TRANS FEMININE PEOPLE

In both Asia and the Pacific, typically these the terms in the table on the right describe people who were presumed / assigned male at birth (AMAB) but identify as a woman or as another gender (sometimes described as a "third gender" in parts of South Asia or the Pacific). The terms used in the Pacific also convey a person's connection to their family and culture, and often are used to describe someone who has a diverse gender expression or sexual orientation too.

ENGLISH LANGUAGE TERMS

English language terms are also used within this region. In some countries, the most common terms combine English and local words. For example, trans*pinay* for transgender women and trans*pinoy* for transgender men in the Philippines. In Indonesia, two similar terms are trans*puan* for trans women and trans*pria* for trans men.

NEW TERMS

In some parts of Asia, including China, most terms used to describe trans people are new. They have been influenced by Western terms used internationally. These include *bian xing ren* (变性人) to describe someone who has transitioned through medical interventions. Other new terms are *kua xing bie* (跨性别, transgender), *xiong di* (兄弟 for trans men, meaning 'brothers') and *jie mei* (姐妹, for trans women, meaning 'sisters'). In Thailand, some activists have used the terms *kon* (or *phuying, phuchaai*) *khaam phet* (a person who has crossed sex), and *khon* (or *phuying, phuchaai*) *plaeng phet* (a person who has changed sex).

NON-BINARY

While terms such as non-binary, gender non-conforming or genderqueer are less common in Asia than in Australasia, North America, or Western Europe, they are increasingly used, particularly among trans young people. Many *brastos* in Fiji also describe themselves as gender non-conforming.

The term non-binary is used most commonly in this document with the descriptors 'assigned male at birth (AMAB)', and 'assigned female at birth (AFAB)'. This is usually to convey difference between trans women and non-binary people AMAB compared to trans men and non-binary people AFAB.

These terms explaining different trans identities are important concepts to understand. However, it is more important is to recognise that everyone is unique and deserves to be respected as the person they are.





COUNTRY	CULTURALLY SPECIFIC TERMS
Thailand	*kathoey*
Malaysia	*mak nyah*
Indonesia	*waria*
Bangladesh, India and Pakistan	*hijra*
India	*thirunangai and aravani*
Pakistan	*khwaja sira*
Nepal	*meti*
Samoa & American Samoa	*fa'afafine*
Tonga	*leiti/ fakaleiti*
Niue	*fakafifine*
Cook Islands	*akava'ine*
Tuvalu	*pina*
Tahiti and Hawaii	*māhū*
Papua New Guinea	*palopa*
Fiji	*Vakasalewalewa* — In Fiji, trans people of Indian descent are referred to as *hijra* or by the Fiji Hindi term *jiji*.





1.3

Sexual orientation, attraction and behavior

Sexual orientation refers to each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, another person.

A person who is attracted solely to someone of the same sex might identify as gay or, if female, as lesbian. Someone who is attracted to another person regardless of their sex might use the term bisexual or pansexual. Someone who has no sexual or romantic desire may identify as asexual or aromantic.

A trans person has the same right as others to choose and define their sexual orientation. Many trans women have been misgendered in healthcare settings, including through data collection and research that placed trans women within the category 'men who have sex with men' (MSM). If a trans woman identifies as a woman and has a male sex partner, she is a woman having sex with a man. The term MSM describes men, including trans men, who have sex with men. In countries where HIV reporting still requires trans women to be included as part of the MSM category, it is particularly important to ensure that administrative and clinical practices do not misgender trans women as men.

The terms people use to describe their sexual orientation are generally based on their gender identity. So, a trans woman who chooses to have male sex partners is likely to identify as heterosexual/straight (or bisexual/pansexual If she is also attracted to people who aren't male). However, in some parts of this region, some trans women who are attracted to cisgender men may still describe themselves as gay. It is helpful to not make assumptions and follow your patients' lead about the terms they use.

Sexual behavior affects a person's risk of getting or passing on sexually transmitted infections (STIs), including HIV. Therefore, it is important for clinicians to focus on a person's sexual attraction and sexual behavior, rather than their sexual orientation or identity. For a variety of reasons, including stigma and discrimination, it is common for a person's sexual behaviors to not always match their sexual identity or orientation.

1.4

Sex characteristics

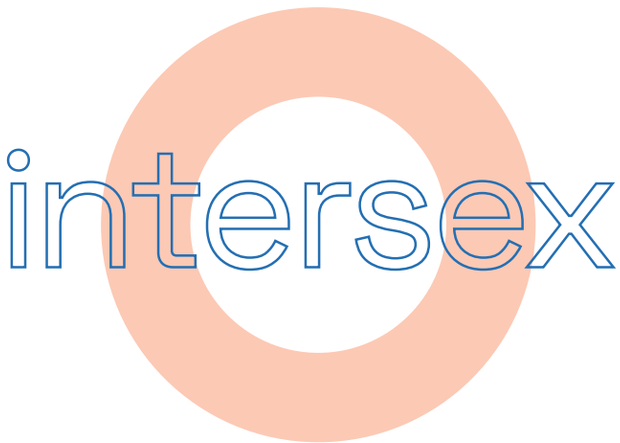
Sex characteristics refer to the chromosomal, gonadal, and anatomical features of a person.

PRIMARY SEX CHARACTERISTICS

Reproductive organs, genitalia, chromosomes, and hormones

SECONDARY SEX CHARACTERISTICS

Muscle mass, hair distribution, breast development



Intersex is an umbrella term used to describe people born with physical sex characteristics that do not fit medical and social norms for male or female bodies.

Intersex people's bodily diversity is innate, though may not be apparent at birth. Unless a trans person is also intersex, the physical changes they experience are not innate, and require gender-affirming hormones or surgeries.

Some intersex people also identify as transgender, but most transgender people do not have variations of sex characteristics and so are not intersex.

In some parts of this region, local terms conflate the experiences of intersex and trans people. For example, in some parts of South Asia there is an assumption that people with a 'third gender' cultural identity, including hijras and khwaja siras, are intersex.

Sexual orientation, gender identity and gender expression are not limited to two binary concepts such as homosexual or heterosexual, female or male, or feminine or masculine. People can identify as anywhere on the spectrum between each of the pairs of two points, or as outside of them. Similarly, there is a broad range of variations in sex characteristics.

Understanding gender and sexuality

Gender Identity

identify as

Agender
Cis/Trans Man or Boy
Cis/Trans Woman or Girl
Demiboy/Demigirl
Fa'atama / fa'afafine
Gender Non-conforming
Genderfluid
Gender Queer
Gender Diverse
Hijra
Kathoey
Leiti/ Fakaleiti
Meti
Non-binary
Third Gender
Transpinoy / Transpinay

There are many identities and terms that might not be listed, but just as valid, including local, cultural, and traditional terms.

Sexual Orientation

attracted to

Asexual / Aromantic
Bisexual
Gay / Homosexual
Lesbian
Pansexual / Panromantic
Queer
Straight / Heterosexual

Other sexual orientations and Local/Cultural/ Traditional Identities

Biological Sex

sex assigned at birth

Female
Intersex / Other
Male

Gender Expression

express self as

Androgynous
Butch
Feminine
Femme
Fluid
Queer
Masculine
Non-Conforming
Tomboy

Other

(Sorted alphabetically)

1.5

Gender affirmation

A person's gender affirmation (or transition) is the process of being seen and validated in their authentic gender. It can involve one or more of the following steps and is an evolving journey that is unique to each individual trans person.

Personal

This involves coming to understand and accept one's gender identity and bringing other people into the process. As a clinician, if you are one of the first people a trans person approaches to discuss their gender identity, your affirming response can make a significant difference to their wellbeing.

Legal

This involves legally changing one's name and gender marker on some or all official documents. Doctors can provide letters of support that, in some countries, may facilitate some forms of legal gender recognition.

GENDER MARKERS

These are details indicating a person's gender that are often used in administrative records, and on identity documents and other official documents. Gender markers may include binary (male or female) or non-binary gender options, and be implemented through text or numerical coding systems. In most countries in Asia and the Pacific, it is not currently possible for trans people to change their name and gender marker to match their gender identity. This has significant impacts on trans people's ability to navigate many areas of life safely and exposes them to discrimination and exclusion (UNDP and APTN 2017).[6]

Social

For example, informally changing your name, pronoun, clothes or hairstyle, wearing binders, packers, or breast forms to alter your body shape,[5] and using bathrooms and other facilities that match your gender. Clinicians can link a trans person to information and any peer support services, and also provide support to the wider family.

Medical

This involves taking gender-affirming healthcare steps. A family or community doctor plays a key role by listening to a patient's gender history and goals and providing medical knowledge about next steps, including any irreversible side effects or risks.

[5] These are discussed again in TOPIC 9

[6] TOPIC 12 includes more information about advocating for the human rights of transgender people, including their right to legal recognition,

1.6

Gender-affirming healthcare

This refers to any form of healthcare that trans and gender diverse people receive to align their body with their gender.

GENDER-AFFIRMING HEALTHCARE

Includes:

- Non-medical or non-pharmacological care (such as hair removal, counselling support, mental health assessments, and voice therapy)
- Medical care such as gender-affirming hormones / hormone replacement therapy (hrt) and
- A wide range of surgeries as explained in TOPIC 10

Sometimes the term is also used more broadly to include any form of trans-inclusive healthcare that is respectful and affirming of a person's unique sense of gender and provides support to identify and facilitate a trans person's gender healthcare goals.

TRANS-AFFIRMATIVE CARE

The practice of actively listening to, learning about, and meeting the needs of trans people using your service.

It aims to overcome the negative legacy of historic gatekeeping and stigmatizing models of care which have created significant barriers to health access and therefore health disparities for trans communities.[7]

TRANS-COMPETENT CARE

This refers to care that demonstrates the following two components:

- **Trans-cultural competency** refers to the ability to understand, communicate with, and effectively interact with trans people, in a respectful, non-judgmental, compassionate manner, in settings free of stigma and discrimination.
- **Trans-clinical competency** refers to demonstrated competency across the specific gender-affirming healthcare needs of trans people and about the application of prevention and screening tools for general healthcare to trans people.[8]

[7] Gatekeeping is a term that transgender people use to describe what appear to be unnecessary and unfair hurdles in the path of affirmative care and is explained more in TOPIC 3.

[8] APTN. Regional Mapping Report on Trans Health, Rights and Development in Asia. 2019, p. 8 https://weareaptn.org/2020/02/19/regional-mapping-report-on-trans-health-rights-and-development-in-asia/

SELF-REFLECTION

What are the local language terms used in your area to describe trans people?

Do some of these terms have negative or derogatory meanings?

What steps can your practice take to consistently use positive terms to describe trans people and gender diversity?

PRACTICE POINTS

- ☑ Learn and respect a person's gender identity and pronouns in order to establish rapport and trust.
- ☒ Don't assume a person's gender identity or sexual behavior based on their name or appearance.
- ☑ Ask every client how they would like you to refer to them (e.g. which pronoun or title to use).
- ☑ Be open to learning new terms when you encounter them and correcting yourself if you make a mistake.
- ☑ From a clinical perspective, a person's sexual behavior is more important than their sexual orientation, as it is linked to STD/HIV outcomes. Find out who a person is attracted to, who they have sex with, and how.
- ☒ Do not make assumptions about the gender-affirming care someone is seeking, based on the identity term they use. For example, non-binary people may wish to have gender-affirming surgeries and not all trans women or trans men wish to have gender-affirming hormones.

→ **TOPIC 4 includes practice tips about using a person's correct name, gender, pronoun, or titles in clinical settings, including in patient management systems.**

RESOURCES

An Australian video with a diverse mix of trans and gender diverse young people talking about some common terminology: https://trans101.org.au/video1.html

Gender Minorities Aotearoa's free online 101 'supporting trans people' course with curriculum covering Sex, Gender, and Transgender Terms, Transphobia and Discrimination, and Protective Factors and Support. International Organization for Migration's LGBTI glossary as part of its LGBTI training package https://lgbti.iom.int/sites/default/files/LGBTI_Glossary_2017.pdf

Trans 101: Glossary of trans words and how to use them, Gender Minorities Aotearoa, Wellington New Zealand, 2020. Includes indigenous Te Reo Māori terms: https://genderminorities.com/database/glossary-transgender/

The Gender Unicorn is a set of scales a person can use to illustrate their gender identity, gender expression, sex assigned at birth, and physical and emotional attraction to others (if applicable): https://transstudent.org/gender/ Translations are available in Japanese, Khmer, and Thai.

TransHub Australia's online Language guide: https://www.transhub.org.au/language

UNDP and APTN. 2017. Legal Gender Recognition: A Multi-country Legal and Policy Review in Asia. https://weareaptn.org/2018/02/06/legal-gender-recognition-multi-country-legal-policy-review-asia/

2

Minority stress and mental health and wellbeing

Learning objectives

1. Understand minority stress and its impacts on trans people's mental health and wellbeing

2. Consider ways to discuss mental health and well-being without assuming that your patient's gender is the underlying cause or that mental health issues must be resolved before the person can access gender-affirming services

2.1

Minority stress and psychosocial impacts on mental health

In recent years, the focus of research on mental health inequities affecting transgender people has shifted from pathologizing models that conceptualize transgender identities as being mentally disordered to understanding that marginalizing social environments lead to adverse mental health outcomes for transgender people.

Trans people experience hostility, rejection, violence, unemployment, and social isolation (Health Policy Project, APTN and UNDP 2015, Winter et al 2018). Consequently, they have higher rates of stress, depression, anxiety, helplessness, self-harming, suicidal thoughts, and attempts.

The Gender Minority Stress and Resilience (GMSR) model (Testa et al, 2015) has proposed that these negative health outcomes are the result of stress specifically experienced by trans people. These can lead to negative outcomes directly (e.g. poor mental health) or indirectly, when trans people avoid using healthcare services. At the same time, protective factors (such as connection to other trans people, and family, community, or cultural support) may mitigate these negative effects by promoting individual resilience (Veale et al, 2019; Radix et al 2017).

NEGATIVE HEALTH OUTCOMES
Higher rates of stress
Higher rates of depression
Higher rates of anxiety
Higher rates of helplessness
Higher rates of self-harming
Higher rates of suicidal thoughts and attempts

PROTECTIVE FACTORS
Connection to other trans people
Connection to family
Connection to community
Cultural support

2.2

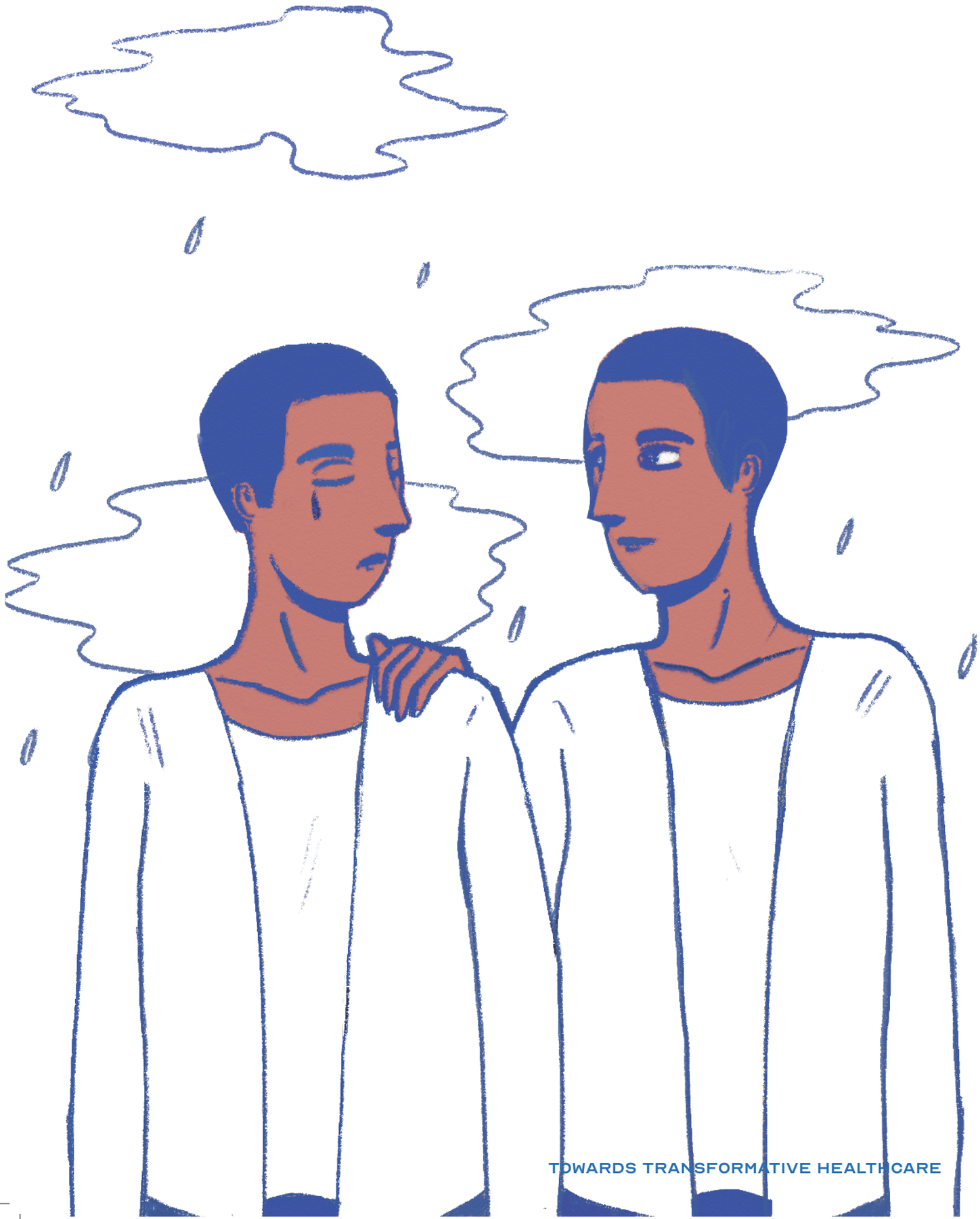
Mental health and wellbeing context for trans people in this region

Being trans is not a mental illness. As TOPIC 3 discusses, there is a long tradition of celebrating gender diversity across some cultures within this region. This contrasts with the relatively recent and now outdated use of mental health diagnoses to describe gender diversity.

The Asia Pacific Trans Health Blueprint identified the potential cumulative impacts of stigma, discrimination, isolation, and family rejection on trans people's mental health and wellbeing. At the same time, it noted the lack of attention to the specific mental health needs of trans people in this region. Trans people continue to advocate for trans-inclusive services to support their mental health and wellbeing.

APTN recently completed the first community-led Key Populations Research and Advocacy project looking at the health, including mental health, of trans people in Nepal, Vietnam, Thailand, and Indonesia (Fisk and Byrne 2020). The study included focus group and key informant interviews as well as a survey of 250 trans people in each country. This peer-led survey of 1,000 trans people found high rates of recent and severe symptoms of depression and anxiety. These contrasted with low rates of testing and diagnosis of depression and anxiety in all four countries. There was a high prevalence of suicidal ideation and attempts, and little professional help afterwards. Rates of accessing professional counselling and mental health services (lifetime prevalence) were very low.

The quantitative analysis found that the discrimination people had experienced from a doctor or HIV service provider was a key reason why mental healthcare services were not accessible for many trans people. Lack of trans-competent guidance or practices also reduced the acceptability of such services. Finally, there were simply not enough mental health services available in any of the countries, including for young people who desperately needed that support. The research showed signs of the difference that connection to a trans community can make. In Nepal and Indonesia, transgender people who were CBO (community based organization) members had lower rates of anxiety and depression. In Indonesia and Thailand, transgender people who rated high on a pride measure had better mental health.



2.3

Mental health care

Health professionals should be aware that mental health problems trans people experience may be related to the effects of minority stress or trauma or due to other causes.

Trans people may seek support from mental health professionals for a range of reasons, including in relation to living in their affirmed gender. However, psychotherapy is not a requirement for accessing gender-affirming care.

The Asia Pacific Trans Health Blueprint cited examples of mental health professionals responding to pressure from families to try to change a trans person's gender identity so they would identify as cisgender. Such practices are not evidence-based and are no longer considered ethical (WPATH SOC 7, p. 16). APTN is currently completing research on so-called "conversion therapy practices" across four countries in Asia – India, Sri Lanka, Indonesia, and Malaysia.

→ **TOPIC 3 looks at the role that mental health diagnoses have played traditionally as a requirement for accessing gender-affirming care, and current developments that move away from this approach.**

SELF-REFLECTION

In what ways can your practice help to promote protective factors that support trans people's mental health and wellbeing?

Example of Protective factors - connections to other trans people, and family, community, or cultural support

In what ways can your practice or profession make an evidence-based, ethical stand against so-called "conversion therapy" practices?

PRACTICE POINTS

- Include mental health issues as part of a holistic psychosocial assessment, for example discussion of anxiety, depression, risk of self-harm, while being clear that having mental health issues is not a barrier to accessing gender-affirming services.
- Recognize the impact of hostile environments on trans people, (i.e. minority stress) and validate the experiences that people have navigating those environments.
- When discussing stressors, follow the transgender person's lead as to whether their current challenges and health needs are focused on their gender or on something else in their life.
- With the involvement and consent of the transgender person, plan for provision of ongoing support for any mental health issues identified, if this available.
- Find and provide information about how transgender people can access peer support, or trans-affirming counselling or other primary mental health services as needed, where these are available.
- Work with colleagues and health professional bodies to critique and combat so-called "conversion therapy practices" which aim to change a person's gender identity, expression, or sexual orientation.[9] (Based on Oliphant et al, 2018)

[9] As these so-called "conversion therapy practices' are not therapeutic, the alternative term used increasingly to describe them is practices that are designed to change or suppress a person's sexual orientation, gender identity or expression, or sex characteristics.

RESOURCES

Fisk K and Byrne J. 2020. The Cost of Stigma: Understanding and Addressing Health Implications of Transphobia and Discrimination on Transgender and Gender Diverse People. Evidence from Trans-led Research in Nepal, Indonesia, Thailand, and Vietnam. Bangkok: Asia Pacific Transgender Network (APTN), 2020. https://weareaptn.org/wp-content/uploads/2021/01/KPRA-Regional_21.01.18.pdf

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Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019) Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand. Transgender Health Research Lab, University of Waikato: Hamilton NZ. https://countingourselves.nz/index.php/community-report/

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3

Depathologization, informed consent and gender-affirming healthcare models

Learning objectives

1. Understand the legacy of pathologization of gender diversity on attitudes towards trans people

2. Understand how informed consent and the gender-affirming models of care counter such pathologization

3.1

Depathologization — being trans is not an illness

Transgender people have existed in all cultures through human history, in all parts of the world. In some cultures, including in this region, gender diversity was celebrated. There are indigenous terms for gender diverse people, or the traditional roles they performed, in both the Pacific and Asia.

In contrast, pathologization of gender diversity means assuming that a trans person is intrinsically unwell or has a disease and needs medical treatment to be healed.

→ **Gender-affirming medical steps are described in TOPICS 8 and 10, and in TOPIC 11 in relation to trans young people.**

Taking hormones or having surgeries are affirming steps that support a person to live as their authentic gender. One useful analogy could be to the medical support given to someone who is pregnant. Like someone who is trans, a person who is pregnant is not ill; yet both may require medical support for their transition or their pregnancy.

When trans people first started to seek gender-affirming healthcare last century, gender diversity was pathologized and considered a mental illness. Trans people were labelled with specific diagnoses including 'Gender Dysphoria', 'Gender Identity Disorder', and 'transsexualism'. This topic shows current developments that move away from pathologizing diagnoses, and towards affirming trans people's gender identities.

Such an affirming approach recognizes that trans people's gender journeys are unique to them, and do not always involve taking hormones or having gender-affirming surgeries. It is pathologizing to assume that a trans person's identity requires medical transition, or to define a person by whether they have had gender-affirming surgeries or not.

For example, in the past, the term 'post-op' was used to distinguish between trans people who had undergone a genital reconstruction surgery and those who had not (who were referred to as 'pre-op'). This was often reinforced by laws or policies that required people to undergo these surgeries to be recognized in their appropriate gender. Such an approach is out of step with international human rights standards that affirm trans people's right to define their own gender, without undergoing any medical or surgical steps. For these reasons, health professionals should avoid using the terms 'post-op' and 'pre-op' to describe their patients.

3.2

Depathologizing diagnoses used to provide gender-affirming healthcare

The medical classification of gender diversity as a mental illness is relatively new.

‘TRANS SEXUALISM’

1977

‘Trans-sexualism’ appeared as a distinct diagnostic category in the International Statistical Classification of Diseases and Related Health Problems (ICD) in 1977.

‘GENDER IDENTITY DISORDER’

1980

‘Gender identity disorder’ appeared in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980.

DEPATHOLOGISING GENDER DIVERSITY

2010

By 2010, the World Professional Association for Transgender Health’s position was clear that gender diversity should not be defined by a mental health diagnosis.

> The expression of gender characteristics, including identities that are not stereotypically associated with one’s assigned sex at birth, is a common and culturally diverse human phenomenon which should not be judged as inherently pathological or negative.
>
> WPATH DE-PSYCHOPATHOLOGIZATION STATEMENT, 26 MAY 2010

REMOVAL OF MENTAL HEALTH STIGMA

2011

Regionally, in 2011, the Psychological Association of the Philippines spoke out in support of "global initiatives to remove the stigma of mental illness" that long has been associated with trans and LGB people.

GENDER DYSPHORIA

2013

In 2013, the DSM reverted to an older term, 'gender dysphoria' focusing more specifically on the psychological distress some trans people feel due to an incongruence between their experienced / expressed gender and their assigned gender.

GENDER INCONGRUENCE

2019

The changes in medical classifications are even clearer in the WHO's International Classification of Diseases and Related Health Problems (ICD). In 2019, the ICD Version 11 (ICD-11) introduced the category 'gender incongruence' to replace diagnostic categories in the ICD-10 such as 'transsexualism' and 'gender identity disorder'. Most significantly, 'gender incongruence' was moved out of the 'Mental and behavioral disorders' chapter and into a new chapter on 'Conditions related to sexual health'.

This reflects evidence that trans-related and gender diverse identities are not conditions of mental ill health, and classifying them as such can cause enormous stigma.

WHO/EUROPE BRIEF - TRANSGENDER HEALTH IN THE CONTEXT OF ICD-11, 2019

ICD DIAGNOSES OF GENDER INCONGRUENCE

The two age-based WHO ICD-11 codes are as follows

Gender Incongruence of Adolescence and Adulthood is characterized by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other healthcare services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behavior and preferences alone are not a basis for assigning the diagnosis.

HA60 Gender incongruence of adolescence or adulthood - WHO ICD-11

Gender incongruence of childhood is characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about two years. Gender variant behavior and preferences alone are not a basis for assigning the diagnosis.

HA61 Gender incongruence of childhood - WHO ICD-11

DSM DIAGNOSIS OF GENDER DYSPHORIA

The diagnosis of Gender Dysphoria was listed in the 5th edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) in 2013.[10] This was broadly considered a positive step, as it shifted the clinical focus from 'who trans people are' to 'something trans people might experience'.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[1] provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults.

The DSM-5 defines gender dysphoria in adolescents and adults as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least six months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

To meet criteria for the diagnosis, the condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-5 defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least six months, as manifested by at least six of the following (one of which must be the first criterion):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender

As with the diagnostic criteria for adolescents and adults, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The term gender dysphoria does reinforce the incorrect assumption that all trans people have had, or currently have, dysphoria. There is also a difference between the diagnosis of gender dysphoria and the feeling of gender dysphoria experienced by some trans people. Such feelings of gender dysphoria could be described as a social condition that is exacerbated by, for example, misgendering, discrimination, stereotyping and barriers to gender-affirming healthcare.

[10] https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

3.3

Informed consent

The "informed consent model" of gender-affirming healthcare counteracts pathologization and places trans people at the center of their own lives.

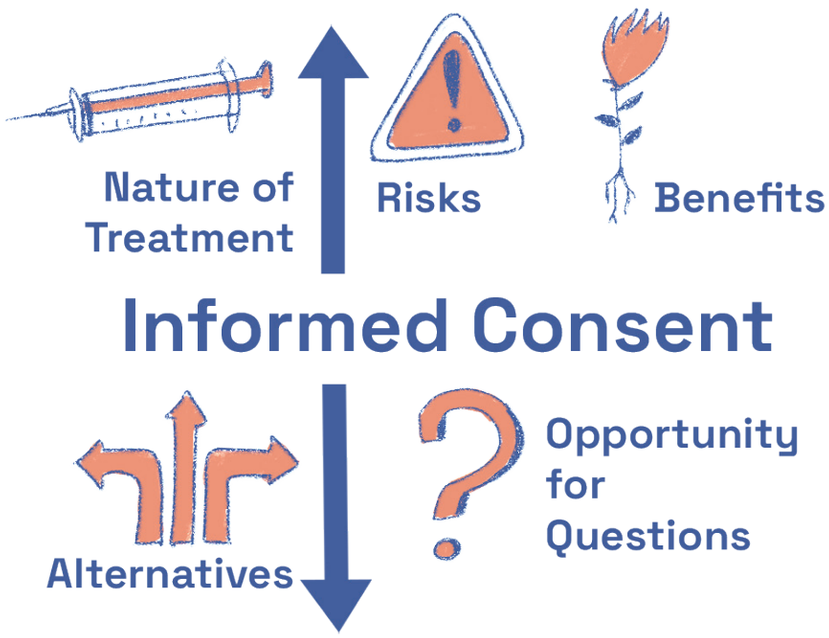
It reaffirms trans people's self-determination and their knowledge of their own needs, identities, and self. Informed consent enables health providers to work alongside trans people in a flexible and responsive way.

Bodily autonomy in the context of transgender healthcare involves transgender people being able to make informed choices for themselves regarding what gender-affirming healthcare they do and do not wish to seek. It means being free from experiencing harmful pathologization and other barriers when making these decisions and accessing this healthcare.

The informed consent model of healthcare is used by many primary healthcare providers to support trans people who are starting or maintaining gender-affirming hormones.

→ **There is more practical information in TOPIC 8: Gender-affirming hormones about how to apply an informed consent approach to your clinical practice.**

Typically, this means that a mental health assessment with a psychiatrist prior to commencing gender-affirming hormones is not a mandatory requirement for clients unless they have significant mental health issues impacting their ability to provide informed consent. Even when such an assessment is not required, trans people may choose to seek this professional support around their transition.



3.4

Gatekeeping

Gatekeeping is a term that transgender people use to describe unnecessary and unfair hurdles in the path of accessing trans-affirmative healthcare.

Gatekeeping is a term that transgender people use to describe unnecessary and unfair hurdles in the path of accessing trans-affirmative healthcare. It has a history in previous standards of healthcare that imposed restrictive barriers including 'real life tests' and required trans people to justify their gender identity and expression to meet very prescriptive eligibility and readiness criteria for medical gender affirmation.[11]

This legacy has implications for health professionals' therapeutic relationship with their patients. An informed consent approach enables health professionals to move beyond acting, or being perceived to act, as gatekeepers. Instead, it proposes that health professionals are guides to informed consent bringing medical knowledge and clinical experience to discussions with a patient about possible options. This includes explaining potential risks and, if possible, how they might be worked around. In some situations, the appropriate clinical advice may be to delay care or to prescribe medications at a lower level or frequency. A gender-affirming approach emphasizes the importance of clear communication of the rationale behind this advice, responding to any concerns the patient has about such a plan, and a timeframe for reassessing the decision.

The term gatekeeping also has another meaning in medical settings, when it is used to describe steps taken to reduce unnecessary overutilization of care, particularly in countries where medical insurance may push up the demand for procedures. This enables health resources to be more equitably distributed and prevents potential harm to individual patients caused by unnecessary medical treatment.

[11] The term gatekeeping is also used in medical settings to describe steps taken to reduce unnecessary overutilization of care, particularly in countries where medical insurance may push up the demand for procedures. This form of gatekeeping enables health resources to be more equitably distributed and prevents potential harm to individual patients caused by unnecessary medical treatment.

SELF-REFLECTION

The TransHub website in Australia includes some examples of what gatekeeping can look like for trans and gender diverse people

https://www.transhub.org.au/gatekeeping?rq=Gatekeeping

Review the gatekeeping examples given in the link below.

Do any of these examples occur in your local context?

How would you respond to a patient who was concerned about gatekeeping practices?

PRACTICE POINTS

- Increase awareness that being trans is not a mental or physical illness and that WHO's ICD-11 diagnostic classification of 'gender incongruence' specifically affirms that gender diversity is not a condition of mental ill health.
- Avoid using terms such as 'pre-op' or 'post-op' which define a trans person based on medical steps they have taken. This should be treated as private clinical information, and it is up to your patient whether they disclose that information to others.
- Consider how the Informed Consent Model of gender-affirming healthcare enables health providers to work alongside trans people in a flexible way, responding to trans people's gender affirmation goals.
- Have discussions with your patients and colleagues about what practices amount to, or could be perceived to be, gatekeeping.

RESOURCES

Equinox Gender Diverse Health Centre, "Informed Consent" Protocol for the Initiation of Hormone Therapy V2 Aug 2020 and other resources https://equinox.org.au/resources/

TransHub material about gatekeeping, citing examples of what it can look that: https://www.transhub.org.au/gatekeeping?rq=Gatekeeping]

WHO/Europe brief – transgender health in the context of ICD-11: https://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions/whoeurope-brief-transgender-health-in-the-context-of-icd-11

WPATH De-Psychopathologization Statement, 26 May 2010 https://www.wpath.org/policies

AusPATH statement in support of WPATH's Statement on De-psychopathologization of Gender Variance, 19 September 2020. https://auspath.org/auspath-support-for-the-world-professional-association-for-transgender-healths-statement-on-de-psychopathologization-of-gender-variance/

4

Creating an affirming and inclusive environment

Learning objectives

Create an affirming and inclusive environment for transgender patients:

1. **Including the physical clinic environment**
2. **Administrative practices and systems for collecting patients' details**
3. **When discussing parts of the body or conducting a physical examination**

4.1

Overarching principles

A person's gender identity is self-determined – your patient is the expert on their own gender.

Two fundamentals when working with trans clients

→

HONOR

Honor the patient's gender and use the name, pronouns, and terms that the patient uses to describe themself and their body.

+ AFFIRM

Take special care to affirm a patient's gender identity when you are addressing issues or providing treatments that you usually provide to someone of a different gender.

4.2

The physical clinic environment

The physical environment at the clinic and its online information is an important way to signal that it is safe and welcoming for trans people.

Some of the resources at the end of this and other topic sections include posters celebrating gender diversity or health promotion campaigns featuring trans people. Your waiting room is an ideal place to post information about peer support groups, and to showcase any initiatives that you are involved in with local trans communities.

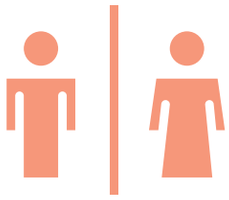
A TRANS-FRIENDLY CLINIC

Without clear indications that you support trans people, a clinic can be read as unwelcoming. Simple things like promotion material, affirming intake forms, and having facilities for people of all genders can make a big difference. This may include having:

A specific gender-neutral bathroom option

Signage describing the facilities within a toilet block (such as a urinal and/or private stalls)

Toilet seat by Mohammad Iqbal . Urinal by The Icon Z from the Noun Project from the Noun Project



Clarifying that people are welcome to choose the toilet that is most appropriate for them, based on their gender identity

Toilet sign by Ian Rahmadi Kurniawan from the Noun Project

Where toilets are gendered, ideally baby changing facilities and disposal containers for menstrual products are included in facilities for both men and for women

Changing Station by Yu luck from the Noun Project

4.3

Name, pronoun and gender details

A good way to make it easier for trans people to feel safe to share their name, gender and pronoun is to normalize asking for that information.

Collecting details from patients

While asking for pronouns and using new pronouns may feel strange at first, it gets easier every time you do it. Ask all patients, not just those you presume may be trans, to provide their name, gender, title/honorific (and pronoun if these are gendered in your local language). For example, by saying:

- "We ask all patients for these details. Please fill out the name and other details you want us to use for you".
- Many healthcare settings in this region are very crowded, which may limit the privacy available for discussions. Again, normalizing the discussion by asking all patients the same questions and displaying your own pronouns, may make trans patients feel less exposed.
- Consider adding pronouns on all staff nametags, business cards, and email signatures.

The Callen-Lorde Community Health Center in New York ran a Pronouns Matter! campaign, as an initiative to create a more welcoming, safe and respectful clinic atmosphere.12 In addition to staff wearing a sticker, badge or nametag with their pronoun, nametag stickers were available at every front desk for patients to fill in their pronouns. This is also a simple way for someone to let their staff know if their pronouns have changed since their previous visit.

In some countries in this region, including Thailand, gendered pronouns aren't used to substitute someone's name. For example, in Thai conversations, it is common to use a gender-neutral pronoun like **เค้า** instead of using he (**เขา**) or she (**เธอ**, **หล่อน**). In these circumstances, it may not be useful to ask clients what pronouns they prefer, but to clarify what, if any, gendered title they would like you to use, even if they are not able to legally change their gender marker.

[12]Callen-Lorde Community Health Center: https://callen-lorde.org/transhealth/

Clarifying if a patient uses different names in different settings

In parts of this region, it is normal for people to continue to live with their parents until they are married. This means many trans people may be living in a family setting and may use a different name there than when they come to your clinic.

Clinic forms and charts should include a space for people to indicate if there is a different name, gender, pronoun or title they want to be used in specific circumstances (e.g. phone calls, correspondence to their home address, or when being called in the waiting room).

- ☑ Do you want us to use these details in all our discussions with you and about your care? If not, let us know when you want us to use different terms.

Practicing using a new pronoun

Practicing pronouns on your own or with someone else also helps to reinforce them, especially if the pronoun is one you haven't used much before.

- ☑ If you have a patient who you often refer to by the wrong pronoun, or you are still getting used to a new pronoun, write a reminder to yourself before the appointment or practice using the correct pronoun.

Another option is to review your notes before an appointment, reading them out loud using the correct name, pronoun, and title. For example, if you were worried about forgetting to use 'they / their' for a non-binary client, you might remind yourself by summarizing your notes out loud like this -

"In their last appointment we discussed increasing their testosterone dose today. They were getting bloods done before their appointment. We can discuss their levels and see what decision they would like to make."

Even if you regularly collect pronouns and chosen names, there will be times when you do not have that information. In these cases, it is best not to guess a person's gender and possibly get it wrong.

- ☑ Assume nothing, routinely ask to clarify people's details and/or, avoid using words or phrases that assume gender.

Sometimes a patient may have a very negative reaction to being misgendered as it can be very triggering for some people or be one of many micro-aggressions they have faced. Try to stay calm, and not take their reaction personally.

Non-gendered alternatives in introductory conversation

GENDERED	NON-GENDERED
☒ How can I help you, Ma'am?	☑ How may I help you?
☒ Mr Khan, please come with me.	☑ Please come with me.
☒ She is waiting to see the doctor.	☑ The patient is waiting to see the doctor or Dr Tan's patient is here.

☑ If you make a mistake, briefly apologize and correct yourself, then carry on.

SOURCE Based on National LGBT Health Education Center. 2020.

When ID details do not match your clinic records

Inform transgender clients if there are situations where their legal name or gender is required, explaining why.

In most parts of Asia and the Pacific, it is not possible for trans people to change their legal gender or name (UNDP and APTN 2017). This means that any time a trans person is required to show a formal identification document, it is likely to have their name and gender that was assigned at birth.

- ☑ Train all staff to ask, "Are the name and other details on this ID card the ones you would like us to use when talking to you?"
- ☑ If a patient's name or gender identity does not match their insurance or medical records, ask if they use a different name for those records.
- ☑ Having a print-out or screen option for checking details may also be more private for some people.

Where a person's ID does not match your patient records, you can verify a person's identification by checking other details such as their date of birth and addresses.

4.4

Discussing parts of the body sensitively

Many trans people describe parts of their body, especially their genitals or secondary sex characteristics, using deliberately chosen words that affirm their gender.

When a healthcare provider uses these terms, it shows respect for their trans patient and increases trust within that professional relationship. Many trans people describe parts of their body, especially their genitals or secondary sex characteristics, using deliberately chosen words that affirm their gender. When a healthcare provider uses these terms, it shows respect for their trans patient and increases trust within that professional relationship.

Offer a variety of ways for trans people to provide any preferred terms they use to describe their body.

→ **For example, this might be on a confidential patient intake form or when you are taking a sexual history (discussed in TOPIC 6).**

Be aware that this is likely to be a sensitive issue for many trans people because it is common for someone to be misgendered based on their bodily diversity.

Using gender-neutral terminology is a good way to demonstrate sensitivity to the discomfort a trans patient may have in relation to talking about some parts of their body. Some examples are listed below. These phrases can be used to talk about parts of the body, without assuming the gender of the person who has that specific anatomy.

GENDER NEUTRAL TERMINOLOGY

TRY	EXAMPLE	INSTEAD OF
Person with _____ People with _____ Anyone with _____	If a person with a prostate has urinary symptoms, they should speak with their doctor	man with … males with … male-bodied people…
Person who has _____ People who have _____ Anyone who has _____	We recommend that anyone who has a cervix consider having a cervical screen	woman who has … female who have … female-bodied people …
_____ may occur _____ can begin You may experience _____	Pregnancy may occur without contraception. Hair loss can begin at any age after puberty. You may experience cramps as a side effect.	women may become … male pattern balding … women may experience…

SOURCE TransHub resource on Trans-Affirming Clinical Language[13]

[13] This resource was developed by Trans Care BC, Canada and adapted with permission by TransHub, NSW, Australia. Accessed 16 April 2021 at: https://static1.squarespace.com/static/5d8c2136980d9708b9ba5cd3/t/5fc9a8282f5dbb44b77798d1/1607051305514/Trans+Affirming+Clinical+Language+Guide_Final.pdf

4.5

Avoiding unnecessary and invasive questions

Many trans people have been asked unnecessary and invasive questions about their bodies, surgeries they have had, their sex life, and reasons for transitioning. These questions may come from casual acquaintances or strangers, or in inappropriate settings including workplaces. Asking such questions infringes trans people's privacy and displays a pathologizing fixation on medical transition steps.

When a trans person is asked "Why are you trans?" or "Why do you want to be a woman (or man)?", it can also imply that a trans person is mistaken about their gender identity or trying to deceive others. These stereotypes undermine trans people's right to define and claim their own gender identity. If sexual questions or remarks are unwelcome and inappropriate, they are likely to also constitute sexual harassment.

There are legitimate reasons why health professionals may need to ask some or all of these questions. For example, some of this information might be collected as part of a readiness assessment when referring a patient for gender-affirming surgeries, or when reviewing past surgeries to determine the preventative screenings your patient needs.

However, because these questions have been asked inappropriately by others, trans people may be reticent to provide such information. Explaining the need for specific information, and the limits on who can access this material, may help reassure your patient that their privacy is being respected.

> As healthcare practitioners we have a duty of care to our patients, and this includes being culturally competent enough to recognize when we are being inappropriate—however unintentional. . . . If you provide care to trans people and want to avoid being inappropriately curious, then ask yourself: Why do I need to know this? If the answer is that it will impact the care that you will give, go ahead and ask the question or do the investigation. If you're not sure why, then perhaps it's better that you don't.[14]
>
> THE BMJ OPINION, 9 SEPTEMBER 2019

The need to ask such questions should be determined on a case-by-case basis, and responses should be retained within clinical records so that the trans person is not asked repeatedly for the same information. Access to sensitive information should be limited to those who have a genuine need for this material, with private clinical records kept separate from administrative data.

[14]Shepherd A, Hanckel B, and Guise A. 2019. Trans health and the risks of inappropriate curiosity. The BMJ Opinion, 9 September 2019. Accessed 16 April 2021 at: https://blogs.bmj.com/bmj/2019/09/09/trans-health-and-the-risks-of-inappropriate-curiosity/

4.6

Physical examinations

Physical examinations can be difficult for many trans people because of previous experiences of inappropriate, disrespectful, or intrusive treatment, particularly examination of genitalia and secondary sex characteristics when this has not been required (Health Policy Project, APTN and UNDP, 2015).

When conducting a physical exam, providers should take particular care to use gender-affirming language, including the patient's preferred terms for relevant parts of their body. Ideally a conversation about appropriate terms has happened in an earlier appointment with the patient, and has been recorded in their patient notes. If this has not occurred, have these discussions before the patient disrobes.

Before commencing a physical examination, explain why the procedure is needed, which parts of the body you are examining, and therefore which clothes your patient will need to remove. If you do not need to examine a patient's genitals or chest area, it can be reassuring to let them know that explicitly too. If a trans person is not comfortable with your proposed physical examination, discuss if there are alternative ways to obtain the required medical information.

4.7

Simulation exercises

These are two trans-affirming simulation exercises from the Canadian Alliance of Nurses:

For clinic reception staff How to respond after misgendering someone by referring to the name on their ID card, when the patient had previously supplied their correct name and pronoun details: http://www.can-sim.ca/games/sogirecept/story_html5.html[15]

For medical staff How to perform a physical examination with a trans man who presents with respiratory symptoms and then transfer care to another healthcare provider in a way that ensures confidentiality and continuity of care http://can-sim.ca/games/sogi4e/story_html5.html

This is one example of a toilet sign that is inclusive and accessible 'Wharepaku' is an indigenous Te Reo Māori term for a toilet.

SOURCE Veale, J.et al. 2019. Artist: Huriana Kopeke-Te Aho.

[15] There is also a similar script with reflective questions in National LGBT Health Education Center, 2020, p.10

SELF-REFLECTION

Think about any current patients who are trans, or if a new trans patient came to your clinic. Would you be able to assure them that your clinic is affirming and inclusive of trans people? For example:

Look around your clinic. Is there any positive promotional material about trans people?

If you have a public bathroom, is it safe and welcoming for trans people?

Are there ways that trans patients can share private information with your administrative staff, for example about the difference between the name and gender they use and what is written on an identity document?

Are there ways you could make it easier for trans people to share any preferred terms for parts of their body?

PRACTICE POINTS

- ☑ Promote gender diversity inclusion in the clinic and in online information, including by displaying inclusive material, such as health promotion posters.
- ☑ Recognize that each individual is the expert of their own gender identity, and that their unique journey needs to be acknowledged (respect self-determination).
- ☑ Ask what name, title, gender, and pronouns (if used) a person wants you to use, and terms they prefer when talking about parts of their body.
- ☑ Register the person's self-identified gender identity on electronic patient records and any relevant national health database (with discussion and consent from the person whose record is being updated).
- ☑ Ask patients if they have any preferred terms for parts of their body, and consistently use these terms. Refer to anatomy in a gender-neutral way, for example, "people who have penises".
- ☒ Avoid unnecessary physical examinations, and conduct any that are required in ways that affirm your patient's gender.
- ☒ Avoid unnecessary and invasive questions. Check clinical records first to see if the material has already been recorded, and whether any additional questions are needed to address the issue the patient is raising in this visit.
- ☒ Don't make assumptions. If you require specific information, explain why, ask for it clearly, providing reassurances about how you will protect the confidentiality of that information.
- ☑ Provide gender-neutral toilet options.

RESOURCES

Callen-Lorde Community Health Center's Pronouns Matter! campaign video. 2016. https://youtu.be/QQIVjE_P5jA

Carroll, R. 2020. Why the way we approach transgender and non-binary healthcare needs to change. Article by Dr Rona Carroll, Senior Lecturer, Department of Primary Health Care and General Practice, University of Otago, Aotearoa New Zealand. https://theconversation.com/why-the-way-we-approach-transgender-and-non-binary-healthcare-needs-to-change-149816

Gender Minorities Aotearoa, Wellington. 2019. What Transgender Health Promoters want you to Know. https://genderminorities.com/2019/11/15/healthcare-presentation-sexual-health-transgender/ PowerPoint presentation. Posters: https://genderminorities.com/2018/05/18/transgender-posters-new-zealand/

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Potter J, Peitzmeier SM, Bernstein I, Reisner SL, Alizaga NM, Agénor M, and Pardee DJ. 2015. Cervical Cancer Screening for Patients on the Female-to-Male Spectrum: A Narrative Review and Guide for Clinicians. J Gen Intern Med. 2015 Dec; 30(12): 1857–1864. Published online 2015 Jul 10. doi: 10.1007/s11606-015-3462-8

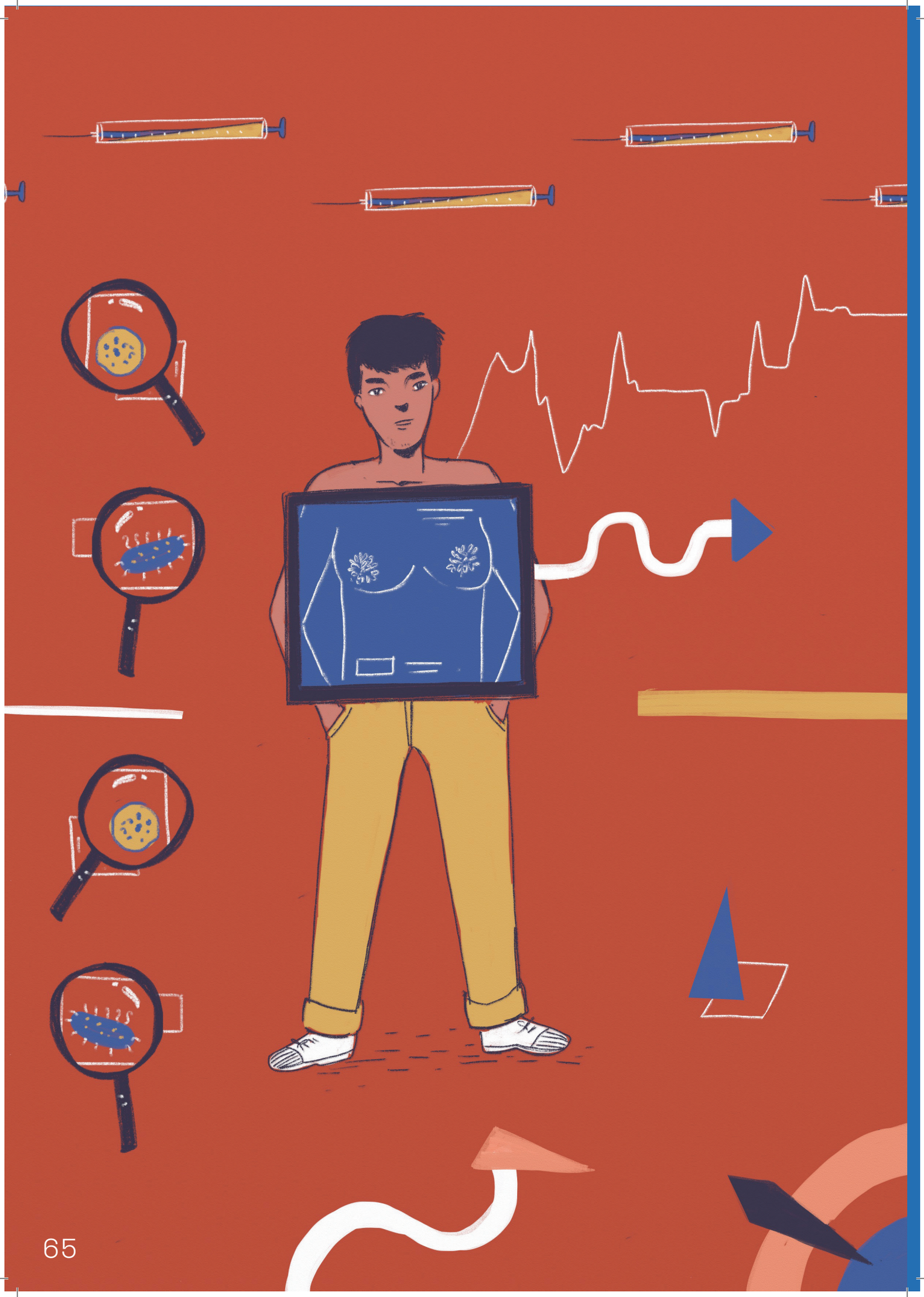
Shepherd A, Hanckel B, and Guise A. 2019. Trans health and the risks of inappropriate curiosity. The BMJ Opinion, 9 September 2019. Accessed 16 April 2021 at: https://blogs.bmj.com/bmj/2019/09/09/trans-health-and-the-risks-of-inappropriate-curiosity/

The Trans and Gender Diverse in Community Health (TGDiCH) Training Project in Victoria, Australia: A TGD-led, evidence-based, state-wide training project by and for health professionals: https://thorneharbour.org/lgbti-health/training-and-capacity-building/tgdich/

TransHub's 10 tips for clinicians working with trans and gender diverse people: https://static1.squarespace.com/static/5d8c2136980d9708b9ba5cd3/t/5e7bf42b7882f95360ea39fb/1585181759763/FactSheet_10Tips.pdf

UNDP and APTN. 2017. Legal Gender Recognition: A Multi-country Legal and Policy Review in Asia. https://weareaptn.org/2018/02/06/legal-gender-recognition-multi-country-legal-policy-review-asia/

Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T & Bentham R (2019) Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand. Transgender Health Research Lab, University of Waikato: Hamilton NZ. https://countingourselves.nz/index.php/community-report/



5

General prevention and screening

Learning objectives

1. Gain confidence in taking a medical and surgery history from trans patients, including use of soft tissue fillers, and in creating an anatomy inventory to improve prevention and screening.

2. Understand appropriate cancer screening for trans people based on a person's anatomy.

3. Recognize that many trans people find cancer screening very challenging, both physically and emotionally, and learn ways to mitigate this, including during a cervical screening test.

5.1

Medical and surgery history

The most important principle for prevention and screening is to provide care for the anatomy that is present. This requires creating sufficient trust for your client to disclose their medical and surgical history.

Many trans people do not share this information with healthcare professionals and avoid physical examinations because they fear their gender identity will be invalidated during such procedures.

→ **TOPIC 4 has already introduced ways for healthcare providers to learn about affirming terms that a trans patient uses to describe their body.**

It is useful for a healthcare provider to maintain a list of these terms in the patient's records. In addition, keeping an up-to-date inventory of your patient's anatomy, and any gender-affirming surgeries they have undergone, can help direct any indicated preventative screenings (Deutsch et al 2013).

TRANSGENDER PATIENTS: INVENTORY OF ORGANS

Breasts / Cervix / Ovaries / Penis / Prostate / Testes / Uterus / Vagina

In many parts of this Asia and the Pacific, trans people have very limited access to gender-affirming surgeries, therefore it may not be necessary to have such an extensive checklist. However, a health professional should ask about any previous surgeries and other forms of body modification, including use of soft tissue filler injections.

5.2

Use of soft tissue fillers

The term 'silicone injections' in the context of transgender health refers to any one of a number of soft tissue fillers, typically injected by an unlicensed or unscrupulous medical provider (Deutsch 2016).

The actual composition of the injected substances is often unknown, and may not be of medical grade; contents may include aircraft lubricant, tire sealant, window caulk, mineral oil, methylacrylates, petroleum jelly, or other substances.[3] In cases of these unsupervised injections, the injected volume (1-3 liters or more) far exceeds what may be performed by a licensed medical provider. In parts of this region, a high proportion of transgender women use soft tissue fillers (Guadamuz 2011).[16]

It is important to ask trans people whether they have injected soft tissue fillers into their body to feminize their hips, buttocks, thighs, lips, breasts or face. In some countries, these are the only forms of body modification available for trans women. They carry risks of local and systemic infection, embolization, and painful granuloma formation, and may cause a fatal systemic inflammatory syndrome.

Healthcare providers should employ a harm reduction approach to trans women who continue to inject soft tissue fillers. Clients should be advised against sharing needles or participating in pumping parties. Consideration should be given to providing clean needles, gloves, and advice about sterile techniques to help reduce injection-site infections. A health professional may consider giving these injections for safety reasons or referring their patient to another medical professional. However, the amount of injected silicone typically sought in unsupervised and unregulated settings far exceeds what may be injected by a licensed medical provider (Deutsch 2016).

Complications resulting from prior injections may require surgery to remove fillers or repair excessive damage.

[16] More than two-thirds (68.6%) of the 325 trans women surveyed in a 2005 Thai study (in Bangkok, Chiang Mai and Phuket) reported having either silicone injections or implants, mainly into their breast, face or upper legs. This survey did not differentiate between implants or injections, and included both silicone and non-silicone implants.

5.3

Cancer screening

Many trans people find cancer screening very challenging, both physically and emotionally. In each of these instances, fully explain the procedure, why it is important to do, how it works, and what the patient will experience.

When cancer screening programs are available, trans people who have not used gender-affirming hormones or had gender-affirming surgeries should be screened using the same criteria and risk parameters as for other people assigned the same sex at birth.

Transgender people who have not undergone surgical removal of their breasts, cervix, uterus, ovaries, prostate or testicles remain at risk of cancer in these organs and should undergo screening as recommended for these cancers. Apply the same criteria and risk parameters that you would use for other people assigned the same sex at birth (e.g. transgender women would be assessed against the criteria and risk parameters for cisgender men).

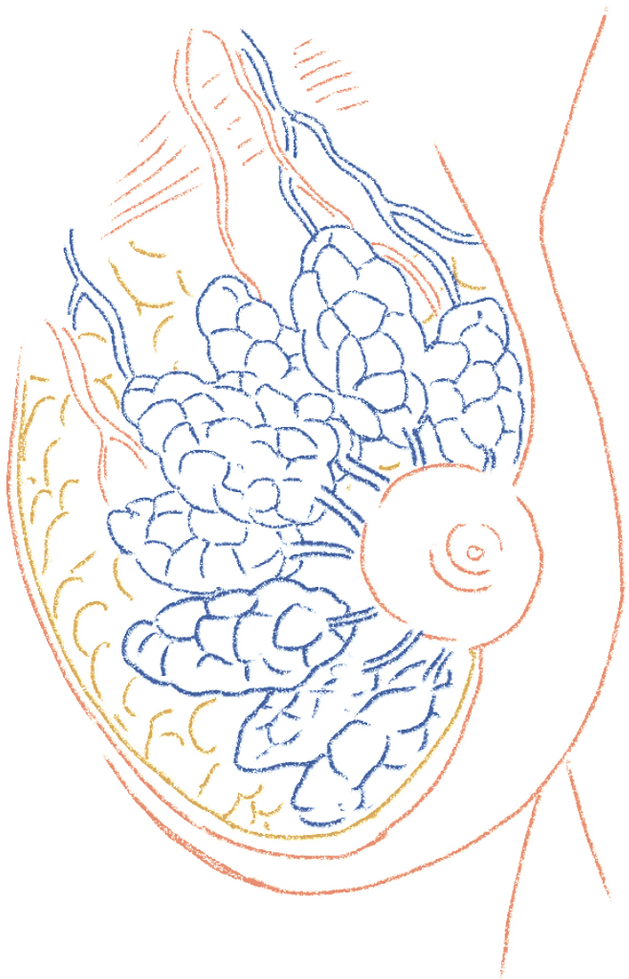
Many trans people find cancer screening very challenging, both physically and emotionally. In each of these instances, fully explain the procedure, why it is important to do, how it works, and what the patient will experience. If you do not already know from prior consultations, ask the trans person what words they use to refer to their relevant body parts.

Follow standard national screening recommendations for other cancers not listed here.

PROSTATE CANCER

For any trans woman or non-binary client AMAB who has a prostate:

- Use a digital rectal examination to evaluate the prostate in trans women (following the national guidelines for cisgender men).
- In trans women who have had a vaginoplasty, the prostate can be palpated in the anterior neovaginal wall. → **See TOPIC 6 for a short section on neovaginal sexual health.**
- If you are doing a PSA test, note that trans women who are on androgen blockers will have suppressed PSA levels.



BREAST CANCER

Anyone with breast tissue may need to be screened for breast cancer based on current guidelines for cisgender women. The guidance for transgender people who have breast tissue is different for transgender men and non-binary people AFAB compared to transgender women and non-binary people AMAB who have developed breast tissue.

Transgender women and non-binary people AMAB

Existing retrospective data on transgender women and the risk of breast cancer have mixed findings, though it appears that transgender women may have a lower risk of breast cancer than the cisgender female population (Deutsch 2016).

There are some factors that may contribute to a reduced risk of breast cancer for transgender women and non-binary people AMAB who have breasts. These include potentially less lifetime overall or cyclical exposure to estrogen and, in some cases, little or no exposure to progesterone. However, transgender women have a high prevalence of dense breasts; this is an independent risk for breast cancer, and a predictor of increased rates of false negative mammograms.

Healthcare providers should talk with patients about their individual risk factors and, where indicated, screen for breast cancer using mammograms based on national guidelines. As with cisgender women, formal clinician or self-breast exams for the purpose of breast cancer screening are not recommended for transgender women.

Transgender men and non-binary people AFAB

Transgender men and non-binary people AFAB who have not undergone bilateral mastectomy, or who have only undergone a breast reduction, should undergo screening according to current guidelines for cisgender women. Therefore, where a patient has had some form of breast or chest reconstruction surgery, it is important to obtain a clear surgical history about the extent and type of surgery.

The risk of breast cancer in residual breast tissues after mastectomy is unknown and no reliable evidence exists to guide the screening of transgender men who have undergone mastectomy.

Mastectomy reduces the incidence and mortality of breast cancer by more than 90% in cisgender women. There is some empirical evidence that breast cancer risk is reduced for trans men after having this procedure; however, the risk does not decrease to that of a cisgender man. There are documented reports of breast cancer in trans patients who have had a mastectomy (Kopetti 2020).

If most or nearly all breast tissue has been removed, a mammography may not be technically feasible to evaluate a palpable lesion. Where available, alternatives such as ultrasound or MRI may be necessary. Some guidelines recommend annual chest wall exams in transgender men after mastectomy. However, this is not based on evidence, and conflicts with the move away from clinician exams in general for cisgender women (Deutsch, 2016).

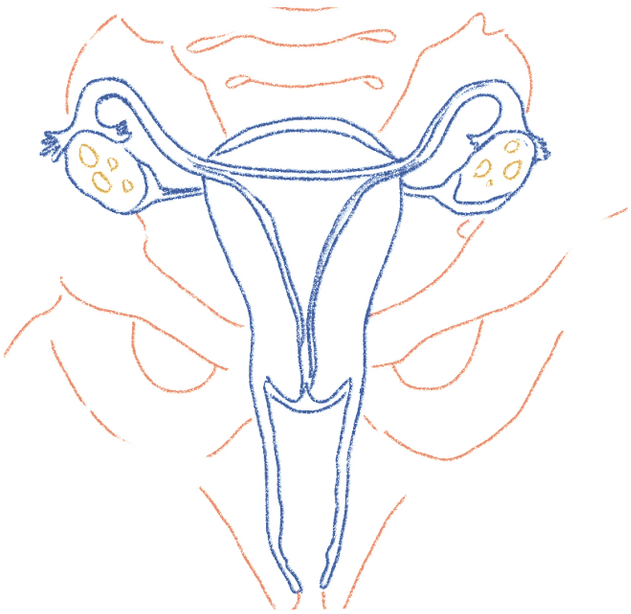
For trans men and non-binary people AFAB:

- Anyone who has not undergone chest reconstruction surgery should be screened for breast cancer according to current guidelines for cisgender / non-transgender women.
- Regular mammograms are also recommended, as per the national guidelines, for trans men and non-binary people AFAB if they have any remaining breast tissue. This includes those who have only had a breast reduction surgery.

The lack of evidence to guide screening has led to calls to systematically collect data to understand what, if any, impact gender-affirming hormones have on the development of breast cancer. This would help identify those trans patients at potential risk of breast cancer, and ultimately define more evidence-based screening and treatment guidelines

CERVICAL CANCER

Transgender women who have undergone vaginoplasty (either using penile tissue or colon graft) do not have a cervix. Therefore, screening for cervical HPV is not required.



Transgender men and non-binary people AFAB with a cervix

- Perform a speculum examination and cervical screening test in accordance with national standards.

A study at Fenway Health, Boston found that trans men avoid pelvic exams. They are less likely to have cervical cancer screening and more likely to have an inadequate pap smear test, particularly if they have been on testosterone for more than six months (Peitzmeier, 2014).

When sending swabs from a trans man for processing, inform the lab that the patient is using testosterone and that it is a cervical, and not an anal, specimen. If your patient is not menstruating (has amenorrhea), also indicate this on the lab form.

Reducing discomfort during a cervical screening test

If your patient is uncomfortable with, or refuses a speculum exam, you might consider discussing these options:

- Prescribe an internal estrogen cream the trans person can take in the week prior to a cervical test, to reduce the discomfort caused by vaginal atrophy and the chance of an inadequate smear test
- Your patient tries inserting the closed speculum, under the guidance of a nurse or doctor who completes the test by opening the speculum and collecting a sample
- Self-collection of swabs for HPV according to national guidelines.

This guidance from a trans health center collates anecdotal experiences about techniques that have helped trans men feel more comfortable having a cervical screening test.

- Use a smaller pediatric speculum to reduce discomfort, though avoid using one so short that it requires excessive external pressure to visualise the cervix.
- Your patient may wish to try moving their buttocks past the end of the examination to encourage pelvic relaxation.
- Taking time to go through a verbal relaxation exercise can be helpful.
- Lubricate a narrow speculum with warm water prior to insertion. This will not compromise test results.
- Using a minimal amount of water-based lubricant on the outer portion of a speculum may reduce patient discomfort while minimally increasing the risk of an unsatisfactory sample.(Hathaway et al 2006, Holton et al 2008). Excessive lubricant should be avoided as studies show conflicting results on the effect of excessive lubricant on test results.
- Place a finger or two in the vagina/front hole and perform posterior pressure while asking the patient to flex and relax their pelvic floor muscles.

SOURCE Hsiao KT. 2016 in Deutsch M (ed.) 2016

OVARIAN CANCER

The current evidence is inconclusive to determine how testosterone affects the risk of ovarian cancer. (Coleman 2012)

For Trans men

- There are no recommended ovarian cancer screening tests for trans men.

UTERINE CANCER

The current evidence is inconclusive to determine how testosterone affects the risk of uterine cancer. (Coleman 2012)In the absence of evidence-based screening guidelines, there are some clinical practice points to consider when screening trans men who have had past or current hormone use:

- If there is spontaneous vaginal bleeding, check if your patient has missed testosterone doses or taken excessive testosterone dosing that may have led to increased estrogen levels.
- In the absence of these or other mitigating factors, evaluate spontaneous vaginal bleeding (as you would for a post-menopausal cisgender woman).

SELF-REFLECTION

Which TWO of the following statements regarding cancer screening for transgender and gender diverse patients are correct?

a. It is insensitive to ask trans people about any previous surgeries or use of soft tissue filler injections to modify their body.

b. For trans people who have not undergone chest or genital reconstruction surgeries, offer cancer screening as per usual guidelines for someone with this anatomy.

c. Patients taking masculinizing hormones do not require cervical cancer screening.

d. Patients taking feminizing hormones do not require prostate cancer screening.

e. Recalls for cancer screening should be based on gender, not sex assigned at birth.

f. Recalls for cancer screening should refer to anatomy, not gender.

The question above is adapted from an online training module developed by Cathy Stephenson, Alex Ker and Rachel Johnson based on an article they jointly published in NZ Doctor (Stephenson et al, 2020).

ANSWER b. and f.

PRACTICE POINTS

- Take a medical and surgical history, using the patient's preferred terms, and create an anatomic inventory.
- Ask trans patients whether they have injected soft tissue fillers into their body, explain the risks, and take a harm reduction approach.
- Ask what words a trans person uses to refer to their relevant parts of their body.
- Reinforce that screening is based on a person's anatomy rather than their gender — "If you have it, check it"
- A trans woman or non-binary person AMAB who still has a prostate should be screened for cancer using the same criteria and risk parameters for cisgender men.
- A trans man or non-binary person AFAB who still has breast tissue or a cervix should be screened for cancer using the same criteria and risk parameters for cisgender women.
- For a transgender woman or non-binary person AMAB who has breasts, talk to them about their individual risk factors and, where indicated, screen for breast cancer using mammograms based on national guidelines.
- The risk of breast cancer in residual breast tissues after mastectomy — including nipples — is unknown. No reliable evidence exists to guide the screening of transgender men who have undergone mastectomy. Talk to your patient about their individual risk factors and, where indicated, consider feasible screening options for breast cancer.

- [x] If your patient is uncomfortable with a speculum examination for a cervical screening test, discuss possible options including estrogen cream or self-collection of a HIV swab.

- [x] The current evidence is inconclusive to determine how testosterone affects the risk of ovarian or uterine cancer for trans men.

- [x] Evaluate spontaneous vaginal bleeding for a transgender man or non-binary person AFAB who is using testosterone, as you would for a post-menopausal cisgender woman.

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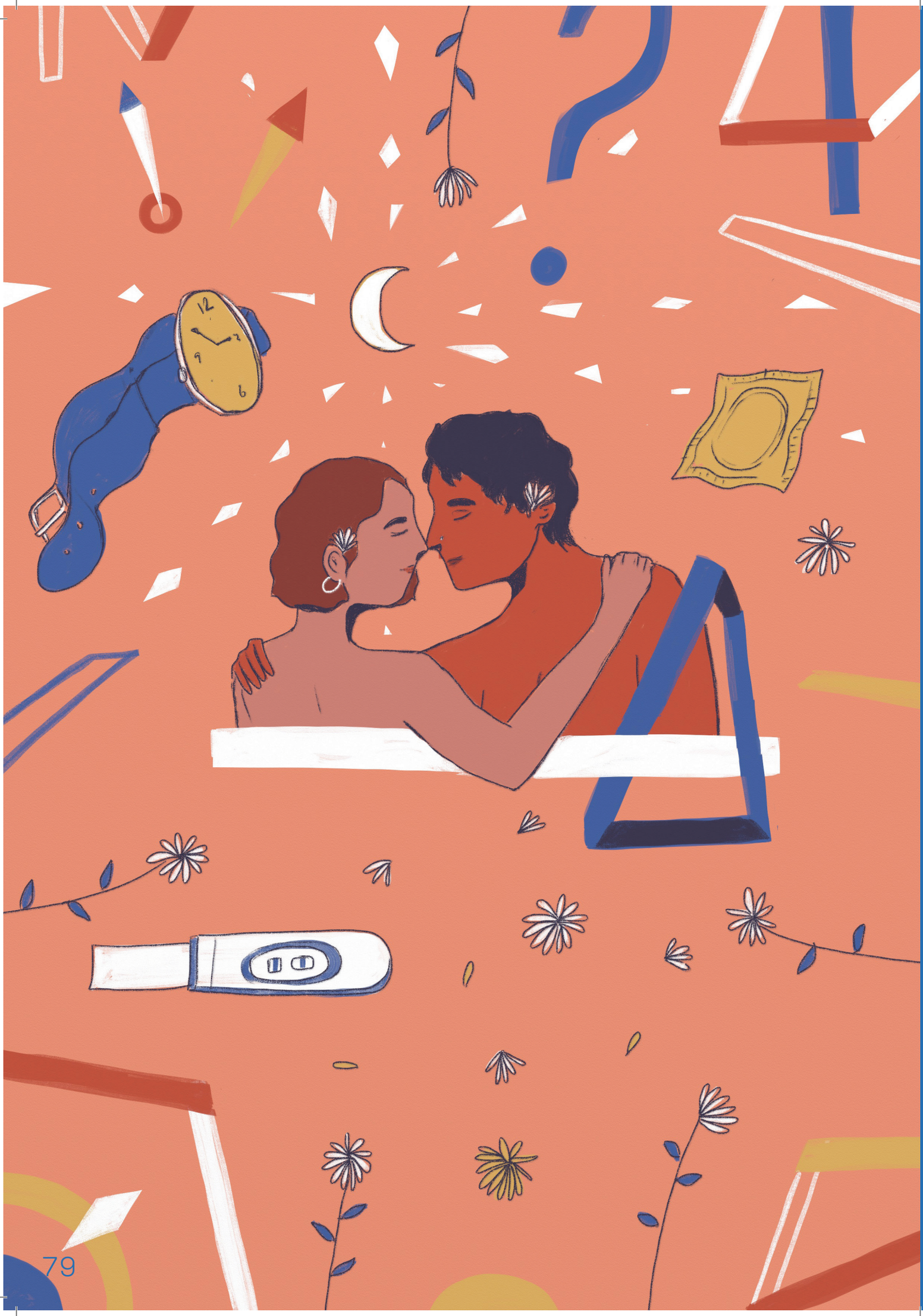


6

Sexual and reproductive health

Learning objectives

1. Understand how to assess STI-related risks for trans patients based on current anatomy and sexual behaviors.

2. Understand how to take a sexual history from trans patients that is trans-inclusive and trans-affirming.

3. Review sexual health issues that may arise for someone who has had gender-affirming genital surgeries.

4. Understand contraception issues and gamete storage options for trans people.

5. Understand trans people's experiences of sexual violence and good practices for supporting trans people after a sexual assault.

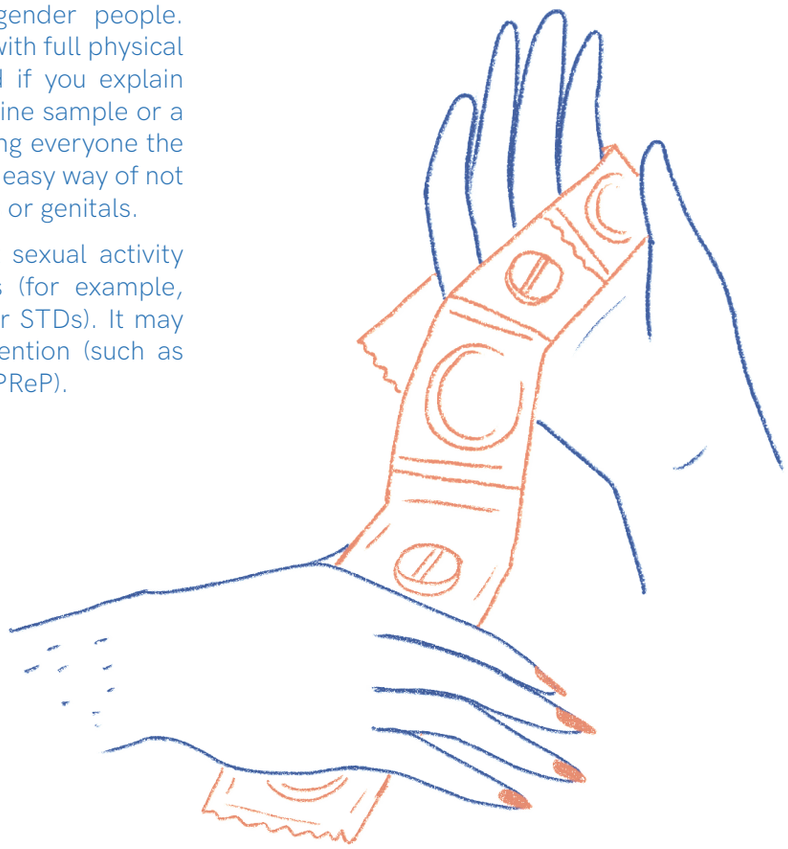
6.1

Importance of sexual and reproductive health

Sexual health history is an important part of a routine medical exam or physical history for anyone. It is integral to a person's general health and associated with happiness, well-being, and longevity.

Clinicians should assess STI-related risks for trans patients based on current anatomy and sexual behaviors. Trans people can be tested for all the same bacterial and viral infections as cisgender people. Many trans people are uncomfortable with full physical examinations. They may be reassured if you explain that some tests can be done using a urine sample or a swab that they take themselves. Offering everyone the option of providing a urine sample is an easy way of not making assumptions about their bodies or genitals.

A person's sexual history and current sexual activity may explain current health problems (for example, those linked to sexual violence or prior STDs). It may determine the need for primary prevention (such as immunizations, contraception, PeP, or PReP).



6.2

Taking a sexual history

Asking about sexual activity is not intimidating if it is normalized in a medical history, as part of a confidential, non-judgmental, professional discussion.

Having some prominently displayed educational sexual health material is useful. Start by explaining why you need to ask these questions, and that these are routine questions that you ask all your patients.

8Ps Sexual History

1 PREFERRED LANGUAGE/ PARTS

I'm going to take a brief sexual history, and I want to respect the words you use to describe your body.

What words do you prefer that I use to discuss your genitals? Are there any other specific words you'd like me to use when I need to talk about parts of your body? To understand what type of screening you need, I have to ask about any lower surgeries that you have had.

2 PARTNERS

Are you having sex? To understand your STI/HIV risk, I need to know a little about your partner or partners. How many partners are you having sex with? Do you have sex with someone who has a penis? Do you have sex with someone who has a vagina?

3 PRACTICES

For the same reason, I also need to understand the kind of sex you are having. Tell me about your sexual activity. Which sexual activities might expose you to a partner's fluids?

4 PROTECTION FOR STIs

How do you protect yourself against STIs including HIV? Do you or any of your partners use a barrier such as a condom, glove, dental dams or take PrEP? Do you use PEP? Have you had any recent unprotected sex that may require PEP?

For trans people, the 5Ps clinical interview for taking a sexual history is often expanded to include three additional elements – preferred language / parts, pleasure, and intimate partner violence. This 8Ps sexual history interview, with some specific trans-inclusive questions, is in the table below. Each of the questions provide valuable information but there may not be time to cover them all in an initial consult.

For some trans people, gender-affirming hormones or surgeries may alter their sexual desires or function. A conversation that asks what changes they've experienced, and what changes they feel comfortable or uncomfortable with, can create space to talk about how you may be able to assist them. For example, some trans women may welcome the impact of estrogen on sexual function while others may wish to discuss altering their hormones or prescribing other medication to counter this.

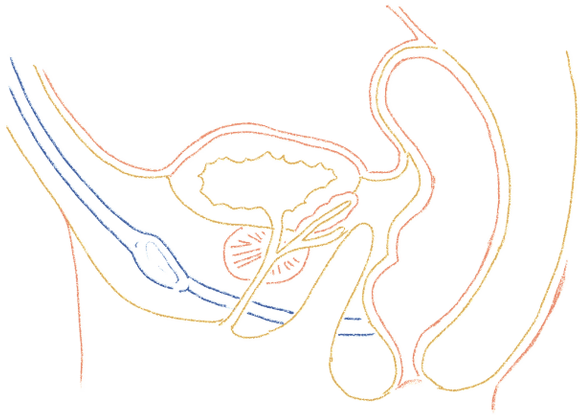
Examples of questions using trans-inclusive terms

5 PAST HISTORY OF STIs	6 PREGNANCY	7 PLEASURE	8 INTIMATE PARTNER VIOLENCE
Have you ever had symptoms of STIs? Have you ever had a sexual health screen check?	Is there a risk of pregnancy from any of the sex you are having? If yes, have you had any recent unprotected sex that may require emergency contraception? Are you currently trying to have a child?	How satisfied are you with how you experience sex? Do you have any pain or discomfort during sex?	Has anyone forced you to do anything sexually? Do you feel unsafe in an intimate relationship?

6.3

Neovaginal sexual health

Supporting your patient's sexual health and wellbeing will involve monitoring how well her neovagina is healing. It may also include providing clinical advice to a trans woman who is exploring sex for the first time after a vaginoplasty.



There are specific things to be aware of when you are performing a vaginal examination for a transgender woman who has a neovagina.

Neovaginal walls are usually made of penile skin, not a mucous membrane. Since the vagina is skin lined, there is a risk of developing the same skin cancers that occur on the penile and scrotal skin, or other skin disorders such as psoriasis. They should be treated similarly to such conditions on external skin.

It is reasonable to consider a yearly visual pelvic exam to look for granulation tissue, warts, or lesions using an anoscope or small vaginal speculum.

If a prostate exam is indicated, it can also be performed from inside the vagina (see the diagram to the right).

There have been a few case reports of STIs and other infections involving the neovagina (e.g., gonorrhea, bacterial vaginosis). When clinically indicated due to symptoms, a physical examination and appropriate testing should be performed.

A vagina created using colon grafts must be visually inspected for evidence of colon cancer following cancer screening guidelines and should be monitored if a patient develops inflammatory bowel disease.

→ **As noted in TOPIC 5, a neovagina does not have a cervix, so cervical screening tests for HPV are not applicable.** Pap smears are also not indicated as the neovagina lining cannot be evaluated with a Pap smear.

6.4

Metoidioplasty, phalloplasty and sexual health

Callen-Lorde Community Health Center in New York has published Pump: a sexual pleasure and health resource guide for trans men who have sex with men (TMSM) (Callen-Lorde 2021).[17] The booklet was produced with input from TMSM communities and experts in trans healthcare to meet a stark information gap about sexual health for TMSM. It is designed for both healthcare providers and trans patients, and includes the following advice about STIs after metoidioplasty or phalloplasty.

Depending on what tissue is moved during surgery, it is very possible to acquire new STIs and HIV after surgery. The new urethra can be lined with tissue vulnerable to infection, and those of us who had surgery can get STIs in our new urethras. Testing urine for gonorrhea and chlamydia is needed if you have been having sex without a condom in that part of your body after surgery.

If you have urethral lengthening and still have your vagina, and have sex with your vagina, receiving a separate test for infections that can be local to the vagina is necessary, as the urethra is now in a different location. This test can be done with a swab of the area instead of by testing urine.

If your penis does not contain any urethra, some STIs can still be spread via skin-to-skin contact, such as herpes and syphilis. In addition, cuts on a new penis . . . including very small cuts from shaving extra hair from the penis before sex, would leave you more open to infections transmitted via blood like HIV.

CALLEN-LORDE. 2021. PUMP: A SEXUAL PLEASURE AND HEALTH RESOURCE GUIDE FOR TRANS MEN WHO HAVE SEX WITH MEN. HTTP://CALLEN-LORDE.ORG/GRAPHICS/2021/02/PUMP-TMSM-HEALTH-GUIDE_FINAL_V3.2.PDF

[17] http://callen-lorde.org/graphics/2021/02/PUMP-TMSM-Health-Guide_Final_V3.2.pdf

6.5

Reproductive health

Fertility preservation should be discussed with trans and gender diverse people before they start puberty suppression or gender-affirming hormone therapy.

Fertility preservation should be discussed with trans and gender diverse people before they start puberty suppression or gender-affirming hormone therapy.

Using gender-affirming hormones may reduce fertility; this may be permanent even if hormones are discontinued.

Estrogen may have the effect of reducing libido, erectile function, and ejaculation in trans women. Testosterone generally increases libido.

If required, an internal genital examination should be based on a client's past and recent sexual history, and whether the person is comfortable with examination. A discussion of any concerns and benefits of the procedure should precede any physical examination. Use a gloved finger, and/or an appropriate-sized speculum.

GAMETE STORAGE

Gonadotropin Releasing Hormones (GnRH) agonists/ puberty blockers are reversible, and should not affect long-term fertility. However, it is important that children and young people are given developmentally appropriate information about the options available for them now and in the future.

Where it is possible and affordable to store sperm, this should be considered prior to going on puberty blockers.

For those considering taking feminizing hormones who have reached at least Tanner stage 3, it is recommended that cryopreservation of sperm be considered, where this is an available and affordable option. For those in early adolescence (Tanner stage 2-3), collection of mature sperm will not usually be possible as mature sperm are produced from mid puberty (Tanner stage 3-4) onwards. Sperm can be collected and stored later, prior to decisions about starting gender-affirming hormones, However, adolescents are often reluctant to have the break from puberty blockers, which is required for storing sperm, due to the risk of masculinization. Cryopreservation of testicular tissue obtained via biopsy is being offered in some countries but is considered experimental.

For those considering taking masculinising hormones, the option of egg or ovarian tissue storage should be discussed, if it is available. However, this involves invasive procedures. There is not the same pressure to harvest eggs before starting gender-affirming hormones. This is because there is no current evidence to suggest that testosterone exposure affects the likelihood of future healthy egg harvesting.

CONTRACEPTION ADVICE

Some trans people are in sexual relationships where pregnancy is possible, and may seek contraception, a pregnancy test, or an abortion.

Testosterone alone is not an effective form of contraception for trans men and gender diverse people who have a uterus. Similarly, estrogen and/or progesterone alone are not an effective form of contraception for trans women and gender diverse people with penises, even after long term use.

Ask patients about their sexual behaviors and partners, to clarify if they need information about contraception options.

Trans men and contraception

It is important that contraception advice is provided, prior to starting testosterone. Testosterone therapy does not provide a guarantee of adequate contraception and is contraindicated in pregnancy because of potential harm to the fetus from the androgenizing effects of treatment. Trans men having unprotected sex with non-trans men are at risk of pregnancy as well as STIs.

Consider offering trans men who have sex with men (trans MSM) appropriate contraceptive options that do not lead to unwanted systemic feminization. Progesterone-based Long Acting Reversible Contraception (LARCs) such as (Depo provera®, Jadelle®) or IUDs (Mirena®)/IUCDs are suitable options for contraception, while condoms provide additional protection against STIs. The insertion of an IUD may be more painful and technically more challenging in someone who has some cervical atrophy from testosterone therapy.

6.6

Sexual assault

In the broadest terms, "gender-based violence" is violence that is directed at an individual based on their biological sex, their gender identity, or when their gender expression is perceived to infringe socially defined norms of masculinity and femininity (Khan, 2011).

Violence against trans people because of their gender identity or gender expression is a form of GBV (Betron and Gonzalez-Figueroa, 2009).

Gender-based violence includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. When targeted against transgender people, gender-based violence frequently includes trans-specific power and control tactics. For example, these might include:

- Undermining a trans person's identity through using incorrect name, gender of pronoun, or ridiculing their body
- Threatening to disclose someone's trans status
- Controlling a person's gender expression or declaring they are not a 'real' woman or man or
- Denying or controlling access to hormones or other medical treatment

Trans people experience very high rates of sexual violence. Chapter 3 of the Asia Pacific Trans Health Blueprint cites both quantitative data and qualitative research from many countries in Asia and the Pacific documenting sexual violence against trans women (Health Policy Project, APTN and UNDP 2015). At that time, there was no quantitative data in this region about gender-based violence against trans men.

Here & Now is a set of online resources for and by trans people and healthcare professionals supporting trans people who have experienced sexual assault.[18] It contains two animations for healthcare professionals, included in this module, and two other animations for community members. This first resource includes a clinician and community members talking about trans people's experiences of sexual violence, and how to make it easier for trans people to seek support from healthcare providers.

SOURCE TransHub's Here and Now campaign: transhub.org.au/herenow

VIDEO LINK https://youtu.be/nwwQo5pAhzw

[18] Find the videos and other information transhub.org.au/herenow
This project was funded by, and created in close collaboration with the Prevention and Response to Violence and Neglect unit (PARVAN) at the New South Wales Ministry of Health.

Statistics on sexual assault across Asia Pacific

AUSTRALIA

TRANS PARTICIPANTS

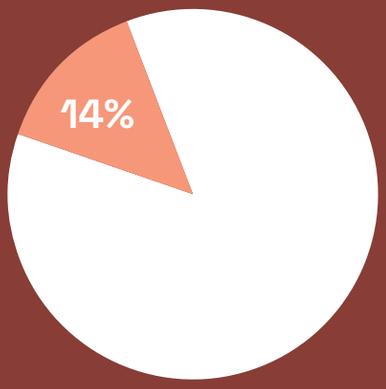
Callander et al 2018

Reporting at least one incidence of sexual assault

Trans Persons

With higher rates among trans men and non binary people AFAB

General Population



<50%

of **trans people** sampled in Australia ever told anyone or sought support following a sexual assault

Recent research by Australia's National Research Organisation for Women's Safety found that **trans women of colour, living in Australia**, were more likely than **cisgender women** to report having been sexually assaulted by a stranger

Ussher et al 2020.

AOTEAROA, NEW ZEALAND

1178
PARTICIPANTS

→ Trans men
→ Trans women
→ Non binary persons

Reported someone having had sex with them against their will

2-3x↑
Higher than **Women** in the general population

7-12x↑
Higher than **Men** in the general population

Veale et al 2019

11% of **trans or non-binary people** who experienced sexual violence ever sought support from a rape or sexual abuse service.

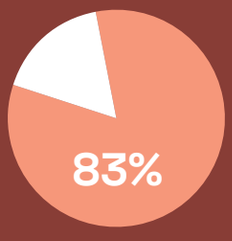
3% of **trans or non-binary people** who experienced sexual violence approached the police at that time.

FIJI

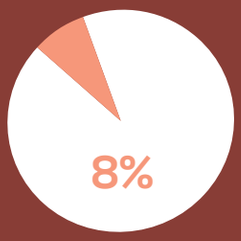
645
PARTICIPANTS

→ Lesbians
→ Bisexual women
→ Trans men
→ Trans masculine persons
→ Gender non-conforming persons

Reporting physical / sexual assault as per perpetrator



Participants said they experienced physical and/or sexual violence by an intimate partner.



Participants said they experienced sexual assault by a family member

DIVA 2019

Screening for GBV / IPV

Guidance about screening for gender-based violence (GBV) and intimate partner violence (IPV) typically focus solely on (cisgender) women and rarely mention transgender people. Given the high rates of violence experienced by trans people, across all gender identities, screening for GBV and IPV should be done equally as often with trans patients (Peitzmeier et al, 2020). This might include an initial intake screening and follow-up visits.

A pilot project in Thailand and Mexico on screening within HIV clinics for violence against trans women and MSM emphasized the importance of creating a safe, private space for such screening. This included ensuring staff were respectful of trans people, aware of legal protections against violence, and able to provide support when trans patients disclosed experiences of violence, or to make referrals to other organizations (Betron, 2009).

Supporting trans people after sexual assault

Service providers should be trained in how to provide first-line response for survivors of gender-based violence, as well as how to refer to other service providers as needed and requested. This module focuses on some of the specific challenges trans people may face when they experience gender-based violence.

Sexual assault affects the lives of many trans people, and yet we know that less than half of trans people sampled in Australia ever told anyone or sought support following a sexual assault (Callander et al., 2018). In New Zealand, only 11% of trans or non-binary people who experienced sexual violence ever sought support from a rape or sexual abuse service and only 3% approached the police at that time. Trans communities can have a complex history and relationship with police, especially in countries where trans women are targeted under laws criminalizing sex work, so-called 'cross-dressing', homosexuality or begging, or under vagrancy or public nuisance provisions (UNDP and APTN 2017).

Making your service or practice gender-affirming will help ensure trans patients feel safe, supported, and respected, and they are more likely to seek and receive the support they need after a sexual assault. Topic 4 covered many of the steps you can take to create an affirming and inclusive environment for all your trans patients. For example, these include having affirming intake forms, displaying trans flags, posters, and health promotion resources, and having bathroom facilities for people of all genders.

Demonstrating support for trans sexual assault survivors

Specific ways you can show your professional support for trans people accessing your service after they experienced sexual assault.

Respecting self-determination

Support your patient to decide how they access support after a sexual assault by providing them with the information they need and empowering them to make the decisions that are best for them. This may require taking longer to acknowledge past negative experiences and talk through possible options, respecting their autonomy when it comes to making decisions.

Affirming your patient's gender

Check your practice records to see if they include information about the terms your patient uses to refer to parts of their body.

Knowing your patient's rights

After experiencing sexual assault, a patient may be traumatised, disoriented, distracted, or have a range of other feelings and emotions. Even in cases where your patient seems okay, they may not have a good understanding of their rights. Being able to inform a patient of their options and rights can help empower them to start making decisions.

Your patient has a right to:

- Make decisions about what services they want to attend, and what they want to happen there
- Not consent to any procedures or testing after a sexual assault, or to subsequently withdraw consent

Knowing what a complaint to the police entails

There are many reasons why trans people may be hesitant or uninterested in approaching police even after being the victim of a crime. Respecting these feelings and decisions is important.

When working with trans people who have experienced sexual assault, it can be helpful to outline exactly what going to the police could mean, what their rights are, and what support is available for them.

SOURCE TransHub's Here and Now campaign: transhub.org.au/herenow

VIDEO LINK https://youtu.be/9iXkxO4iPbk

SELF-REFLECTION

What steps does your practice take to support people who have experienced gender-based violence or intimate partner violence?

Do trans people access this support?

Are there ways these services could be more accessible or welcoming for trans people?

PRACTICE POINTS

- Create welcoming clinical sites where trans people feel safe to disclose their gender identity, bodily diversity, and sexual behavior.
- Assess STI-related risks for trans patients based on current anatomy and sexual behaviors.
- Adapt general sexual history questions to make the language trans-inclusive and by adding three extra elements – preferred language (parts), pleasure and intimate partner violence.
- Trans women and non-binary people AMAB who have a neovagina do not require a pap smear or cervical screening test.
- Fertility preservation should be discussed with trans and gender diverse people before they start puberty suppression or gender-affirming hormone therapy.
- Gender-affirming hormones alone are not an effective form of contraception. Ask patients about their sexual behaviors and partners to clarify if they need information about contraception options.
- Screen trans patients for experiences of gender-based violence as regularly as you screen women and girls, given their shared high risk of violence.
- When a trans patient has experienced a sexual assault, affirm their gender, provide information about their rights and support options so they are empowered to make the decisions that are best for them, including about whether they wish to talk to the police.

RESOURCES

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License details: https://creativecommons.org/licenses/by-nc-nd/4.0/

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Pref

7

HIV prevention, care, and treatment

Learning objectives

1. Understand the interrelated nature of HIV service delivery and gender-affirming services.
2. Review the HIV prevention, care, and testing cascade testing and updated 2025 targets
3. Understand the HIV burden for trans women in this region.
4. Note the lack of data about HIV infection and risk for trans men in this region.
5. Review PrEP and PEP guidance for trans people, and recent research about interactions between HIV medications and gender-affirming hormones.

7.1

Introduction

Before covering practical information for healthcare providers about HIV prevention, care and treatment for trans people, it is useful to emphasize the strong links between this area of healthcare and the provision of gender-affirming healthcare services.

For example, in this region, sexual health services play a pivotal role as frontline providers for both types of healthcare. Trans people are more likely to access HIV prevention, care and treatment if services also enable them to access gender-affirming healthcare such as hormones. Health services that better meet the needs of trans clients will be better positioned to offer HIV prevention, testing and treatment services for this population as well.

This topic starts by reviewing the HIV services cascade before looking at the HIV burden for trans women in this region and the very limited data about the experiences of trans men. It then focuses on providing trans-specific information about PrEP and PEP, and drug to drug interactions between HIV medications and gender-affirming hormones.

→ **'Taking a Sexual History' in TOPIC 6 covered the steps needed to do a risk assessment for STIs, including HIV.**

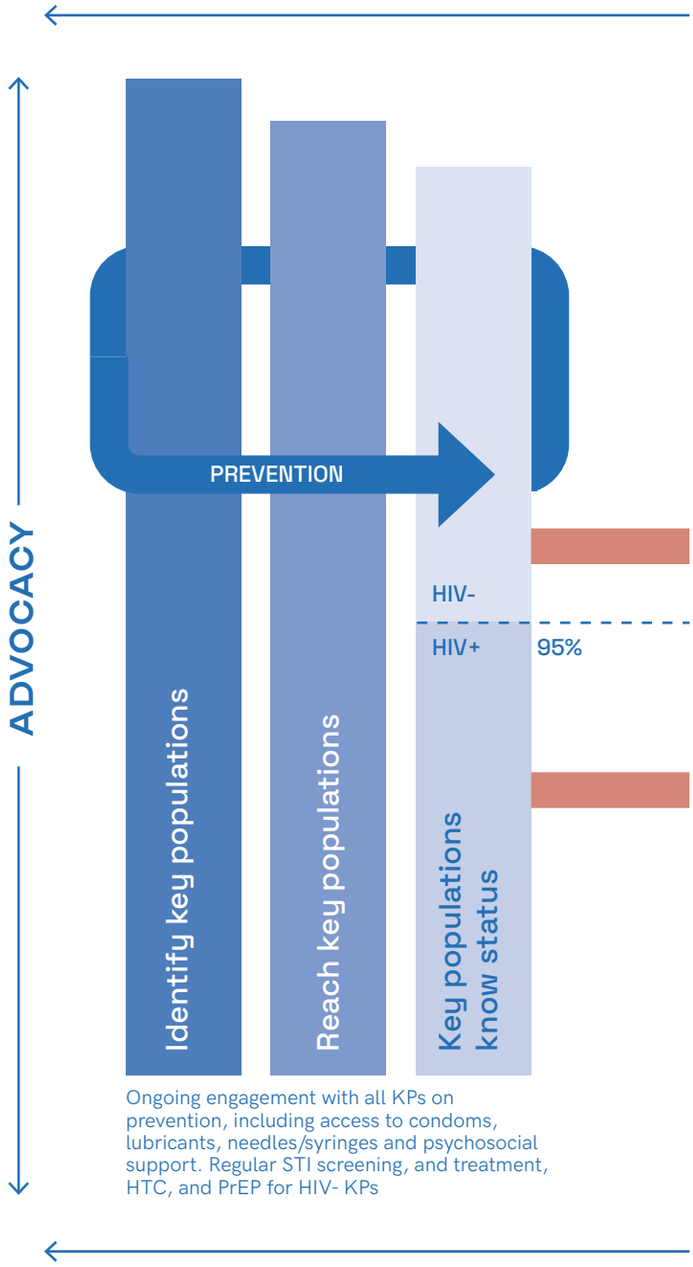
7.2

HIV prevention, care and treatment cascade

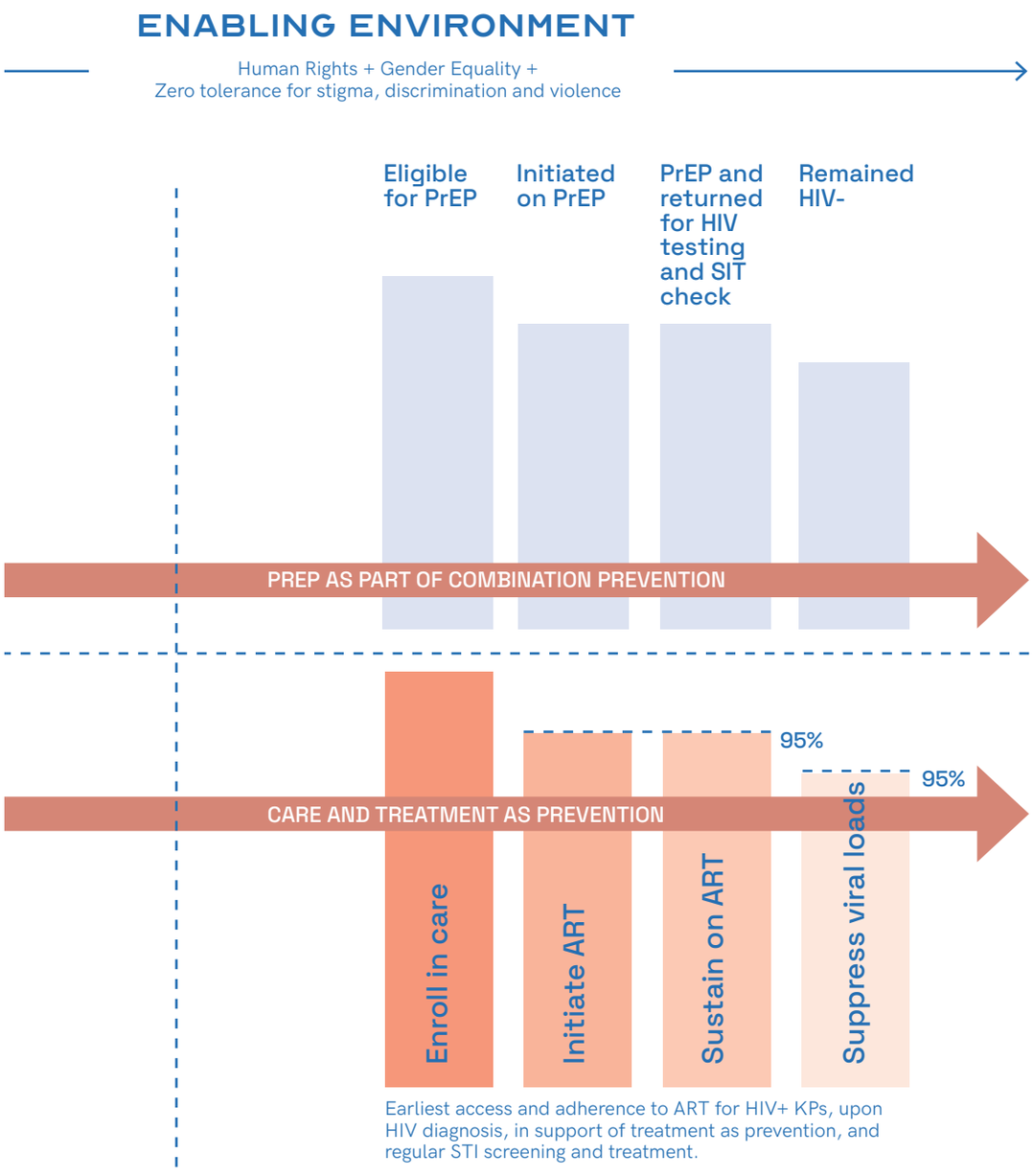
HIV counselling and voluntary testing for HIV and other STIs should be offered routinely to trans people, both in community and clinical settings (WHO, 2014). This should be part of a comprehensive and integrated program of services ensuring that trans people have early and sustained access to targeted HIV prevention, care, and treatment services.

This model is sometimes referred to as a "cascade" of HIV services.[19]

The HIV services cascade depicts how successful HIV programming requires strong linkages between prevention, care and treatment. This means that HIV transmission is interrupted, and that HIV-positive individuals are identified in the early stages of infection and successfully linked to long-term, sustainable antiretroviral (ARV) treatment. Greater connection between different interventions is needed to ensure that fewer people are lost to follow-up as they move across the cascade of services. Trans people are more likely than cis people to fall through these gaps, and this is heightened for specific groups including trans sex workers, drug users, and youth.

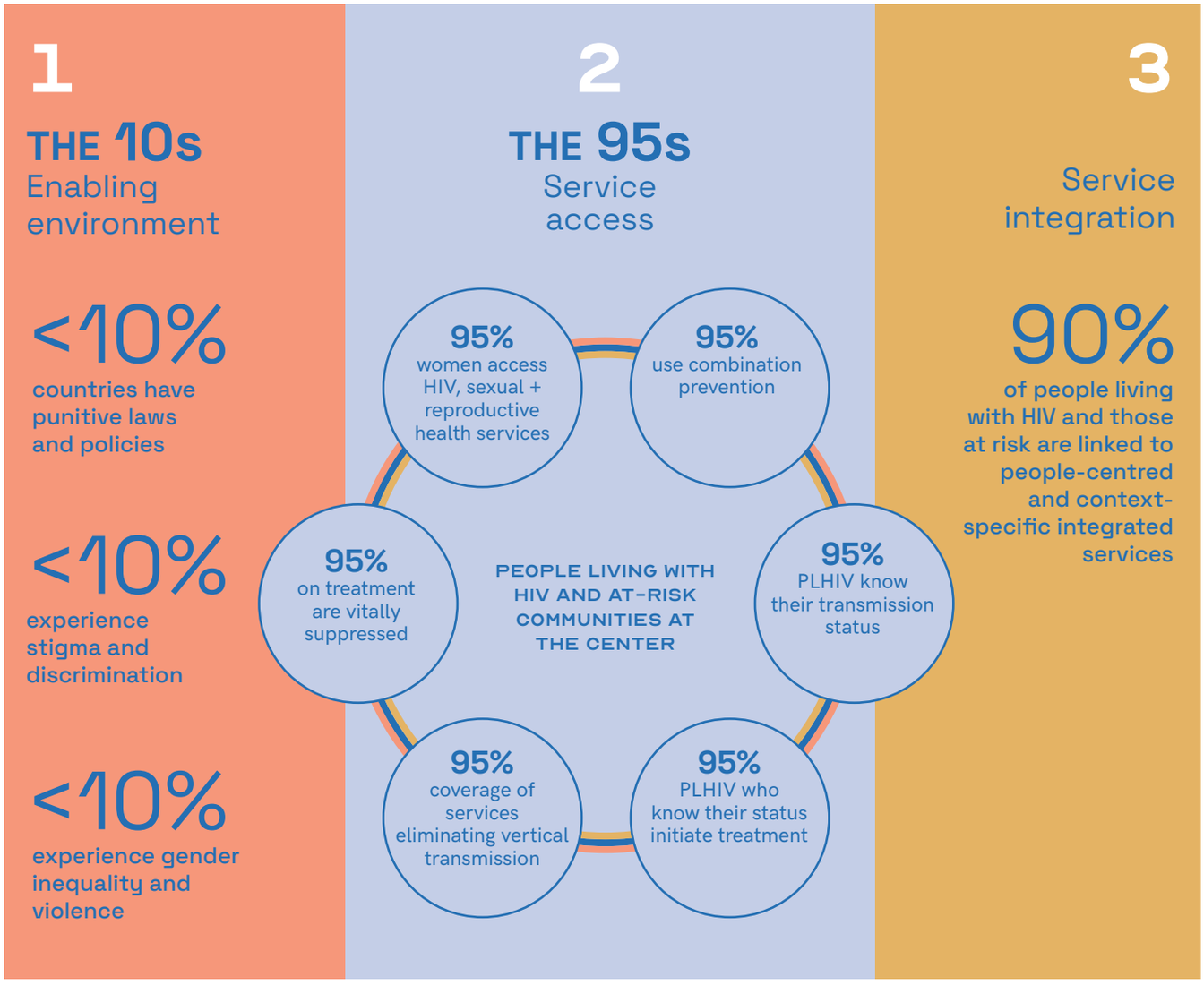


[19] ADAPTED FROM SOURCE FHI 360: https://www.fhi360.org/projects/meeting-targets-and-maintaining-epidemic-control-epic



EpiC
Meeting Targets and Maintaining Epidemic Control

Global AIDS targets for 2025



ADAPTED FROM SOURCE UNAIDS 2020. Prevailing against pandemics by putting people at the centre

In 2016, the United Nations General Assembly's Political Declaration on Ending AIDS committed countries to the 90-90-90 targets. These targets describe a pathway aiming to bring HIV testing and treatment to the vast majority of people living with HIV, to reduce the amount of HIV in their bodies to undetectable levels, so they keep healthy, and to prevent the further spread of the virus.

HIV programming for trans populations should identify specific gaps, propose strategies to improve linkages, and monitor program performance across the cascade. This is vital to ensure that trans people can access HIV services that do no harm, and are sensitive to trans health and HIV needs.

The 90-90-90 targets, known as the 'Fast-Track' era, ran from 2014 until December 2020. They are now updated by the 'Global AIDS Targets 2025' leading towards ending AIDS as a public health threat by 2030. These 2025 targets focus on three interlinked areas – the enabling environment (known as 'the 10s'), service access ('the 95s'), and service integration – with at-risk communities and people living with HIV at the center.

The enabling environment targets include that less than 10% of countries have punitive laws and policies, and less than 10% of key populations, including transgender people, experience stigma and discrimination, or gender inequality and violence.

7.3

HIV burden for trans women

Available data consistently show that trans women are disproportionately affected by HIV. They are more likely to be HIV positive than the cisgender population.

A 2013 meta-analysis of studies published globally between 2000 and 2011 showed that the pooled HIV prevalence rate for trans women was 19.1 percent, and they were 49 times more likely to acquire HIV than the general adult population (Baral et al., 2013). This meta-analysis noted the structural risks for HIV infection that transgender women face including social exclusion, economic marginalization, and unmet healthcare needs. In doing so, it echoed earlier concerns that high rates of HIV infection among trans women in this region are strongly linked to stigma and prejudice (Winter 2012).

The Baral et al. meta-analysis included data from five countries in Asia: India, Indonesia, Thailand, Vietnam, and Pakistan. In all five countries, trans women were more likely to be living with HIV than the general adult population, with the disease burden particularly high in India and Indonesia. Other recent studies, summarized in the tables below, show that prevalence amongst trans women living in urban cities or states is even higher than national prevalence levels.[20]

HIV PREVALENCE FOR TRANS WOMEN

19.1%

LIKELIHOOD OF ACQUIRING HIV THAN GENERAL POPULATION

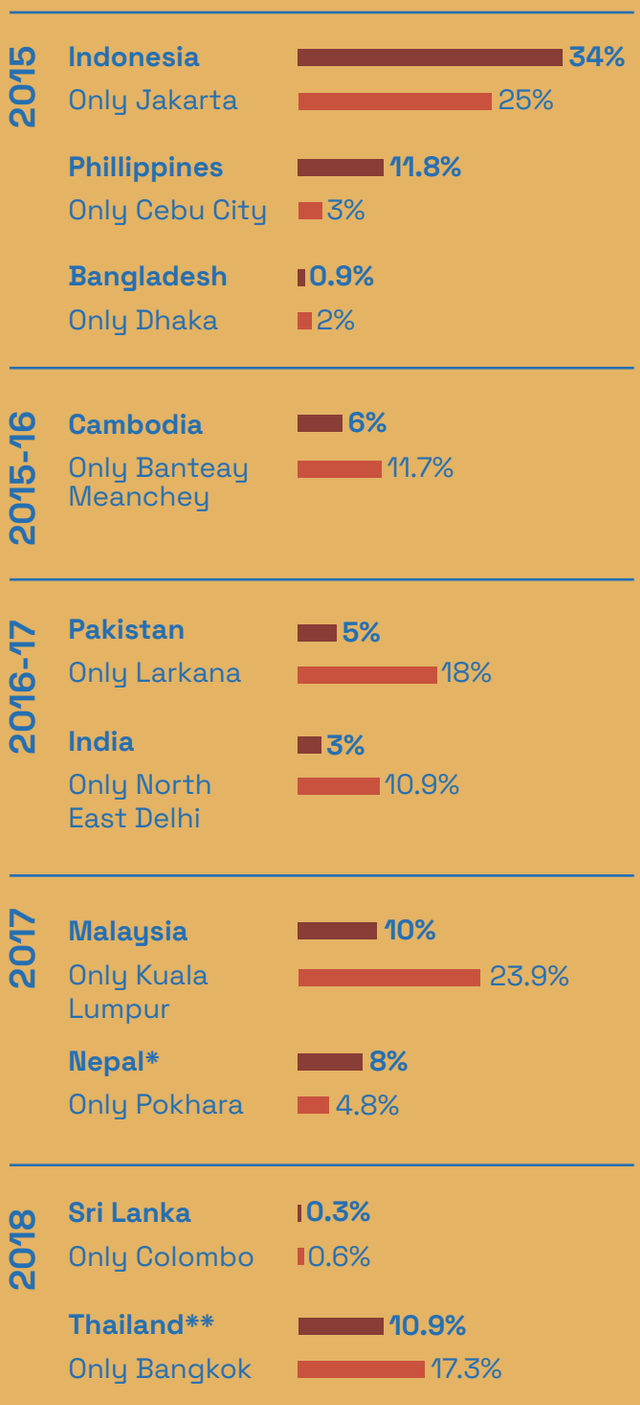
49x

2000 → 2011

[20] https://www.aidsdatahub.org/resource/transgender-slides

Available data about transgender women indicates higher HIV prevalence in certain geographical areas in selected countries

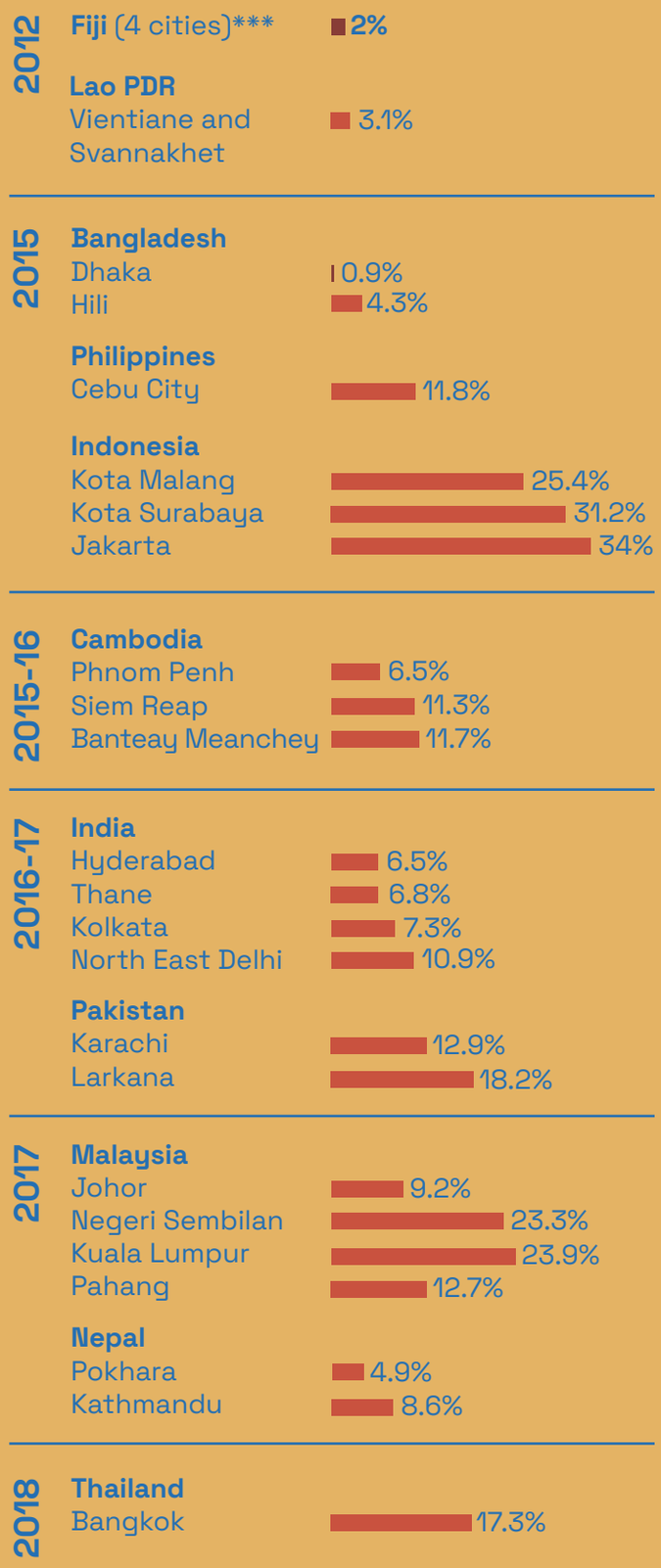
National versus location specific HIV prevalence among transgender, among countries where data is available, 2016 - 2018.



*Data for Kathmandu is reported as national data for Nepal. **4 cities (Bangkok, Chiang Mei, Chonbury, Phuket) **ADAPTED FROM SOURCE** Prepared by www.aidsdatahub.org based on HIV Sentinel Surveillance Reports, Integrated Biological and Behavioural Surveillance Reports and other serological survey reports.

High HIV prevalence among trans women observed in certain cities and geographical locations

HIV prevalence among transgender people, 2012 - 2018.



***TG sex workers in Suva, Nadi, Lautoka, Labasa. **ADAPTED FROM SOURCE** Prepared by www.aidsdatahub.org based on HIV Sentinel Surveillance Reports, Integrated Biological and Behavioural Surveillance Reports and other serological survey reports.

7.4

HIV prevalence of trans men and non-binary people AFAB

There is a paucity of data on HIV infection in trans men and non-binary people AFAB, making it very difficult to assess HIV risk in this population (Reisner 2016).

The very limited research evidence is almost solely based on small convenience samples in North America where self-reported prevalence among trans MSM has ranged from 0 to 5.9% (Scheim et al 2016). These prevalence estimates are low compared to transgender women and cisgender MSM (Baral 2013). However, the higher estimates are much greater than HIV prevalence in the adult populations of Canada and the United States. There is no data about the prevalence of HIV amongst trans men in Asia.

7.5

Awareness and testing

Data shows significant gaps remain in HIV knowledge and testing among transgender women in this region, and in HIV prevention and testing coverage of most national responses.

APTN KPRA

Key Populations Research and Advocacy Project

It found most transgender people across all countries were aware of STIs and HIV. Use of preventative and prophylactic treatments like PEP and PrEP were low across the four countries.

Trans women in all four countries, and third gender participants in Nepal, were tested for HIV at much higher rates than trans men.

Nepal

250 PARTICIPANTS

PARTICIPANTS THAT HAD NEVER SEEN A DOCTOR

48.4% TO GET PEP

42.8% TO GET PrEP

The number of Nepal survey participants people using PEP every three months was less than 10, as was the number using PrEP.

Thailand

250 PARTICIPANTS

PARTICIPANTS THAT HAD NEVER SEEN A HEALTHCARE PROVIDER

79.6% FOR PEP

72.3% FOR PrEP

In Thailand most participants said they had never visited a doctor specifically for these reasons.

There is no national data on the experiences of trans men, or discussion about the experiences of non-binary people.

APTN worked with trans community researchers on the KPRA Project, first in the region to also gather data on trans men.

FROM JULY 2018 - LATE 2020

1000 PARTICIPANTS

Low self-perceived risk of exposure and fear of stigma were the most common reasons for transgender people not being tested.

In addition, many trans men believed that they could not get HIV if their only sexual partner/s were cisgender women.

Indonesia

250 PARTICIPANTS

PARTICIPANTS WHO DID NOT KNOW IF THEY HAD VISITED A DOCTOR

65.6%

FOR EITHER PEP OR PrEP

Awareness was lowest in Indonesia.

Vietnam

250 PARTICIPANTS

PARTICIPANTS THAT HAD NEVER SEEN A HEALTHCARE PROVIDER

70.6%

FOR PEP

63.5%

FOR PrEP

In Vietnam most participants said they had never visited a doctor specifically for these reasons.

7.6

HIV medication for prevention and treatment

Once enrolled in a treatment program, HIV-positive trans people may follow the same antiretroviral therapy (ART) national guidelines in the same way as other HIV positive people.

ART and gender-affirming hormones

Currently there are no documented serious drug interactions between gender-affirming hormones and first-line antiretrovirals (ARVs).

For trans women and non-binary people taking estrogen, some HIV medicines have the potential to reduce estrogen levels. Options include adjusting estrogen dosing or using HIV medicines that have no interactions. This decision should be individualized for each patient, depending on their HIV treatment history and available choices.

For trans men and non-binary people taking testosterone, some HIV medicines have the potential to either increase or decrease levels of testosterone. Although there have not been many direct studies, the type of interaction depends on the type of HIV drug. Protease inhibitors (e.g. atazanavir, adrunavir and ritonavir) may increase levels of testosterone, while some NNRTIs (e.g. efavirenz, etravirine and nevirapine) may decreased testosterone levels. The easiest option is to choose a combination which has no interactions.

Liverpool University has an excellent online drug-interaction resource: http://www.HIV-druginteractions.org. The online drug interaction charts let you first select HIV medicines, and then check potential interactions by generic name or by drug class.

For many trans people, the need for hormones to affirm their gender will override other health concerns, including about HIV or STIs. Discuss the advantages and disadvantages of different HIV medicines for your patient's individual care. This gives all patients more information to make informed choices. It can be an important harm reduction step if your patient obtains hormones online, from friends, or from other unregulated sources. Explain the risks of unregulated hormones, and try to provide access to regulated supplies, if possible.

PrEP and PEP

When you are asking a patient about their sexual health history, the information they provide may show they are at risk of acquiring HIV. PEP and PrEP are effective methods of preventing HIV infection, and are safe to use with affirming hormones. The following information is to be read alongside any national guidelines and recommendations for the use of PrEP and PEP.

'Pre-Exposure Prophylaxis' (PrEP) involves HIV negative people taking antiretroviral drugs to protect them and prevent HIV infection. PrEP is safe and effective for people who are transgender or gender diverse.

Dosing choices depend on the type of sexual behavior, but generally daily dosing is recommended.

Anyone having vaginal / frontal sex needs to take daily PrEP at least six days a week. This is to make sure PrEP levels are high enough in these tissues to provide protection. Trans men and non-binary people taking testosterone are likely to have less natural lubrication and thinner tissue inside their vagina / front hole. There is no specific research on whether this may make PrEP less effective or change how long it takes for PrEP to reach protective levels. However, this is another reason why daily PrEP is the recommended option for trans men.

Some people take PrEP 'on-demand', just before and after a sexual encounter. This non-daily or 'event-based' dosing for PrEP involves taking four pills, some just before a sexual encounter and some soon afterwards. There is not yet enough research to show that this is safe for trans or gender diverse people.

Therefore, daily dosing is currently the only recommended PrEP regime for trans women and non-binary people AMAB using feminizing hormones and for trans men or non-binary people AFAB who have frontal sex.

PrEP is very safe with hormone treatment and does not affect hormone levels. However, recent research in Thailand and the United States have found that feminizing hormones may reduce the efficacy of one of the ingredients of PrEP (Hiransuthikul et al 2019, Cottrell et al 2019). It is unclear if this means that PrEP is less effective, but it does mean PrEP is slightly more complicated for trans people using feminizing hormones. More research is needed to clarify the clinical significance of this drug-hormone interaction in order to improve HIV prevention and care for transgender women. This includes exploring any interactions between gender-affirming hormones and the TAF/FTC formulation of PrEP that will be more common in the region in generic forms of PrEP.

The implication is that transgender women may avoid PrEP or miss doses because of concerns that PrEP will lower their estrogen levels. Healthcare professionals may wish to address this directly with transgender patients taking feminizing hormones. Providing reassurance about monitoring your patients' estrogen levels may improve their willingness to take and adhere to PrEP.

There is very limited research about trans men and PrEP. One recent U.S. national study of trans MSM found that PrEP uptake was modest, despite the fact that more than half of those sampled being PrEP users indicated a high prevalence of sexual behaviors that posed a risk of HIV acquisition (Reisner et al 2021). There is no data about the efficacy of specific PrEP formulations for transgender men who have sex with men or with transgender women (Vail 2020).

'Post-Exposure Prophylaxis' (PEP) involves a four-week course of HIV treatment after a recent exposure to HIV. PEP stops the virus from replicating, so the cells originally infected with HIV die naturally within a short period of time. This reduces the risk that HIV will establish itself in the body.[21]

If PEP is available, it is for anyone who thinks they may have been exposed to HIV, whether they are transgender or cisgender. Anyone who has been exposed to HIV should start PEP as soon as possible, ideally within a few hours after the risk event. If it is not started within 72 hours (three days) of exposure to HIV, it is likely that treatment will not work.

[21] ASHM. 2016. Post-Exposure Prophylaxis after Non-Occupational and Occupational exposure to HIV. Australian National Guidelines (Second edition). Accessed 16 April 2021 at: http://www.pep.guidelines.org.au/

SELF-REFLECTION

What opportunities exist in your practice to:

Promote trans-specific information about HIV, PrEP, and PEP, and about ARV and gender-affirming hormones to all your trans patients

Address misinformation and stereotypes about HIV prevention that are held by trans people, including trans men

Integrate access to gender-affirming healthcare with HIV prevention, care, and treatment?

PRACTICE POINTS

- Talk about HIV prevention with all patients, focusing on sexual behaviour and risks, to help counter myths about HIV and stigma against people who are HIV positive.
- Reassure trans people living with HIV that there are safe ways to take gender-affirming hormones and HIV medicines, and you can help identify the combination that will work best for them.
- Where PEP and PrEP are available, advise trans patients that these can be used alongside gender-affirming hormones and that daily, rather than on-demand, dosing is recommended for PrEP.

RESOURCES

Links to sexual health resources for trans and non-binary people, collated by a United Kingdom trans and non-binary holistic wellbeing and sexual health service: https://cliniq.org.uk/resources/

Liverpool University's online drug-interaction resource: http://www.hiv-druginteractions.org.

ASHM. 2016. Post-Exposure Prophylaxis after Non-Occupational and Occupational exposure to HIV. Australian National Guidelines (Second edition): http://www.pep.guidelines.org.au/

Asia Pacific Trans Health Blueprint, section 4.4. pages 81-84: https://weareaptn.org/2017/06/01/blueprint-for-the-provision-of-comprehensive-care-for-trans-people/ Also available in Thai and Chinese from https://weareaptn.org/publications/

https://www.aidsdatahub.org/resource/transgender-slides

Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) PrEP Guidelines Update. Prevent HIV by Prescribing PrEP Sydney, 2019. This includes specific information for both trans women and trans men: http://prepguidelines.com.au/

Baral, S.D., Poteat, T., Strömdahl, S., Wirtz, A.L., Guadamuz, T.E. and Beyre, C. (2013) 'Worldwide burden of HIV in transgender women: a systematic review and meta-analysis', Lancet Infect Dis 2013;13: 214–22.

Centres for Disease Control and Prevention (CDC), USA, HIV Prevention and Care for the Transgender Population online resources. https://www.cdc.gov/hiv/clinicians/transforming-health/index.html

Cottrell ML, Prince HMA, Schauer AP, et al. 2019. Decreased tenofovir diphosphate concentrations in a transgender female cohort: Implications for HIV pre-exposure prophylaxis (PrEP). Clin Infect Dis 2019;69(12):2201-2204. [PMID: 30963179] https://www.ncbi.nlm.nih.gov/pubmed/30963179

Hiransuthikul A, Janamnuaysook R, Himmad K, Kerr SJ, Thammajaruk N, Pankam T, Phanjaroen K, Mills S, Vannakit R, Phanuphak P, Phanuphak N; iFACT Study Team. 2019. Drug-drug interactions between feminizing hormone therapy and pre-exposure prophylaxis among transgender women: the iFACT study. J Int AIDS Soc. 2019 Jul;22(7):e25338. doi: 10.1002/jia2.25338. PMID: 31298497; PMCID: PMC6625338.

Reisner SL, Moore CS, Asquith A, Pardee DJ, Mayer KH. 2021. LGBT Health, Volume 8, Number 2, 2021. DOI: 10.1089/lgbt.2020.0232

Reisner SL and Murchison GR. 2016. A global research synthesis of HIV and STI biobehavioral risks in female-to-male (FTM) transgender adults. Glob Public Health. 2016; 11(7-8): 866–887. doi:10.1080/17441692.2015.1134613 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4993101/pdf/nihms809032.pdf

Scheim AI, Bauer GR, Travers R. HIV-related sexual risk among transgender men who are gay, bisexual, or have sex with men. 2017. J Acquir Immune Defic Syndr 2017;74(4):e89-e96. [PMID: 27798432] https://www.ncbi.nlm.nih.gov/pubmed/27798432

UNAIDS. 2020. Prevailing against pandemics by putting people at the center. World AIDS Day report 2020. https://aidstargets2025.unaids.org/assets/images/prevailing-against-pandemics_en.pdf

Vail RM with the Medical Care Criteria Committee. 2020. PrEP to Prevent HIV and Promote Sexual Health. New York State Department of Health AIDS Institute (NYSDOH AI): Clinical Guidelines Program. https://www.ncbi.nlm.nih.gov/books/NBK556471/

Winter S. 2012. Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region. Bangkok: APTN and UNDP. https://weareaptn.org/2017/04/01/lost-in-transition/

World Health Organization (2014) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

8

Gender-affirming hormones

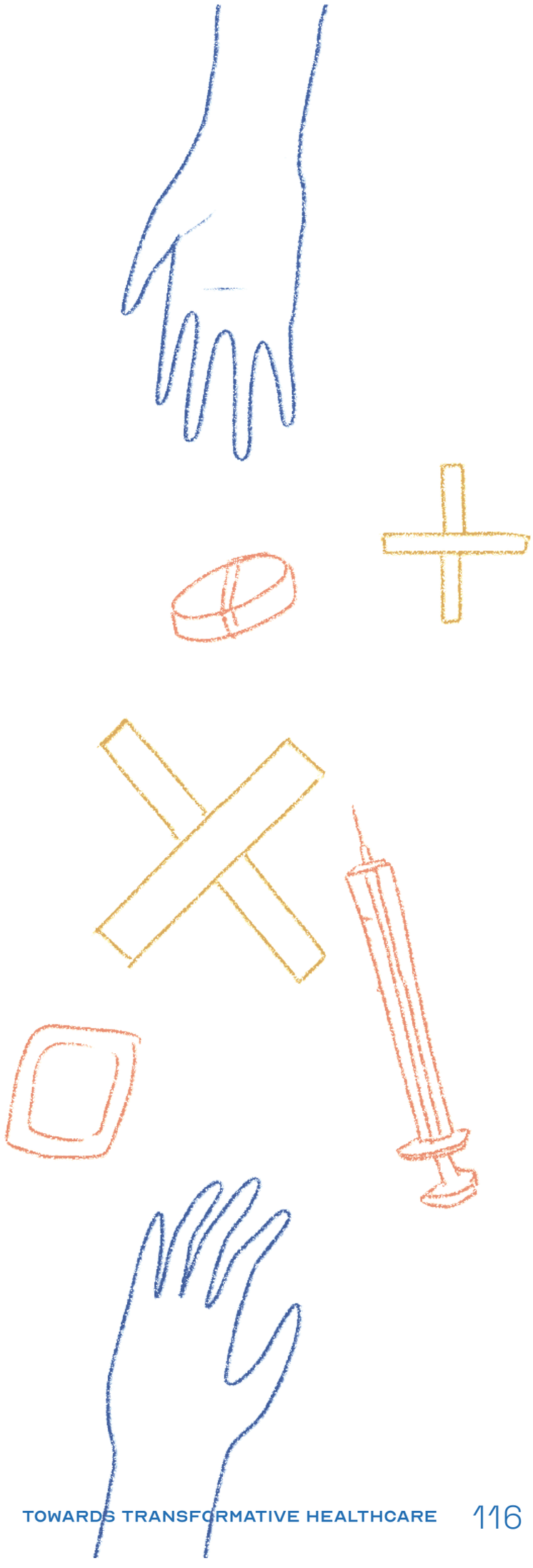
Learning objectives

1. Understand the key issues in hormone management for gender affirmation (including types, dosing and effects, potential risks, basic laboratory monitoring and cardiovascular assessments).

2. Gain knowledge about good practice standards of care for transgender patients including how to apply the Informed Consent Model to prescribing gender-affirming hormones.

8.1

Regional overview



Many trans people across Asia and the Pacific purchase hormones outside the formal medical sector, with no monitoring before or after starting gender-affirming hormones.

Access to hormones is scarce in the Pacific, and in some countries in Asia. Oral contraceptive pills may be the only hormones available for trans people, despite these not being the recommended form of estrogen. In these countries, trans masculine people typically have no access to testosterone.

In some countries in Asia, there is a wide range of hormones available, with little or no regulation of suppliers. Trans people from other countries in Asia and the Pacific tend to rely on accessing hormones from a few key countries in the region, mainly Thailand. Hormone supplies have been affected by border closures and freight delays since the COVID-19 pandemic started in early 2020.

8.2

Informed consent pathway to gender-affirming hormones

Informed consent involves a health professional providing adequate and accurate information to enable a person to make an informed decision regarding potential medical treatment to affirm their gender.

For an intervention such as gender-affirming hormone treatment, the individual must understand the short-term and long-term risks and benefits of the intervention, and how this may affect any existing medical or mental healthcare needs.

The WPATH SOC7 provides this clarification of the relationship between the Standards of Care and Informed Consent Model Protocols:

> A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011, 2015; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH Standards of Care, Version 7

While there is specific information to obtain, informed consent is not simply completing a checklist or form, but the beginning of a discussion that starts from a patient's goals, desired effects, and concerns, based on their current knowledge. It is the healthcare provider's role to explain expected side effects and risks, and to ensure that patients' expectations of hormone treatment are reasonable and that they fully understand which changes are irreversible.

The Informed Consent Model is an alternative to models that require a mandatory mental health assessment. It does not require a healthcare professional to make all decisions on their own. If in doubt, health professionals may wish to collaborate and seek advice from colleagues.

8.3

Offering gender-affirming hormone treatment using the Informed Consent Model

The following information comes from the TransHub online resource developed by and for trans communities and clinicians in New South Wales in Australia.[22]

It sets out an Informed Consent Model offering a framework and protocol that supports general healthcare practitioners to commence and manage gender-affirming hormonal treatment. For doctors wishing to offer access to gender-affirming hormones using an informed consent approach, the process might (for e.g.) include the following steps for an adult:

1. Consult with your patient across two to three appointments. This will include assessing physical health, family history, and previous hormonal or gender affirmation experience. In some cases, one appointment may be sufficient, if baseline blood tests have already been done.

2. Discuss how they want to affirm their gender medically, and associated goals.

3. Assess the patient's capacity to make an informed decision and consent to treatment, ensuring that they are making a decision of their own free will.

4. Assess the patient's medical history to check for contraindications:
   - Absolute contraindication - current pregnancy
   - Consider relative contraindications to testosterone or estrogen such as polycythemia, thrombosis, liver disease or cardiac failure
   - There is insufficient data regarding the long-term effects of hormonal therapy on cardiovascular outcomes[1] and well controlled cardiovascular conditions are not considered contraindications.

[22]https://www.transhub.org.au/clinicians/informed-consent The illustration is by Samuel Luke Art.

5 Identify any history of migraines, liver disease, seizures, breast tissue lumps and irregular bleeding, and decide whether it warrants further investigation prior to commencing hormone therapy.

6 Assess current prescribed and non-prescribed medications, allergies, alcohol, and other drug use, including tobacco use.

7 Discuss your patient's social and emotional support networks, and offer referral to advocacy groups, counsellors or mental health practitioners as needed.

8 Discuss fertility goals and reproductive health needs. Provide information on fertility preservation, where this is available.

9 Assess preventative health needs - last cervical screen, STI test, contraception methods, bowel cancer screen, etc.

10 Conduct blood tests to establish baseline levels for lipids, liver function, luteinizing hormones, estradiol, testosterone and, if indicated by risk factors, Hba1c levels. For those starting feminizing hormones, also measure prolactin levels and, if starting spironolactone, electrolytes as well. For those starting masculinizing hormones, also conduct a full blood count.

11 Measure blood pressure, height and weight for all trans patients, and also the Tanner stage adolescents have reached.

12 Provide your patient with informed consent paperwork, which shows that the patient has been provided with and understands all the necessary information before consenting to the process.

8.4

Types of hormones, dosing and effects

The examples of gender-affirming hormones, routes and dosing reproduced in this topic are based on those produced for the Asia Pacific Trans Health Blueprint.

When the Blueprint was developed, medical providers in the region provided additional information about common types of hormones used across Asia and in some parts of the Pacific. Each country should consider which medications and formulations are feasible and available.

The doses in the tables that follow are based on the aim of increasing estradiol levels to the female reference range for trans women and non-binary people AMAB, and increasing testosterone levels to the male reference range for trans men and non-binary people AFAB. This guidance is meant to be flexible. Decisions about dosage and route of hormones should be led by each individual's goals, with due consideration of underlying health concerns, adverse effects, and serum hormone levels, if available.

People with underlying health concerns, or who want slower or fewer changes, can use doses that are lower than provided in these tables. In particular, non-binary people who use gender-affirming hormones may wish to be on lower doses.

ESTROGENS

- Non-oral estrogens, including sublingual, transdermal, and injectable hormones, are preferable because they bypass the liver.
- Oral estrogens confer an increased risk of blood clots (thromboembolic disease) for smokers over the age of 35.
- After gonadectomy, lower doses are recommended. Titrate to effect, considering your patient's tolerance.

Ethinyl estradiol, the form of estrogen commonly used in oral contraceptives, is not recommended. It and has well-characterized adverse effects, such as blood clots in the veins (venous thromboembolism).

The WPATH SOC7 also discourages the use of ethinyl estradiol for gender-affirming healthcare. Clinicians should be aware that this is the only formulation of estrogen available to many trans women in Asia and the Pacific, in the form of oral contraceptives and not judge trans women for obtaining and using oral contraceptives, while advising about the higher risk of blood clots (thrombotic events). Identify if alternative forms of estrogen are available and, if not, monitor for any side effects.

EXAMPLES OF ESTROGENS, ROUTES AND DOSING

HORMONE	ROUTE	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Estradiol/estradiol valerate	Oral or sublingual	2mg daily	4mg daily	6mg daily
Estradiol valerate	Intramuscular	20mg every 2 weeks	20mg every 2 weeks	20mg every 2 weeks
Estradiol cypionate	Intramuscular	2mg every week/ 5mg every 2 weeks	2mg every week/ 5mg every 2 weeks	2mg every week/ 5mg every 2 weeks
Estradiol gel	Topical	0.75mg twice daily	0.75mg thrice daily	150 mcg thrice daily
Estradiol patch transdermal (preferred for over age 40, smoker). Patches may be formulated to be applied weekly or 2x weekly.	Transdermal	25-50 mcg	100-200 mcg	200 mcg
Conjugated estrogen (Premarin®)	Oral	1.25-2.5mg daily	5mg daily	10mg daily
Ethinylestradiol (not recommended)	Oral			

SOURCE Adapted from Royal College of Psychiatrists 2013 and Hembree et al. 2017

ANTI-ANDROGENS

Initial administration of anti-androgens (e.g., spironolactone or cyproterone) should be done in a single or divided dose, with titration, usually over 4-12 weeks to the average dose. Occasionally clients, especially those who are larger or younger, require higher doses to achieve serum levels in an appropriate range. Progesterone may have some anti-androgenic activity, and may be an alternative if spironolactone is contraindicated.

If clients have significant hair loss issues, finasteride may be added as an adjunct (even initially). Hair implants may also be considered, where available.

EXAMPLES OF ANTI-ANDROGENS AND DOSING

ANTI-ANDROGEN	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Spironolactone	50mg daily	150mg daily*	300mg daily*
Finasteride	2.5mg daily	2.5mg daily	5mg daily
Cyproterone acetate	12.5 -25mg daily	50mg daily	50mg daily
Goserelin	3.6mg/month	3.6mg/month	3.6mg/month
Leuprolide acetate	3.75mg/month	3.75mg/month 11.25mg/3 months	3.75mg/month 22.5mg/12 weeks 11.25mg/10 weeks

***Higher doses of spironolactone (e.g., ≥100mg daily should be split into 2 or 3 doses in a day)**

SOURCE Adapted from Royal College of Psychiatrists 2013 and Hembree et al 2017

PROGESTERONE

The risks and benefits of progesterone are not well characterized. Although some providers anecdotally have found it to have positive effects on the nipple areola and libido, it is usually not recommended. Mood effects may be positive or negative. There is a risk of significant weight gain and depression in some individuals.

As per other studies using oral progesterone in post-menopausal women[23], the oral use of medroxyprogesterone may increase the risk of coronary vascular disease, whereas intramuscular injections (e.g., Depo-Provera) may minimize this additional risk.

FEMINIZING HORMONES

EFFECTS OF FEMINIZING HORMONES

EFFECT OF OESTROGEN	EXPECTED ONSET	EXPECTED MAXIMUM EFFECT	REVERSIBILITY
Redistribution of body fat	3-6 months	2-3 years	Likely
Decrease in muscle mass and strength	3-6 months	1-2 years	Likely
Softening of skin/decreased oiliness	3-6 months	unknown	Likely
Decreased sexual desire	1-3 months	3-6 months	Likely
Decreased spontaneuous erection	1-3 months	3-6 months	Likely
Breast growth	3-6 months	2-3 years	Not possible
Decreased testicular volume	3-6 months	2-3 years	Unknown
Decreased sperm production	unknown	>3 years	Unknown
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[a]	Possible
Male pattern baldness	Variable	[b]	
Voice changes	None	[c]	

SOURCE Oliphant 2018 - adapted from Hembree et al 2017 and Telfer 2017

[23] For example, the Women's Health Initiative Study. Available at: http://www.nhlbi.nih.gov/whi/.

[a] Complete removal of hair requires laser treatment
[b] Familial scalp hair loss may occur if estrogens are stopped
[c] Treatment by speech-language therapists for voice training is most effective

TESTOSTERONE

Testosterone is available as injected and topical preparations, which have been designed for use in non-transgender men with low, but some, naturally occurring testosterone. Therefore, higher dosing may be needed in transgender men than are commonly used in non-transgender men (Deutsch 2016).

The table below includes types of testosterone preparations that may be available in the region. At any point in time, only one of these options should be used.

All are 'bioidentical', meaning that they are chemically equivalent to the testosterone secreted from the human testicle.

Some clients using testosterone do well on lower doses and weekly injections, especially those with a history of trauma (avoiding excessive peaks and troughs, which may set off emotional reactions). Excessive testosterone can convert to estrogen and impede desired effects.

EXAMPLES OF AVAILABLE TESTOSTERONE PREPARATIONS

HORMONE	STARTING DOSE	AVERAGE DOSE	MAXIMUM DOSE
Testosterone (cypionate or enanthate) (intramuscular) (Depo-Testosterone®)	100mg q 2w	200-250mg q 2-3 weeks	200-250mg q 2-3 weeks
Transdermal testosterone gel 1%	2.5g daily	5-10g daily	10g daily
Testosterone patch	2.5mg/d	5mg/daily	5mg/twice daily
Testosterone undecanoate (oral)	40-80mg once daily	160-240mg/daily	
Buccal testosterone	30mg once daily	30mg twice daily	
Testosterone undecanoate (intramuscular / im)		750-1000mg every 10-14 weeks	
Sustanon 250 testosterone (propionate/ phenylpropionate/ isocaproate/decanoate)	1 ml every 4 weeks	1 ml im every 2-3 weeks	1 ml im every 2 weeks
10% dihydrotestosterone cream	20mg three times daily (clitoral)	Used 3 months before metoidioplasty	

SOURCE Adapted from Royal College of Psychiatrists 2013 and Hembree et al. 2017

TRANSDERMAL TESTOSTERONE GEL

These gels are recommended to be applied on upper arms or shoulders in the morning, and are slowly released over the course of the day. Care should be taken to avoid any contact of the gel with others, especially women and children. Gel should be applied only to upper arms or shoulders and kept dry for at least two hours. It is also recommended that the application site be washed later if close skin-to- skin contact with another person is expected (Deutsch 2016).

MASCULINIZING HORMONES

EFFECTS OF MASCULINISING HORMONES

EFFECT OF TESTOSTERONE	EXPECTED ONSET	EXPECTED MAXIMUM EFFECT	REVERSIBILITY
Skin oiliness/acne	1-6 months	1-2 years	Likely
Facial body/hair growth	6-12 months	4-5 years	Unlikely
Scalp hair loss	6-12 months[a]	Variable	Unlikely
Increased muscle mass/strength	6-12 months	2-5 years	Likely
Redistribution of body fat	1-6 months	2-5 years	Likely
Cessation of periods	1-6 months		Likely
Clitoral enlargement	1-6 months	1-2 years	Unlikely
Vaginal atrophy	1-6 months	1-2 years	Unlikely
Deepening of voice	6-12 months	1-2 years	Not possible
Increased sexual desire	Variable	Variable	Likely

[a] highly dependent on age and inheritance; may be minimal

SOURCE Oliphant 2018 - adapted from Hembree 2017 and Telfer 2017

8.5

Risks associated with gender-affirming hormone therapy

The following table summarizes the likelihood and level of risk of feminizing and masculinizing hormones. Only bolded conditions are clinically significant.

RISKS ASSOCIATED WITH GENDER-AFFIRMING HORMONE THERAPY

RISK LEVEL	FEMINIZING HORMONES	MASCULINIZING HORMONES
Likely increased risk	• Venous thromboembolic disease • Gallstones • Elevated liver enzymes • Weight gain • Hypertriglyceridemia	• Polycythemia • Weight gain • Acne • Androgenic alopecia (balding) • Sleep apnea
Likely increased risk with presence of additional risk factors [b]	• Cardiovascular disease	
Possible increased risk	• Hypertension • Hyperprolactinemia or prolactinoma	• Elevated liver enzymes • **Hyperlipidemia**
Possible increased risk with presence of additional risk factors Additional risk factors include age	• **Type 2 diabetes** Risk is greater with oral estrogen than with transdermal estrogen administration	• **Destabilization of certain psychiatric disorders** It includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone • **Cardiovascular disease** • **Hypertension** • **Type 2 diabetes**
No increased risk or inconclusive	• **Breast cancer**	• Loss of bone density • **Cancer of breast, cervix, ovary, and uterus**

a. Risk is greater with oral estrogen than with transdermal estrogen administration.
b. Additional risk factors include age.
c. It includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

NOTE Bolded conditions are clinically significant.

8.6

Basic laboratory monitoring while on gender-affirming hormones

The specific tests obtained depend on the regimens chosen—for example, different androgen blockers for trans women require specific and targeted monitoring. A general guide is that after initiating hormones, lab tests should be monitored every three months for the first year, then once or twice a year thereafter (see the table below).

Frequency of monitoring should be increased if there are untoward effects, changes in doses, or initiation of other medications with potential drug-drug interactions.

EXAMPLE OF BASIC LABORATORY MONITORING WHILE ON GENDER-AFFIRMING HORMONES

	EVERY 3 MONTHS FOR THE FIRST YEAR	EVERY 6 –12 MONTHS
Feminising regimens	• Potassium (if on spironolactone) • Liver function tests (if on cyproteron, flutamide) • If available: testosterone* and estradiol** levels	• Prolactin • Lipids (triglycerides) • Potassium (if on spironolactone) • Liver function tests (cyproterone, flutamide) • If available: testorterone and estradiol levels
Masculinising regimens	• Lipid levels • Liver function tests • Hematocrit*** • If available: testosterone level****	• Lipid levels • Liver function tests • Hematocrit • If available: testosterone level

SOURCE: APTN Trans Health Blueprint, p. 139 with additional footnotes from Oliphant, J. 2018

* Aim for level < 2 nmol/l
** Avoid supraphysiological levels (target < 500 pmol/l)
*** Polycythemia risk, consider testosterone dose reduction if Hct > 0.54
**** Testosterone should be measured midway between injections for depo-testosterone or sustanon, and immediately prior to an injection for testosterone undecanoate.

The target level of estradiol in feminising regimens is based on the female reference range. Similarly, the target level of testosterone in masculinising regimes is based on the male reference range. This means that a trough total testosterone level would aim to be in the lower end of the male reference range (10–15nmol/L). Some trans people, including non-binary patients, may desire lower levels. Speak with your patient to discuss their needs.

8.7

Cardiovascular assessment for trans people using gender-affirming hormones

The most important intervention for prevention of cardiovascular disease is tobacco cessation. The most important intervention for prevention of cardiovascular disease is tobacco cessation. In many parts of the world, trans people have higher tobacco prevalence than the cisgender population. Aggressively screen and treat for known cardiovascular risk factors.

Trans women currently taking estrogen

Coronary Artery Disease / cerebrovascular disease closely monitor for cardiac events or symptoms, especially during the first one to two years of hormone therapy; in clients at high risk (including pre-existing CAD), use transdermal estrogen, reduce estrogen dose, and omit progestin from the regimen.

Hypertension Monitor blood pressure every one to three months; consider using spironolactone as part of antihypertensive regimen.

Lipids Follow national guidelines for monitoring and treatment.

Trans men not currently taking testosterone

Screen and treat high levels of lipids in the blood (hyperlipidemia) as with non-trans clients.

Trans men currently taking testosterone

Annual fasting lipid profile if hyperlipidemia is detected, avoid high (supraphysiologic) testosterone levels

SELF-REFLECTION

The following quiz is an excerpt from an online training module developed by Cathy Stephenson, Alex Ker and Rachel Johnson based on an article that they jointly published in NZ Doctor (Stephenson et al, 2020).

1 Which THREE of the following should you do when working with a transgender or gender diverse patient in primary care?

a. Affirm your patient's gender and autonomy.
b. Always use the patient's name and gender listed on your practice management system.
c. Assume the patient has come to discuss their transition as this will remain their highest need.
d. Help the patient decide their gender.
e. Try to be your patient's advocate and ally.
f. Work with the patient in a way that aligns with their world view and meets their healthcare needs.

2 Which of the following is a permanent effect of masculinizing hormone therapy?

a. Cessation of periods
b. Deepening of voice
c. Increased muscle mass and strength
d. Increased sexual desire
e. Redistribution of body fat

SELF-REFLECTION

3 Which of the following is a permanent effect of feminizing hormone therapy?

a. Breast growth
b. Decreased sexual desire
c. Redistribution of body fat
d. Softening of skin and decreased oiliness
e. Thinning of facial and body hair

4 Which THREE of the following investigations are recommended every three months during the first year of masculinizing therapy?

a. Electrolytes
b. Full blood count
c. Genital examination
d. Liver function tests
e. Testosterone level

5 Which THREE of the following are potential complications of feminizing therapy?

a. Cardiovascular disease
b. Liver dysfunction
c. Obstructive sleep apnea
d. Venous thromboembolism

ANSWERS Q1 a, e and f; Q2 b; Q3 a; Q4 b, d and e; Q5 a, b and d

PRACTICE POINTS

- It is the healthcare provider's role to explain expected side effects and risks of gender-affirming hormones, ensure patients' expectations of hormone treatment are reasonable and that they fully understand which changes are irreversible.
- If your trans and gender diverse patients are using gender-affirming hormones, lab tests should be monitored every three months for the first year, then once or twice a year after that.
- Increase the monitoring if there are any untoward effects, changes in doses, or new medications with potential drug-drug interactions.
- Due to the risk of blood clots, oral contraceptives are not recommended as a gender-affirming hormone for trans women and non-binary people AMAB. Where this is the only formulation of estrogen available, advise against its use, attempt to identify alternative forms of estrogen, and monitor for any side effects.

RESOURCES

APTN, 2020. I am Trans Feminine and I think I want to start using hormones! What should I know before I begin? https://weareaptn.org/wp-content/uploads/2020/12/APTN-KPRA-Factsheet-on-GAHT-Trans-Feminine-30Nov2020.pdf

APTN, 2020. I am Trans Masculine and I think I want to start using testosterone! What should I know before I begin? https://weareaptn.org/2020/12/02/i-am-trans-masculine-and-i-think-i-want-to-start-using-testosterone-what-should-i-know-before-i-begin/

Cheung A S, Wynne K, Erasmus J, Murray S, Zajac J D. 2019. Position statement on the hormonal management of adult transgender and gender diverse individuals. Med J Aust 2019; 211 (3): 127-133. doi: 10.5694/mja2.50259

https://www.mja.com.au/journal/2019/211/3/position-statement-hormonal-management-adult-transgender-and-gender-diverse

Deutsch M (ed.) 2016. Guidelines for the primary and gender affirming care of transgender and gender minority people. Centre of Excellence for Transgender Health, University of California, San Francisco. Second edition. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Hassan Murad M, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab, November 2017, 102(11):3869–3903.

Equinox Gender Diverse Health Centre, HT Prescribing Guideline V3 Aug 2020, Protocols for the Initiation of Hormone Therapy V2 June 2020 and other resources https://equinox.org.au/resources/

Hauora Tāhine / Pathways to Transgender Healthcare. This website describes gender-affirming healthcare available through the public health system in Auckland, Aotearoa / New Zealand. Downloads from this website page include background information and consent forms for puberty blockers and gender-affirming hormones. https://www.healthpoint.co.nz/public/sexual-health/hauora-tahine-pathways-to-transgender-healthcare/

Royal College of Psychiatrists. 2013. United Kingdom good practice guidelines for the assessment and treatment of adults with gender dysphoria.

Stephenson C, Kerr A, Johnson R. 2020. Gender affirming healthcare. NZ Doctor, 23 October 2020 https://patha.nz/resources/Documents/HTT%20Gender affirming%20healthcare%20-%20Educational%20reading.pdf

Telfer M, Tollit M, Pace C, Pang K. Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents. Melbourne: The Royal Children's Hospital; 2017

WHO. 2015. Transgender people and HIV, Policy Brief https://www.who.int/hiv/pub/transgender/transgender-hiv-policy/en/


STP

9

Other non-surgical forms of gender-affirming healthcare

Learning objectives

1. Understand the range of non-surgical forms of gender-affirming healthcare that trans people may be seeking.

2. Understand any potential health issues linked to the use of non-surgical forms of gender-affirming healthcare.

9.1

Hair removal

Many trans women and non-binary people AMAB seek hair removal on the face, neck, and in the genital area prior to gender-affirming lower surgery.

Trans men and non-binary people AFAB, preparing for a phalloplasty, will require hair reduction on a forearm or thigh graft site.

Permanent hair reduction/removal is achieved through light amplification by stimulated emission of radiation (laser) and/or and through electrolysis. Laser hair removal is considered a medical procedure. Both procedures can form an important part of gender-affirming healthcare for many trans women and non-binary people AMAB, since anti-androgens and estrogen therapies will not completely halt facial hair growth that is already established. In 2016, WPATH issued a policy statement confirming that both procedures can be medically necessary.[24]

Be aware of local providers of laser hair removal, and work with trans and gender diverse people to find ways that they may be able to afford to access this treatment.

[24] https://s3.amazonaws.com/amo_hub_content/Association140/files/Letter%20Re_Medical%20Necessity%20of%20Electrolysis_7-15-15.pdf

9.2

Voice and communication training

Some trans people benefit from voice and communication training.

This may include:

- Trans women or non-binary people AMAB might seek voice and communication training to raise the pitch of their voice, because estrogens and anti-androgens make no difference to their voice.
- Trans masculine people often wait until they see the impact of testosterone on their voice, and may seek voice and communication training to reduce vocal fatigue.

There is a range of resources online for people wishing to modify their voice. The WPATH SOC7 do not include standards in this field. However, a companion document reviewed relevant evidence-based literature and discussed trans-specific voice-and-communication assessment, voice feminization protocols and voice feminizing surgeries, and speech and voice masculinization (Davies S et al 2015). The paper concludes with recommendations for good clinical care, including that:

- Transgender voice and communication services should be part of a comprehensive approach to transgender health.
- The speech-language therapist's primary goal is to help a trans or gender diverse person develop voice and communication that more closely approximates their sense of self.
- Trying to feminize or masculinize the voice involves non-habitual use of the voice-producing mechanism. To prevent the possibility of vocal damage, professional evaluation and assistance are essential.

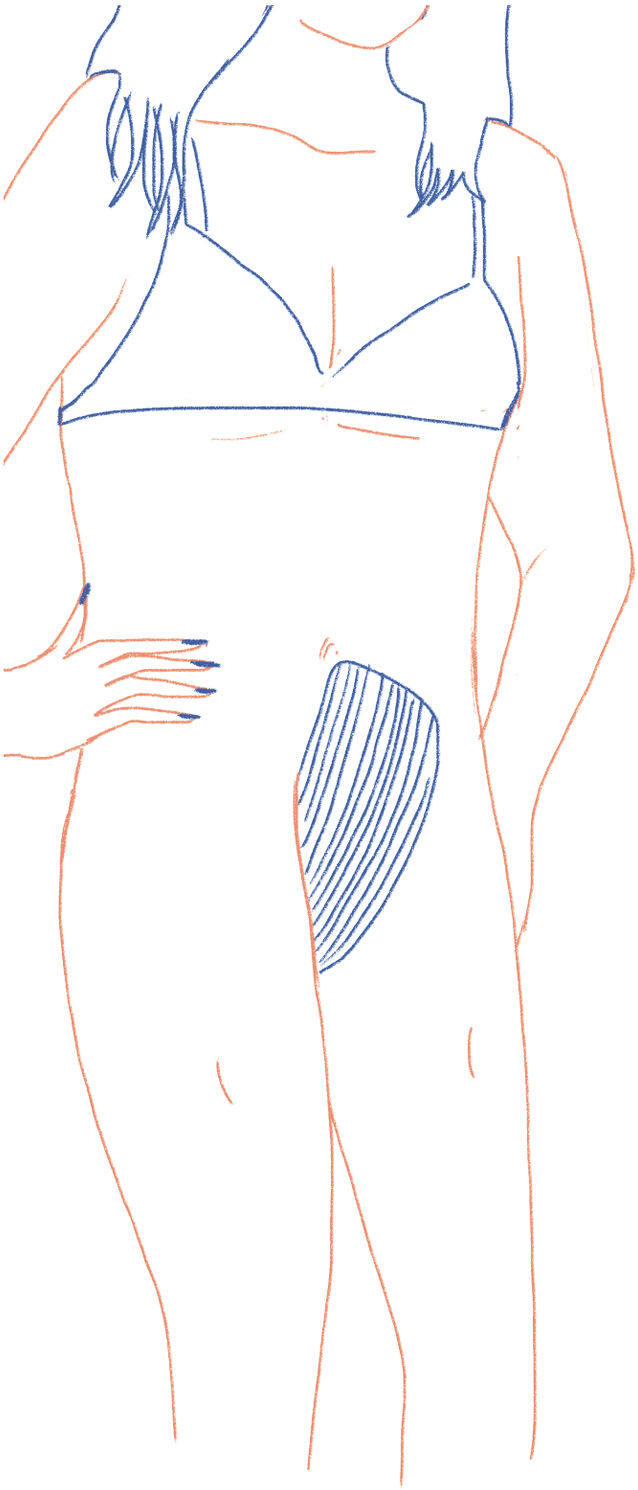
This companion document to the WPATH SOC therefore concluded that self-guided voice and communication change without professional supervision was not recommended. Instead, trans people intending to take up self-guided voice change are encouraged to, at a minimum, have an initial professional assessment and then to consult with their primary care provider if they develop symptoms of vocal fatigue or negative changes to vocal quality.

At the same time, an increasing number of resources are available online for self-guided voice change. A short Callen-Lorde pamphlet guide reiterates the risks of causing permanent and severe damage to vocal anatomy, and that self-guided study should not be substituted for direct care from a qualified professional.[25] It notes that the symptoms to watch for include difficulty swallowing, uneven voice, vocal fatigue, loss of range, hoarseness or pain, and throat discomfort. If someone experiences these symptoms, they should stop the speech therapy and see their doctor immediately.

[25] Callen-Lorde: Finding Your Voice: A Short Guide to Vocalization: http://callen-lorde.org/graphics/2018/09/HOTT-Voice-Brochure_Final.pdf

9.3

Tucking



Tucking creates a visibly smooth crotch contour.

It involves gently pushing the testicles up inside the body (into the inguinal canal) and then pulling the penis back in between the legs. This is all held in place with tight-fitting underwear, surgical tape or a special undergarment known as a gaffe.

There is not a lot of research on the safety and practice of tucking. People may experience some light symptoms of chafing, and should always check for any open or irritated skin before and after tucking to prevent infection. There is some research showing that tucking of the testicles and penis may lead to hernias or other complications at the external inguinal ring or skin breakdown at the perineum, or result in urinary infections. (Deutsch 2016)

Healthcare professionals are encouraged to discuss tucking sensitively with trans women and non-binary people AMAB, to assess any related symptoms.

9.4
Binding

For trans men and non-binary people AFAB, chest binding involves compressing chest tissue to create a flatter chest and more masculine gender expression.

Commercial binders are widely available in some parts of Asia, particularly Thailand, but it can be hard to obtain either binders or the fabric to make them in many other countries in the region, or in the Pacific. In those circumstances, depending on a person's chest size, a similar effect might be achieved by wearing multiple layers of sports bras and/or shirts, or an athletic compression shirt. These options will often be too hot to wear in many countries in this region.

A cross-sectional study of the health impact of chest binding among 1800 transgender adults found binding was associated with significant improvements in mood and mental health (Peitzmeier et al 2017). Participants consistently affirmed that the advantages of binding outweighed the negative physical effects. These benefits included reduced anxiety, dysphoria-related depression, and suicidality. Binding improved overall emotional well-being, and enabled participants to go out in public feeling confident and safe.

However, binding was associated with many negative physical health outcomes, with almost all participants reporting at least one negative outcome. The most common were back pain (53.8%), overheating (53.5%), chest pain (48.8%), shortness of breath (46.6%), itching (44.9%), bad posture (40.3%), and shoulder pain (38.9%). Around three-quarters of participants reported skin/soft tissue concerns (76.3%) and pain symptoms (74.0%).

PROS
Reduced anxiety
Reduced dysphoria-related depression
Reduced suicidality
Improved overall emotional well-being
Enabled participants to feel confident and safe in public

CONS	
Back pain	53.8%
Overheating	53.5%
Chest pain	48.8%
Shortness of breath	46.6%
Itching	44.9%
Bad posture	40.3%
Shoulder pain	38.9%
Skin/Soft tissue concerns	76.3%
Pain symptoms	74.0%

9.5

Prosthetics

Healthcare providers may be able to help their patients reduce negative outcomes associated with binding by recommending 'off days' from binding when possible, avoiding elastic bandages, the use of duct tape and plastic wrap as methods for binding, and using caution with commercial binders. Providers should counsel patients on how to prevent common symptoms, such as practicing good skin hygiene to avoid skin issues.

For those wishing to have top surgery, timely chest reconstruction will limit the duration of binding and its associated negative health outcomes, as well as potentially improve a trans person's quality of life.

Prosthetics commonly used by some trans people include:

Packers These are placed in one's underwear, giving both an outward appearance and feel of a penis.

Stand to Pee device (STPs) As the name suggests, these enable someone who does not have a penis to stand to pee. More expensive versions look more realistic.

Breast forms / padding They create the shape and weight of breasts.

SELF-REFLECTION

Are you aware of safe options for your trans patients to access laser hair removal or voice and communication training?

Is there information available in your practice about safe binding and tucking? If not, review and consider providing links to some of the resources below.

PRACTICE POINTS

- Be knowledgeable about options such as binders, tucking, and prosthetics such as packers and breast forms.
- Regularly assess transgender patients' binding, any symptoms they attribute these practices, and their motivations for binding to understand the risks and benefits for them. Empower patients with the most current research to make informed decisions about binding that support all aspects of their physical and mental health.
- Inquire sensitively about transgender patients' tucking practices and assess any related symptoms.

RESOURCES

BINDING

Peitzmeier S, Gardner I, Weinand J, Corbet A & Acevedo K 2017. Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study, Culture, Health & Sexuality, 19:1, 64-75, DOI: 10.1080/13691058.2016.1191675. Open access: https://bindinghealthproject.files.wordpress.com/2016/06/binding-project-postprint.docx

Callen-Lorde Community Health Centre. Safer binding pamphlet: http://callen-lorde.org/graphics/2018/09/Safer-Binding_2018_FINAL.pdf

Safe binding information including breathing and stretching exercises from Gender Minorities Aotearoa and Physiospot, Aotearoa New Zealand https://genderminorities.com/binding-info/

APTN's trans masc guide: https://weareaptn.org/wp-content/uploads/2020/10/APTN-TransMascPostcards-15x15cm_HighRes_ViewingCopy.pdf

Peitzmeier S, Gardner I, Weinand J, Corbet A & Acevedo K 2017. Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study, Culture, Health & Sexuality, 19:1, 64-75, DOI: 10.1080/13691058.2016.1191675. Open access: https://bindinghealthproject.files.wordpress.com/2016/06/binding-project-postprint.docx

TUCKING

How Does Tucking Work and Is It Safe? – Healthline

Safer tucking pamphlet from Callen Lorde Clinic, New York: http://callen-lorde.org/graphics/2018/09/HOTT-Safer-Tucking_Final.pdf

Trans Hub illustrated online guide: How to tuck and tucking safely: https://www.transhub.org.au/tucking?rq=tucking

PROSTHETICS

TransHub page with information about packers, Stand to Pee device (STPs), and Breast forms / padding: https://www.transhub.org.au/prosthetics?rq=packing

APTN's trans masc guide: https://weareaptn.org/wp-content/uploads/2020/10/APTN-TransMascPostcards-15x15cm_HighRes_ViewingCopy.pdf

HAIR REMOVAL

Reeves C, Deutsch MB and Stark JW. 2016. 'Hair Removal'. In Deutsch M (ed.) 2016. Guidelines for the primary and gender affirming care of transgender and gender minority people. Centre of Excellence for Transgender Health

VOICE AND COMMUNICATION TRAINING

Davies S, Papp VG & Antoni C. 2015. Voice and Communication Change for Gender Nonconforming Individuals: Giving Voice to the Person Inside, International Journal of Transgenderism, 16:3, 117-159, DOI: 10.1080/15532739.2015.1075931 https://doi.org/10.1080/15532739.2015.1075931

Callen-Lorde: Finding Your Voice: A Short Guide to Vocalisation: http://callen-lorde.org/graphics/2018/09/HOTT-Voice-Brochure_Final.pdf

10

Gender-affirming healthcare using surgery

Learning objectives

1. Understand the range of gender-affirming surgeries trans people may seek.

2. Understand the role of a general health professional before, immediately prior to, and after such surgeries.

3. Review current eligibility criteria for patients to access gender-affirming surgeries under WPATH SOC7.

10.1 Introduction

This topic briefly covers the range of gender-affirming surgeries.

- Top surgeries (chest reconstruction and breast augmentation)
- Lower / genital reconstruction surgeries
- Other gender-affirming surgeries

Primary care providers can play a significant role in improving health outcomes for trans people. For example, general practitioners and family doctors may be providing information or preventative care, conducting initial assessments, managing transition-related and general health issues, or making appropriate referrals. The information in this topic is designed to support primary care providers as they do this work.

Each section refers to the eligibility criteria set out in the WPATH SOC v7 guidelines. This best practice consensus document provides internationally recognized standards and criteria for accessing individual surgeries. The WPATH SOC are currently being revised and SOC v8, due in 2021, will inform practice internationally, including in Asia and the Pacific. At that point they will be available on the WPATH website.

10.2 Regional context

Most trans people in Asia and the Pacific cannot afford to access gender-affirming surgeries.

Those who can afford to have such procedures often travel to other countries within Asia where such surgeries are available and may be more affordable. This is not a realistic option for most people in the Pacific due to high travel costs.

In this region, apart from Hong Kong SAR, China, and some targeted assistance in parts of India, the costs of most gender-affirming healthcare services are not covered by public health systems or social insurance. There is a wide range of gender-affirming surgeries that are medically necessary for many trans people, including breast augmentation, chest reconstruction, and genital reconstruction. In a few countries, including Myanmar, such surgeries are illegal. In China, regulations exclude many trans people from such procedures, including if they are married, under the age of 20, or have any criminal record.

In countries where surgeries are available, the lack of insurance coverage means that such procedures are not an option for most trans people. In addition, the absence of regulations, protocols, or healthcare professionals with the required trans-cultural or trans-clinical competence, mean some trans people may consider their only options are unregulated, non-qualified practitioners. This includes resorting to silicone and other forms of tissue fillers, despite the negative and sometimes fatal consequences of this form of body modification.

10.3

A general healthcare professional's role

Primary healthcare professionals have an important role to play supporting their patients before, around, and after surgeries.

Being familiar with the range of surgeries is a key component of that support. These are summarized below, and are adapted from the information for clinicians on the TransHub website in Australia.

Supporting trans patients

1 before

Your patient will need to be referred to a mental health professional for support and assessment to confirm their readiness for surgery. The WPATH SOC7 includes a list of recommended criteria that your trans patient will need to meet to be eligible for specific surgeries (Coleman et al., 2012, Appendix C). These are also set out later in this section of the module. In addition, countries may have their own guidelines.

The WPATH SOC7 also outline the details a mental health professional should include in such a referral letter for surgery (Coleman et al., 2012, pages 27-28). TransHub in Australia has created a template letter for such referrals.[26]

At appointments in the lead up to surgery, it will be important to have an open conversation about what surgery can and cannot do. This might cover summarizing the surgical process, possible complications, risk factors and outcomes.

If a patient is considering having surgery overseas, it is useful to discuss the benefits and risks of this option. Risks tend to be lack of access to post-surgical care, especially if there are complications. Scheduling an appointment immediately upon their return may help address some gaps in information or care, and reinforce the importance of taking time off work and/or study to heal.

[26] https://www.transhub.org.au/s/TH-Readiness-Referral.docx

in surgery

2 during

Some surgeons require patients to decrease hormones, particularly estrogen, before and immediately following surgery. Your patient may want to discuss timeframes, expectations, and any potential side effects from this. For those using estradiol implants, it may be worth suggesting to your patient to try to schedule surgery so that their blood levels are low when surgery takes place and inserting the next implant after surgery.

3 after

If you are the patient's regular general doctor, you are likely to be the first point of contact for any post-surgical care and complications.

Many trans people wait a long time to have surgeries, and may expect only excitement and other positive feelings after the procedure. Discuss with your patient that it is also normal to feel overwhelmed and uncomfortable. This doesn't mean they have made a mistake. It is a normal part of recovering from surgery, and reconnecting with how their body appears and functions.

10.4

Overview of types of gender-affirming surgeries

This sub-topic provides background information on a range of gender-affirming surgeries.

Gender-affirming surgeries such as vaginoplasty and phalloplasty are not available in most countries in Asia, especially those that are resource limited. Many trans people travel within Asia to those countries where such surgeries are available. Different surgeries, techniques and approaches can have varying levels of complexity. Complication rates may also vary between surgeons. Understanding what procedures different surgeons perform, their experience, frequency with which they perform these procedures, and complication rates, can be very helpful for your patients.

More countries in this region will have access to surgeries such as hysterectomy, orchiectomy, and mastectomy, as these are procedures sought by non-transgender people too. Where these surgeries are available, they should be equally accessible for trans people.

Surgeries for Trans women + Non-binary people AMAB

Orchiectomy is the removal of the testes and may be done on its own without the removal of a penis (penectomy) or construction of a vagina (vaginoplasty). If your patient was already on estrogen, the dose may be reduced after this surgery, and testosterone blockers (anti-androgens) are no longer needed.

Vaginal construction / Vaginoplasty is the construction of a vagina using tissues from the penis or a colon graft. The procedure usually involves creating a clitoris and labia from surrounding tissues (clitoro-labioplasty). A vagina constructed using colon grafts, rather than penile tissue, does not require dilation and is self-lubricating. However, the lubrication is always present; itmay become bothersome to some trans women.

Penectomy is the removal of the penis. This procedure is not commonly done on its own except in parts of South Asia where castration is still common in some communities. Instead, generally the penis is removed as part of a vaginoplasty. In the most common surgical technique, the penile skin is used to form the vagina.

Augmentation mammoplasty (Breast augmentation) If estrogen does not stimulate sufficient breast growth (progressing only to the 'young adolescent' stage of breast development), augmentation mammoplasty may be medically necessary.

Reduction thyroid-chrondroplasty This surgical procedure reduces prominent thyroid cartilage.

Voice surgery is intended to raise the pitch of the speaking voice. Speech therapy is recommended before seeking this surgical solution.

Facial feminization includes a variety of aesthetic plastic surgery procedures that modify the proportions of the face.

Surgeries for Trans men + Non-binary people AFAB

Chest reconstruction is the procedure most frequently required by trans men, to remove existing tissue and create a flatter chest. A variety of techniques, including bilateral mastectomy. may be used depending largely on the amount of tissue to be removed. Scarring may result and nipples may need to be grafted, depending on the surgeon's technique.[27]

Hysterectomy / Oophorectomy surgically removes either all or some parts of the uterus or cervix. The surgeon may remove the ovaries – a procedure called an oophorectomy – or may leave them in place.[28]

The WPATH SOC7 state that a hysterectomy is considered "a medically necessary component of gender-affirming surgical therapy for those transgender men who choose to seek this procedure" (Coleman 2012).

A hysterectomy may be a part of a phalloplasty/ vaginectomy procedure when the vaginal tissue is used to construct the urethral canal. It may also be necessary in the event of fibroid growth, endometrial conditions, or for clients with a family history of cancer.

Metoidioplasty is a surgical procedure that works with existing genital tissue to form a phallus or new penis. It can be performed on anyone with significant clitoral growth caused by using testosterone. The phallus generally will be small with the appearance of an adolescent penis, but erectile tissue and sensation are preserved. This procedure releases the clitoral hood and sometimes the suspension ligaments to increase organ length. This procedure is much less invasive than a phalloplasty procedure (see below). Performing an urethroplasty allows the individual to urinate standing up.

Phalloplasty is a multi-staged surgical procedure where a penis is created. The surgeries may include lengthening the urethra so a trans patient can stand to pee, creating the tip (glans) of the penis, creating scrotum, removing the vagina, and placing erectile and testicular implants. Each staged surgical plan is unique to that patient and may or may not include some or all of these procedures.

There are three primary types of skin flaps a surgeon can use to create the penis. These use skin, fat, nerves, arteries, and veins tissue from the arm (radial forearm free flap), leg (anterolateral thigh flap) or the side of the patient's back (musculocutaneous latissimus dorsi flap). Factors that indicate which donor site is used include the patient's health and fat distribution, nerve functionality, blood flow, and the patient's goals and desired surgical outcomes including sensation.

Scrotoplasty is the construction of a scrotum, usually using labia majora tissue and saline or silicone testicular implants. Some surgeons will use tissue expanders, and place the implants after the tissue has been stretched sufficiently to accommodate the implants. This procedure is rarely done separately but is usually performed in conjunction with either a metoidioplasty or a phalloplasty procedure.

Urethroplasty involves lengthening the urethra by creating a urethral canal through the neophallus. Performing a urethroplasty allows the individual to urinate standing up.

Vaginectomy (the removal of the vagina) may be done with an ablative technique or surgical techniques. It is required if the vaginal opening is to be closed.

[27]TransHub provides this summary of the different types of procedures: https://www.transhub.org.au/clinicians/top-surgery#what-happens

[28]When the fallopian tubes are removed the procedure is called a salpingectomy. When the entire uterus, both tubes, and both ovaries are removed, the complete procedure is called a hysterectomy and bilateral salpingectomy-oophorectomy.

10.5

WPATH SOC v7 eligibility criteria for surgeries

The next section of this module sets out the WPATH SOC v7 criteria for accessing gender-affirming surgeries.

Each of the criteria refers to "persistent, well-documented gender dysphoria". The current version of the SOC was developed before the creation of the new ICD diagnostic classifications that are based on "gender incongruence". It is expected that WPATH SOC 8 is likely to use both terms. Other aspects of the SOC will also be updated.

The SOC do not specify an order by which surgeries should occur, and are consensus guidelines, not legislated requirements. The document opens by emphasizing that individual health professionals may modify the criteria, including as a harm reduction strategy, and should explain and document any such clinical departures from the SOC.

As in all previous versions of the SOC, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for healthcare—and the SOC—to evolve.

SOURCE COLEMAN ET AL. 2012, P. 2

Chest reconstruction and breast augmentation

WPATH SOC v7 criteria for access to chest reconstruction and breast augmentation surgery:

- Persistent, well-documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Age of majority
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note that hormone therapy is:

- not a pre-requisite for masculinizing chest surgery
- not an explicit criterion but it is recommended that patients undergo feminizing hormone therapy for a minimum of 12 months prior to breast augmentation surgery (The purpose is to maximize breast growth to obtain better surgical/aesthetic results.)

After chest reconstruction surgery, your patient will be required to wear a surgical binder for many weeks after surgery, depending on the type of surgery undertaken, the size of their chest, and how their body is recovering. Many patients require additional aspiration to reduce fluid build-up, and this is managed by the surgeon. Recovery from top surgery can take up to eight weeks.

Hysterectomy, salpingo-oophorectomy and orchidectomy

WPATH SOC v7 criteria for access to hysterectomy, salpingo-oophorectomy and orchidectomy:

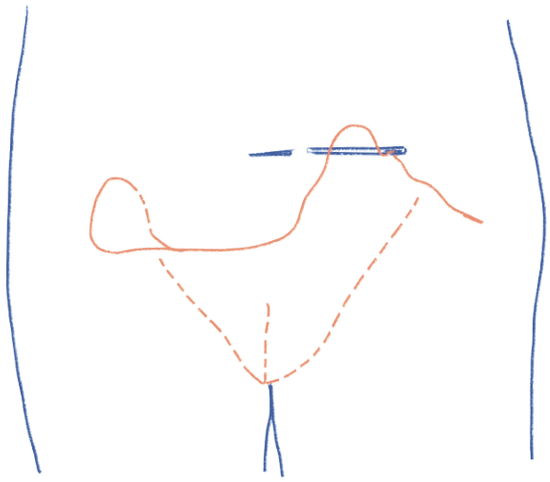
- Persistent, well documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Age of majority
- Significant medical or mental health concerns, if present, must be well controlled
- 12 continuous months of hormone therapy as appropriate to the patient's transition goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones)

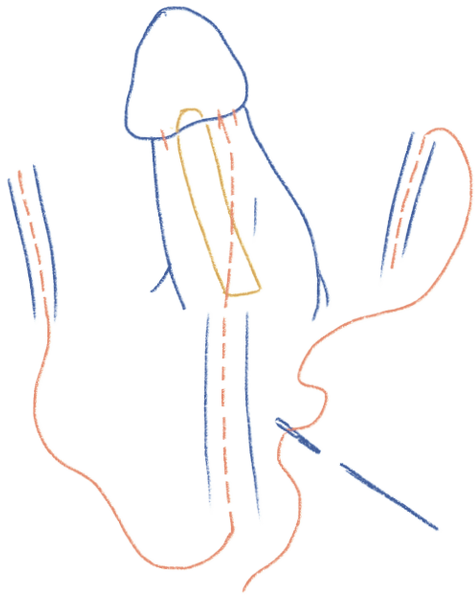
The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention.

Genital reconstruction surgeries

WPATH SOC v 7 criteria for access to metoidioplasty or phalloplasty (masculinizing) and for vaginoplasty (feminizing):

- Persistent, well documented gender dysphoria
- Capacity to make a fully informed decision and to consent for treatment
- Age of majority
- Significant medical or mental health concerns, if present, must be well controlled
- 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones)
- 12 continuous months of living in a gender role that is congruent with their gender identity (including gender identities other than male and female)





10.6

Post-surgical follow-up

After chest reconstruction

Patients should be examined for difficulties in healing. Complications in chest reconstruction may include partial or total nipple necrosis (when reconstructed nipple tissue dies), hematoma, or abscess formation. Drains and compression bandages used after surgery do not always prevent these complications. Keloid scarring may occur. In some instances, scarring may be lessened by ensuring that incisions are not stretched prematurely during healing.

Asian people have a higher tendency toward hyperpigmentation and scar formation. A recent Chinese expert consensus statement on clinical prevention and treatment of scars provides some advice and references for the management of scarring in Asian patients (Lv and Xia 2018).

After phalloplasty or metoidioplasty

In addition to general risks associated with any surgery, there is a range of risks specific to phalloplasty. These include risk of flap loss (the skin and related tissues used to create the neophallus), urethral complications, pelvic bleeding or pain, bladder or rectal injury, lack of sensation, prolonged need for drainage, or need for further procedures. Donor site risks include unsightly scarring, wound breakdown, granulation tissue formation, decreased mobility, hematoma, pain, and decreased sensation. Many of these, such as wound breakdown, infection, urethral stricture, and fistula, are also risks after metoidioplasty although the incidence is lower (Deutsch 2016).

If patients are discharged from their surgeon's care and are not local, they should see their primary healthcare provider every three months during the first year after a phalloplasty or metoidioplasty.

After a vaginoplasty

Clients should be examined for difficulties in healing. Post-operative complications may include bleeding, infection, or impaired wound healing. Possible late complications may include a stricture, due to the new opening of the urethra narrowing. If this occurs, refer to a surgeon with the necessary expertise.

For anyone who has had a vaginoplasty created from penile tissue., it is essential to dilate three to four times daily for the first three months, following the surgeon's recommendations. There are clinical cases in this region of trans women with severe complications because they do not appear to have received or understood information about dilation.

From three months after surgery, dilation is required less frequently, using progressively larger dilators. After the initial six to 12-month period post-surgery, for someone who has regular penetrative sexual intercourse, no further dilation is required. Otherwise, routine dilation once or twice per week is suggested. Lubrication will be necessary for intercourse.

SELF-REFLECTION

Have you supported trans patients wanting a referral for a gender-affirming surgery, in preparation for that surgery, or to provide post-surgical healthcare perhaps in response to complications?

If so, what lessons have you learnt from providing that care? Is there further information you require that would be helpful for others in your role?

If you haven't provided this care, what additional knowledge or skills do you feel you would need to support your trans patients?

Are you aware of any quality and safety concerns about the gender-affirming surgeries your trans patients are receiving? If yes, are there harm reduction steps you could play in response to these concerns?

PRACTICE POINTS

- Primary healthcare professionals have an important role to play supporting their patients before, around, and after surgeries. Being familiar with the range of gender-affirming surgeries is a key component of that support.
- Your patient will need to be referred to a mental health professional for support and assessment to confirm their readiness for surgery.
- At appointments in the lead up to surgery, it will be important to have an open conversation about what surgery can and cannot do.
- If a patient is considering having surgery overseas, it is useful to discuss the benefits and risks of this option. Risks tend to be lack of access to post-surgical care, especially if there are complications.
- If you are the patient's regular general doctor, you are likely to be the first point of contact for any post-surgical care and complications.

RESOURCES

Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. Int J Transgend. 2012;13(4):165-232.

Deutsch M (ed.) 2016. Guidelines for the primary and gender affirming care of transgender and gender minority people. Centre of Excellence for Transgender Health, Department of Family and Community Medicine, University of California, San Francisco. Second edition. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf

Fenway Health. 2015. The Medical Care of Transgender Persons. Boston: Fenway Health Transgender Health Program. https://www.lgbthealtheducation.org/publication/transgender-sod

Lv K and Xia Z. 2018. Chinese expert consensus on clinical prevention and treatment of scar. Burns Trauma. 2018; 6: 27. Published online 2018 Sep 17. doi: 10.1186/s41038-018-0129-9 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6154406/

ADVICE ABOUT SURGICAL REFERRAL LETTERS

Boston Children's Hospital's Centre for Gender Surgery: https://www.childrenshospital.org/centers-and-services/programs/a-_-e/center-for-gender-surgery-program/eligibility-for-surgery

Coleman E, Bockting W, Botzer M, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. WPATH, pp 27-28: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341

TransHub's online information for clinicians includes this Surgical Readiness referral template letter for health professionals making a referral to a surgeon: https://www.transhub.org.au/s/TH-Readiness-Referral.docx

11

Supporting gender diverse children and young people

Learning objectives

1. Understand the importance of gender affirmation for children and young people, and the roles a general health practitioner can play in supporting a young person's gender journey.
2. Understand the role of psychosocial support for trans and gender diverse children and their families.
3. Become aware of evidence-based consensus guidelines for assessing eligibility, prescribing and monitoring use of reversible puberty blockers.
4. Acquire knowledge of evidence-based consensus guidelines about the use of partially reversible gender-affirming hormone for adolescents, including harm reduction around unregulated use of hormones.
5. Understand eligibility criteria for adolescents wishing to access gender-affirming surgical procedures.
6. Become aware of confidentiality and consent issues and how they apply to trans and gender diverse children and adolescents seeking gender-affirming healthcare.

11.1

Overview

There is considerable research showing high levels of rejection, discrimination, bullying and other forms of violence experienced by trans and gender diverse children and young people.

This is including within their families, communities and schools in this region (Health Policy Project, APTN and UNDP, 2015). This includes conversion practices that attempt to change or suppress a trans person's gender identity or expression.

Despite strong statements from health professional bodies that such practices have no scientific basis and are unacceptable, unethical, and harmful (Coleman et al, 2012; Indian Association of Clinical Psychologists[29], 2020; Australian Psychological Society statement, 2021; New Zealand Psychological Society, 2021) they persist, including by healthcare professionals in this region. Forthcoming APTN research in Malaysia, Indonesia, Sri Lanka, and India documents conversion practices perpetuated by parents and wider family members, religious leaders and institutions, healthcare professionals, schools, and through state-sanctioned programs.

Cumulatively, these stressors have significant negative impact on the mental health and wellbeing of trans and gender diverse young people (Strauss et al, 2017; Veale et al, 2019). [30]Conversely, where family support exists, it can help build resilience and reduce the negative impacts of such exclusion and marginalization (Veale et al, 2019).

Conducting a broad psychosocial interview such as a HEEADSSS assessment will help identify a young person's resilience and screen for any mental health risks linked to stressors they may be experiencing.[31]

The assessment can help a young person explore how any gender dysphoria they may be feeling plays out in different parts of their life, including triggers for this distress. A healthcare professional can help the young person and their family to develop a safety plan, make available information on coping with gender dysphoria or distress, and provide referrals to mental health support if needed.

Healthcare professionals play an important role working directly with trans and gender diverse children and their families and providing letters of support and referrals if patients want to explore options for socially, medically, or legally affirming their gender. For example, this might include encouraging schools to have policies that enable trans and gender diverse children and young people to participate in all aspects of school life based on their self-defined gender identity. These might include being able to:

- Change their name and/or gender marker on school records and administrative systems so that they are addressed consistently using these correct details
- Have their name and gender used
- Wear the appropriate school uniform
- Participate in school and sporting activities and
- Use facilities, such as toilets and changing rooms, all based on their gender identity

[29]Available online at: https://www.youthkiawaaz.com/2020/05/several-indian-mental-health-associations-oppose-gay-conversion-therapy/

[30] Recent surveys showed high rates of self-reported depression (75%) and anxiety (72%) diagnoses among trans and gender diverse young people in Australia; 80% reported self-harming and 48% ever attempting suicide (Strauss et al, 2017), and in New Zealand, 86% of trans and non-binary young people experienced psychological distress; 84% had seriously thought about attempting suicide, and 17% had attempted suicide in the last year (Veale et al, 2019)

[31]This HEEADSSS module is an intro to the assessment, which covers a youth's Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression and Safety: https://www.goodfellowunit. org/courses/introduction-heeadsss-assessment. The HEEADSSS 3.0, released in 2014, reflects a strengths based approach and the impacts of social media: https://bit.ly/2SgX3fT

11.2

The importance of gender affirmation for children and young people

The gender-affirmative healthcare model for children and young people promotes support for children as their gender identity develops, with no expectations about what direction that gender journey will take.

Children are provided with the space to explore and try out different self-expressions to discover a place that is comfortable for them (Ehrensaft, 2016; Newhook et al, 2018).

A growing body of research on the health and wellbeing of trans children who are affirmed in their gender identity indicates that their mental health outcomes are similar to their cis peers (Durwood et al., 2017; Olson, Durwood, DeMeules, & McLaughlin, 2016). This contrasts with high levels of psychological distress and behavioral problems documented among children who have been actively discouraged from asserting their identities in childhood (Turban, J. 2017;). A gender affirming approach avoids the use of diagnoses that would pathologize children, and is based instead on respect for a child's gender identity and expression

The gender-affirmative model of healthcare for trans youth has the support of many practitioners and major professional and scientific associations worldwide. Examples of gender-affirming treatment guidelines include those from WPATH (Coleman et al 2012), the Endocrine Society (Hembree et al 2017) and developed in Australia (Telfer et al 2018) and New Zealand (Oliphant et al 2018). Position and policy statements supporting gender-affirming healthcare for children and young people include those from the American Psychological Association, the Australian Psychological Society, the UK Royal College of Psychiatrists, the American Academy of Child and Adolescent Psychiatry, the American Academic of Pediatrics, the Australian Psychological Society and the Royal Australasian College of Physicians.

11.3

The role of general healthcare practitioners

Healthcare professionals should have basic knowledge on gender-affirming healthcare for young people, including about any local specialist services or referral pathways (if they exist) and community-based support or resources for young people and their families.

Although no specific medical intervention is required for pre-pubertal children, family members often require information about how best to support their child's wellbeing, including around any social transition steps and possible medical steps in the future. Where possible, provide culturally appropriate resources that support the young person's cultural identity as well as their gender identity.

This may include information about socially transitioning, when a child is expressing a desire to present and live in a gender other than their sex/gender assigned at birth. This might include wanting to change their name and gender marker, hairstyle, or types of clothes.

Social transition should be led by the child and does not have to take an all or nothing approach. The child might make different choices, for example, about how they present at home and at school. A letter of support from a healthcare professional can help facilitate discussions with a school or childcare center. **Evidence suggests that trans children who have socially transitioned do well, with rates of depression, anxiety and self-worth that are comparable to their cisgender peers (Olson et al 2016, Durwood et al 2017).**

It is important to communicate to the child that they will be supported on their journey, wherever it takes them. For some children, that journey may bring them back to claiming a cis identity. Family members are in their own processes of adjusting to their child's gender journey, and it is common for there to be a diverse range of reactions within a family. When talking to family members, it is important to acknowledge that any feelings of grief, loss, guilt, and fear come from a place of caring about their child.

If a young person is **insistent, consistent,** and **persistent** in their gender identity or is experiencing gender dysphoria, the healthcare professional's role includes providing age-appropriate information and education to them and their parents/carers regarding options for medical transitioning. This may involve making a referral to local gender-affirming services or a specialist experienced in the care of trans and gender diverse adolescents, where these options are available. Ideally such a referral would be around the age of nine, before the onset of puberty.

A recent statement from WPATH and its regional chapters USPATH and EPATH emphasizes that *"clinical guidelines for youth experiencing an incongruence between their gender identity and sex assigned at birth have been published, are widely used internationally, and are based on the current evidence. These guidelines support the use of medical interventions for appropriately assessed minors"* (Leibowitz et al, January 2020).

Avoiding harm is an important ethical consideration for healthcare professionals when considering referrals for gender-affirming healthcare. Withholding a referral or delaying gender-affirming treatment by maintaining a "wait and see" approach is not considered a neutral option (Telfer et al 2018). It may exacerbate distress by increasing depression, anxiety, suicidality, and social withdrawal, and push young people to obtain hormones illegally without medical oversight.

11.4 Confidentiality

Confidentiality is an ethical and legal right for adolescent clients who are sufficiently competent to make their own medical decisions (Joint Adolescent Health Committee of the Royal Australasian College of Physicians, 2008).

Confidentiality concerns may be even greater for trans youth and children than for trans adults. Children and youth are reliant on parents for housing and financial support, including covering their education costs. Even trans adolescents who have grown up with a strong sense that their gender identity differs from their sex/gender assigned at birth may not feel it is safe to disclose this information to family or peers. Others may be seeking support from healthcare professionals to explore their feelings, including guilt about not meeting family expectations, and to discuss options.

11.5 Consent

Many young people have the capacity to make decisions about healthcare.

They understand (or are capable of understanding when informed) the likely effects, as well as the potential side effects, of healthcare procedures. This includes understanding the consequences of declining, delaying or being refused healthcare. The same is true for trans youth seeking puberty suppression or gender affirming hormones. Many are well informed on potential options before they even approach a healthcare provider. For example, trans youth may know what the effects of puberty will be, how these can be paused using puberty blockers, and how delayed or denied access will lead to permanent changes to their body.

For these reasons, the gender-affirming healthcare model advocates that healthcare professionals give due weight to the wishes of trans youth, and operate based on informed consent, putting the patient at the center of decision-making.

This also reflects human rights obligations under the United Nations Convention on the Rights of the Child which require that the best interests of the child shall be a primary consideration in all actions concerning children (Article 3) and a child's views should be "given due weight in accordance with the age and maturity of the child" (Article 12).[32]

Any limits on young people's ability to consent for gender-affirming healthcare should, under no circumstances, be more onerous than for any other form of healthcare.

[32] UN Convention on the Rights of the Child

[33]The standard is based on the 1985 decision of the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority. The case is binding in England and Wales, applied under other laws in Scotland and Northern Ireland, and has been adopted to varying extents in Australia, Canada, and New Zealand.

[34]Re Jamie (2013), and Re Kelvin (2017)

[35]Re Imogen (2020) Early reports suggest that the practical effect will be that where one parent cannot be tracked down, or is unresponsive, the child or youth will be denied healthcare.

International, regional, and national bodies representing healthcare professionals working on transgender health have spoken out strongly against laws or court decisions that undermine an informed consent approach. In 2020, three bodies from this region (AsiaPATH, AusPATH and PATHA) joined WPATH (and its regional bodies in the United States and Europe) and CPATH in Canada to recommend:

> **...that capacity to consent is evaluated on a case-by-case basis by the treating clinician and not by a court of law. We do not agree that transgender healthcare is so different in kind to that provided to cisgender people as to warrant separate legal provision.**
>
> WPATH ET AL, 2020

An extended version of that statement was published in April 2021, outlining the scientific evidence and references on which it was based. The authors further detailed their concern regarding "the harm which may be caused by legal judgements which interfere with necessary medical treatment for transgender youth, undertaken in a shared decision-making process between patients and qualified clinicians, in precisely the same way as other necessary medical treatments for minors which are not transgender-related." (de Vries et al, 2021)

The age at which a young person can make their own medical decisions without parental consent varies internationally, including across this region. In many countries around the world, 16-year-olds are legal adults for medical decision-making and do not require parental consent (Coleman et al 2012).

[36]Under s. 17 of the Infants Act, 1996 the healthcare provider is required to explain, and be satisfied that the minor understood, the nature and consequences and the reasonably foreseeable benefits and risks of the healthcare. They must also have made reasonable efforts to determine, and have concluded, that the healthcare is in the child's best interests. In British Columbia, a child who is assessed by a healthcare provider as being capable to give consent is called a "mature minor".

The concept that a young person under the age of 16 may have "Gillick competency" to understand treatment options and consequences and give consent to their own medical treatment, without parental permission, has been well established in case law in common law jurisdictions and been applied to decisions about trans adolescents in this region.[33]

In Australia, for example, a Gillick-competent child can consent to gender-affirming hormonal treatment.[34] If the child is not Gillick-competent and the treating medical practitioners agree, the child's parents can consent to commencing hormonal treatment without requiring court approval. However, a recent Australian court decision clarified that if there is any dispute between those with parental authority about the young person's Gillick-competence, diagnosis of gender dysphoria or proposed treatment, the decision about treatment must go before the Family Court.[35]

AusPATH's statement in response to that decision highlighted the negative mental health implications caused by anticipated delays in accessing gender-affirming healthcare, as well as the risk that young people denied hormones would purchase them without any medical oversight. AusPATH asserted that "young people of sufficient maturity should be allowed to provide informed consent to their own treatment, in partnership with their treating medical practitioners, without being put to the expense, delay, public profile and undermined privacy involved in court authorization when parents are in dispute" (AusPATH 2020).

A January 2020 decision from the highest court in the Canadian province of British Columbia confirmed that provisions permitting mature minors to consent to their own medical treatment,[36] applied to a 15 year old trans boy wanting to start testosterone (A.B. v. C.D., 2020 BCCA 11). The consent of a parent was not required because the healthcare provider was satisfied both that the minor had the maturity to understand the treatment's nature and consequences, and that the healthcare was in the minor's best interests. This appeal upheld an earlier decision of the British Columbia Supreme Court (a lower court), that the one dissenting parent's actions had been contrary to the child's best interest.

11.6

Fully reversible medical steps

The first forms of medical care available to trans and gender diverse adolescents are gonadotropin-releasing hormone analogues (GnRHa), often referred to as puberty blockers (Hembree et al, 2017).

These delay the onset of puberty to allow an adolescent time to explore their gender, and to avoid unwanted physical changes that could potentially cause intense distress. Puberty blockers also give the adolescent time to develop emotionally and cognitively, prior to making decisions on gender-affirming hormone use that may have some irreversible effects.

Puberty blockers are safe and reversible medications that pause puberty by stopping the production of sex steroids, and have been used for many years to treat precocious puberty in younger children. Their high cost is likely to make puberty blockers unaffordable for many trans and gender diverse young people and their families across Asia.

Puberty blockers typically relieve distress for trans adolescents by halting physical changes such as breast growth in trans males and voice deepening in trans females (Telfer et al, 2018), and are ideally used from Tanner stage 2-3. They can also be helpful later in puberty for transfeminine adolescents, to stop the masculinising changes that would otherwise continue. However, they are not usually the preferred medication for transmasculine young people to start later in puberty. While they will still be effective in menstruation, there are other options with fewer side effects that should be considered first (Stephenson, 2020) such as the progesterone / weak androgen Norethisterone, Depo-Provera, or the continued use of the combined oral contraceptive pill.

Minimum criteria for puberty-suppressing hormones

The WPATH SOC7 set out the following minimum criteria before an adolescent can receive puberty-suppressing hormones. These are likely to change in SOC8:

- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed).
- Gender dysphoria emerged or worsened with the onset of puberty.
- Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, so the adolescent's situation and functioning are stable enough to start treatment.
- The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

A list of recommended medical examinations and investigations before a young person starts, and while they are on, puberty blockers can be found in Appendix 1 of the Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents (Telfer 2018).

Healthcare providers should also discuss any available fertility preservation options with young people before they start puberty blockers. Puberty blockers are reversible, and should not affect long-term fertility. This can be particularly reassuring for families to understand.

→ **As discussed in TOPIC 6, it is important that children and young people are given developmentally appropriate information about fertility options available for them now and in the future.** When collecting mature sperm is physically possible (after an adolescent has reached mid puberty / at least Tanner Stage 3), this option should be considered before starting puberty blockers. While sperm can be collected and stored later, prior to decisions about starting feminizing hormones, this requires a break from puberty blockers. Adolescents are often reluctant to take such a break because of the risk of masculinization.

For those considering taking masculinizing hormones, the option of egg or ovarian tissue storage should be discussed, if it is available. However, this involves invasive procedures, and there is also less pressure to take these steps before deciding whether to start testosterone. This is because there is no current evidence to suggest that testosterone affects the likelihood of harvesting healthy eggs in the future.

The main concern with use of puberty suppression from early puberty is the impact that lack of estrogen or testosterone has on bone mineral density. Measuring bone density is very expensive, and may not be an available option. It is recommended by some gender clinics, particularly if there is concern around likely low bone density, for example where a child has a very low BMI or anorexia. Bone mineral density improves if an adolescent starts gender-affirming hormones (Vlot et al 2016).

To optimize bone health, it is recommended that adolescents on puberty blockers are encouraged to do weight bearing exercise, and have adequate intake of calcium intake and of vitamin D, through sunlight exposure or with a supplement if indicated (Mahfouda et al, 2017). Where there is concern around bone density, consider reducing the length of time an adolescent is on puberty blockers before starting gender-affirming hormones (Telfer 2018).

There is a growing body of smaller studies showing that puberty blockers result in favorable mental health outcomes for trans young people.[37] A recent study, based on data from the largest survey of transgender adults to date, found that that access to pubertal suppression during adolescence is associated with lower odds of lifetime suicidal ideation among transgender young adults (Turbin et al, 2020). Longitudinal cohort studies are underway, including a recent one based in Australia (Tollit MA et al, 2019).

[37]For those wishing to review the studies and academic literature on puberty blockers, this article from a website by two parents of a trans child provides access to a comprehensive overview, with links to all cited papers and a full bibliography. https://growinguptransgender.com/2020/06/10/puberty-blockers-overview-of-the-research/

11.7

Partially reversible gender-affirming hormone treatment for adolescents

Only some of the effects of such hormones are reversible. (Hembree et al., 2017; Coleman et al., 2011).

→TOPIC 8 provides more detailed informed about gender affirming hormone treatment.

In regulated contexts, gender-affirming hormones are available as early as age 16 and may be indicated before 16 in individualized scenarios (Hembree et al., 2017). They are ideally administered with parental or guardian consent and/ or support. As already discussed, the young person should be able to demonstrate informed consent through their understanding of the impact of gender-affirming hormone treatment on their physical, emotional, and social health and wellbeing and understand the potential side effects. This process usually includes support from a specialized youth mental health professional, sometimes in the form of psychotherapy, to ensure the young person can give informed consent.

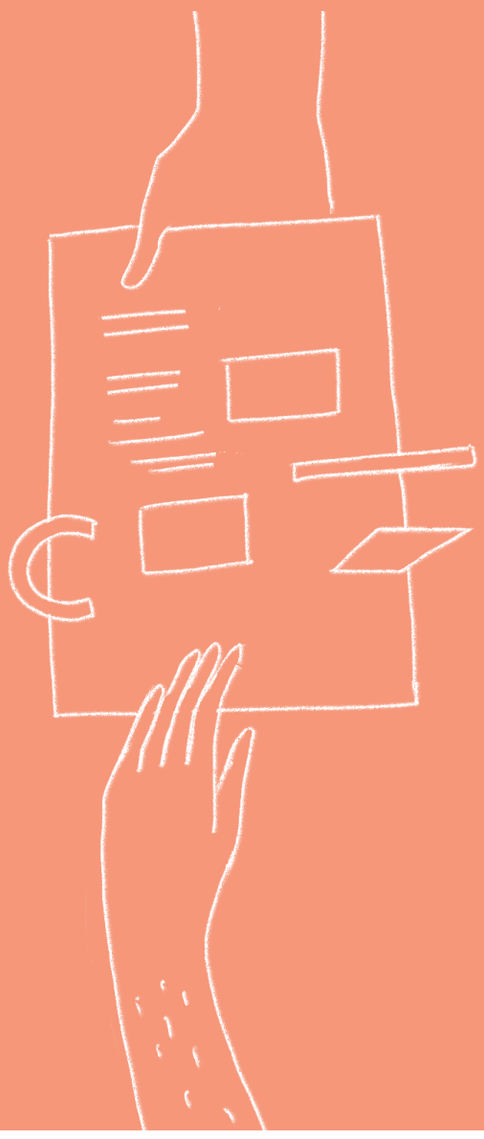
Clinicians prescribing gender-affirming hormones for adolescents who have been on puberty blockers since early puberty (Tanner stage 2-4) should be aware of the specific regimes recommended for pubertal induction that differ from standard hormone prescribing for adults (Hembree et al 2017).

In the lower- and middle-income countries of this region, such mental health expertise is usually not available or affordable for most trans youth. In those countries in Asia where hormones are easily purchased, many young trans people start gender-affirming hormones on their own, or with peers, as early as 11 to 12 years of age, with no supervision by healthcare professionals. Where hormones are available over the counter at low cost, most adolescents already will have initiated hormone treatment without any psychotherapy. If health professionals stipulate that psychotherapy is essential, it may discourage young people from seeking assistance and advice about their transition.

In Thailand, pharmacists and physicians in the vicinity of larger hospitals in Bangkok have worked together to ensure that quality, affordable hormones are available to young people, based on such harm reduction principles. The Gender Variation (Gen-V) Clinic at Ramathibodi Hospital in Bangkok was the first clinic in Thailand for gender diverse children and adolescents. It was officially established in September 2014 by Dr Jiraporn Arunakul, an adolescent medicine specialist. The clinic provides medical care and counselling for any LGBT adolescents, aged 10–24 years, and offers counselling to the parents of LGBT and gender-nonconforming children (Health Policy Project, APTN and UNDP 2015; Panyasuppakun, 2018).

Harm reduction strategies

Harm reduction strategies may be an effective means to reduce the negative consequences of such early and unregulated hormone use. These might include the following:



1. Building trust with trans adolescents so they disclose their hormone usage (type, dosage, and frequency)
2. Educating about correct hormone use, including adjusting dosage over time to mimic natural body processes and to account for body size
3. Educating about the negative health impacts of unregulated hormone use, mindful that this strategy on its own may deter youth from seeking assistance
4. Partnering with older trans peers and role models, who often provide advice to trans and gender diverse youth considering hormone use
5. Educating about the dangers of sharing or reusing needles for injecting hormones
6. Encouraging monitoring by a physician rather than risky, unregulated practices, including by providing a pathway to medical transition in stages appropriate to the adolescent's age and development
7. Assessing for other risk behaviors and addressing accordingly

11.8

Irreversible surgical interventions for trans and gender diverse adolescents

→ **TOPIC 10 provides more details about gender-affirming surgical interventions. These are not reversible.**

Chest reconstructive surgery (also known as top surgery) may be appropriate in the care of trans males during adolescence (Coleman 2012, Marinkovic 2017). It is regularly performed across the world in countries where the age of majority for medical procedures is 16 years.

The decision to undertake irreversible chest reconstructive surgery during adolescence requires considered and thorough assessment by professionals experienced in working with adolescents with gender dysphoria. An individualized approach is needed, assessing the cognitive and emotional maturity of the adolescent, their support networks, and their capacity to understand the risks and benefits of surgical intervention. A decision about whether the surgery is in the adolescent's best interest should be made jointly, with consensus reached between the adolescent, their parents/guardians, and the clinicians involved in their care.

Around the world, it remains relatively uncommon for **genital surgery** to be performed on a patient under the age of 18, though surgeons' views vary (Milrod and Karasic 2017). Decisions regarding an individual adolescent's best interest and ability to consent for genital surgery are more complex because of the greater risks and long-term impacts of these surgeries.

SELF-REFLECTION

Many trans and gender diverse young people in this region start taking hormones early without proper supervision.

How does your clinic practice a harm reduction approach that encourages and enables trans youth to seek medical support for their gender transition goals?

To what extent do you partner with trans peers or organizations to reduce the harm caused by early and unregulated hormone use?

PRACTICE POINTS

- Support the child to explore their gender identity and expression over time, and help them and their family to understand that gender diversity is part of normal human variation.
- Educate that gender is a spectrum, and everyone's gender journey is unique. Encourage people to be open to wherever the journey may lead.
- Listen, affirm, and acknowledge that the young person is the expert on their own gender. Use their chosen name, title, and pronouns (where applicable) if it's safe to do so. Ask what terms the young person uses in other settings.
- If the young person is not accompanied by a caregiver, ask which adult family members could be involved in their healthcare to provide support. Include family in discussions, whenever it is safe to do so, while also being available to listen to the trans young person and their family separately.
- Gently reinforce to family members the importance of affirmation and family support for their child's wellbeing.
- Conduct a broad psychosocial interview such as a HEEADSSS assessment to identify a young person's resilience, screen for any mental health risks, and ensure access to mental health support if required.
- If the child is showing a desire to express a gender other than their sex assigned at birth, provide psychological support and practical assistance to them and their family to facilitate their exploration of socially transitioning.
- Ask the young person or child about any support they may want with their social transition. For example, discuss safe chest binding or consider resources that may support the young person at school.

PRACTICE POINTS

- Advocate on behalf of the adolescent and their family, if necessary, to ensure that gender-affirming support is provided within their school environment or place of work.
- Provide information and education to the adolescent and their parents / carers about options for medical transitioning including risks and benefits of puberty suppression and gender affirming hormones.
- Provide developmentally appropriate education about the impact of puberty blockers or gender-affirming hormones on fertility before these medical interventions commence, including about any available fertility preservation options.
- If needed, discuss menstrual cessation options, and consider the young person's contraceptive needs.
- Be familiar with any pathways for gender-affirming healthcare for young people in your area, including unregulated medical or surgical interventions where harm reduction strategies may be necessary.
- If a child is insistent, consistent, and persistent in their gender identity, or is experiencing gender dysphoria, refer to local gender-affirming services or a specialist experienced in the care of trans and gender diverse adolescents if available.
- Prescribe and/or administer puberty blockers or gender-affirming hormones, working with specialists if necessary, and be aware of the specific gender-affirming hormone regimes for adolescents who have been on puberty blockers since early puberty.

PRACTICE POINTS

- Advise adolescents and their parent(s) / caregiver(s) about available gender-affirming surgical options such as chest reconstruction, providing referrals where appropriate.
- Monitor your patient's physical and medical health if they medically transition, including any risks.
- With the consent of your patient, provide medical documentation to assist them to change their formal identity documents to reflect their correct name and gender marker.

(Adapted from Stephenson 2020 and Telfer 2018)

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TRANS
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12

Advocating for the health and human rights of trans people

Learning objectives

1. Identify opportunities to advocate for individual trans patients, including through supplying letters of support for amending their name or gender on identify documents or administrative records.

2. Consider the range of available complaints mechanisms and how to promote these within your practice.

3. Identify opportunities to work with health professional bodies to advocate for systemic improvements to the health and human rights of trans people.

4. Consider how community-based monitoring (CBM) could assist your service to respond to the needs of your local trans communities.

12.1

Advocating for individual patients

The status given to medical professionals, including in many countries in this region, means this can be an important opportunity to support the informed decisions your transgender patient has made.

Healthcare professionals are often requested to provide letters of support for transgender people using their services.

> **An important component of ethical health care provision is for providers to be advocates for the trans people who use their services. This could include educating or working with family members, schools, workplaces, healthcare settings, and other parts of the community on being inclusive and affirming of trans people. Recognizing stigma, discrimination, and violence as the source of many issues that trans people face . . . all health professionals should work collaboratively with trans people to advocate for social and public policy change to reduce the negative effects of minority stress.**
>
> SOURCE OLIPHANT J ET AL. 2018.

Some healthcare providers work alongside community law centers or other para-legal services to help trans people change their name and gender on identity documents or administrative records, where it is possible. This is particularly helpful when current laws, policies or regulations require evidence from a medical professional. In some countries, including parts of the United States, this type of collaboration is formalized through medical-legal partnerships.[38]

12.2

Promoting complaints mechanisms

Many transgender people are not aware of the complaints mechanisms available for them to complain about the clinical or cultural competence or ethical conduct of health professionals.

Where there are anti-discrimination laws that cover discrimination against transgender people, usually based on their gender identity or expression, these may apply to discrimination when accessing healthcare services. In some countries in this region, transgender people are also able to make complaints under gender equality laws.

In addition to general anti-discrimination protections, transgender people often can make complaints through an individual health practice's internal complaints process, to a health professional body about the conduct of its members, or to independent regulatory bodies.

Transgender people may be reluctant to make complaints, fearing they will be denied care, especially if there are few alternative local providers of gender affirming care. Having posters and other information in public areas asking for feedback about your services and describing available complaints processes can indicate an ongoing commitment to providing clinically and culturally competent care.

[38] https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/08/Transgender-Health-and-Medical-Legal-Partnership-1.pdf

12.3

Advocating for systemic change

While there are few countries in this region that enable transgender people to change their gender marker, health professional bodies have played a significant role in highlighting the health implications of criminalization, and lack of legal gender recognition or anti-discrimination protections.

→ **As TOPIC 11 noted, health professional bodies, including in this region, have opposed so-called "conversion therapy", that is practices designed to change or suppress a person's sexual orientation, gender identity or expression.**

WPATH's public policies have regularly highlighted laws, policies, and court decisions that endanger trans people's health or risk causing significant harm. These have included public statements, letters to governments, and responses to revisions to how gender-affirming healthcare is framed within the International Statistical Classification of Diseases and Related Health Problems (ICD).

There are also three standalone professional associations focusing on transgender health in this region, AusPath in Australia, PATHA in Aotearoa / New Zealand and, most recently, AsiaPath. As Topic 11 noted, in December 2020 all three bodies joined WPATH and other regional associations to express strong disagreement with a United Kingdom court decision that children are highly unlikely to be able to consent to taking puberty blockers. That joint statement highlighted their shared and grave concerns about the ruling's "significantly adverse impact upon gender diverse youth and their families by imposing barriers to care that are costly, needlessly intimidating, and inherently discriminatory".

EXERCISE

Reviewing statements from health professional bodies

These questions can be used as a personal exercise or incorporated into a team or workshop discussion.

- What international, regional or local health professional bodies are you a member of?

- What policies or statements do those bodies have that specifically focus on the right to health for transgender people (e.g. depathologization, access to gender-affirming healthcare)?

- What policies or statements do those bodies have that specifically focus on other human rights issues faced by transgender people (e.g. legal gender recognition, banning conversion therapy practices, etc.)

- What broader policies or statements are consistent with gender-affirming models of care (e.g. support for informed consent, bodily integrity, patient-centered care, or harm reduction)?

12.4

Community-based and community-led monitoring of health services

The human rights standards outlined in the introduction to this module are an important framework for monitoring the right to health, including the extent to which healthcare services are available, accessible (including affordable), and acceptable, and of quality (CESCR 2000).[39]

Community-based monitoring (CBM) is a powerful way of ensuring that monitoring is led by trans people, so that services respond to the needs of their local communities. CBM encourages trans people to assess and score the health services they access. Alongside that process, healthcare professionals review their own service against a checklist ,and develop an action plan to address any weaknesses and gaps.

Within PEPFAR's work, this has been referred to as community-led monitoring (CLM), which puts communities, their needs, and their voices at the center of the HIV response.[40] Existing community-based and/or community-led monitoring activities for key populations often focus on the needs and perspectives of MSM populations. This section of the module includes guidance on APTN's CBM tool to ensure that the perspectives of trans people are specifically considered.

To be effective, CBM processes should be systematic and routine, tailored to the needs of local communities, and solution-oriented. APTN has recently worked with country partners to develop a community-based monitoring tool, Trans COMP. The aim is for health services to improve their work in response to feedback from trans communities, and their own regular auditing of their work.

The Trans COMP community-based monitoring tool has four parts, a scorecard for trans community members (available in two different formats) and a checklist and action plan template for service providers.

The scorecard for trans community members asks people to mark how much they agree with statements about their experiences with:

1. The clinic's reception and other administrative processes and facilities
2. The healthcare provider/s they saw
3. Accessing specific health services
    - HIV prevention, testing and treatment
    - STI diagnosis, testing and treatment
    - Gender-affirming healthcare and
    - Mental health and harm reduction
4. Their general reflections on the service after using it

The spreadsheet version combines the basic generic questions (sections 1,2 and 4) and responses to the mix of services (in section 3) that are relevant to each specific healthcare provider.

The checklist for healthcare providers is divided into these two parts, improving the clinic experience and improving the provision of health services. It is copied below.

After reviewing both their responses and the community members' Trans COMP Scorecard, providers can use a separate template to develop their action plan. This should map out solutions, wherever possible, to mitigate issues raised.

[39]The AAAQ framework draws extensively on General Comment 14 from the United Nations Committee on Economic, Social and Cultural Rights.

[40]https://www.state.gov/community-led-monitoring/

Trans COMP CBM Provider Checklist

Improving clinic experience

#	INDICATOR	Y	N
1.	Our clinic has easily available information both online and offline for patients to learn about our clinic and make appointments with ease.		
2.	Our clinic has trans-inclusive health materials available at the clinic including signage, brochures, and pamphlets.		
3.	Our staff including the receptionist, doctors, and nurses ask each patient their preferred name/ pronouns, and use this name when addressing the patient.		
4.	Our clinic uses a unique identity code (UIC) to ensure confidentiality.		
5.	Our clinic requires informed consent from clients.		
6.	Our clinic works to ensure service affordability.		
7.	Our clinic/organization conducts an annual needs assessment to ensure that we are meeting the needs of the trans community.		
8.	I have participated in such assessments.		
9.	Our clinic/organization conducts cost assessments to support sustainability of new targeted interventions including staffing.		
10.	Our clinic/organization has alternative timings to align with the needs of the community.		
11.	Our clinic/organization has regular refresher trainings on confidentiality and privacy protocols.		
12.	I have been trained and understand the ramifications of confidentiality breaches.		
13.	Our clinic/organization has a policy on how to support trans people's health needs through existing insurance models.		
14.	Our clinic/organization has Trans Friendly Standard Operating Procedures (SOP).		
15.	I am sensitized and trained in this SOP.		
16.	The SOP is revised annually.		
17.	Our clinic/organization has a Working with Vulnerable Populations Workplace Policy.		
18.	I am socialized in this policy.		
19.	This policy is revised annually.		
20.	Our clinic/organization could be defined as understaffed.		
21.	Our clinic/organization has trans staff,mand a policy for hiring trans staff.		
22.	Our clinic/organization provides training on SOGIESC Principles.		
23.	Our clinic/organization provides refresher trainings on SOGIESC Principles.		
24.	Gender identity and expression are included in clearly posted non-discrimination policies/ mission statements/personnel policies.		
25.	Our waiting rooms, intake areas, check out areas, bathrooms, and other physical spaces in our clinic/organization are welcoming to all gender identities.		
26.	Our organization has intake forms that allow patients to write their preferred name, pronouns, and gender identity.		
27.	Our organization reports trans-specific data as was gathered in intake forms, to relevant authorities and does not report their sex assigned at birth.		

Improving provision of health services

#	INDICATOR	Y	N
1.	Our clinic/organization is working on the development of medical protocols/standards/ guidelines/policy of trans-specific health interventions.		
2.	I have been trained on these.		
3.	Our clinic/organization provides training on trans-specific Healthcare including gender-affirming healthcare and mental healthcare		
4.	Our clinic/organization provides training on trans-specific STI/HIV healthcare.		
5.	Our clinic/organization provides refresher and updated training on trans-Specific healthcare.		
6.	Our list of referral service providers includes those that work on harm reduction. Note: For all referral services, this list should also be regularly updated.		
7.	Our list of referral service providers includes those that work on mental health issues.		
8.	Our list of referral service providers includes those that work on sexual and gender-based violence.		
9.	Our list of referral service providers includes those that work on legal aid.		
10.	Our list of referral service providers includes those that offer gender-affirming surgeries and other gender-affirming healthcare services.		
11.	I regularly follow up or check on the status of these kinds of referrals.		
12.	We have mechanisms to ensure that we do not experience stockouts, or use expired medication or condoms/lubricants.		

SELF-REFLECTION

Some elements of this tool have been covered in this module. Work through the full checklist above, answering questions that are relevant to your clinical practice. Where you answer 'No', reflect on:

How this gap could be addressed:

How you could obtain feedback from trans patients or the local trans community about possible improvements to your practice:

PRACTICE POINTS

- Listen to each transgender patient to understand ways that they would appreciate you advocating for them, which may be on an immediate interpersonal level (for example with family members or other health providers) or on a broader level in relation to other settings such as schools and workplaces.
- Work within your professional association and/or through associations focused on transgender health, to advocate for the health, wellbeing, and broader human rights of transgender people.
- Publicize information about transgender people's rights when accessing healthcare, including relevant complaints mechanisms, and about any initiatives to improve trans people's right to health.
- Continue to improve your services by participating in community-based monitoring initiatives such as Trans COMP, which combine regular self-auditing and responding to feedback from your local trans community.

RESOURCES

Committee on Economic, Social and Cultural Rights. 2000. General Comment 14: The right to the highest attainable standard of health, UN. E/C 12/2000/4

The Global Fund. 2020. Community-Based Monitoring: An Overview. https://www.theglobalfund.org/media/9622/core_css_overview_en.pdf

The Royal New Zealand College of General Practitioners. Practice audit: Inclusive primary health care for gender diverse clients. https://s3-ap-southeast-2.amazonaws.com/s3.goodfellowunit.org/symposium_resources/2017/Practice%20audit%20-%20Final.pdf

UNAIDS. 2019. Rights Based Monitoring and Evaluation of National HIV Responses. https://www.unaids.org/sites/default/files/media_asset/JC2968_rights-based-monitoring-evaluation-national-HIV-responses_en.pdf

INTERNATIONAL AND REGIONAL POLICIES

WPATH polices: https://www.wpath.org/policies

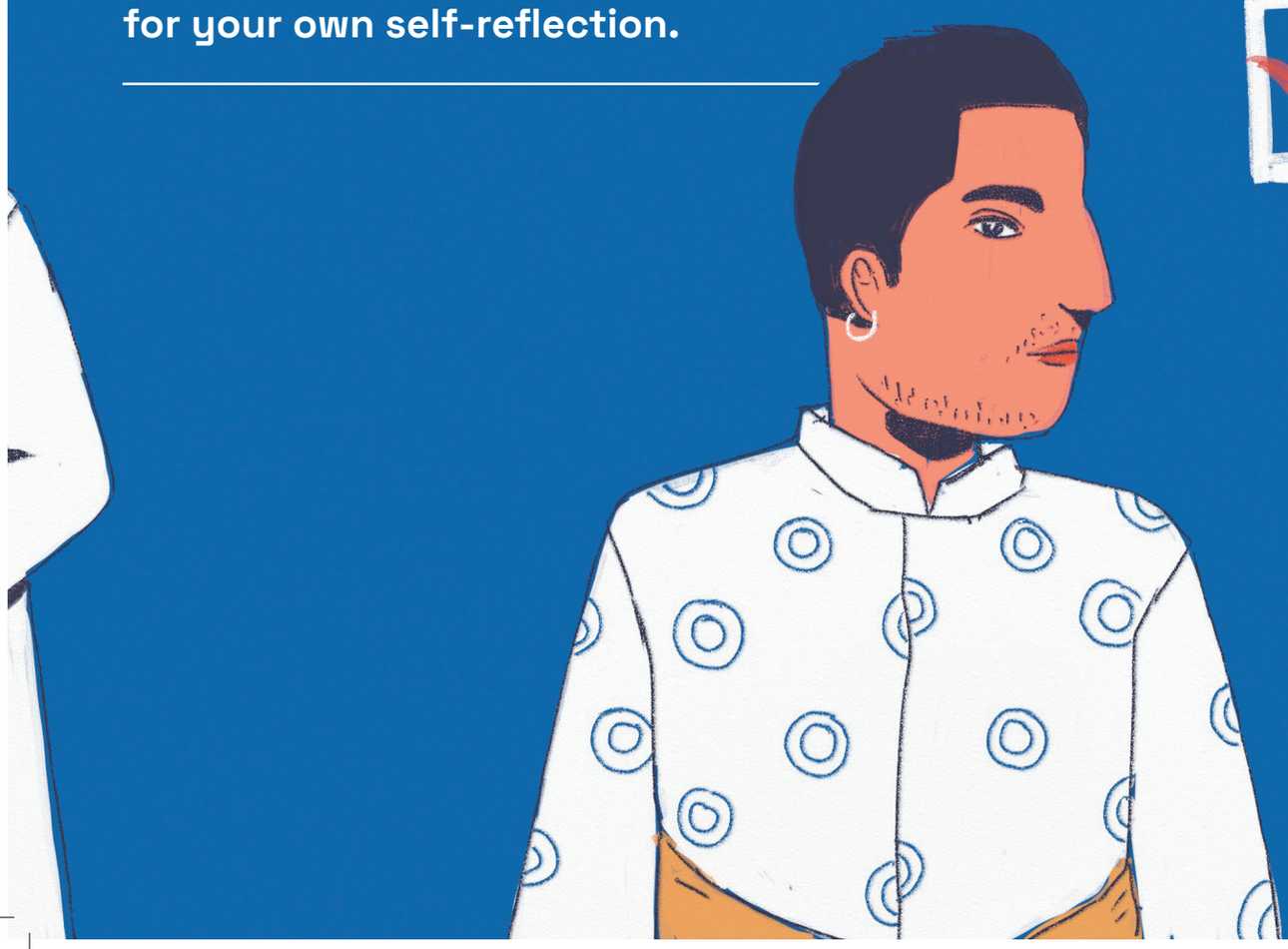
AusPATH polices: https://auspath.org/news/

PATHA policies: https://patha.nz/News

AsiaPath: https://www.asiapath.org/

Closing self-reflection

This self-reflection repeats the statements asked at the beginning of the module. This is a chance to reassess your knowledge and views about transgender health and gender-affirming healthcare. This information is solely for your own self-reflection.



SELF-REFLECTION

Understanding a client's experience of their gender identity will help me provide better care as a clinician. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know enough terms to be comfortable talking with a trans client about their gender identity and gender-affirming healthcare needs. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am competent in discussing mental health issues as part of a holistic psychosocial assessment.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand that gender diversity is not a mental illness, and the role I can play in supporting trans patients around any mental health challenges they experience so that these are not a barrier to accessing gender-affirming healthcare.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand the principles of gender-affirming healthcare and informed consent.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand how to create an affirming and inclusive clinical environment for trans and gender diverse people. STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of how to apply cancer screening guidelines to trans clients.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know how to ask a trans patient about their sexual history using language that is affirming and gives me enough information to know what screenings they may need.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know how to talk with trans women, trans men, and gender diverse people about HIV prevention, care and treatment including any concerns about interactions between gender-affirming hormones and PEP, PrEP or HIV medications.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand key issues in gender-affirming hormone management.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

SELF-REFLECTION

I am aware of how binding, tucking and use of prosthetics such as packers and breast forms can be gender-affirming for many trans people, and I can advise on how to use these safely.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of the range of gender-affirming surgeries and the type of general medical support that may be required before, around, and after surgery.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I understand the roles a general health practitioner can play in supporting a young person's gender journey such as providing psychosocial support and developmentally appropriate information to young people and their family as well as specialist referrals, where indicated and available.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am aware of the options available if my patients wish to access gender-affirming healthcare, including where to refer trans and gender diverse people if they need specialist care.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know where to refer trans and gender diverse people if they need peer support.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I know where to find resources to gain a deeper understanding of HIV prevention, testing and treatment, general healthcare, and gender-affirming healthcare for trans and gender diverse people.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I am comfortable discussing gender-affirming healthcare with my colleagues and friends.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I feel comfortable educating and speaking with a colleague who makes derogatory remarks towards or about trans and gender diverse individuals.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐

I can deliver appropriate and effective healthcare to trans and gender diverse clients.

STRONGLY DISAGREE ☐ DISAGREE ☐ NEUTRAL ☐ AGREE ☐ STRONGLY AGREE ☐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