Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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17 November 2020

9(2)(a) [redacted]

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RE Official information request CDHB 10418

I refer to your email dated 10 September 2020 requesting the following information under the Official Information Act from Canterbury DHB and West Coast DHB. Specifically:

1. **Of the following list of services, which (if any) does the District Health Board provide? Does the DHB provide any services for transgender health care not listed, if so, what?**
   - **Puberty blockers**
   - **Hormone replacement therapy**
   - **Fertility preservation**
   - **Mastectomy**
   - **Hysterectomy**
   - **Orchiectomy**
   - **Facial hair removal**
   - **Breast augmentation**
   - **Voice training**
   - **Facial feminisation surgery**
   - **Genital reconstruction surgery**
   - **Counselling**
   - **Other mental health support (please specify services in response)**

Canterbury DHB funds and provides all the above services for transgender patients on a limited basis, except for facial hair removal and genital reconstruction surgery.

Please refer to the **Appendices** attached.

- **Counselling / Psychological support:**

Specialist Mental Health Service provides gender dysphoria readiness assessments for adults, children and youth.

The Transgender Specialised Assessment Community HealthPathways (CHP) provides options for community counselling including Canterbury DHB funded psychological packages of care as a Pilot. These provide psychological support, counselling, or family therapy in the community for people of all ages who are gender questioning with a psychological need or have mild to moderate psychological issues that do not meet the threshold for Specialist Mental Health Service. (refer to appendices attached).

BIC (Brief Intervention Counselling) is funded at the primary health level to provide counselling services. Referrals are made via the patient's GP. There are criteria, and patients can receive up to 5 free counselling sessions each year for mild to moderate mental health difficulties. BIC counsellors are registered mental health professionals. https://www.healthinfo.org.nz/index.htm?Brief-intervention-counselling-BIC.htm If specialist support is needed, your GP/Specialist will direct you to the right service via Canterbury DHB Specialist Mental Health Service (SMHS).

- **Other mental health support**

Specialist Mental Health Services provide mental health support and treatment for people with serious or acute mental disorders, including addiction, who are unable to be treated elsewhere. This support is equally available to transgender people.

For services provided by the DHB:

2. **What is their current status? What clinic (or clinics) provides the service? Are they accepting new patients?**

Access criteria for referral to services provided by the DHB is documented on the Transgender Specialised Assessment Community HealthPathways (CHP).

General practice can make requests for services aligned to the agreed access criteria as documented on HealthPathways, for Fertility, Mental Health, Endocrinology, Gender-affirming surgery, Primary Care, Speech Therapy, and Fertility Preservation. Please refer to the attached Appendices for the full list of services.

The services listed accept new patients according to their access criteria and, in line with the Ministry of Health guidelines, a first specialist appointment is available within 120 days of the referral being accepted. Follow up appointments are guided by clinical criteria and prioritised accordingly.

3. **Broken down by provided services (and initial consultation and readiness assessments or other if applicable), how long is the current wait time on appointments for transgender health? How long have these wait times been in previous years that the service was available?**

In line with the Ministry of Health guidelines a first specialist appointment is available within 120 days of the referral being accepted, follow up appointments are guided by clinical criteria and prioritised accordingly.

4. **What set(s) of transgender health guidelines are used to inform practice?**

The Oliphant (2018) Guidelines for gender affirming healthcare have been used to inform the Canterbury DHB Clinical Health Pathway relating to transgender healthcare. These guidelines are endorsed and used as a reference point by those clinicians working in the provision of transgender healthcare. The World Professional Association for Transgender Health (WPATH) guidelines are also taken into account. ***https://www.wpath.org/about/ethics-and-standards;***

5. **What requirements are there for patients accessing care? (e.g. Readiness assessment)**

Access criteria document the assessments required for referral to services provided by the DHB. These are documented on the Transgender Specialised Assessment Community HealthPathways (CHP) and vary according to the specialist care being sought.

Patients are assessed based on Community HealthPathways guidelines and may vary, depending on the care being sought.

6. **For HRT specifically, what is the standard practice regarding choice of medication and dosages? Are GPs expected to be able to provide HRT, and if so what support are they given to ensure quality of care? What measures are in place to ensure that all patients are fully informed of all medications that could meet their HRT needs besides the suggested treatment plan?**

Canterbury DHB follows the guidelines set down by the Ministry of Health. There are four phases of gender transition after a diagnosis of Gender Identity Disorder has been made. Information on these phases, which can help assess a person's readiness for gender reassignment surgery is provided on the Ministry of Health website, please find attached as **Appendix 1.**

The Canterbury DHB Clinical Health Pathways provide guidance to clinicians including supporting fully informed patient journey, medication options, written material as well as patient consent forms for feminising hormone therapy and masculinising hormone therapy.

Appendix 1a: Consent form for feminising hormone therapy
Appendix 2: Consent form for starting masculinising hormone therapy

7. **Does the DHB have a Transgender Health Key Worker (or similar)?**

No, the Canterbury DHB does not have a Transgender Health Key Worker (or similar).

A Canterbury Clinical Network Transgender Health Working Group has been established to continue to strengthen the partnership between trans community and health professionals and advise the Canterbury Health system on ways to improve equity of health outcomes for transgender and non-binary people.

8. **Are there any youth-specific service providers? How would an underage person access trans-specific healthcare in the DHB?**

In 2019 a co-design team made up of three members of the transgender community, a member of Manawhenua Ki Waitaha, a GP with an interest in transgender health, and a Pegasus health manager developed services and pathways following international best practice [Telfer 2018] and national guidelines informed by Te Pae Māhutonga [Oliphant 2018].

A report of the process and outcomes of the co-design can be found at https://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Co-design-gender-affirming-care-Jun-2019.pdf

This work was translated into practice as the following Community (CHP) and Hospital (HHP) HealthPathways and a request page (attached as the following appendices):

Appendix 3 - Gender-affirming Hormones (CHP)
Appendix 4 - Gender-affirming Surgery (CHP)
Appendix 5 - Sub-fertility (CHP)
Appendix 6 - Transgender Health in Adults (CHP & HHP)
Appendix 7 - Transgender Health in Children (CHP & HHP)
Appendix 8 - Transgender Health in Youth (CHP & HHP)

Children and youth can access services through general practice aligned with the Community HealthPathways documented in Appendices 7 & 8. They can also access updated information which is publicly available on HealthInfo. https://www.healthinfo.org.nz/gender-identity.htm

9. **When were the available services first offered?**
10. **Have these services ever been unavailable, and if so, between what dates?**

Services are across many specialty areas and we don't record service activity by whether the provision was related to gender affirming care.

For the services that are not provided by the DHB:

11. **Are patients referred elsewhere for these services? If so, where are they referred to?**

Genital reconstruction surgery - This surgical service is provided in Auckland for all genital reconstruction surgery in New Zealand but is funded by the local DHB. Previously referrals were only accepted from a Canterbury DHB specialist, but now any general practitioner can refer by filling in the Ministry of Health referral form which can be found at https://www.health.govt.nz/our-work/preventative-health-wellness/delivering-health-services-transgender-people#forms

12. **Were any of these services ever previously provided by the DHB?**

Facial hair removal and genital reconstruction surgery have not previously been provided by Canterbury DHB

Regardless of transgender health service status:

13. **Is there any additional support made for healthcare needs that are not particular to transgender health but are particular areas of interest for transgender health? e.g. Substance use, mental health care.**

Within Specialist Mental Health Services, there are staff who have a special interest in transgender mental health who provide individual and group supervision to staff who are caring for those on the gender diversity pathway, including support for substance abuse.

14. **What plans are there, if any, to expand or improve care for transgender patients within the DHB?**

A Canterbury Clinical Network Transgender Health Working Group has been established to continue to strengthen the partnership between trans community and health professionals and advise the Canterbury Health system on ways to improve equity of health outcomes for transgender and non-binary people.

15. **Have there been any internal reviews of the care provided or outcomes for transgender patients? If so, what were the results of those reviews, and what action was taken based on them?**

We have recently responded to another Official Information Act request regarding services provided to LGBTQIA and community and transgender and gender diverse populations (CDHB 10427) and this response has been posted on our website.
https://www.cdhb.health.nz/about-us/document-library/?_sft_document_type=official-information-act-response

16. **What measures does the DHB currently have in place to educate healthcare workers not working in transgender health areas on the needs of transgender patients they may encounter? How is their right to be treated with dignity upheld?**

Training programmes are available for Canterbury DHB staff via www.healthlearn.ac.nz The course in 'cultural competency' covers various factors which includes race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation.

Cultural competence in health care is broadly defined as the ability of health practitioners to understand and integrate these factors into the delivery of healthcare practice.

Specialist Mental Health Service has:

- Education available for social workers, community staff and Child and Family Health workers on the needs of transgender patients.
- Consumer and family information kits include transgender community support services.
- Health history and assessment forms include a non-binary option for gender identification.
- There are resources under development to enable mental health staff to better support and work with people from the Rainbow community.
- There is also work underway to update the gender safety policy that includes transgender safety.

17. **Have any actions been taken based on complaints by transgender patients? If so, what actions have been made in response to complaints?**

Specialist Mental Health Service have had two complaints related to delay in gender dysphoria assessment. These delays were related to staff absences and complexity of the individual cases. The only other complaint is related to use of birth name rather than chosen name. In response, the clinical record was updated and staff training on appropriate terminology arranged.

For information across the Canterbury DHB:

As no timeframe was given we have researched with the timeframe that 'Safety first' has been utilised for complaints, since 2018. **Please note:** As we or the complainant don't necessarily utilise the word 'transgender' in the complaint documentation and response as a 'key word' we have reviewed our system based on our staffs' memory of our complaints over the past 2-3 years.

As per Canterbury DHB complaints policy all complaints by transgender patients have been acknowledged and a response provided.

Actions undertaken in response to complaints:

- Acknowledgement, apology offered and, in most cases, a clinical explanation or clarification of the concern. For example, why a certain medication was utilised to alleviate a symptom being experienced. On one occasion a recommendation was made that a further referral was required if the complainant gave permission for that to proceed.
- Canterbury DHB has changed the standard clinic letter format which now states the full name of the patient with no prefixed title or gender indicator.
- Explanation given that Canterbury DHB does offer a female chaperone if required or requested.
- Agreements are now sought in Speech Language Therapy for a student to be included in the consultation and the department agreed to consider a context of 'trauma' when dealing with transgender person's voice concerns
- Canterbury DHB have altered titles on our computer system as requested.
- Canterbury DHB addresses transgender patient by their preferred title in person and have had additional face to face meetings if requested.
- After gender reassignment surgery Staff have been reminded to be alert to specific requests regarding return of tissue/body parts.
- Reminder to staff to review current medications on HealthOne where appropriate

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

APPENDIX 1

Gender reassignment surgery

There are 4 phases of gender transition after a diagnosis of Gender Identity Disorder has been made. Information on these phases, which can help assess a person's readiness for gender reassignment surgery, is provided below.

There are 4 phases of gender transition after a diagnosis of Gender Identity Disorder has been made:

- real life experience in the desired role
- hormones of the desired gender
- surgery to change genitalia and other sexual characteristics
- post-transition monitoring.

It is important to note that not everyone with Gender Identity Disorder will need or desire all these elements of transitioning. Similarly, it is also important to understand there is a difference between **eligibility** for a phase and **readiness** to undertake it.

Real life experience

Who's involved

This phase is assisted and assessed by the psychiatrist and psychologist.

Eligibility

Living and working full time for at least 2 years as a woman/man.

Readiness

Demonstrating further consolidation of the evolving female/male gender identity with consequent improving mental health.

Hormone therapy

Who's involved

This phase is assisted and assessed by the endocrinologist and GP.

Eligibility – for people over 18 years old

- Demonstrating knowledge of what hormones can and cannot do, as well as their risks and benefits.
- Documented real-life experience of more than 3 months and/or counselling for at least 3 months.

Readiness – consolidation of gender identity during real life experience

- Progress in mastering other identified mental health issues.
- Will take hormones in a responsible manner.

The maximum physical response to hormones may take up to 2 years of continued use, and the degree of effect obtained varies widely from person to person. Medically unmonitored hormone therapy is dangerous and can jeopardise or preclude transitioning surgery as can self harming and mutilation.

For some people hormone therapy is adequate for social functioning and surgical intervention becomes unnecessary.

It may be of use to talk about sperm banking with the endocrinologist or GP prior to undertaking hormone therapy.

Surgery

Transitioning in general and surgery in particular, has profound personal, social and medical consequences that need very serious consideration. These impact on all aspects of life – family, vocational, interpersonal, educational, economic and legal. Therefore surgery is only undertaken after comprehensive multidisciplinary evaluation.

A person's suitability for Gender Reassignment Surgery can be assessed using the internationally accepted World Professional Association for Transgender Health's Standards of Care (http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926)

These standards are minimum requirements and therefore it is also important to be mindful of other factors not related to gender identity that may preclude surgery (for example co-existing medical conditions or surgical risk). Similarly, although someone may be eligible to be considered for Gender Reassignment Surgery, both non-medical and medical considerations may impact on their suitability for surgery beyond what is described below.

The journey towards Gender Reassignment Surgery is complex. The decision to offer surgery is by consensus and just undertaking the pre-requisites for surgery does not necessarily mean an operation will be offered.

Who's involved

This phase is assessed and performed by the anaesthetist and surgeons.

Eligibility – for people over 18 years old

- More than 12 months of continuous hormonal treatment .
- More than 2 years of successful and continuous real life experience as a woman/man.
- 2 psychiatric reports by senior psychiatrists with some experience in this field, 1 of which is by an evaluating (not treating) doctor.
- 1 psychologist's report by a senior psychologist or social worker with experience in this field.

Readiness

- Demonstrated progress in transitioning including consolidation of gender identity, dealing with work, family and interpersonal issues as well as significant improvement/stability in mental health
- No other medical conditions that constitute a surgical or anaesthetic risk
- Able to have a full understanding of the procedure with its risks and expected outcomes to allow for the most informed consent.

Funding

A limited amount of funding is available from the Special high cost treatment pool (/our-work/hospitals-and-specialist-care/high-cost-treatment-pool).

Post-transition follow-up

Postoperative follow-up is one of the factors associated with a good outcome and therefore the ability and readiness of someone to commit to this forms part of their evaluation.

After surgery the person is asked to:

- stay in regular touch with a doctor for the ongoing prescribing of hormonal therapy
- be monitored for possible conditions consequent to the medical and surgical interventions
- continue with normal screening (eg, for prostate cancer)
- be open to further mental health input that would assist with any problems adjusting after operation.

Follow-up is helpful to the person, but it also improves the understanding of the limits and benefits of this type of surgery so as to enable the best possible counselling and assessment of others who might follow.

Consent form for feminising hormone therapy

This consent form outlines important information you might want to talk to your health team about before starting hormones to feminise the body.

Progynova (estradiol valerate) tablets or **Estradot** (estradiol hemihydrate) patches provide the feminising hormone estrogen. Testosterone blockers are needed as well unless gender reassignment surgery has occurred.

Estrogen tablets/patches will gradually feminise the body.

Permanent body changes (even if you stop taking the tablets):

- Gradual increase in breast size over 2-3 years
- Your estrogen dose is increased slowly for best breast development
- It is not known if taking estrogen increases the risk of breast cancer. Take care of your breasts - it is recommended to follow the normal breast screening guidelines for women

Non-permanent body changes (that may reverse if you stop the estrogen):

- Softer skin
- Decreased muscle mass
- Less body hair
- More fat on buttocks, hips and thighs

Things that don't change much:

- Facial hair slows down but doesn't stop completely
- Voice stays the same
- Bone structure of your face and Adam's apple doesn't change

If you stop taking your hormones some body changes stay but you may find that your body will slowly masculinise.

Fertility

Taking the hormones stops your testicles producing testosterone. Your testicles may shrink by up to 50% and may eventually stop sperm production. If it is important for you to preserve your fertility you might want to freeze your sperm before you start treatment. Your health team will talk to you about this.

Sex

Taking the tablets may lower your sex drive so that you are not as interested in having sex anymore. You may find that you get erections less often and that your penis doesn't get as hard anymore. If you want to be able to use your penis for sexual pleasure talk to your health team and they will review your medications.

Mental health

Some people may feel more emotional taking estrogen. Some people find their mental health improves – the effects of hormones on the brain are not fully understood. Transitioning can be a stressful time and many people need some help adjusting to the physical and emotional changes. It is really important that you let your health team know if you are having problems so that they can help you access the support you need.

Common side effects

- Nausea
- Headaches
- Tender breasts
- Weight gain

Most side effects should settle within a few days to weeks of starting the medications. Please tell your health team if you have any side effects, especially headaches or migraines.

Adapted with permission from Hauora Tāhine.

Potential risks of estrogen

The full medical effects and safety of taking hormones are not fully known. The potential risks of taking estrogen must be weighed against the benefits that hormones can have on your health and quality of life.

Likely increased risk

- Blood clots - deep vein thrombosis (DVT), pulmonary embolism (blood clot in the lung), stroke, heart attack
- Changes to cholesterol (may increase risk of pancreatitis and heart disease)
- Gallstones

Possible increased risk

- Increased blood pressure
- Liver problems
- Increased prolactin and possibility of benign pituitary tumours

Possible increased risk if you have extra risk factors

- Heart disease
- Diabetes

No increased risk/unknown risk

- Breast cancer

Some of these risks are reduced by using estrogen patches instead of tablets.

Go to the emergency department or seek medical help urgently if:

- You have a swollen painful leg
- Chest pain or difficulty breathing
- Vision or speech problems

These symptoms might mean you have a serious problem like a blood clot.

The risk of having a blood clot is much higher if you smoke or are overweight.

Blood clots are more common as you get older. Stopping estrogen before and after surgery can help reduce the risks of blood clots around this time.

Keeping in touch with your health team for regular checkups and blood tests is an important part of your care and will reduce the risks of taking hormonal therapy.

Are there any other questions you want to ask?

It is your health team's responsibility to best support you to make the decisions that are right for you and to keep ourselves up to date so that we can best inform you.

For many different reasons people question whether or not they want to continue to take hormones. This can be a normal part of your journey. Please feel free to discuss this with your prescriber before you stop your medication. Come and talk – your health team is always ready to listen.

I wish to start feminising hormone therapy:	
Name	Date

Prescribed by:	
Name	Date

Adapted with permission from Hauora Tāhine.

APPENDIX 2

Consent form for starting masculinising hormone therapy

This consent form outlines important information you might want to talk to your health team about before starting hormones to masculinise the body.

There are different types of testosterone that are taken to masculinise the body. Everyone is different in how quickly they respond to testosterone but you will start to notice changes in your body gradually over the first few months. It may take several years before the full effect is felt. While there are different ways of getting testosterone into the body most people are on injections.

Permanent body changes *(even if you stop taking testosterone)*:

- Deeper voice
- Increased growth of hair – with thicker hairs on arms, legs, chest, back and abdomen
- Gradual growth of moustache/beard hair
- Hair loss at the temples – possibly becoming bald with time
- Genital changes – clitoral growth (typically 1 - 3 cm) and vaginal dryness

Non-permanent body changes *(that may reverse if you stop the testosterone)*:

- Skin changes – increased oil and acne
- Change in body shape – less fat on buttocks, hips and thighs
- Increased muscle mass and upper body strength
- Increased sex drive
- Periods usually stop after 1-6 months

Things that don't change much:

- Breast tissue looks a bit smaller due to fat loss
- Possible weight gain or loss

Fertility

While it is not known what the long term effects are of taking testosterone some transmen find that if they stop their testosterone they will become fertile again and can get pregnant. There are no guarantees for anyone and it is probably harder to get pregnant the older you are and the longer you have been on testosterone.

Testosterone is dangerous for the developing fetus – **you must not get pregnant while you are on testosterone.** Even after your periods stop you might still be at risk of getting pregnant. If you are having any sexual contact that puts you at risk of pregnancy you must talk to your health team about contraception options.

Sex

Taking testosterone causes your vagina to become dryer and more fragile. This increases the risk of sexually transmitted infections (STIs), including HIV if you are having any sexual contact with this part of the body. Condoms provide good protection against STIs and lubricant helps to prevent any discomfort.

Mental health

Some people find that testosterone can cause emotional changes such as increased irritation, frustration and anger. Some people find their mental health improves – the effects of hormones on the brain are not fully understood. Transitioning can be a stressful time and many people need some help adjusting to the physical and emotional changes. It is really important that you let your health team know if you are having problems so that they can help you access the support you need.

Adapted with permission from Hauora Tāhine.

Potential risks of testosterone

The full medical effects and safety of taking hormones are not fully known. The potential risks of taking testosterone must be weighed against the benefits that hormones can have on your health and quality of life.

Likely increased risk

- Increased red blood cells (polycythemia) - might thicken the blood and increase the risk of a stroke or heart attack
- Sleep apnoea (sleep disorder)

Possible increased risk

- Changes to cholesterol (may increase risk for heart disease)
- Liver problems

Possible increased risk if you have additional risk factors

- Diabetes
- Increased blood pressure

No increased risk or unknown

- Breast cancer
- Cervical, ovarian, uterine cancer
- Blood clots – deep vein thrombosis (DVT)

The risk of health problems is higher if you are a smoker or overweight.

Keeping in touch with your health team for regular checkups and blood tests is an important part of your care and will reduce the risks of taking hormonal therapy.

Are there any other questions you want to ask?

It is your health team's responsibility to best support you to make the decisions that are right for you and to keep ourselves up to date so that we can best inform you.

For many different reasons people question whether or not they want to continue to take hormones. This can be a normal part of your journey. Please feel free to discuss this with your prescriber before you stop your medication. Come and talk – your health team is always ready to listen.

I wish to start masculinising hormone therapy:	
Name	Date

Prescribed by:	
Name	Date

Adapted with permission from Hauora Tāhine.

APPENDIX 3

Community HealthPathways Canterbury

Gender-affirming Hormones

This pathway is about gender-affirming hormone treatment and ongoing management. For puberty blockers, see Transgender Health in Children. See also:

- Transgender Health in Adults
- Transgender Health in Youth

Background

About gender-affirming hormones

About gender-affirming hormones

There are 3 types of hormone treatments which can be used in transgender health

- Puberty blockers using gonadotropin-releasing hormone (GnRH) agonists to suppress puberty and secondary sexual characteristics. This treatment is reversible. If discontinued, the young person will go though endogenous puberty after approximately six months – including retained ability to ovulate or produce sperm. These are not discussed in this pathway, see Transgender Health in Children.
- Gender-affirming hormone therapy or gender-affirming hormones – estrogen and testosterone. These are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the appropriate gender. These are considered irreversible.
- Anti-androgens, which block the effects of testosterone on the body – spironolactone or cyproterone.

Gender-affirming hormone therapy usually starts at 16 years of age, though there is recognition of consideration in younger people in special circumstances.

There is no upper age limit to starting hormones.

Assessment

1. Assess medical, sexual health and mental health conditions
2. Consider any precautions before hormonal treatment.

Precautions before hormonal treatment

- Current or recent smoker
- Heart failure, cerebrovascular disease, coronary artery disease, atrial fibrillation (AF)

- Cardiovascular risk factors – Body mass index (BMI) > 30, hyperlipidaemia, hypertension
- History of hormone-sensitive cancers, e.g. breast, prostate, uterine
- Possible drug interactions
- Sleep apnoea
- Some intersex disorders of sex development (DSD) conditions
- Pregnancy

Estrogen only:

- History or family history of venous thromboembolism (VTE)
- Migraine

3. Check if the patient meets the criteria for hormone treatment

Criteria for hormone treatment

- Persistent well documented gender dysphoria
- A single psychological assessment for gender dysphoria (see Transgender Health in Children, Transgender Health in Youth, or Transgender Health in Adults pathway for provision of this service in Canterbury)
- Capacity to make a fully informed decision and the consent for treatment (see Transgender Health in Youth to assess)
- Age of consent 16 years, except under special conditions
- If significant medical or mental health concerns are present, they must be reasonably controlled.

4. Examination – measure body mass index (BMI) and blood pressure (BP). A physical examination of secondary sexual development is rarely indicated.
5. Investigations:
   - Arrange baseline tests before feminising therapy

Baseline assessment before feminising therapy

Blood tests:

- Electrolytes and creatinine if starting spironolactone
- HbA1c and lipids if risk factors
- Prolactin, luteinizing hormone (LH), and pre-9am testosterone levels.

   - Arrange baseline tests before masculinising therapy

Baseline assessment before masculinising therapy

- Blood tests:
  - CBC, LFT, lipids.
  - HbA1c if risk factors.
  - Luteinizing hormone (LH), estradiol, and testosterone levels.
- Urine HCG if appropriate. Testosterone is contraindicated in pregnancy.

Management

1. Ensure informed consent.

Informed consent

It may take a number of consultations to start treatment. This is to ensure the patients understanding of the treatments and the potential for irreversible outcomes. Provide hormone therapy form for information and consent:

- Consent Form for Feminising Hormone Therapy
- Consent Form for Masculinising Hormone Therapy

2. Provide information and supports.
3. Discuss fertility preservation, as hormonal therapy may affect future fertility.

Fertility preservation

- Discuss the patient's desire for fertility preservation.
- Decisions are best made before starting puberty blockers, hormone therapy, or undergoing surgery to reproductive organs.
- Sperm preservation:
  - For patients on feminising therapy, testicular volume is greatly reduced by long-term estrogen use, which impacts on the maturation and motility of sperm.
  - If the patient is in late puberty or post-puberty, consider sperm storage as mature sperm are likely to be present. For younger people, request fertility assessment or advice regarding the viability of fertility preservation. Advice and preservation is publicly funded.
  - Provide fertility preservation information for those starting estrogen.
- Ovarian tissue or egg preservation:
  - Patients on masculinising therapy who retain their ovaries and uteri may regain fertility after stopping testosterone. The likelihood of successful pregnancy is related to the person's age.
  - Discuss ovarian tissue or egg preservation. These require invasive procedures that are not currently publicly funded unless the patient is having a publicly funded

hysterectomy or oophorectomy.

- If the patient has complex questions regarding sperm or egg viability, storage times, and treatment options in the future (e.g. testicular biopsy and storage), request fertility specialised assessment (this is publicly funded).

4. Initiate hormone therapy or refer for initiation if outside of scope. Initiating hormone therapy usually occurs in secondary care (endocrinology) or, if the patient is older than 20, is carried out by a general practitioner with an interest in transgender care.

- Initiating feminising hormone therapy

Initiating feminising hormone therapy

- Consider whether a puberty blocker should be used in addition to gender-affirming hormone therapy – see Transgender Health in Children.
- Prescribe estrogen.

Estrogen options

Transdermal estrogen has lower risk for venous thromboembolism (VTE) so should be considered, especially in patients older than 40 years, with raised BMI or with other risk factors for VTE.

- NZF Estradiol valerate (Progynova) – starting dose 1 mg daily, usual maintenance 2 to 4 mg, maximum 6 mg
- NZF Estradiol patch (Estradot) – starting dose 25 microgram patch twice weekly, usual maintainence 100 to 200 microgram patch twice weekly

- Prescribe antiandrogens unless the patient has had an orchidectomy or genital reassignment surgery.

Antiandrogens

- NZF Cyproterone – starting dose 25 to 50 mg daily, usual maintenance 25 to 50 mg daily although smaller doses of 12.5 mg may be effective
- NZF Spironolactone – starting dose 50 to 100 mg daily, usual maintenance 100 to 200 mg daily

- Progesterone therapy is not recommended as it is not effective at improving breast development and is associated with breast cancer, depression, weight gain and cardiovascular disease (CVD).
- Discuss effects and reversibility of feminising hormones.

- Initiating masculinising hormone therapy

Initiating masculinising hormone therapy

- If the patient is prepubertal or in early puberty, consider whether a puberty blocker should be used prior to or in addition to gender-affirming hormone therapy, see Transgender Health in Children.
- Discuss:
  - whether testosterone is appropriate. Testosterone is:
    - contraindicated in pregnancy.
    - not recommended while breastfeeding as it inhibits lactation.
  - the effects and reversibility of masculinising hormones.
- Prescribe testosterone.

> **Prescribe Testosterone**
>
> - Testosterone cypionate (Depo-Testosterone) 1 g/10 mL. Commence 50 mg (0.5 mL) every 2 weeks. For adolescents gradually increase every 6 months by 50 mg per dose. Consider a more rapid increase in adults, increasing every 3 months by 50 mg per dose until the patient is taking 200 mg every 2 weeks.
> - Other less favoured options include:
>   - Testosterone esters (Sustanon) 250 mg/mL. The usual final dose is 250 mg every 3 weeks but this can be built up over 3 to 6 injections.
>   - Testosterone patches (Androderm) 2.5 or 5 mg. The usual dose is 5 mg applied at night, but the patient can start with 2.5 mg patch and increase to 5 mg dose after 3 to 6 months.
> - When on a full maintenance dose, transition to Reandron 1000 mg intramuscularly every 10 to 14 weeks (second dose at 6 weeks to achieve steady state).
> - See guidelines for more information.

- Discuss contraception.

> **Contraception**
>
> Testosterone is not adequate contraception even if periods have ceased. For contraception and menstrual suppression if patient is not on puberty blocker see Transgender Health in Adults.

5. Provide monitoring and ongoing prescribing of hormones:

- Feminising hormones

> **Monitoring and ongoing prescribing of feminising hormones**

- Hormone prescribing consultations

Hormone prescribing consultations

- Blood pressure (BP) and body mass index (BMI)
- Effects of hormones on physical and emotional health
- Review of doses and desire for change
- Side effects of hormones
- Mental health and body image assessment
- Social Supports
- Lifestyle, e.g. smoking exercise and nutrition

- Frequent measurement of estradiol levels is not advocated.

Frequent measurement of estradiol levels is not advocated

- Frequent measurement of estradiol levels may produce variable results.
- The main reason to measure estrogen levels is to avoid over-replacement.
- Oral estrogen preparations are not accurately measured by the plasma estradiol assay and measurement is of little value for patients using these preparations.

- Annual and biennial investigations

Annual and biennial investigations

- Once a year:
  - Electrolytes – monitor more frequently if on spironolactone
  - LFT
  - HbA1c – if risk factors suggest it is indicated
  - Lipids – if risk factors suggest it is indicated
  - Oestradiol - avoid supraphysiological levels (target less than 500 pmol/L)
  - Testosterone (aim for level less than 2 nmol/L)
- Once every 2 years – Prolactin

- If major risk factors for osteoporosis, consider a bone density scan.
- Consider the adverse effects of feminising hormone therapy.

Adverse effects of feminising hormone therapy

- Venous thromboembolism (VTE) – reduced risk on transdermal estrogen.
- Liver dysfunction, gallstones
- Insulin resistance
- Cardiovascular disease (CVD) – lipids and hypertension
- Alterations in mood and libido
- Small risk of osteoporosis, breast cancer and hyperprolactinaemia

- Masculinising hormones

Monitoring and ongoing prescribing of masculinising hormones

- Hormone prescribing consultations

Hormone prescribing consultations

- Blood pressure (BP) and body mass index (BMI)
- Effects of hormones on physical and emotional health
- Review contraception requirements
- Review of doses and desire for change
- Side effects of hormones
- Mental health and body image assessment
- Social Supports
- Lifestyle, e.g. smoking exercise and nutrition

- Annual investigations

Annual investigations

- CBC – every 3 months for first year, then 1 to 2 times a year
- LFT
- Lipids
- Testosterone – aim for normal male range. Measurement of hormone levels:
  - For Depo-Testosterone or Sustanon, measure at mid-point of injections to ensure levels are supraphysiological, and measure pre-injection to ensure correct dosing frequency.
  - For Reandron, measure immediately prior to injection.
- HbA1c if risk factors

- If major risk factors for osteoporosis, consider bone density.
- Consider the adverse effects of masculinising hormone therapy.

> **Adverse effects of masculinising hormone therapy**
>
> - Polycythaemia – consider reducing testosterone dose if haematocrit is above 0.54
> - Cardiovascular disease (CVD) risk
> - Mood changes
> - Acne
> - Obstructive sleep apnea (OSA)
> - Small risk of liver dysfunction, insulin resistance, and endometrial hyperplasia

Information

For health professionals

Further information

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Association of Transgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Association for Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identity

Printable Resources

- Canterbury DHB - Fertility Preservation Information for Those Starting Estrogen

Patient Support Information

- Ministry of Health – Transgender New Zealanders

Search My Medicines for patient information leaflets for any medications not listed in this section.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.

KEY LINKS

- Consent Form for Feminising Hormone Therapy
- Consent Form for Masculinising Hormone Therapy

Topic ID: 610143

APPENDIX 4

Community HealthPathways Canterbury

Gender-affirming Surgery

I

This page is about preparation for gender-affirming surgeries for patients aged 18 and over. See also:

- Transgender Health in Children for pre-puberty or early puberty
- Transgender Health in Adults
- Transgender Health in Youth

Background

About gender-affirming surgery

About gender-affirming surgery

While some transgender people are comfortable with the expression of their gender identity without some form of surgery, for others surgery is essential to alleviate their body dysphoria and/or live fully and authentically in their gender.[1]

Canterbury DHB offers a range of feminising and masculinising surgeries. Genital reconstruction surgery is not provided in Canterbury, but patients from Canterbury DHB can be referred to the Gender Affirming (Genital) Surgery Service via a DHB specialist or any general practitioner. There is currently 1 surgeon (based in Auckland) providing genital reconstruction surgery in New Zealand, so the waiting list is long.

Assessment

1. Measure body mass index (BMI).
2. Check if the patient meets the current inclusion criteria for surgery:
   - Chest reconstruction surgery – either mastectomy or augmentation.

Chest reconstruction surgery

- Persistent, well documented gender dysphoria, having completed 1 psychological/psychiatric assessment. The readiness for hormones assessment done prior to hormones is acceptable. A patient that has not had an assessment would require a formal assessment.
- Capacity to make fully informed decision and to consent for treatment.
- Aged 18 years or over

- 2 or more years of hormone therapy (not a pre-requisite for mastectomy/masculinising chest surgery.
- Significant reduction in quality of life. See Ministry of Health Impact on Life Scale.

> **Ministry of Health Impact on Life Scale**
>
> - English
> - Cook Island
> - Hindi
> - Māori
> - Simplified Chinese
> - Traditional Chinese
>
> The questionnaire should be filled out by the general practitioner or nurse with the patient.

- If significant medical or mental health concerns are present, they must be reasonably controlled
- Non-smoker and nicotine-free for longer than 3 months

> **Nicotine-free**
>
> All products that contain nicotine have an adverse affect on wound healing. Patients must be smoke-free, and no longer using nicotine replacement therapy and vaping products which contain nicotine, for at least 3 months before surgery.

- BMI less than 32

- Orchidectomy, hysterectomy, oopherectomy

Orchidectomy, hysterectomy, oopherectomy

- Persistent, well documented gender dysphoria, having completed 1 psychological/psychiatric assessment. The readiness for hormones assessment done prior to hormones is acceptable. A patient that has not had an assessment would require a formal assessment.
- Capacity to make fully informed decision and to consent for treatment.
- Aged 18 years or over.
- 2 or more years of hormone therapy.
- Significant reduction in quality of life. See Ministry of Health Impact on Life Scale.

- If significant medical concerns are present, they must be reasonably controlled. If significant mental health concerns are present they must be well controlled.
- Non-smoker and nicotine-free for longer than 3 months.

3. Check for exclusion criteria. These patients cannot be referred.

Exclusion criteria

- Current smoker. The patient must be a non-smoker and nicotine-free for at least 3 months.
- Poorly controlled medical health, e.g. chronic obstructive pulmonary disease (COPD), ischaemic heart disease (IHD), hypertension.
- Poorly controlled mental health.
- BMI greater than 32 (chest surgery only).

4. Investigations – Arrange HbA1c, CBC, LFT, renal and any other blood tests relevant to a patient's medical condition.

Management

1. Prepare the patient for possible referral outcomes.

Possible referral outcomes

Ensure the patient understands that the referral for surgery does not guarantee surgery, and that they can be declined at any step in the process.

The patient may be invited for medical photography for chest surgery. This is to ensure adequate surgical planning. Acknowledge that the dysphoric patient may find this difficult. Advise the patient that they will be able to bring a support person if desired.

2. If referring for oophorectomy, hysterectomy or orchidectomy, discuss fertility and sexual health:
   - Sperm storage is available on the public service in Canterbury DHB. Testicular biopsy, and egg retrieval and storage are not publicly funded. Consider private options.
   - Fertility treatment is a complex area which would usually require the patient stopping gender-affirming hormone therapy for a time. Consider seeking advice from a general practitioner colleague with an interest in transgender care, or written fertility advice.
3. If a smoker, offer smoking cessation.
4. If mental health issues which are not well controlled, offer mental health community support or specialist mental health referrals (as is appropriate to severity of symptoms) to achieve moderately to well-controlled mental health.
5. Ensure that any medical conditions are well controlled, e.g. hypertension, diabetes.

6. For concerns about surgery or further discussion about the patient's care or health navigation, consider referral for discussion, or contacting a general practitioner colleague with an interest in transgender care.

7. Request a mental health assessment for gender dysphoria, if not already done, before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if patient wishes to start hormones, puberty blockers or is considering surgical procedure.
>
> - If patient is younger than 18 years, or aged 18 years and still at school, request non-acute child and adolescent mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervention assessment".
> - If patient is 18 years or older (unless aged 18 and still at school), request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervention assessment".
> - For genital reconstruction surgery, national and international guidelines state that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waiting list is long, only 1 assessment is required. If a patient has already had a psychological assessment before starting hormone treatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstruction waiting list.
>
> As the waiting list for public mental health assessments is long, patients may wish to consider private options.

8. For chest surgery, orchidectomy, hysterectomy, oophorectomy, request a surgical assessment from the appropriate department.

9. For genital reconstruction surgery, refer to the the Gender-affirming (Genital) Surgery Service.

> **Gender-affirming (Genital) Surgery Service**
>
> This surgical service is provided in Auckland for all genital reconstruction surgery in New Zealand, but is funded by the local DHB. Previously referrals were only accepted from a Canterbury DHB specialist, but now any general practitioner can refer by filling in the Ministry of Heath referral form.
>
> For more info, see Ministry of Health – Updates from the Gender Affirming (Genital) Surgery Service
>
> Email referral forms to gender.surgery@health.govt.nz and include a copy to Ralph.Lasalle@cdhb.health.nz

Request

- For concerns about surgery or further discussion about the patient's care or health navigation, consider referral for discussion, or contacting a general practitioner colleague with an interest in transgender care.
- Consider seeking advice on fertility treatment from a general practitioner colleague with an interest in transgender care, or written fertility advice.
- For chest surgery, orchidectomy, hysterectomy, oophorectomy, request a surgical assessment from the appropriate department.
- For genital reconstruction surgery, refer to the the Gender-affirming (Genital) Surgery Service.
- Request a mental health assessment for readiness for surgery only if no previous assessment has been done. Only 1 assessment is required regardless of whether it is for hormones or for surgery.

Information

For health professionals

Further information

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Association of Transgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Association for Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identity

Search My Medicines for patient information leaflets for any medications not listed in this section.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.

Topic ID: 609837

APPENDIX 5

Community HealthPathways Canterbury

Sub-fertility

Background

About sub-fertility

About sub-fertility

- 1 in 5 couples in New Zealand experience fertility problems.
- 80% of couples wanting to conceive will do so within a year.
- Age is the most important determinant of a woman's fertility. There is also some decline in male fertility from 40 years of age and a reduction in sperm quality with age.
- Smoking has a direct negative effect on fertility. In women, it halves the chance of conception each month. Smokers are not eligible for public fertility funding.
- Alcohol (> 8 standard drinks per week for women and ≥ 20 for men) is associated with reduced fertility.
- High caffeine intake may reduce fertility.

Assessment

1. Ask the couple about this history.

   History

   - Time trying to conceive
   - Previous pregnancies for either
   - Smoking and alcohol intake
   - Frequency and timing of intercourse

2. For women, check:
   - menstrual and gynaecological history.
   - previous investigations or treatments.
3. For men, check for significant history.

   Male significant history

- Erectile dysfunction
- Testicular, e.g. infection, trauma, tumour, surgery
- Congenital anomalies
- Genetic problem, e.g. cystic fibrosis, Klinefelter syndrome

4. Examination:
   - female – BMI, pelvic examination, STI screen.

Sexually transmitted infection (STI) screen

- If patient is asymptomatic, perform a clinician-collected or a self-collected vulvovaginal nucleic acid amplification test (NAAT) chlamydia swab. Do not screen for chlamydia using serological tests.[1] In Canterbury, both labs perform gonorrhoea tests on all chlamydia requests.

Nucleic acid amplification (NAAT) test

- Molecular test for the detection of organism-specific DNA.
- Relatively high sensitivity and specificity, but both false positives and false negatives do occur.
- The diagnostic test platforms have not been fully validated for extragenital and non-urine specimens, but NAATs are more sensitive than culture and are recommended in these situations.
- Local laboratory NAAT testing of urine and swabs checks for chlamydia and gonorrhoea.

Vulvovaginal nucleic acid amplification test (NAAT) swab

Clinical collection

- Canterbury SCL:
  - Use the pink shank swab.
  - Rub the swab around the external urethral area 2 to 3 times.
  - Slide it about 5 cm into the vagina and rotate it around the vaginal walls for 5 to 10 seconds.
  - Insert the cotton bud end of the swab into the orange-label tube, snap the shaft off at the black line, and replace the container top tightly.
- Canterbury Health Laboratories – Use the orange-topped collection tube for all chlamydia swab testing.
- See swab guides.

Swab guides

Canterbury SCL:

- Bacterial and Viral Swab Guide
- Sexually Transmitted Infection (STI) or Genital Swab Guide

Canterbury Health Laboratories – Swab Identification Guide

Patient instructions – See Instructions for using Self-collected Pink Shank Swabs

Calculate BMI

Body mass index = kg/m^2 (weight divided by height squared)

Use the Ministry of Health's healthy weight calculator.

- Less than 18.5 = underweight
- Between 18.5 and 24.9 = healthy weight
- Between 25 and 29.9 = slightly unhealthy weight (overweight)
- Over 30 = very unhealthy weight (obese)

- male – assess genitals if any significant history.

5. The threshold for considering investigations is lower than the threshold for publicly funded specialist assessment. Consider investigations for both male and female partners if trying to conceive for either:

Investigations

The referral threshold for publicly funded specialist assessment of sub-fertility is much higher than the threshold for considering investigations.

These investigations are required for all sub-fertility referrals:

Male partner

Semen analysis:

- Use the Request for Semen Analysis form and give patients instructions for seminal fluid collection. The instructions on the form must be followed.
  - Ashburton Seminal Fluid Collection Instructions
  - Christchurch Seminal Fluid Collection Instructions
- Both the male and female's NHI number must be included on the form to identify the partners.

- The sample needs to be taken to Canterbury SCL. There is no charge to the patient for using this lab.
- If the first sample is abnormal, organise to repeat the sample in 4 to 6 weeks.

Normal ranges for fertility analysis

Volume	> 1.4 mL
pH	> 7.1 at 1 hour
Sperm Count	> 14 million/mL
Motility: Progressive	> 32%
Motility: Progressive + Non-progressive	> 39%
Morphology	> 3% normal forms

Female partner

- Day 3 FSH and oestrogen (estradiol E2) – It is essential to do this on day 2 to 4 of the cycle. Order ovulation disorder blood tests at the same time, if an ovulation disorder is suspected.

Tests for suspected ovulation disorder

- Prolactin
- FSH, Free androgen index, free testosterone, SHBG (day 2 to 4)
- Thyroid function tests
- See also – PCOS

- Day 21 progesterone. For women with a prolonged cycle, do a day 21 progesterone, then advise the patient and write on the lab form that this needs to be repeated every 7 days until menstruation e.g., day 21, 28, 35. Progesterone levels > 20 nmol/L indicate ovulation is likely.
- For patients who are amenorrhoeic or oligomenorrhoeic, appropriate timing can be achieved by doing a progestogen challenge test following a negative pregnancy test.

Progestogen challenge

Prescribe NZF norethisterone 10 mg twice a day for 5 days.

Menstruation should start 48 to 72 hours later, blood tests can then be timed and taken.

- Antenatal bloods (and HIV) – these include rubella.

  Rubella

  If the patient is not immune, offer vaccination. Advise to avoid pregnancy for one month after vaccination.

- Cervical smear and STI screen.

- > 6 months and the female partner is aged ≥ 35 years, or
- > 12 months if the female partner is aged < 35 years

and/or

- predisposing factors that may affect fertility, e.g. oligomenorrhoea, undescended testes, signs or symptoms consistent with endometriosis.

Management

1. Discuss lifestyle advice for men and women.

   Lifestyle advice

   - Advise about smoking cessation.
   - Discuss healthy body mass index (BMI)
     - if either partner is overweight, starting active steps to reduce weight will increase their fertility and chance of qualifying for funding of fertility services.
     - encourage physical activity. Consider Green Prescription.
     - underweight women may benefit from weight gain.
   - Discuss alcohol and advise women that there is no known safe limit of alcohol in pregnancy.
   - Discuss fertility awareness and frequency of intercourse (aim for three times a week). Consider:
     - patient information on fertility fitness.
     - referral to Natural Fertility New Zealand
   - There is some evidence that a male vitamin supplement can support sperm health.[2]

2. If repeat semen analysis is abnormal, provide advice. Request sub-fertility advice or assessment and consider arranging karyotype prior to assessment if there is azoospermia, or significant oligospermia (< 5 million/mL).

   Repeat semen analysis is abnormal

- Discuss lifestyle factors e.g., smoking, alcohol, and medications that may impact sperm health.
- Advise wearing loose fitting underwear and to avoid saunas or hot tubs.
- Consider prescribing menevit which contains antioxidants that may improve sperm health. Sperm production cycles take 74 to 78 days, so ideally patient takes for 3 months.

3. Offer vaccination for rubella if non-immune. Avoid pregnancy for 1 month after this.
4. Continue or start folic acid.

Folic acid

- Start folic acid at least 4 weeks before conception and continue up to 14 weeks.
- 0.8 mg once daily for most women.
- 5 mg once daily if patient has diabetes, BMI > 30,[3] coeliac disease (or other risk of malabsorption), sickle-cell anaemia, thalassaemia, is on anti-epileptic medication, or if either partner has personal or family history of spina bifida or a previous pregnancy affected by a neural tube defect.
- For information and other medications and conditions see: Ministry of Health – Folate/folic acid

5. If anovulation is related to PCOS, consider management as outlined in the PCOS pathway first. Guidelines recommend that clomiphene is not initiated without cycle monitoring in view of the risk of multiple pregnancy. See also Dietary information for Women with PCOS.
6. Consider publicly funded assessment if eligible for publicly funded health services and criteria are met, and if:

Criteria

- BMI 18 to 32
- Non-smoker or ex-smoker > 3 months
- Aged < 40 years
- < 2 children aged ≤ 12 living in the home.

- > 2 years sub-fertility, or anovulation (other than premature ovarian failure), or

Anovulation criteria

- > 2 years sub-fertility and blood tests indicative of anovulation in one cycle
- < 2 years sub-fertility and blood tests indicative of anovulation in two cycles, and the patient has been trying to conceive for:
  - > 6 months if aged ≥ 35 years, or

- > 12 months if aged < 35 years.

- sub-fertility conditions and > 1 year of sub-fertility.

Sub-fertility conditions

- Azoospermia or oligospermia (< 5% normal forms)
- Bilateral salpingectomy
- Oophrectomy
- Premature ovarian failure

Where one of the couple has had a sterilisation, the duration of fertility delay starts from the date the couple first see a doctor about having a child, not from the date of surgery.

Sterilisation

A history of surgical sterilisation of either partner reduces the Clinical Priority Assessment Criteria (CPAC) score for publicly funded treatment. See Resources below.

7. If not eligible for publicly funded health services, consider private fertility specialised assessment.

Request

- If > 2 years sub-fertility, or anovulation (other than premature ovarian failure), request publicly funded fertility specialised assessment from Christchurch Women's Hospital.
- If sub-fertility conditions and > 1 year of sub-fertility, request publicly funded fertility specialised assessment from Fertility Associates.
- If not eligible for publicly funded health services, or criteria are not met, request private fertility specialised assessment.
- If unsure of the significance of the investigations, e.g. two abnormal semen analysis, seek fertility specialised advice.

Information

For health professionals

- BMJ Learning – The Royal New Zealand College of General Practitioners Modules [requires registration] – Infertility in primary care
- Canterbury SCL – STI Genital Swab Guide

- Fertility Associates:
  - Public Funding Eligibility
  - Information for GPs
- National Institute for Health and Care Excellence (NICE) – Fertility Problems: Assessment and Treatment

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "fertility".
- HealthInfo – Fertility problems

Printable Resources

- Fertility Associates – Public Funding
- SCL – Instructions for Seminal Fluid Collection

Patient Support Information

- Fertility New Zealand

Search My Medicines for patient information leaflets for any medications not listed in this section.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.

Topic ID: 16204

APPENDIX 6

Community HealthPathways Canterbury

Transgender Health in Adults

See also – Transgender Health in Youth

Background

About transgender health

About transgender health

For some people, their sex assigned at birth is different to their gender identity.

Gender identity is the personal sense of self as a gendered individual.

Respecting a gender diverse person means respecting their gender identity and not referring to them based on their sex assigned at birth.

Transgender, trans, and gender diverse are umbrella terms used to describe individuals who identify their gender as different to the legal sex that was assigned to them at birth. This includes people who are transitioning from one sex to another (i.e. male to female, female to male) but also includes people who identify as non-binary, that is, within, outside of, across or between the spectrum of the male and female binary.

Withholding gender-affirming care is not a neutral option as this may cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. Ask the patient about their pronoun, name, title, and gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identity description

Ask:

- "What would you like to record as your gender identity?"

The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relationship and avoiding poor mental health outcomes.[1]

Pronoun

- Pronouns (e.g. he, she, they, them) can be a sensitive issue for some people.
- Some people may need a private space in which to answer questions.
- People present at different stages of social transition so responses from the same person may change over time.
- Ensure all staff are aware of how to ask sensitively about preferred pronouns e.g.
  - Hi my name is ….. What do you call yourself?
  - What pronoun, like "he, she, they", would you like this team to use when referring to you?

2. History – ask about:
   - ⌄ gender-specific history ⌃.

Gender-specific history

- Duration of awareness of gender identity issues.
- How they would describe their gender to others.
- Care received to date.
- Who they have disclosed to and their main support (family or other).
- How comfortable or distressed they are with currently living in the gender they are expressing.

   - medical, drug and alcohol, and sexual health history.
   - ⌄ mental health and suicidal ideation and intent ⌃.

Mental health and suicidal ideation and intent

Gender diverse people are at higher risk of anxiety, self harm, and depression, and have high rates of suicide and suicide attempts. They are at risk of abuse, bullying, and drug and alcohol abuse. The best mental health outcomes are achieved with support and early intervention.

- medications – prescribed and non-prescribed.

> **Medications**
>
> - Ask about:
> - complementary therapies.
> - self-medicating with hormones.
> - previous or current use of puberty blockers.
> - The patient may already be buying and taking unregulated hormonal therapy products, often via the internet.
> - Discuss risks if the patient is self-medicating.
> - If the patient is already on hormonal therapy and has experienced improvement in their gender dysphoria do not suddenly stop hormones as this may have unpredictable psychological consequences.

3. Depending on the patient's goals, consider recording height, weight, body mass index, and blood pressure, and sexual health checks. Specific examination and investigations are not needed unless the patient is being referred for surgery or hormone treatment.

Management

Timely and appropriate management reduces the risk of self-harm and suicidal intent, and leads to better health outcomes.

1. Do not withhold gender-affirming treatment as this may cause or exacerbate any gender dysphoria or mental health problems.
2. Discuss patient's individual goals and needs which may include:

- social transition.

> **Social transition**
>
> Social transition involves changing or experimenting with gender presentation, including:
>
> - personal appearance, e.g. haircuts, clothing, genital tucking, breast binding.
> - asking other people to use a different name, gender pronoun or both.

- hormone treatments.

> **Hormone treatments**
>
> Gender-affirming hormones are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the appropriate gender. These are considered irreversible.

> Gender-affirming hormones usually start at 16 years of age, though there is recognition of consideration in younger people in special circumstances.
>
> There is no upper age limit to starting hormones.
>
> See Gender-affirming Hormones.

- surgical treatments.
- other supports, e.g. psychological, family, legal, education, work.

Do not assume that all transgender people want to conform to binary gender norms. Each person's gender expression (how they present to the world) is unique.

3. Provide information and supports. Include information on non-medical body interventions, e.g. safe binding and tucking.
4. If any identified mental health condition, seek appropriate mental health support. Treat mental health diagnoses as for any condition (dependant on severity) but seek trans-friendly services.

   Access to hormones and surgery requires mental health concerns (excluding gender dysphoria) to be well controlled.

5. Ensure appropriate cancer screening according to national guidelines.

> **Cancer screening**
>
> - Gender diverse people who have not undergone the surgical removal of breasts, cervix, uterus, ovaries, prostate, or testicles remain at risk of cancer in these organs.
> - Manage this carefully, as many gender diverse people find cancer screening physically and emotionally challenging. Ask the patient what terms they would prefer are used for body parts.
> - Cervical screening:
>   - Screening should be carried out unless the patient has had surgical removal of the cervix.
>   - Frequency of screening is as per national cervical screening recommendations.
>   - Consider use of internal estrogen for a few weeks before smear to make this more comfortable.
> - Breast screening is recommended for all transgender people with breast tissue. Frequency of screening is as per national breast screening recommendations.
> - Prostate screening:
>   - There is minimal research around risks and indications for screening for transgender women. The prostate remains after orchidectomy and genital reassignment surgery. Estrogen is likely to be somewhat protective. Discuss with each individual.
>   - Ensure transgender women treated with estrogen undergo individualised screening for prostate cancer according to their personal risk. PSA should be considered pre-treatment and patients advised that once on hormone therapy PSA levels become a poor screening test for prostate cancer.

6. Ensure appropriate support for ⌄ older adults ⌃.

> **Older adults**
>
> - These patients are likely to have experienced discrimination, non-acceptance, and significant barriers to healthcare during their life.
> - If cognitive impairment and chronic disease are concerns, consider a multidisciplinary approach including primary care, endocrinology, geriatric medicine, and other speciality input.
> - If the patient is receiving support within the aged-care system, or is a resident in an aged care facility, offer to act as an advocate to ensure a safe and inclusive environment.
> - There is no upper age limit for the use of hormones.

7. For patients who wish to consider hormone treatments or gender-affirming surgery:
   - discuss lifestyle changes to address cardiovascular risk associated with hormonal treatments, e.g. smoking cessation, weight loss, regular exercise, and ceasing drug or alcohol dependence.
   - request a ⌄ mental health assessment ⌃ for gender dysphoria before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if patient wishes to start hormones or is considering surgical procedure.
>
> - Unless the patient has already had a readiness assessment, request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervention assessment".
> - For genital reconstruction surgery, national and international guidelines state that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waiting list is long, only 1 assessment is required. If a patient has already had a psychological assessment before starting hormone treatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstruction waiting list.
>
> As the waiting list for public mental health assessments is long, patients may wish to consider private options.

   - discuss ⌄ contraception ⌃.

> **Contraception**
>
> - NZF Medroxyprogesterone acetate (Depo provera) 150 mg intramuscularly every 12 weeks.
> - NZF Medroxyprogesterone (Provera) orally 10 mg three times a day or 20 mg every night.

- Norethisterone (Primolut N) orally 5 mg to 10 mg three times a day – It is partially metabolised to ethylestradiol and at high doses is equivalent to the level of estrogen in the combined oral contraceptive.
- Levonorgestrel implant (Jadelle).
- Combined oral contraceptive taken continuously – Some people may be uncomfortable being prescribed estrogen.
- Levonorgestrel intrauterine device (Mirena) – Insertion may be very difficult with a masculinised cervix and uterus.

- offer medication to suppress menstruation.

Medications to suppress menstruation

- Norethisterone (Primolut N) 5 mg, 2 to 3 times a day
- Medroxyprogesterone (Provera) 2.5 mg to 5 mg once a day
- Combined oral contraceptive pill – active pills taken continuously. Some patients may not be comfortable with being prescribed estrogens.
- Medroxyprogesterone acetate (Depo Provera) 150 mg intramuscularly every 12 weeks
- Levonorgestrel intrauterine device (Mirena)

- provide access and information about hormone therapy.
- provide access and information about gender-affirming surgery.

8. Discuss voice training. If patient has been on hormonal therapy for 12 months or more request adult speech language therapy assessment.
9. If concerns about the patient's care or health navigation, consider referral to a general practitioner colleague with an interest in transgender care.

Request

- If concerns about the patient's care or health navigation, consider referral to a general practitioner colleague with an interest in transgender care.
- Before an endocrine or surgery assessment, request a mental health assessment for gender dysphoria.
- If any identified mental health condition which is poorly controlled, seek mental health support. The type of support depends on the severity of the condition.
- If the patient has been on hormone treatment for 12 months or more, request adult speech language therapy assessment.

Information

For health professionals

Further information

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Association of Transgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Association for Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identity

Search My Medicines for patient information leaflets for any medications not listed in this section.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.

Topic ID: 400110

APPENDIX 7

Community HealthPathways Canterbury

Transgender Health in Children

This page is for prepubertal and early-puberty patients where it may be appropriate to suspend puberty with puberty blockers.

Background

About transgender health in children

About transgender health in children

It is common for prepubertal children to express gender fluid and gender non-binary behaviour. This is not abnormal and does not necessarily signify gender dysphoria.

Many children who experience gender dysphoria in childhood do not go on to experience dysphoria in adolescence or adulthood.

There are some children that display persistent and fixed dysphoria from a young age and it is likely these children will need early intervention to support a healthy puberty.

No medical intervention is required pre-puberty. In early adolescence it may be appropriate to suspend puberty with puberty blockers. This is a reversible intervention to delay the development of secondary sexual characteristics.

Supporting all children requires a gender-affirming approach with education, navigation and mental health support. Withholding gender-affirming care is not a neutral option as this may cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. History – using age-appropriate questions, ask about:
   - gender diversity or gender dysphoria.

Gender diversity or gender dysphoria

Ask the child about:

- how they would describe their gender.
- duration of their awareness (must be longer than 6 months to fulfil DSM-5 criteria) and any associated distress or dysphoria.
- level of impairment – social, school, sport, family, etc.
- dislike of their sexual anatomy.

- whether they have a desire to do the activities of another sex or whether they wish to be the other sex (DSM-5 criteria states that a strong desire to be of another gender or an insistence they are another gender is essential to the diagnosis).
- whether they have a play preference for non-assigned birth gender roles and friends.
- whether they have a preference for non-assigned birth gender clothing and strong avoidance of birth gender clothing.

- family/whanau support and relationships.

Family/whanau support and relationships

Often there are differing opinions within the family about gender diversity and whether to support a child's wishes.

- mental health.

Mental health

Gender diverse children are at higher risk of developing anxiety, self harm, drug and alcohol dependance and depression. They have high rates of suicide and suicide attempts. They are at risk of abuse and bullying.

Explain to parents that supporting their child's gender preferences greatly reduces these outcomes.

- traits of autism spectrum disorder (ASD), if appropriate.

Autism spectrum disorder (ASD)

The prevalence of people with ASD and gender dysphoria is higher than the general population. It is important to refer for diagnosis of ASD before a mental health referral or referral for puberty blockers.

- sexual health and risk of STIs, if appropriate.

2. Ask the patient about their pronoun, name, title, and gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identity description

Ask:

- "What would you like to record as your gender identity?"

  The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relationship and avoiding poor mental health outcomes.[1]

Pronoun

- Pronouns (e.g. he, she, they, them) can be a sensitive issue for some people.
- Some people may need a private space in which to answer questions.
- People present at different stages of social transition so responses from the same person may change over time.
- Ensure all staff are aware of how to ask sensitively about preferred pronouns e.g.
  - Hi my name is ….. What do you call yourself?
  - What pronoun, like "he, she, they", would you like this team to use when referring to you?

3. Examination – record height, weight, body mass index (BMI). No examination of pubertal stage is required.

No blood tests are needed before referral.

Management

Practice point

Prioritise mental health

Transgender patients often have significant mental health symptoms and management of this should take priority over medical intervention.

Patients should be referred promptly to access early interventions during pre-puberty and early puberty as timeliness is particularly important for long-term physical and mental health outcomes.

1. Use affirming language and call the patient by their preferred name and pronoun – this is essential to developing a respectful relationship and avoiding poor mental health outcomes.[1] Continue to support the child's gender identity over time as it may change.

2. Discuss the patient's individual goals and needs, which may include:

- social transition.

> **Social transition**
>
> Research shows that children supported by parents, their community, and school have good mental health outcomes. Most families want to know there is not something else going on and will ask for mental health assessment.

- puberty.

> **Puberty**
>
> If appropriate, ensure the child understands the concepts of puberty and that referral for endocrinology discussion will occur when they are aged 8 years or older.

- puberty blockers.

> **Puberty blockers**
>
> - Puberty blockers, also called gonadotropin-releasing hormone (GnRH) agonists:
> - suppress puberty and halt development of secondary sexual characteristics.
> - have a positive impact on future well-being.
> - are considered fully reversible and give a child or young person time prior to hormones to make a decision. If discontinued, the young person will go though endogenous puberty (including retained ability to ovulate or produce sperm) after 6 months.
> - are usually started in secondary care.
> - Goserelin (Zoladex) subcutaneous implants have sole subsidy status but leuprorelin (Lucrin) intramuscularly can be fully funded for children who cannot tolerate goserelin.
> - Adverse effects if used in early puberty include reduced bone mineral density, increased height (if used for a significant period), potential reduction in scrotal and penile tissue.
> - Provide consent forms for information purposes:
> - Consent Form for Blocking Female Hormones
> - Consent Form for Blocking Male Hormones

- future availability of hormone treatment, and gender-affirming surgery and genital reassignment surgery, if appropriate.

3. Provide information and supports for both the child and family, and consider:

- sociocultural factors.

- requesting psychological support for the family to work through this process.

> **Psychological support**
>
> For general psychological support, request youth mental health counselling and therapy or child and parenting community support.
>
> Consider referral to a mental health clinician with a special interest in transgender health. A package of care for therapy may be available.

- practical assistance to facilitate social transition.

> **Facilitating social transition**
>
> Explain to families that the best mental and physical health outcomes for children are obtained by supporting social transition and listening to their child's wishes.
>
> - No harm is done if the child changes their mind. See Rainbow Health Ontario – If You Are Concerned About Your Child's Gender Behaviours.
> - Social transition may include:
>   - wearing different clothes.
>   - changing their name or pronoun.
>   - changing hairstyles.
> - Social transition may vary in different environments, e.g. school or home.
> - See HealthInfo – Social Transition.

- connection to other families through peer support.
- screening for negative experiences such as episodes of bullying and discrimination.
- advocating on the patient's behalf to ensure gender-affirming support is provided in their school environment. Communicate with the school about your management, after consent has been gained. Schools have a special role in supporting gender-diverse children. See Leading Lights – Gender Identity and Gender Diversity.

4. If ASD is suspected, request non-acute paediatric medicine assessment for a developmental assessment.

> **ASD is suspected**
>
> It is important to make a diagnosis of ASD before requesting a mental health assessment or a referral for puberty blockers. Children with established ASD are managed the same as other children, but consultation with their developmental team is recommended if they are still under care.
>
> See Developmental Concerns in Schoolchildren.

5. Prioritise mental health concerns over hormone readiness assessment:
   - If significant mental health symptoms are causing significant distress and functional impairment, request child and parenting community support or non-acute child and adolescent mental health assessment.
   - If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.

> **Gender dysphoria**
>
> Gender dysphoria describes the distress experienced by a person due to incongruence between their gender identity and their sex assigned at birth. Not all gender diverse children experience distress. The Child, Adolescent and Family Specialist Mental Health Service (CAF) will see a child with moderate to severe gender dysphoria at any age if there is significant functional impairment and distress, e.g. not attending school, not maintaining peer relationships, etc.

6. If the patient is considering puberty blockers to suppress the development of secondary sex characteristics and meets the criteria, request non-acute child and adolescent mental health assessment or assessment with a private mental health clinician with a special interest in transgender health for a gender dysphoria hormone readiness assessment before a child health endocrine assessment.

> **Criteria for gender dysphoria assessment for puberty blockers**
>
> - Other mental health conditions are moderately or well controlled (if not refer to appropriate community or DHB service)
> - Between age 8 and 15 years and considering puberty blockers.

7. If hormonal treatment of puberty suppression is part of the patient's plan and they are aged 8 years or older, request non-acute paediatric medicine assessment:
   - Ensure the mental health gender dysphoria hormone readiness assessment is complete.
   - Advise the patient that the endocrinologist will need to examine them to determine their puberty stage.

Ongoing management of puberty blockers

1. Prescribe puberty blockers as needed. These will be initiated in secondary care and primary care may be responsible for ongoing prescribing.

> **Prescribe puberty blockers**
>
> - Leuprorelin (Lucrin) 11.25 mg intramuscularly every 12 weeks.
>
> See Medsafe - New Zealand Data Sheet for special precautions for disposal and other handling.

- Goserelin (Zoladex) 10.8 mg subcutaneous implant insertion into lower abdomen every 12 weeks.

  See Zoladex – Dosing and Administration for a video on how to administer Zoladex.

If evidence of insufficient pubertal suppression, e.g. luteinizing hormone greater than 2 IU/L, pubertal progression, or continued menses, the interval between puberty blockers can be shortened to 10 weeks or the dose increased.

For ongoing administration of puberty, families have the choice of self-administering, attending Children's day ward or visiting a general practitioner.

2. If necessary, discuss fertility preservation with the patient (this will have been discussed in paediatric endocrinology but should be revisited as the child ages).

Fertility preservation

- Puberty blockers are reversible and should not affect fertility. However, children starting in early puberty who continue on to hormone therapy will not develop mature gametes.
- Sperm storage may be possible in children who start puberty blockers later in puberty.
- Discuss ovarian tissue or egg preservation – however, this requires invasive procedures that are not currently publicly funded. Decisions around fertility can be revisited again at any time during treatment.

3. Monitor patient regularly.

Monitor patient regularly

- Measure BMI every 3 to 6 months. Risk of increased height if blockers started in puberty.
- Encourage healthy eating and exercise to reduce risk of future lowered bone density.
- Address mental health issues including bullying and offer support.

Patients will continue to be monitored in paediatric endocrinology until 16 years of age.

4. If concerns about the patient's care or health navigation, consider referral to a general practitioner colleague with an interest in transgender care.

Request

- If concerns about the patient's care or health navigation, consider referral to a general practitioner colleague with an interest in transgender care.
- If ASD is suspected, request non-acute paediatric medicine assessment for a developmental assessment.
- Request non-acute child and adolescent mental health assessment if:

- moderate to severe mental health concerns at any age that indicate a mental health diagnosis which may include gender dysphoria or any other mental health diagnoses.
- the child has a well-controlled mental health condition or good mental health, is 8 years or older, and is wishing to proceed to endocrine discussion. Request a gender dysphoria hormone readiness assessment.

- If child is 8 years of age or older and the gender dysphoria hormone readiness assessment is complete, request non-acute paediatric medicine assessment for consideration of puberty blockers. Include the mental health assessment with the referral.
- For general psychological support, request youth mental health counselling and therapy or child and parenting community support.
- Consider referral to a mental health clinician with a special interest in transgender health.

Information

For health professionals

Further information

- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Association for Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "transgender".
- HealthInfo – Gender Identity in Children and Youth

Printable Resources

- Rainbow Health Ontario – If You Are Concerned About Your Child's Gender Behaviours

Search My Medicines for patient information leaflets for any medications not listed in this section.

> *Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.*

KEY LINKS

Leading Lights - Gender Identity and Gender Diversity

Topic ID: 462501

APPENDIX 8

Community HealthPathways Canterbury

Transgender Health in Youth

This pathway is for post-pubertal young people requiring gender affirming healthcare.

Background

About transgender health

About transgender health

For some people, their sex assigned at birth is different to their gender identity.

Gender identity is the personal sense of self as a gendered individual.

Respecting a gender diverse person means respecting their gender identity and not referring to them based on their sex assigned at birth.

Transgender, trans, and gender diverse are umbrella terms used to describe individuals who identify their gender as different to the legal sex that was assigned to them at birth. This includes people who are transitioning from one sex to another (i.e. male to female, female to male) but also includes people who identify as non-binary, that is, within, outside of, across or between the spectrum of the male and female binary.

Withholding gender-affirming care is not a neutral option as this may cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. Discuss confidentiality and capacity to consent to medical treatment.

Capacity to consent to medical treatment

Some transgender young people may not have the support of their parents or guardians, but this should not preclude them from receiving support and care.

The legal age of consent is 16 years old. The law assumes that those aged 16 years or older are competent to make their own decisions about their medical treatment.[1]

Patients aged younger than 16 years old can consent to their own medical treatment in the context of sexual health and contraceptive advice, and abortion.[2] [3]

A minor may be legally competent to consent if he or she has sufficient understanding and intelligence to understand fully what is proposed. Consider the patient's:

- age.
- level of independence.
- level of schooling.
- level of thinking:
- concrete or abstract thinking.
- ability to deal with more than one thought or idea at a time.
- ability to express their own wishes.

The nature of the decision is complex, which will require a more advanced thinking level. Make sure the young person fully understands:

- treatment options.
- what the treatment is for and why it is necessary.
- what the treatment involves.
- likely effects, risks, gravity, and seriousness.
- consequences of not treating.

Confidentiality

Defining the limits of confidentiality is very important when caring for young people.

Discuss confidentiality at the beginning of the consultation, i.e. "What you tell me stays here within the clinic. If you tell me something that makes me worried about your safety or someone else's safety, then I may need to talk to someone else. I would not do this without discussing it with you first."

2. Ask the patient about their preferred pronoun, name, title, and gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identity description

Ask:

- "What would you like to record as your gender identity?"

  The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relationship and avoiding poor mental health outcomes.[4]

Pronoun

- Pronouns (e.g. he, she, they, them) can be a sensitive issue for some people.
- Some people may need a private space in which to answer questions.
- People present at different stages of social transition so responses from the same person may change over time.
- Ensure all staff are aware of how to ask sensitively about preferred pronouns e.g.
  - Hi my name is ….. What do you call yourself?
  - What pronoun, like "he, she, they", would you like this team to use when referring to you?

3. Take a psychosocial assessment using Heeadsssss, to identify broader concerns, risks, and resiliencies in the patient's life.
4. History – ask about:
   - gender-specific history.

Gender-specific history

- Duration of awareness of gender identity issues.
- How they would describe their gender to others.
- Care received to date.
- Who they have disclosed to and their main support (family or other).
- How comfortable or distressed they are with currently living in the gender they are expressing.

   - medical, drug and alcohol, and sexual health history.
   - mental health and suicidal ideation and intent.

Mental health and suicidal ideation and intent

Gender diverse people are at higher risk of anxiety, self harm, and depression, and have high rates of suicide and suicide attempts. They are at risk of abuse, bullying, and drug and alcohol abuse. The best mental health outcomes are achieved with support and early intervention.

- family support, including functioning and dynamics.

> **Family support**
>
> Transgender and gender diverse children have better mental health outcomes when they are supported and affirmed by their family.[5]

- social, vocational and educational situation.
- medications – prescribed and non-prescribed.

> **Medications**
>
> - Ask about:
> - complementary therapies.
> - self-medicating with hormones.
> - previous or current use of puberty blockers.
> - The patient may already be buying and taking unregulated hormonal therapy products, often via the internet.
> - Discuss risks if the patient is self-medicating.
> - If the patient is already on hormonal therapy and has experienced improvement in their gender dysphoria do not suddenly stop hormones as this may have unpredictable psychological consequences.

5. Examination:
   - Record height, weight, body mass index (BMI).
   - Check blood pressure.

   No further examination is required.

Management

> Practice point
>
> **Prioritise mental health**
>
> Transgender patients often have significant mental health symptoms and management of this should take priority over medical intervention.

Timely and appropriate management reduces the risk of self-harm and suicidal intent, and leads to better health outcomes.

1. Discuss patient's individual goals and needs which may include:
   - ˅ social transition ˄.

     Social transition

     Social transition involves changing or experimenting with gender presentation, including:

     - personal appearance, e.g. haircuts, clothing, genital tucking, breast binding.
     - asking other people to use a different name, gender pronoun or both.

   - ˅ hormone treatments ˄.

     Hormone treatments

     There are 2 types of hormone treatments:

     - Puberty blockers using gonadotropin-releasing hormone (GnRH) agonists to suppress puberty and secondary sexual characteristics. This is reversible. If discontinued, the young person will go though endogenous puberty after approximately 6 months including retained ability to ovulate or produce sperm.
     - Gender-affirming hormones. These are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the appropriate gender. These are considered irreversible.

     Gender-affirming hormones usually start at 16 years of age, though there is recognition of consideration in younger people in special circumstances.

     There is no upper age limit to starting hormones.

     See Gender-affirming Hormones.

   - surgical treatments.
   - other supports, e.g. psychological, family, legal, education, work.

   Do not assume that all transgender people want to conform to binary gender norms. Each person's gender expression (how they present to the world) is unique.

2. Provide information and supports:
   - Include information on non-medical body interventions, e.g. safe binding and tucking.
   - Advocate on the patient's behalf to ensure gender-affirming support is provided in their school or work environment. See Gender Identity Resources for Schools and Sport Organisations.
   - Connect to other families through peer support networks.

3. Prioritise mental health concerns over hormone readiness assessment:
   - If significant mental health symptoms are causing significant distress and functional impairment, depending on severity, request youth mental health and counselling and therapy, youth community support, non-acute child and adolescent mental health assessment or refer to a private health

clinician with a special interest in transgender health. A package of care for therapy may be available.

- If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment or refer to a private health clinician with a special interest in transgender health. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.

> **Gender dysphoria**
>
> Gender dysphoria describes the distress experienced by a person due to incongruence between their gender identity and their sex assigned at birth. Not all gender diverse children experience distress. The Child, Adolescent and Family Specialist Mental Health Service (CAF) will see a child with moderate to severe gender dysphoria at any age if there is significant functional impairment and distress, e.g. not attending school, not maintaining peer relationships, etc.

4. For patients who wish to consider hormone treatments or gender-affirming surgery:
   - discuss lifestyle changes to address cardiovascular risk associated with hormonal treatments, e.g. smoking cessation, weight loss, regular exercise, and ceasing drug or alcohol dependence.
   - request a mental health assessment for gender dysphoria before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if patient wishes to start hormones, puberty blockers or is considering surgical procedure.
>
> - If patient is younger than 18 years, or aged 18 years and still at school, request non-acute child and adolescent mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervention assessment".
> - If patient is 18 years or older (unless aged 18 and still at school), request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervention assessment".
> - For genital reconstruction surgery, national and international guidelines state that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waiting list is long, only 1 assessment is required. If a patient has already had a psychological assessment before starting hormone treatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstruction waiting list.
>
> As the waiting list for public mental health assessments is long, patients may wish to consider private options.

   - once the gender dysphoria hormone readiness assessment is complete request an endocrine assessment:
     - If younger than 16 years, request non-acute paediatric medicine assessment.

- If aged 16 years or older, request non-acute endocrinology assessment.

- discuss contraception.

> **Contraception**
>
> - Medroxyprogesterone acetate (Depo provera) 150 mg intramuscularly every 12 weeks.
> - Medroxyprogesterone (Provera) orally 10 mg three times a day or 20 mg every night.
> - Norethisterone (Primolut N) orally 5 mg to 10 mg three times a day – It is partially metabolised to ethylestradiol and at high doses is equivalent to the level of estrogen in the combined oral contraceptive.
> - Levonorgestrel implant (Jadelle).
> - Combined oral contraceptive taken continuously – Some people may be uncomfortable being prescribed estrogen.
> - Levonorgestrel intrauterine device (Mirena) – Insertion may be very difficult with a masculinised cervix and uterus.

- offer medication to suppress menstruation.

> **Medications to suppress menstruation**
>
> - Norethisterone (Primolut N) 5 mg, 2 to 3 times a day
> - Medroxyprogesterone (Provera) 2.5 mg to 5 mg once a day
> - Combined oral contraceptive pill – active pills taken continuously. Some patients may not be comfortable with being prescribed estrogens.
> - Medroxyprogesterone acetate (Depo Provera) 150 mg intramuscularly every 12 weeks
> - Levonorgestrel intrauterine device (Mirena)
> - Puberty blockers – specialist only

- provide access and information about hormone therapy.
- provide access and information about gender-affirming surgery.

5. Discuss voice training. If patient has been on hormonal therapy for 12 months or more request adult speech language therapy assessment.
6. For ongoing management of puberty blockers, follow the Transgender Health in Children pathway.
7. If concerns about the patient's care or health navigation, consider a referral to a general practitioner colleague with an interest in transgender care.

Request

- If concerns about the patient's care or health navigation, consider a referral to a general practitioner colleague with an interest in transgender care.
- If significant mental health symptoms are causing significant distress and functional impairment, request youth mental health and counselling and therapy, youth community support, non-acute child and adolescent mental health assessment or refer to a private health clinician with a special interest in transgender health. A package of care for therapy may be available.
- If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.
- Before an endocrine or surgery assessment, request a mental health assessment for gender dysphoria.
- Request an endocrine assessment once the gender dysphoria hormone readiness assessment is complete:
  - If younger than 16 years, request non-acute paediatric medicine assessment.
  - If aged 16 years or older, request non-acute endocrinology assessment.
- If the patient wants voice training and has been on hormonal therapy for 12 months or more, request adult speech language therapy assessment.

Information

For health professionals

Further information

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Association of Transgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Association for Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For patients

On HealthInfo

- Give your patient a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identity in Children and Youth

Search My Medicines for patient information leaflets for any medications not listed in this section.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this section.

Topic ID: 462505