

TRANSGENDER HEALTH TRAINING

Participant Manual



New 2017 Edition



ANOVA
HEALTH INSTITUTE

Transgender Healthcare Training Participants' Manual

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Published by Anova Health Institute NPCPostNet Suite 242
Private Bag X30500 Houghton 2041
Tel: +27 11 581 5000/1
Fax: +27 11 482 1115
Email: info@anovahealth.co.za

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ACRONYMS

AFAB	Assigned female at birth
AIDS	Acquired Immune Deficiency Syndrome
AMAB	Assigned male at birth
ARV	Antiretroviral drug
ASO	Anti-streptolysin O
CDC	Centre for Disease Control
CD4	Glycoprotein found on the surface of immune cells such as T helper cells, monocytes, macrophages and dendritic cells
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
FTM	Female to Male
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HPV	Human Papillomavirus
HRT	Hormone Replacement Therapy
IUD	Intrauterine device
LGBTIAQ+	Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, + other identities & sexualities
LLETZ	Large Lop Excision of the Transformation Zone
MHCW	Mental Healthcare Worker
MSM	Men who have sex with men
MTF	Male to Female
NGO	Non-governmental Organisation
PCOS	Polycystic ovary syndrome
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex workers
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UTT	Universal Test and Treat
WHO	World Health Organisation
WPATH	World Professional Association for Transgender Health
WSW	Women who have sex with women

GLOSSARY

Agender

Can be literally translated as 'without gender'. It can be seen either as a non-binary gender identity or as a statement of not having a gender identity. People who identify as agender may describe themselves as gender-neutral or neutrois.

Assigned sex at birth

Designation of a new-born as being either male or female, usually based on the inspection of the child's external genitalia. From this, we get the terms AMAB/assigned male at birth and AFAB/assigned female at birth, which are better terms to use when describing a trans person's history than to say "born male" or "born female".

Cisgender

(sometimes referred to simply as "cis")

The term for those individuals whose gender DOES ALIGN with the gender assigned to them at birth. i.e. someone who is not transgender.

The prefix "cis" comes from the Latin word for 'this side' as in Ciskei and the prefix "trans" comes from the Latin word for "across" or "the other side".

Cisnormative

The assumption that all people are cisgender.

Deadname

A term that refers to a person's previous name, that they do not wish to be known by any more.

Dysphoria

A feeling of discomfort or unhappiness that results from a discrepancy between someone's gender and their anatomy.

FTM

Short for female to male; this a problematic term and should be avoided. Rather use "assigned female at birth".

Gender-affirming healthcare

Medical services designed to bring a person's physical features and anatomy closer in line with their gender identity. This term covers both hormone replacement therapy and surgery.

Gender binary

The idea that gender must be either completely male or female, and that the two are mutually exclusive.

Gender dysphoria

A medical diagnosis in the DSM-V.

Gender expression

The way in which a person expresses themselves in terms of gender. This includes mannerisms, behaviour, manner of speaking, clothing, make-up etc. This may not always be in line with someone's gender identity. For example, a "tomboy" might have a female gender identity with a masculine-leaning gender expression.

Gender fluid

Gender fluid is a gender identity which refers to a gender which varies over time. A gender fluid person may at any time identify as male, female, neutrois, or any other non-binary identity, or some combination of identities. Their gender can also vary at random or vary in response to different circumstances.

Gender identity

A person's experience of their own gender: Everybody has a gender identity regardless of whether they are transgender or cisgender. Usually, cisgender people have not needed to question their gender identity and therefore are not aware of it as a part of themselves.

Gender queer

Some people identify as gender queer because their gender identity is not entirely male or entirely female but rather somewhere on a gender spectrum.

Gender reassignment

Gender reassignment surgery is the surgical procedure (or procedures) by which a transgender person's physical appearance and function of their existing sexual characteristics are altered to resemble that of their identified gender. It can be part of a treatment for gender dysphoria among transgender people. Related genital surgeries may also be performed on intersex people, often in infancy.

Homophobia

Dislike of or prejudice against homosexual people.

Intersex

A general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. For example, a person might be born appearing to be female on the outside, but having mostly male-typical anatomy on the inside. Or a person may be born with genitals that seem to be in-between the usual male and female types - for example, a girl may be born with a noticeably large clitoris, or lacking a vaginal opening, or a boy may be born with a notably small penis, or with a scrotum that is divided so that it has formed more like labia. Sometimes a person may be born with mosaic genetics, so that some of their cells have XX chromosomes and others have XY chromosomes.

LGBTIAQ+

An acronym meaning Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual, Queer and other identities not mentioned.

MTF

Short for male to female. This is a problematic term and should be avoided; rather use "assigned male at birth".

Neutrois

A non-binary gender identity which is considered to be a neutral or null gender. It may also be used to mean genderless, and has considerable overlap with agender.

Non-binary

Refers to any gender identity or expression that does not conform to the binary notion of gender. This is an umbrella term that incorporates many different concepts.

Sexual orientation

This refers to a person's attraction in terms of sexual partners e.g. gay, lesbian, straight/heterosexual or bisexual. It is unrelated to gender identity – trans people may have any sexual orientation, just like cisgender people.

Trans-Competent General Healthcare

Refers to the same healthcare services or aspects of healthcare that cisgender people need, but with sensitivity to specific trans needs. Also includes adjustments to general healthcare practices to offer support and affirmation for gender diverse people and psycho-social care. This sensitivity to and support and affirmation of gender diverse people will be discussed in more detail in Module 1.

Transgender

(Sometimes referred to simply as "trans")

An umbrella term for people whose gender DIFFERS from the gender assigned to them at birth.

Transphobia

Prejudice towards gender diverse people. It is a negative, discriminatory social attitude similar to other prejudices such as racism, sexism, xenophobia or homophobia.

SERVICES AND TREATMENTS THAT ARE NOT AVAILABLE AT MOST PRIMARY HEALTHCARE FACILITIES

Services

Fasting lipogram (LDL and HDL)
Mammography
Serum testosterone
Sex hormone level: Estradiol (E2)
Sex hormone level: SHBG
Sex hormone level: Total Testosterone

Prescription Medication

Gel/Cream (available at two compounding SA pharmacies but expensive)
Nebido®
Sustanon® (this is not readily available, and is in most cases illegally obtained)
Testosterone Undecanoate (Nebido®)

Surgical Interventions

Bottom Surgery (Gonadectomy, Orchidectomy, Vaginoplasty, Labioplasty for AMAB patients)
Bottom Surgery (Metoidioplasty, Phalloplasty, Scrotoplasty, Hysterectomy, Salpingo-oophorectomy for AFAB patients)
Other Surgery (Facial feminisation surgery, Tracheal shave, Vocal cord surgery for AMAB patients)
Other Surgery (Pectoral implants for AFAB patients)
Top Surgery (Mastectomy for AFAB patients, and Augmentation mammoplasty for AMAB patients)

FOREWORD

In light of an emphasis on extending access to competent sexual health services for two Key Population groupings, namely men who have sex with men (MSM) and sex workers (SW), the transgender population has generally been overlooked within the public health sector. This applies equally to sexual health-related research on Key Populations where transgender people have often been ignored; where they have been included, they have frequently been incorporated as being either MSM or SWs.

Importantly, transgender people experience their own set of unique barriers to accessing essential health services. These include transphobia and trans-prejudice, stigma and discrimination, and a pervasive lack of understanding and insight into their health needs among health professionals.

It is within this context that we welcome you to this training material.

This training content is intended to be preceded by another training course developed by Anova Health Institute, Key Populations Diversity Training. Being exposed to this combined content has been designed, firstly, to facilitate the development of insight into various stereotypes and prejudices regarding members of Key Populations, including transgender people. Secondly, this current course will develop healthcare workers' knowledge regarding the rendering of competent health services specifically for transgender people.

We acknowledge the dedicated hard work of Dr Anastacia Tomson who developed the original content on our behalf and the extensive, research working and amendments made for this new edition by Dr Eli Rosen. It was a pleasure working with these contributors throughout the process and we benefited greatly from their significant insights. We also acknowledge and thank the various trans organisations in South Africa that contributed to improving this manual (mentioned specifically in acknowledgements) and making it a better resource and training tool. We are grateful to Professor Roy Shires of the Endocrinology Department of the University of the Witwatersrand, Dr Johan Hugo and psychiatrist Dr Greg Jonnson for undertaking a review of elements of this training manual. We extend appreciation to Jill Schlachter who edited and structured the original course content and Kim Hatchuel for the amended version. We also thank Anthony Dalton and Trixie Smit for the recently amended layout. The initial process was driven and coordinated by Glenn de Swardt and the newly revised edition by Bruce J. Little.

Finally, we thank our donors for their support and confidence in us to undertake training of healthcare workers on the provision of services to transgender people, and we express our sincere appreciation to the Department of Health for their generous partnership.

Prof James McIntyre
CEO, Anova Health Institute NPC

Dr Helen Struthers
COO, Anova Health Institute NPC

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Zachary Akani Shimange

Gender Dynamix



Joshua Sehoole

Iranti-org



Leigh Ann van der Merwe

S.H.E, Social, Health and Empowerment Feminist
Collective of Transgender Women of Africa



Tebogo Nkoana

TIA – Transgender and Intersex Africa



Whitney Quanita Booysen

Trans Wellness Project



Wandile Dhlamini

UCT: The Trans Collective
Cross-University Trans Collective



Dr Eli Rosen: Independent Consultant, Facilitator, Researcher and Copywriter

Germaine S Gabriel de Larch: Independent Facilitator, Copywriter and Editor

INTRODUCTION

Welcome to this training programme on transgender healthcare. The aim of the training is to empower you, as a healthcare worker, to interact with transgender patients and manage their healthcare with compassion, sensitivity, and competence.

The information in this course was created with the support and guidance of the following South African transgender health and advocacy organisations: *Irant.org*, *Gender DynamiX*, *The Trans Wellness Project*, *TIA*, *UCT: Cross-University Trans Collective*, and *S.H.E.*

Ground Rules

This course will introduce some concepts that may be unfamiliar to you, and you will learn some new terminology to go with it. Some content may be of a sexual nature; this is necessary when discussing sexuality and sexual health. Your facilitator has been carefully selected and trained to run this course and feels quite comfortable to do so. We would like to encourage open engagement and your facilitator will discuss the procedure for feedback and for asking questions during the session.

Expectations

What are your expectations of the training, and what do you want to achieve from attending it?

Course Structure

This training is intended to give you the skills needed to provide competent healthcare that is sensitive to the unique needs of transgender patients.

Module 1 is general sensitivity training for **all staff** working in the healthcare environment. Administrative, cleaning and security staff are invited to attend this module.

Modules 2 and 3 are specifically geared towards **healthcare workers**.

Module 1: Trans-Sensitivity in the Healthcare Environment This module covers the social aspects of creating a trans friendly environment. We will also look at what can be done within the healthcare environment to minimise the barriers to healthcare that many transgender people face.

Module 2: Trans-Competent General Healthcare This module deals with the clinical skills needed in providing general healthcare services to transgender patients in a competent and sensitive manner.

Module 3: Gender-Affirming Healthcare This module relates to the specific interventions that make up gender-affirming healthcare.

Background: Key Populations

This course on transgender healthcare forms part of the global fight against the HIV epidemic, through targeting interventions at Key Populations. A Key Population is *a category of people who are at a highest risk of HIV.*

Large global organisations, such as the World Health Organization, UNAIDS, PEPFAR and USAID recognise the following groups as being Key Populations:

- Men who have sex with men (MSM)
- People who inject drugs (IDU)
- Transgender people (TG)
- Sex workers (SW)
- Prisoners
- Migrants and displaced people

It is essential to focus on HIV among such people to address the general epidemic, but Key Populations are difficult to reach because they are usually invisible.

In South Africa, our Constitution protects diverse sexual and gender identities. Nevertheless, myths and stereotypes about transgender people can lead to prejudice and discrimination and this can limit access to all levels of healthcare including prevention for transgender people. Transgender people often live with chronic stress caused by widespread prejudice which they also often experience at healthcare facilities.

We need to provide healthcare services that ensure members of Key Populations are allowed:

- equal access to high-quality healthcare without fear of prejudice or discrimination;
- respect for their human dignity and their rights to privacy and confidentiality.

Key Populations: South African Context

While the concept of Key Populations is helpful in determining the focus of healthcare interventions for the most at-risk populations, the concept of Key Populations is incomplete when providing care for South Africa's transgender communities.

The focus on trans women as Key Populations may perpetuate the myth that transgender women are MSM and share the same risk factors. The definition of Key Populations excludes people who do not fit into the psycho-socio-medical definition of "transgender", e.g. WSW, transgender men, non-binary and gender diverse people, especially those in rural areas. We will discuss the limits of the word "transgender" in the South African context later in this training.


Social problems that increase the HIV risk of transgender and gender variant people are often not considered when looking at Key Populations' specific interventions. One example of this type of problem is the form of gender-based violence commonly referred to as corrective rape.

Corrective rape is a term that is used and understood in South Africa to describe a form of gender-based violence. The victims of this type of hate crime are usually AFAB (assigned female at birth), regardless of whether they are lesbian or transgender. Perpetrators use rape to punish the person for their sexual orientation or gender expression. This violence isn't as much about turning the person "straight", but rather the intimidation of lesbians, non-binary people, or trans men into not being open about their gender or sexuality and thus living closeted lives.

Sexual assault and rape increases the HIV risk of lesbian, non-binary, and trans men in South Africa, however this risk is not recognised in the international definition of Key Populations as there is a lack of research and data related to it.

Language

ACTIVATION EXERCISE 0.1

	<i>Think about the words you have heard used to describe LGBTIAQ+ people in your community. Write down all the various different words that get used as well as the commonly used words that come from languages other than English.</i>	<i>5 minutes</i>
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Trans Competent Healthcare

The aim of the training programme is to empower you as a nurse or a healthcare worker to interact with transgender patients and manage their healthcare with compassion, sensitivity, and competence. This will make them feel more comfortable and at ease in accessing healthcare services, and make you feel more competent, comfortable and at ease in providing the service.

This includes being able to converse with and refer to transgender patients in a manner that is respectful and appropriate, and to be able to recognise situations that may make transgender patients uncomfortable, so that they can be avoided or addressed.

Attending a training course on how to sensitively manage transgender patients is challenging for most of us. We all carry many misconceptions and prejudices that can get in the way of our learning, as well as in the way of our interactions with other people. We each need to be aware of our own prejudices and of the role that conditioning plays in developing homophobia and transphobia.

MODULE 1: TRANS- SENSITIVITY IN THE HEALTHCARE ENVIRONMENT



MODULE 1: TRANS-SENSITIVITY IN THE HEALTHCARE ENVIRONMENT

INTRODUCTION

This module is designed to give you the necessary skills and understanding to treat transgender patients with respect, in a way that makes them feel safe and unthreatened. Trans patients are often subjected to humiliation or embarrassment when seeking medical care. After studying this module, you should be able to avoid those pitfalls and ensure that your patients feel respected and affirmed when they interact with you.

Aims of the Session

The purpose of this module is to empower people in a healthcare environment to create an environment that is respectful, supportive and affirming of, and conducive to, providing care for gender diverse people.

Reminder: the terms “gender diverse”, “non-binary” and “transgender” are used interchangeably throughout this manual. The word transgender is limited in describing gender variation in the South African context. There are many reasons why people who are in some way gender diverse may choose not to identify as transgender. Regardless of whether a person uses the word transgender to describe themselves or not, they should be able to access affirming healthcare. The interchangeable use of the terms “gender diverse”, “non-binary” and “transgender” shows that the diversity of gender identity does not have to conform to a single definition and nor should one definition or ideal be used to permit or deny care within the healthcare environment.

Learning Outcomes

After completing this module, participants should be able to:

- understand the idea of the gender binary as simultaneously dominant, and limiting/oppressive for many people.
- understand and be accepting and supportive of binary and non-binary transgender people.

- understand the importance of not making assumptions about someone's gender identity or sexual orientation, and that gender and sexual orientation are different elements of identity.
- interact with transgender patients in a manner that is respectful and affirming.
- demonstrate sensitivity to names, pronouns and anatomical terms for gender diverse people and develop the habit of recording these preferences in patient files for future visits.
- recognise ways in which their healthcare environments reinforce the gender binary and cisgender people as a norm, and recommend changes to these environments to make them inclusive of gender diverse people.

Resources

- PowerPoint slides
- [Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions.](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html) (2016). New York (NY): United Nations Development Programme. Chapter 2: "Stigma, discrimination, violence and human rights"; Chapter 3, section 3.2 and Chapter 4: "Service delivery approaches."
<http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>

1. Healthcare as a human right for all under the Constitution of South Africa

Access to healthcare is a human right.

The Constitution of the country protects transgender people from discrimination.

The Health Professions Council of South Africa (HPCSA) includes specific rules in its code of conduct that ensures patients' confidentiality and dignity, and right to self-determination.

1.1 The Constitution of South Africa

Section 27 of the Constitution lays out South African citizens' and non-South African citizens within South Africa, fundamental healthcare rights: *"everyone has the right to have access to healthcare services, including sexual and reproductive healthcare"*.

Section 9 of the Constitution (the Equality Clause) emphasises that:

"(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

*(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, **including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.***

*(4) **No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.***

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair."

1.2 Code of Conduct: HPCSA

The HPCSA has used these Constitutional obligations in terms of the implied responsibilities of healthcare workers in South Africa, to incorporate a code of conduct into its ethical principles of operation. Every healthcare worker is required to:


- respect patients as persons, and acknowledge their intrinsic worth, dignity and sense of value.
- recognise the human rights of all individuals.
- honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.
- treat personal or private information as confidential in professional relationships with patients.
- be sensitive to, and empathise with, the individual and social needs of their patients.
- respect the rights of patients to have different ethical beliefs.
- treat all individuals in an impartial, fair and just manner.

Excerpt from: HPCSA General Ethical Guidelines for the Healthcare Professions; 2008.

Resource: Müller, A. (2013). Sexual and Reproductive Health for Transgender and Gender Non-Conforming People: Guidelines for Health Care Workers in Primary Care, pp. 9-10. Cape Town: Gender DynamiX.

2. Gender Roles, Norms, and Stereotypes

ACTIVATION EXERCISE 1.1

	<i>What makes a man a man, and a woman a woman?</i>	<i>5 minutes</i>
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3. Gender, Sexuality, and Language

3.1 Definitions: Transgender and Cisgender

Transgender

(or simply, 'trans') is an umbrella term for people whose gender DIFFERS from the gender assigned to them at birth.

Cisgender

(or simply, 'cis') is the term for those individuals whose gender DOES ALIGN with the gender assigned to them at birth.

Cisnormative

is the assumption that all people are cisgender

3.2 Binary and Non-Binary Identities

Transgender refers to a person who has a gender identity that is different from what they were assigned at birth. Someone who was assigned female at birth (AFAB) can be male. He might feel more comfortable dressing masculinely, or doing work that society thinks should be done by men. Similarly, someone who was assigned male at birth (AMAB) can be female. She might feel more comfortable dressing femininely, or doing work that society thinks should be done by women.

Some transgender people choose to pursue gender-affirming healthcare to make their bodies more closely match their gender identity. This process of social and medical interventions to align a person more closely to their gender is sometimes called transition. In this manual we use the term gender-affirming healthcare rather than transition. Not all gender diverse people want to access gender-affirming medical interventions.

Binary is a word that means “two of”. When we apply it to gender, it refers to the idea that gender can be either male or female and nothing in-between. It suggests that these are the only two possibilities that exist.

It's important to remember that a person's identity is their own. Some patients will have an identity that conflicts with the idea of “binary” gender. They might feel unusual to us, or difficult to understand, but we must treat them with the same respect as we would treat anyone else.

Remember: we must not expect trans people to conform to the gender binary; however, there are many who do.

Binary identities:

- man/male
- woman/female

Non-binary identities:

- Neutral gender (neutrois)
- Without a gender (agender)
- Shifting gender (genderfluid)
- Genderqueer
- Many others

3.3 What is the word for...

The terms commonly used, and listed above, to describe gender are typically Western and English. In South Africa, gender diverse people might use different terms, or terms in one of our 11 official languages. All genders are equally valid and healthcare practitioners need to take the time to understand different gender identities to act appropriately in ways that respect and affirm these identities.

There is a gap in language with regards to vocabulary for talking about gender and sexuality in most South African languages. Transgender people will use the words that are most common in their own communities to describe themselves. These words may not be the words mentioned in the definitions section of this manual. This will be covered in more detail in Section 5 of this module.

Refer to the words that were collected in **ACTIVATION EXERCISE 0.1**. These words are likely to be the types of words that you may encounter when patients describe themselves.

3.4 Gender Identity vs. Gender Expression

Gender identity is a person's internal, deeply felt sense of being male, female, an alternative gender or a combination of genders. A person's gender identity may or may not correspond with her or his sex assigned at birth. Everybody has a gender identity regardless of whether they are transgender or cisgender. Usually, cisgender people have not needed to question their gender identity and thus are not aware of it as a part of themselves.

Gender expression is how we express our gender through mannerisms, clothing or other forms of self-expression.

Although gender identity and gender expression can be related, they don't have to be. For example, someone may identify as a woman and dress in a traditionally feminine way, while another person may identify as a woman and dress in a traditionally masculine way.

Transgender people may not express their gender outwardly because they fear social stigma and discrimination. They may continue to present as the sex they were assigned at birth to protect themselves, despite feeling that they are another gender. This does not make their gender any less valid.

3.5 Sexual Orientation vs. Gender

Sexual orientation and gender identity are two separate concepts: The common misconception is that transgender means homosexual.

Sexual orientation should always be discussed with reference to a person's identified gender, e.g. if a transgender woman only has sexual attraction to women, then she may identify as a lesbian.

Like cisgender people, transgender people may have any sexual orientation: heterosexual, gay, lesbian, bisexual, etc.

LGBTIAQ+

Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual, Queer and other identities not mentioned.

4. Stigma and Barriers to Healthcare

4.1 Transphobia

Transphobia

Prejudice towards gender diverse people. It is a negative, discriminatory social attitude similar to other prejudices such as racism, sexism, xenophobia or homophobia.

Transphobia can be conscious or unconscious behaviours. (See examples on PowerPoint)

Trans people experience discrimination, marginalisation and violence as a result of transphobia.

Constitutional and legal documents upholding the rights of gender diverse people often exist in form, but not in substance. These prejudices:

- stem from a lack of understanding and education amongst cis people; and may be aggravated by factors such as economic circumstances, race, class, religion and disability, which impact things like access to resources and social acceptance.

Legal structures can be outdated, contradictory and problematic, which can have direct health consequences:

- Marriage Act: marriage is voided if one partner transitions (legally changes their gender marker in their identity documents).
- Criminalisation of Sex Work: there are many trans sex workers, often trans women are assumed to be sex workers just because they are trans.
- Vagrancy and Homelessness: many trans people are homeless and unemployed, and in respect to healthcare, this includes not having a place to store medication such as HRT or ARVs.
- Act 49 Impersonation: Trans people can be treated as criminals for not having the correct identity documents, yet getting amended legal documents is difficult, costly and requires medical interventions.

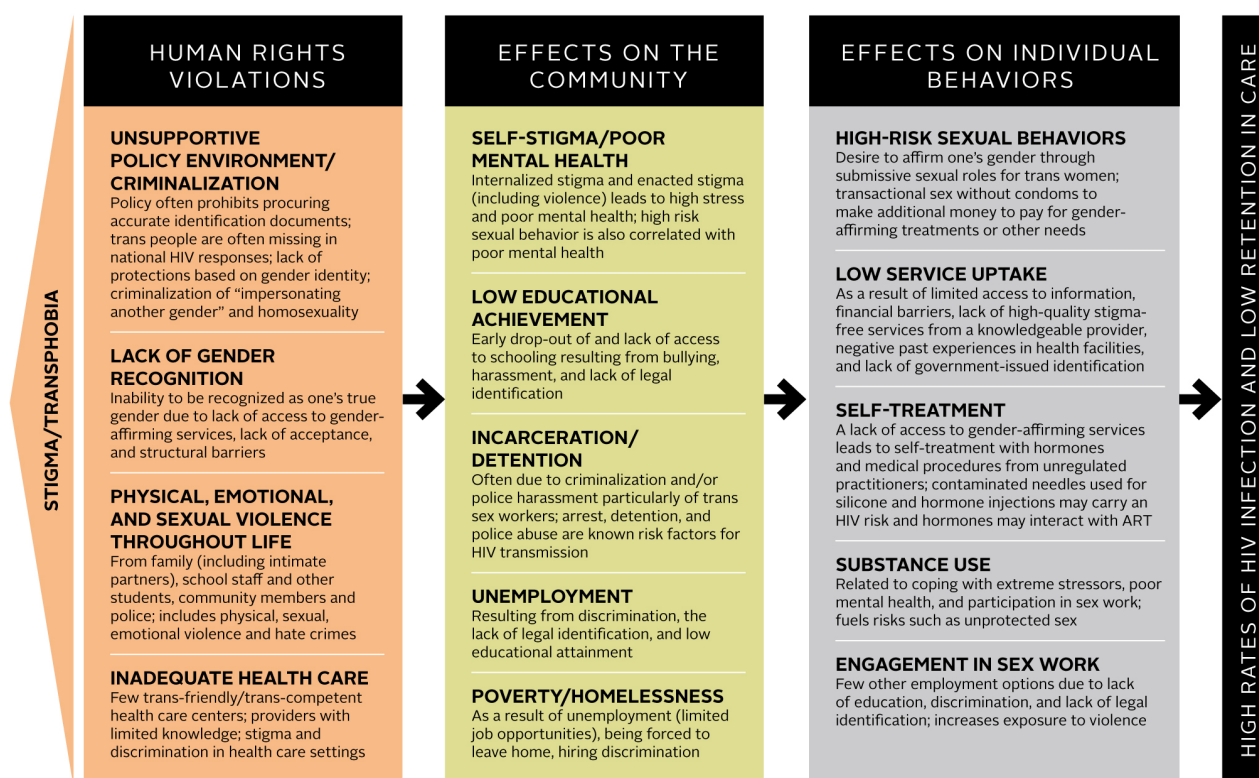
Specific interventions (like this course) are necessary to address transphobia, stigma and discrimination and to ensure that trans people are granted their fundamental rights to equality, dignity and access to services such as healthcare services, as protected by the Constitution.

Resource: [Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html). (2016) New York (NY): United Nations Development Programme. Available at <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>

Levels and Types of Transgender Oppression:

<http://cw.routledge.com/textbooks/9780415892940/data/2%20Levels%20and%20Types%20of%20Transgender%20Oppression.pdf>

4.2 The Effects of Human Rights Violations on Trans People's Health



Resource: [Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html). (2016), p38. New York (NY): United Nations Development Programme. Available at <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>

5. Communication

5.1 Affirming and Non-Judgemental Language

It is important to let the patient express their gender and sexuality in their own words, regardless of whether those terms are politically correct or not. Some gender diverse patients may not identify as transgender as there are limited words to describe people's gender and sexuality, especially in languages other than English. Regardless of how a patient self identifies or what words they use for themselves, they deserve respect and competent healthcare.

Reminder: Always record in the patient's file what the person's word preferences are so that they can be used at future visits.

5.1.1 Names

Ask the patient what their preferred name is..

When trans people use a name that better reflects their gender, their original or given names are often referred to as “deadnames”, reflecting that the names are dead to them. These deadnames can be very painful reminders of the past and the incorrect sex they were assigned at birth. Intentionally using a trans person's deadname is experienced as an act of aggression, intended to hurt/shame/humiliate.

Always use a trans person's chosen name, even if it is not their legal name.

Some gender diverse people legally change their given names and some do not. It is often difficult, costly and time-consuming to amend legal documents. Some trans people may have other reasons for keeping their original names, such as religious or cultural significance, family complexities, etc.

Gender diverse people do not need to explain or justify their choices to anyone to deserve respect or deserve to have their genders accepted and affirmed.

Reminder: Please record in the patient's file what their preferred names are so that they can be used on future visits.

5.1.2 Nouns and Pronouns

In some languages (such as English) pronouns (i.e. I, you, him, her, he, she, or they) indicate a person's gender. In many of South Africa's official African languages there are no gendered pronouns, but the distinction is often made in the nouns: man, woman, brother, sister, etc.

A person's gender must be respected at all times. Nouns and pronouns are a big part of how our perception of and respect for someone's gender is communicated to them.

Nouns: These can be challenging if there is no appropriate gender-neutral noun in a language. In this case, ask the gender diverse person what term they are most comfortable with in their language or in English.

Pronouns: You cannot assume someone's pronouns by looking at them. If you are unsure, you should ask: "When I refer to you, should I use he and him or she and her?". Use whatever pronouns a patient has asked you to use.

Commonly used pronouns:

- He/Him (gendered)
- She/Her (gendered)
- They/Their (gender-neutral).

Reminder: If the person asks for any specific pronoun, including the ones that may be considered offensive, then respect the person's preference. Note this preference in the patient's file to ensure that colleagues who might work with the patient understand this significance and do not dehumanise them.

5.1.3 Avoiding Problematic Language

The terms or phrases below are problematic and inappropriate. It is always important to remember to affirm the trans person's experience of their gender.

If colleagues or co-workers use any of these offensive words, you should politely remind them not to. Some of these words are derogatory and highly offensive, and we should not tolerate their use if we uphold values like respect for the human dignity of all people, as enshrined in our Constitution: **Born a man/woman:** We are born babies, not men or women. It is better to say **assigned [male/female] at birth (AMAB/AFAB)**. When we use terms like this, we acknowledge that it was someone else (usually the doctor/midwife/etc. who delivered them) who assigned the person's gender, and that the gender diverse person was denied any say in this decision.

- **Female bodied/Male bodied:** These terms suggest that there is a specific set of anatomical features that determine gender, which is inaccurate.
 - These terms become especially confusing for trans people who chose to undergo one or more gender confirmation surgeries not all gender diverse people do this, as some do not want to, some cannot afford to, and there are those who do not necessarily change their bodies to match binary, cisgender bodies).
 - A cisgender (cis) woman who does not have breasts (perhaps because of a double mastectomy to treat cancer) still has a woman's body; similarly, a trans woman who does have a penis does not have a "man's body", she simply has a woman's penis.
 - It is better both for clarity and out of respect to use the term AMAB or AFAB.
- **Tranny/Shemale:** Rather refer to a transgender person or a gender diverse person. Establish if the person is comfortable with these terms and if not, establish what term they prefer as there may be a more familiar term in another of our 11 official languages that they identify with better. (Some people may use tranny/shemale for themselves which can be noted in the patient's file, however the healthcare worker should avoid using these terms to describe anyone who doesn't use them for themselves).
- **A transgender:** Transgender is an adjective, not a noun, and so must describe something. Use it to describe a person (a transgender person/a transgender woman, etc.).
- **Transman/Transwoman:** Because transgender is an adjective, the words should always be two separate words: trans man and trans woman. Creating one word suggests a trans man is something other than a man.
- **FTM/MTF:** These terms imply that a trans person was once a different gender. Many transgender women feel they have never been male (and vice versa), and should not be referred to as MTF (or FTM) unless they specifically identify as such. The terms MTF and FTM imply that transition is required to validate a trans person's gender by moving from one gender to another. While some trans people will need to access gender-affirming healthcare (transition) this process is personal and not a requirement to validate the trans person's gender. A trans woman is a woman, she doesn't become a woman through the process of transition.**Transsexual:** This terminology is outdated. It confusingly mixes a person's gender and their sexuality

or sexual orientation which, as discussed, are not the same thing. It is, however, still a term used in medical manuals, and some trans people may use the word to describe themselves.

- **Hermaphrodite:** This is an outdated and offensive term used for intersex people. Rather use intersex person. Explain to participants that intersex identities are complex and not necessarily related to transgender identities, and are therefore not discussed in this manual.

Reminder: If the patient chooses to use any of these terms out of personal preference, please respect their identity and language preferences.

5.1.4 Anatomical Features and Dysphoria

Dysphoria

Refers to a feeling of discomfort or unhappiness that results from a discrepancy between someone's gender and their anatomy..

Some trans patients experience significant dysphoria over certain body parts. Note that not all trans people experience dysphoria. This does not invalidate their gender and make them any less deserving of respect.

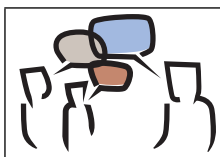
Those patients who experience dysphoria might be triggered into an emotional reaction by the terms used to refer to these parts.

For example, a trans man might be made very uncomfortable when referring to his vagina, breasts or cervix; or a trans woman might be made uncomfortable when referring to her penis. You can ask the patient how you should refer to these parts – some of them will have preferred terms. Acting with sensitivity is very important to gaining their respect.

Reminder: Please record in the patient's file what these terms are so that they can be used on future visits.

5.2. Summary: Gender, Sexuality and Language

APPLICATION EXERCISE 1.1



Refer to the PowerPoint slide your facilitator will show you, and the picture and description below. In your groups, answer the following questions.

5 minutes

A 28-year-old patient presents at your clinic. The patient is 173cm tall, and looks to weigh about 85kg. The patient is dressed in a pair of trousers and a formal shirt with a tie. When asked for their name, the patient answers, "Vuyo". It is clear that Vuyo has breasts underneath the shirt, no facial hair or Adam's Apple, and speaks in a high-pitched voice.



1. What pronouns should you use when referring to Vuyo?


2. So what is Vuyo's gender?

3. Does this mean that Vuyo was "born a woman"?

4. Is Vuyo straight or gay, or does another sexual orientation apply?

6. The Physical Environment

ACTIVATION EXERCISE 1.2

	<i>Take a couple of minutes to think about your clinic or healthcare facility. What aspects of the environment or the procedure may make a transgender person feel uncomfortable?</i>	<i>2 minutes</i>
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The way we structure and run our clinics can go a very long way to making people feel welcome – or unwelcome. Think about your own clinic – there are probably signs on the restroom doors that say ‘men’ and ‘women’. Your intake forms might have tick boxes that say: ‘Sex: M [] F []’. You might use the words ‘sex’ and ‘gender’ interchangeably, when you know by now that they have different meanings.

The space that we create, if it is a sensitive and a safe one, can make patients feel more at ease, even before we have had the chance to talk to them.

A useful reference on this topic is United Nations Development Programme (2016), Implementing Comprehensive HIV and STI Programmes with Transgender People, Chapter 3.2 ‘Trans-competent health services’.

6.1 Paperwork and Forms

Although they may seem quite simple, the forms that patients are asked to complete can present a challenge to transgender people. If you were AMAB, but you identify as a woman, how do you complete the form? Forms and paperwork should be revised to make them more inclusive. Here are some recommendations for how to make the forms more trans-friendly:

- Is the information you're capturing relevant? If not, don't ask (this is best practice and complies with the *Protection of Personal Information Act, 2013*).
- Instead of asking "male or female", consider asking in an open-ended way about gender – allow the patient to fill in the answer.
- You can use the wording "sex assigned at birth" if this information needs to be captured. Ensure that it is stored discreetly to preserve confidentiality, and that the person's correct gender is also stored.
- Ask about partners or spouses instead of using gendered terms like husband and wife.
- Include fields on intake forms and medical records to record the name the patient goes by (which may differ from their legal name), and to record the pronouns that should be used for them. If these fields are not available, add them manually.
- Use the same forms for all patients, rather than having separate forms for patients of different genders.
- Keep these considerations in mind when selecting software for recording and storing patient data. A lot of database systems are designed by binary cisgender people from a very cisnormative perspective and only allow the capture of male/female. This causes problems when you enter an alternative gender manually.

6.2 Restrooms

The common argument against trans people using the bathroom that affirms their gender identity is that trans people are a threat to others. Trans people are not a threat to others any more than cis people are; being trans is not a pathology or deviance. Staff or patients may claim to fear gender diverse people or ask for protection from trans patients, but this causes prejudice and tells gender diverse people that you are not properly educated about gender diversity.

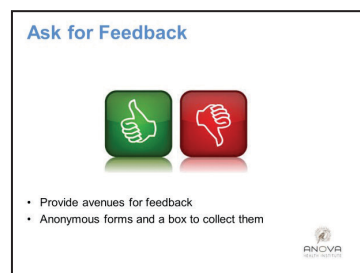
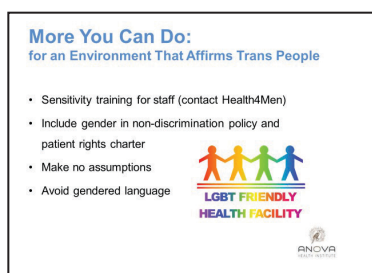
There are also other reasons that gender-neutral bathrooms are important and commonplace, completely unrelated to transgender restroom usage: fathers who need to change their daughter's nappies; mothers who need to accompany their sons to the restroom; and disabled or elderly people who need assistance.

If it is possible to create gender-neutral restrooms in your facility, this is ideal as they can be used by patients of any gender.

Gendered facilities may make gender diverse people (particularly those who are non-binary and don't see themselves as fitting into a particular binary category) feel unsafe or uncomfortable.

Trans people should be allowed to use the restrooms that they are most comfortable with, so as not to undermine their identities.

6.3 More You Can Do for an Environment That Affirms Trans People



Slide M1.22 and Slide M1.23

Provide sensitivity training for staff by contacting Anova Health Institute or your local trans organisation. *Refer to the list provided at the end of this manual.*

Update your Patient Rights Charter to include gender in the Non-Discrimination Policy.

Use inclusive language: Don't make any assumptions about gender identity or sexuality. Avoid gendered language.

Ask for feedback: Give people a direct and anonymous way to tell you if your facility is not meeting their needs, or could do better.

6.4 Summary: The Physical Environment

APPLICATION EXERCISE 1.2



Look at the notes you made in Activation Exercise 1.2. In your small groups, think of ways you could make your own clinics more inclusive. What problems can you identify, and how would you change them? Discuss your answers.

10 minutes

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7. Module Summary



Write down the most important things you learnt in this module.

5 minutes

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MODULE 2: TRANS- COMPETENT GENERAL HEALTHCARE

MODULE 2: TRANS-COMPETENT GENERAL HEALTHCARE

INTRODUCTION

This module deals with the clinical skills needed in providing general healthcare services to transgender patients in a competent and sensitive manner. Trans-competent general healthcare refers to the same healthcare services or aspects of healthcare that cisgender people need, but with sensitivity to the specific needs of transgender patients, and also includes adjustments to general healthcare practices to offer support and affirmation for gender diverse people, as well as psycho-social care.

Aims of the Module

The purpose of this module is to introduce key elements of trans-competent general healthcare for and the specific sexual health issues of transgender patients.

Learning Outcomes

After completing this module, participants should be able to:

- Transform the general healthcare environment to a trans-competent environment that is more accessible to gender diverse people through:
 - Taking a medical history sensitively without unnecessary, invasive questions.
 - Taking a sexual history sensitively without unnecessary, invasive questions.
 - Assessing other areas that influence the patient's health such as social history and mental health, in a sensitive manner.
- Understand and manage specific sexual health issues related to transgender people, including HIV, STIs and adherence to ARV through:
 - Recognising that transgender people (especially trans women) are at a high risk of HIV.
 - Providing HIV counselling and treatment to trans patients in a respectful and appropriate way.
 - Recognising the unique considerations that affect ARV adherence in transgender patients and being aware of strategies to improve adherence in these patients.

- Making an accurate diagnosis of STIs in trans patients and managing the condition in an appropriate manner.
- Identifying additional risks to sexual health for AMAB and AFAB transgender people.
- Understand and manage specific psycho-social requirements related to transgender people through:
 - Taking a mental health history.
 - Taking a social history.
 - Assessing psycho-social needs and providing referrals for further psycho-social support.

Resources

- PowerPoint slides
- [Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html). (2016). New York (NY): United Nations Development Programme. Chapter 2: "Stigma, discrimination, violence and human rights"; Chapter 3, section 3.2 and Chapter 4: "Service delivery approaches." <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>

Purpose and Learning Outcomes

1. Introduction to Medical History Taking

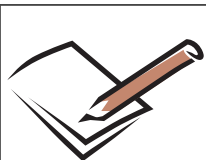
Reminder: If necessary, come back to this page as a reference for each of the medical history taking elements.

The emphasis of this module is to introduce key elements of trans-competent general healthcare for and the specific sexual health issues of transgender patients. In trans-competent Medical History Taking, keep the following in mind at all times:

- Much of the Medical History Taking for a trans patient is the same as what you would ask a cis patient, however in some areas more sensitivity may be needed.
- The focus of history taking should always remain relevant to the presenting complaint. A focus on gender or mental health is not needed unless the patient is looking for healthcare specific to these areas. Stress confidentiality and remember that you might be dealing with patients who are not open about their gender experience (sometimes referred to as being “out”) within their family or community.
- Do not make assumptions.
- Do not take a sexual history if the presenting complaint does not require a sexual history.
- In the case of taking a sexual history, let the patient take the lead on the language they use to refer to their sexual history, their anatomies, their genitals, their sexual orientation and sexual behaviour, and other elements.
- Getting consent to take a sexual history is essential to create a safe and non-judgemental space for patients to discuss their experience and health concerns:
 - Put the patient at ease by repeating that they are not being judged, that what they say is confidential and that they may end the consultation if they are feeling too uncomfortable. Keep in mind that trans patients who experience dysphoria are not always aware:
 - of the functioning of their bodies
 - of the symptoms they might be experiencing
 - of what these symptoms mean (if they are or are not aware of their symptoms)
 - of the treatments or preventative treatments available.

- It is important to explain the above to the patient in a sensitive and respectful manner.

ACTIVATION EXERCISE 2.1

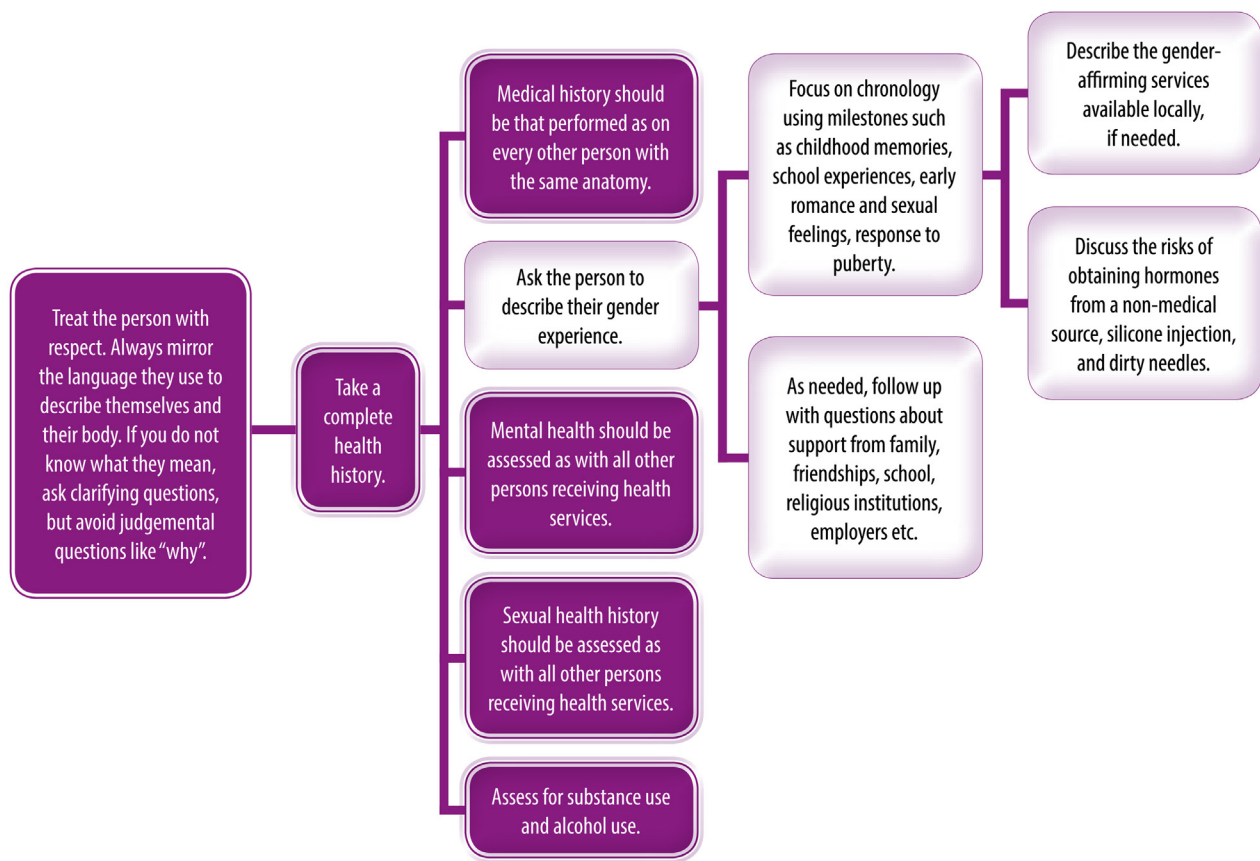


In small groups of 3 or 4 people, write down the process you follow and what you say when you start taking a history from a patient and investigating their complaint.

10 minutes

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1.1 Flowchart for A Trans-Competent Health Assessment



Source: [Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions](#). (2016). New York (NY): United Nations Development Programme, p74.

There are a number of elements that may need to be covered when taking a health history from a transgender person. The focus of the history taking should always remain relevant to the presenting complaint. It should not focus on gender or mental health unless the patient is looking for healthcare specific to these areas. Stress confidentiality and remember that you may be interacting with patients who are not open about their gender experience (sometimes referred to as being "out") within their family or community.

It is essential to create a safe and non-judgemental space for patients to discuss their experience and health concerns.

Elements on history taking include:

- A general medical history
- A sexual health history
- A mental health history, including social support (if they are presenting at the clinic for mental health related care).

1.2 Opening the Consultation: Introductions

Taking a history from a trans patient follows the same format as taking a history for any patient. What makes it different is the sensitivities that may be involved, and the need to make the trans patient feel comfortable.

Before beginning to interact with a patient or to take a history, it's vital to introduce yourself. Include your name and your role, so that the patient knows with whom they are interacting.

As we discussed before, make sure that you know the correct name and pronouns to use for your patient. If you are unsure, you can ask in a respectful manner. Be sure to record this information in the patient's file for future visits. "What is your name?" "How would you like me to address you?"

Remember that the patient's legal documents might not match their preferred name. If you need to confirm the identity of a patient, you can use their date of birth to do so, without making the patient feel uncomfortable.

1.3 Presenting Complaint

It's important to understand why the patient came to see you in the first instance. We will go on to gather a lot more information during the history taking, but be sure to open the interview by asking what it was that prompted them to seek help.

A good way to do this is by saying, "How can I help you?" It's better to ask open-ended questions instead of yes/no questions. This gives the patient the opportunity to offer as much detail as they can. Remember not to interrupt the patient while they are speaking, and try to avoid leading questions.

If you need further information, you can ask some follow up questions. Here are some examples of good open-ended questions:

- Describe the pain for me.
- Tell me more about that symptom.
- When did this begin?

2. Taking a Sexual History

2.1 Discussing Bodies and Genitals

Transgender people are often asked invasive questions about their bodies. Keep any questioning relevant to history taking and do not ask questions out of personal curiosity. Questions should be relevant to the anatomy that the patient has. Ask the patient how they refer to their body parts and use the same language.

2.2 Consent When Taking a Sexual History

Explain to the patient that it is necessary to obtain a sexual history so that you can accurately diagnose and treat their complaint.

Tell the patient that some of the questions might be considered sensitive or make them a little uncomfortable.

Make sure that the patient understands that any information discussed during the consultation is strictly confidential. Whatever they tell you will remain between them and you as their healthcare provider, and you will not give the information to anyone else without their consent.

Tell the patient that they can ask you to stop the process at any time if they become uncomfortable, or if they need a break.

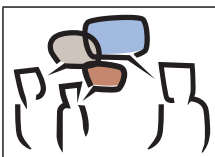
Explain that because of the nature of the history taking, you will need to ask them about certain body parts that they might not feel comfortable with. This is a good opportunity to ask the patient if they have any preferred terminology or language to refer to these parts so as to make them less uncomfortable.

Reassure the patient that they are not being judged based on their answers, and encourage them to answer openly, honestly and completely.

Ask the patient if they have any questions before you begin with their sexual history.

Reminder: Please record in the patient's file what these terms are so that they can be used on future visits.

APPLICATION EXERCISE 2.1



Refer to the PowerPoint slide your facilitator will show you, and the picture and description below. In your groups, answer the following questions.

15 minutes

1. What should you tell Vuyo before you begin taking a sexual history?



2. What should you ask Vuyo before you begin?

2.3.1.1 Patients who have a vagina

Reminder: Sensitivity is key in asking questions about the following symptoms. If the patient does not understand what these questions mean, remember that this may be because of dysphoria. Be respectful of this and explain the symptoms in a sensitive manner.

The trans-competence necessary in this general healthcare history taking is two-fold:

- The knowledge that these symptoms are found in either AFAB patients who have not had gender-affirming bottom surgery (phalloplasty) or AMAB patients who have had gender-affirming bottom surgery (vaginoplasty).
- AFAB patients who have had metoidioplasty should be treated as a patient with a vagina.

The awareness that these parts of the trans person's anatomy can be sources of dysphoria and may be difficult to speak about. Ask the patient how they refer to their genitals and be sensitive to their discomfort.

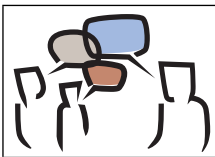
These are common symptoms that can be encountered that relate to the vagina

- Vaginal discharge.
- Dysuria/Frequency.
- Genital skin changes.
- Dyspareunia (Painful intercourse).
- Systemic complaints:
 - Are there symptoms elsewhere that may be related?
 - Have you noticed a rash elsewhere?
 - Do you have pain in your joints?
 - Is there visual pain or difficulty seeing?

Reminder: Health note: AMAB patients who have bottom surgery (vaginoplasty) will still have a prostate gland, and regular prostate screening will still need to be done.

2.3.2 Sexual history taking for patients who menstruate

ACTIVATION EXERCISE 2.3



In small groups of 3 or 4 people, write down the questions you would normally ask a person presenting with a menstrual problem.

5 minutes

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2.3.2.1 Patients who menstruate

Some patients may cease menstruating if they are on testosterone hormone replacement therapy, but not all will.

In patients who have been on testosterone hormone replacement therapy for longer than six months and who are still menstruating:

- Hormone levels need to be checked. Hormone regime may need to be re-evaluated.
- Adherence to HRT needs to be ascertained.
- They need to be tested for cervical pathology. When taking a sexual history for trans patients who menstruate, ask the patient open-ended questions to determine how they refer to their menstrual cycle. Reiterate that what they say is confidential, that they are not being judged, and that they are free to stop the conversation at any time. Ask these questions with sensitivity and compassion as they may be upsetting for trans patients. Since menstruation is strongly associated with being a woman, these questions can make patients quite uncomfortable (dysphoria).

These are symptoms related to menstruation for those patients who have a uterus: When was their last menstrual period?

- If the patient has stopped menstruating, determine if it is because of HRT, IUD or implant, other medication, or another physiological reason (i.e. pregnancy or menopause). Patients on testosterone hormone replacement therapy can become pregnant if contraceptive methods (such as condoms or the IUD) are not being used and the patient has had penis-in-vagina intercourse. The use of contraception while on testosterone is discussed further in Module 3.
- Regularity: Does the period occur predictably, or at irregular intervals?
 - What is the length of the cycle? Does bleeding occur between periods?
- How long does bleeding last?
- Dysmenorrhea:
 - Are the periods very painful?
 - Is there very heavy bleeding?
 - Post-coital bleeding (For patients having penetrative intercourse – is there bleeding afterwards?)
- *Be respectful and take the cue from the patient when asking about sexual practices, as both AFAB and AMAB patients may be sensitive about the topic of penetrative vaginal intercourse.*

2.3.2 Sexual history taking for patients who have a cervix

In trans-competent healthcare, screenings such as pap smears need to be included for all patients who have a cervix.

- This assumes that the patient has had access to healthcare services that offer pap smears.
- Some patients may never have had a pap smear before because of their dysphoria and the transphobia encountered during previous healthcare visits. If pap smears are available at the healthcare centre, one should be offered, otherwise the patient should be given information about what a pap smear is and referred to the appropriate service provider.
- When speaking about pap smears, be sensitive to how invasive this procedure and questions are for trans patients.

2.3.2.1 Patients who have a cervix

These are questions related to the cervix for those patients who have a uterus: When was your last pap smear, and what were the results?

- Have you had any other procedures done, e.g. Loop excision/cone biopsy/LLETZ?

Reminder: It is important to note that AFAB patients on testosterone have an increased risk of cervical cancer, so these questions are an essential part of a trans-competent history taking.

2.3.3 Further Sexual Health Considerations for AFAB Patients

Many AFAB patients still have a vagina:

- They may or may not be the receptive partner in penetrative sex.
- Those with vaginas can develop conditions like vaginitis or bacterial vaginosis.

Many AFAB patients still have a cervix:

- They can be at risk for cervicitis, HPV infection and cervical cancer.
- Regular pap smears are indicated.

AFAB patients may still have a uterus and/or ovaries:

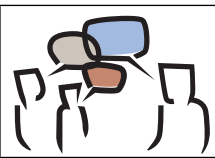
- They can develop conditions like endometriosis, ASO or pelvic inflammatory disease, and ovarian cysts.

AFAB patients may still have breasts:

- Routine self-examination and regular mammography might be indicated.

2.3.4 Sexual history for patients who have a penis

ACTIVATION EXERCISE 2.4



In small groups of 3 or 4 people, write down the questions you would normally ask a person presenting with a problem with their penis.

5 minutes

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

2.3.4.1 Patients who have a penis

The trans-competence necessary in this general healthcare history taking is two-fold:

- The knowledge that these symptoms are found in AFAB patients who have had gender-affirming bottom surgery (phalloplasty), and AMAB patients who have not had gender-affirming bottom surgery.
- The awareness that these parts of the trans anatomy can be sources of dysphoria and may be difficult to speak about. Ask the patient how they refer to their genitals and be sensitive to their discomfort.

These are common symptoms that can be encountered that relate to the penis:

- Pain in testes/scrotum/penis
- Swelling
- Itching/Sore Skin
- Skin Changes
- Discharge
- Dysuria/Frequency
- Systemic complaints
 - are there symptoms elsewhere that may be related?
 - have you noticed a rash elsewhere?
 - do you have pain in your joints?
 - is there visual pain or difficulty seeing?

2.3.4.2 Patients who have a prostate

Reminder: Health note: Most AMAB patients who have bottom surgery (vaginoplasty) will still have a prostate gland, and regular prostate screening will need to be done.

The trans-competence necessary in this general healthcare history taking includes:

- Most AMAB patients, whether they have had bottom surgery (vaginoplasty) or not, will still have a prostate and must have prostate screening as the prostate is not removed during the creation of the neovagina (A false vagina created through sex reassignment surgery).

- Change in sexual function because of oestrogen HRT may hide the typical symptoms of loss of erectile function. Diagnosis of prostate conditions will need to be informed by pain and urinary symptoms, clinical signs and blood tests. Discuss with the patient if digital prostate exams can be performed, and whether it should be done rectally or vaginally.

These are common symptoms that can be encountered that relate to the prostate gland:

- Dysuria/Frequency
- Difficulty passing urine, or passing small amounts of urine
- Frequent waking at night to pass urine
- Genital and pelvic heaviness or pain
- Systemic complaints
 - Fever
 - Lower back pain

2.3.5 Further Sexual Health Considerations for AMAB Patients

Many AMAB patients still have a penis:

- They may or may not be the insertive partner in penetrative sex.
- They can develop conditions like urethritis and balanitis.

AMAB patients might still have testicles:

- They can develop infections like epididymitis or orchitis.
- Mechanical conditions like torsion can occur.
- Testicular cancer can occur.

Most AMAB patients will have a prostate gland:

- They can also develop prostatitis or prostate cancer.

Patients on hormone therapy who are developing breasts:

- Should be instructed in performing breast self-examination. Depending on the patient, you might have to demonstrate this on yourself rather than touching the patient.

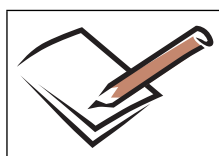
- They may also require mammography at the standard intervals.
- Special caution is advised with a family history of breast cancer.

AMAB patients who have had vaginoplasty:

- Do not need pap smears, but can develop other conditions. A vagina constructed through vaginoplasty (called a neovagina) is often composed either of skin or mucosa (urethral or colorectal) and they can develop ulcers, spots, blisters and other infections – be sure to examine, while being sensitive to the patient's needs.

2.4 Summary: Medical History taking and anatomy

APPLICATION EXERCISE 2.2



Answer the questions below. This is an individual activity

3 minutes

1. Jill, a 22-year-old AMAB patient and uses the pronouns "she/her" presents at your clinic. You learn that Jill has had gender-affirming bottom surgery and has a vagina.

Does Jill require a pap smear?

2. Vuyo, a 28-year-old transgender man who uses the pronouns "they/them" presents at your clinic. Vuyo has not had any surgery.

Does Vuyo require a pap smear?

3. Sexual Behaviour

3.1 Sexual Behaviour History

Remember to handle this topic with sensitivity and to use the patient's language. Explain to your patient that the following questions are of a personal nature. Reassure the patient that they are not being judged based on their answers, and encourage them to answer openly, honestly and completely. Remember that sensitive handling of difficult topics is essential in trans-competent healthcare.

3.1.1 Last sexual contact

The purpose of these questions is to establish whether the patient is at risk for certain conditions or infections based on their sexual behaviour. It's not about gathering scandalous details, or indulging one's own curiosity. Ask the questions in a direct but sensitive manner, and without any judgement. Follow the patient's lead and use their own words. Keeping trans-competence and sensitivity in mind, don't go into too much detail, only go into detail if the patient requests it or seems confused.

Reminder: Health note: Healthcare workers should have sexual health related items (condome, etc.) at hand to point to as patients might be uncomfortable with the language.

These are common questions that relate to taking a sexual history:

- Are you having any sexual contact that involves bodily fluids?
- Remember: The patient's dysphoria and lack of awareness of their own bodies and the gap in language might necessitate that you:
 - Define bodily fluids: oral, vaginal, penile.
 - Sensitive remind patients that anal contact is part of sexual contact and therefore also a risk factor.
- Do you use barriers or contraception?
- Are there any issues that need extra attention? (sex work, sexual assault)

3.1.2 Protection/Contraception



How to Make A Dental Dam out of a Condom!

Source: How to make a dental dam out of a condom.

<http://foryoursexualinformation.tumblr.com/post/136659674416/masakhane-dental-dams-are-another-form-of>

- Explain the need for protection/contraception, in a manner sensitive to the patient's dysphoria and language.
- Explain uses of condoms, etc.
- Remember that the patient might not be able to access these items and may not access healthcare regularly because of their dysphoria and avoidance of healthcare because of transphobia.
- Tell the patient about alternatives (e.g. condoms, gloves or clingwrap instead of dental dams).

Reminder: People who are on testosterone HRT and who have stopped menstruating still need to use contraception of semen will be transferred into the vagina.

3.2 Diagnosis and Management of STIs

Managing STIs is no different for transgender patients than it is for cisgender patients. Below are some of the key points regarding diagnosing and managing STIs in transgender patients:

- To make an accurate diagnosis and treatment, you will need to know some of the details of your patient's anatomy – internal and external.
- The best way to make an accurate diagnosis is by taking a thorough and complete history, including a sexual history. Remember to do this according to the guidelines in the module on sexual history taking.
- Remember that partners might need to be traced and treated for STIs too.
- Trans people are thought to be a high-risk group for STIs and HIV, so these problems cannot be ignored.
- Prevention is always better than cure, so be sure to encourage patients to use safer sexual practices.
- As with other patients, a syndromic approach to treating STIs, one that focuses on the patient's symptoms. is the most effective method.
- This approach will, however, miss asymptomatic STIs.

3.3 HIV Status and Risk

Don't make any assumptions. Not all trans patients are HIV-positive, and not all trans patients engage in risky behaviours. Use the information you gathered through your questions on sexual behaviour and ask follow-up questions where necessary.

- Enquire if the patient has had an HIV test, and if so, what the result was.
- Remember that the patient might not be able to access these tests because of their dysphoria and avoidance of healthcare because of transphobia.
- Ask about the frequency of unprotected intercourse.
- Ask about injected drug use (also referred to in the section on social history below).

Reminder: Trans patients who inject testosterone also need to be made aware of the danger of sharing needles.

3.3.1 HIV and transgender health: Epidemiology

Data from the Centre for Disease Control and Prevention suggests trans people, most especially trans women of colour, have the highest proportion of new positive HIV test results. HIV prevalence in trans women is thought to be around **fifty times greater** than that of other adults of reproductive age. There is very little or no available data on HIV in relation to trans men or non-binary people.

The data is further lacking or skewed because of the failure of Western language in the South African context when it comes to gender diverse and non-binary people. There are difficulties in conducting studies and obtaining data from transgender people related to prejudice. These are often related to prejudice and stigma and fear of disclosing their identities..

3.3.2 Behavioural risk factors

Trans people are more likely to engage in behaviours that put them at higher risk of HIV infection.

- Trans patients have a high rate of drug and alcohol abuse.
- Some trans patients are sex workers.
- Trans people are more likely to be in prison.
- Many trans people do not have stable housing or are homeless.
- Trans people are more likely to be unemployed.
- Trans people have a higher rate of attempted suicide.
- Trans people commonly experience a lack of familial and social support.
- There are significant barriers to access safe and dignified healthcare and other services that leave transgender people at higher risk of HIV and other health problems.

3.3.3 Barriers to combating HIV

There are certain factors that make identifying, preventing and treating HIV more difficult in the transgender population: Institutionalised stigma is a significant factor that prevents transgender people from accessing healthcare services – prior bad experiences may also play a role.

- Insensitive healthcare workers can make trans patients feel unsafe or unwelcome.
- It is often difficult for trans patients to access medication like ARVs.
- Many trans patients think they cannot take ARVs and HRT at the same time. And many will choose to continue hormone therapy and forsake ARVs for this reason, and because of the misgendering that happens when they seek ARV treatment.

Being both transgender and HIV-positive is associated with a lot of stigma and prejudice, both inside and outside the healthcare system. As healthcare providers, we need to recognise that this might make our patients uncomfortable or unwilling to access services, and we should take steps to address this.

3.3.4 HIV testing services (HTS)

HTS should be offered to all trans patients. It's important that this must be done on a voluntary basis. Part of the stigma surrounding transgender people is the idea that all trans people have HIV. Don't make any assumptions about your patient – offer them counselling and testing in a non-judgemental manner.

The same protocols and guidelines that are followed for all people (admin forms at the healthcare facility) must also be followed with transgender people, with additional sensitivity to transgender people, so that they feel able to access the services and are not misgendered, which would prevent them from returning for healthcare, or prevent them from seeking healthcare at all.

Basic principles of dealing with trans patients still apply:

- All paperwork should be revised to use inclusive, trans-sensitive language.
- Basic sensitivity practices should be followed.

Testing

- HTST should be offered to all trans patients on a voluntary basis.
- Voluntary testing, with informed consent, should be offered both in the context of provider-initiated testing and community-based testing.
- The use of rapid tests at the point of care expedites the testing process.
- World Health Organisation (WHO) guidelines for reading, interpreting and disclosing test results should be followed.

Counselling

- Counselling is recommended and should be linked to preventative services, as well as treatment services.
- If a patient is tested and the result is negative, they should be told how to remain negative, and given access to condoms, dental dams, and lube. If the patient is positive, they should be able to receive counselling and begin the treatment process, if indicated, at the same time.

3.3.5 HIV negative patients and safer sex practices

- Remember to consider the window period, depending on the testing method used.
- Patients should be counselled on safe sexual practices.
- Condoms, lubricants, dental dams, etc. should be provided, along with advice on alternatives to these, given that not all trans patients have access to these items, and that not all trans patients feel safe to access healthcare given the institutionalised transphobia. Plan with the patient as to when follow-up testing will be done.
- Consider referring the patient for pre-exposure prophylaxis (PrEP).

3.3.6 HIV-positive patients

The basic principles that apply to cisgender patients also apply to transgender patients:

- Post-test counselling should be carried out.
- Determine if ARVs are indicated. Following the South African treatment guidelines, these patients should be referred to begin ARV treatment:
- ART should be initiated among all adults with HIV regardless of clinical stage and at any CD4 cell count.
- As a priority, ART should be initiated among all adults with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adults with CD4 count ≤ 350 cells/mm³.

Resource: [National consolidated guidelines for the prevention of mother-to-child transmission of HIV \(PMTCT\) and the management of HIV in children, adolescents and adults](http://www.sahivsoc.org/Files/22%208%2016%20Circular%20UTT%20%20%20Decongestion%20CCMT%20Directorate%20(2).pdf) [http://www.sahivsoc.org/Files/22%208%2016%20Circular%20UTT%20%20%20Decongestion%20CCMT%20Directorate%20\(2\).pdf](http://www.sahivsoc.org/Files/22%208%2016%20Circular%20UTT%20%20%20Decongestion%20CCMT%20Directorate%20(2).pdf)

3.3.7 Initiating ARVs

Standard guidelines apply for initiating ARVs in trans patients.

Baseline testing should cover: Verifying HIV status.

- CD4.
- STI screen.
- TB screen.
- Pregnancy test if indicated

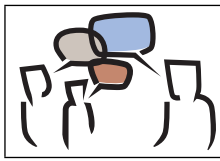
Reminder: Keep in mind that AFAB patients on testosterone can still fall pregnant, and that gender diverse people who identify as male, present as male, or who appear to be male, need to have a sexual history taken to determine whether they need to be tested for pregnancy. Remember to never assume anything about trans patients.

3.3.8 Treatment failure

Second line treatment is the same for trans patients, as with any other patient.

3.3.9 Summary: HIV and transgender patients

APPLICATION EXERCISE 2.3



In your groups, answer the question below.

5 minutes

1. Do transgender patients have the same risk for HIV as the rest of the population?

Why or why not?

2. Do all trans people have HIV?

3. What is the difference in negative post-test counselling if a patient is trans?

4. Can trans patients be referred for PrEP?

3.4 ARV Adherence and Trans People: Research Evidence

There are few or no studies examining adherence issues in trans men, non-binary patients. The studies that exist look almost exclusively at trans women, and many studies use very small sample groups.

Some studies suggest poorer adherence to ARV treatment in trans women than other patient populations. This could be because of the social stigma that transphobia trans women experience:

One study revealed that trans women felt less confident that they could integrate an HIV treatment regimen into their daily routines.

These women also said that fewer positive interactions with healthcare workers also affected their adherence.

Observations from grassroots trans activism organisations in South Africa support the theory that social stigma, lack of access to healthcare, and homelessness are the biggest factors that affect a lack of adherence to ARV protocols.

3.4.1 Factors affecting ARV adherence

There is a misconception among many trans people that HRT and ARVs cannot be used together. For a transgender person who is experiencing dysphoria, we must understand that hormone therapy is a necessity, and many of them will go to any lengths to continue taking hormones. This leads many trans patients to choose hormone therapy over ARVs, when in fact they could safely be on both treatments. It's up to us as healthcare workers to dispel these misconceptions and make sure patients understand that they do not need to choose.

Social issues play a role in adherence:

- Trans patients are more likely to be of poor socio-economic status, which impairs adherence.
- Trans patients are more likely to abuse drugs or alcohol.
- Transgender people are more likely to be homeless.
- Transgender people are more likely not to have a good social support structure, including friends, family and other resources, to help them maintain adherence to treatment regimens.

Transphobia in healthcare results in trans people avoiding seeking medical help or not going to follow-up consultations.

Co-morbid mental health conditions may also impair adherence in those patients who suffer from them.

3.4.2 Improving adherence: Integrating HRT and ARV treatment

One of the best ways to improve adherence is by integrating hormone therapy and HIV treatment at primary care level. This approach has been used successfully in many settings.

Allowing patients to access both hormone treatment and HIV treatment together reduces the burden on patients in continuing their treatment and maintaining their follow-ups. It also works to dispel the idea that hormones and ARVs cannot be used together.

It has been proven in studies that patients who are adherent to hormone therapy are more likely to be adherent to HIV treatment as well.

Starting (or continuing) hormone therapy is often an important motivating factor for transgender patients. It makes them much more likely to want to look after their general health – this includes seeking treatment for HIV and continuing that treatment. So, initiating hormone therapy can be a useful tool to prompt patients to live healthier lives.

3.4.3 Improving adherence: Creating a trans-competent environment

Creating a trans-competent environment makes it easier for trans people to access healthcare services available, which contributes to greater community health:

- Less discrimination and social prejudice is known to result in improved adherence.
- The provision and accessibility of trans-competent healthcare services make it easier for patients to remain on treatment.


A holistic approach is important in addressing adherence.

- Psycho-social support is critical: consider referral to a psychologist, counsellor or social worker.

- Social issues, including familial conflict, social isolation, unemployment and housing must also be addressed. Don't blame the patient or become angry. Be sensitive to the transphobia that they experience and expect.

3.4.4 Summary: ARV adherence

APPLICATION EXERCISE 2.4

	<i>In your groups, answer the questions below</i>	<i>5 minutes</i>
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1. Are transgender patients more or less adherent than other patient groups?

2. Can a transgender person use hormone replacement therapy as well as ARVs simultaneously?

3. What ways can you think of to help a transgender patient be more adherent to their treatment?

4. Psycho-social Support

4.1 Mental Health Services

4.1.1 Taking a mental health history

Mental health history should be handled sensitively.

If there are no psychological support services available at your location, or you cannot offer a referral to the appropriate services, asking questions about the patient's mental health may be invasive and harmful. Use gender-affirming terms rather than medical terms

- Gender dysphoria is not a mental illness, nor should it be screened as part of taking a mental health history.
- Transphobia (stigmatisation, rejection, discrimination, violence) experienced by trans people can lead to mental health disorders.

These are experiences that need to be accessed for that relate to taking a mental health history:

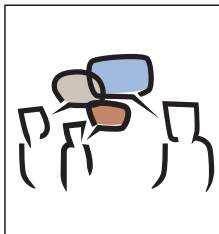
- Assess for trauma, depression, anxiety and/or other stress illnesses.
- Enquire about any experience of domestic abuse/violence.
- Enquire whether they feel ostracised, anxious, or depressed because of the way society perceives them?
- Substance use disorders that should be addressed, include:
 - Smoking: Do you smoke? How many a day? How long have you been smoking? Alcohol: Do you use alcohol? Amount (units) of alcohol per week? Type of alcohol? The strength of alcohol?
 - Recreational drug use: Do you use any recreational drugs? What type/s? How are they taken – injected or inhaled? Enquire about needle use and needle sharing.

Reminder: Some people have a significant improvement in mental health once they can access trans-competent and/or gender-affirming care, especially when dysphoria and the lack of access to this healthcare are part of the situational trigger for the depression and anxiety.

Identify referral options such as: local support groups, psychological support, social support, gender-based violence support, and internet support groups if the patient has internet access.

4.1.2 Mental health services

ACTIVATION EXERCISE 2.5



Your facilitator will allocate one of the following questions to each group. In your small groups of 3 or 4 people, discuss the question you have been allocated, refer to the notes in your manual and then present your input to the rest of the group.

*Preparation: 10 minutes.
Presentation: 3 minutes per group.*

1. What are the important knowledge and competencies that a mental healthcare worker should have, to provide a service to trans patients?

2. What are the possible implications that transition might have on the trans patient?

3. What are the goals of psychotherapy for transgender patients, and what contributions do the different practitioners make to mental healthcare?

Healthcare workers that may perform any or all of the supportive roles in providing mental health services to trans patients include:

- Psychologists
 - Psychiatrists
 - Doctors, especially general practitioners and family physicians
 - Nurses
 - Counsellors
- These supportive services are important both to the trans patient, as well as their family, through what is often a difficult time. Not all of these roles need to be fulfilled, and sometimes multiple roles might be performed by a single person. Each trans patient has different and individual needs, and these must be addressed – there is no 'one size fits all' approach.

4.1.3 Goals of psychotherapy

Psychotherapy is intended to support patients through the process of experiencing body related and social changes, if they have chosen to do so.

A person's gender identity cannot be changed through psychotherapy, and to try to do so is unethical. Remember that being trans is not an illness, it cannot be 'cured' and nor does it need to be.

Psychological support should always be affirming of the patient's identity and aim to help patients achieve the best quality of life that they can. It's important that patients should be able to access support and care at different stages of life and transition. The possibility for future follow-up, even years later, should not be neglected if it is needed.

The role of psychotherapy should be supportive, not advisory or instructive. The goals of psychotherapy in transgender patients are:

- To maximise quality of life, sense of well-being, and self-fulfilment.
- NOT to alter gender identity.
- Explore gender concerns and find ways to alleviate gender dysphoria.
- The long-term goal is to achieve lasting comfort in gender identity expression, with the best chance for maintaining relationships, and obtaining success with regards to education and/or work.
- The role should be supportive, not advisory.

- Building confidence in the new role.
- Facilitating disclosure or coming out
- Follow-up care should be available throughout life.

4.1.4 Essential Knowledge Required by A Mental Healthcare Worker (MHCW)

Anyone providing mental health services to trans patients needs to be knowledgeable about, and sensitive to, gender diverse, non-binary and transgender identities so that patients might be treated with the requisite respect and dignity

Cultural and contextual understanding is important so that the following issues may be considered:

- Social issues: Such as societal prejudice towards transgender people, the positions of religious movements on transgender acceptance (if any). Discrimination within the workplace towards transgender persons.
- Public policy: Such as the legal process for amending identity documents and awareness of laws protecting against discrimination based on gender identity.

Providers must be able to distinguish general co-existing mental health concerns from gender dysphoria:

- Providers need to understand that trans patients can have the same mental health concerns as the general population (e.g. depression, anxiety, other mood disorders, etc.) and that not everything is directly related to gender dysphoria.
- Being trans is not an illness.

Knowledge and understanding of sexuality and sexual health is of benefit, so that trans patients can be counselled on these subjects appropriately.

4.1.5 Information provision and education

Educate patients regarding diverse gender identities and expressions.

Consider different options for addressing the patient's gender dysphoria.

Facilitate the patient's exploration of their own gender.

Consider the possible implications that transitions might have:

- Psychological impact. Social consequences – like the effect on relationships, friends, family members. Physical changes – how the patient might feel as their body starts to change, and how to be realistic about their expectations for these changes. Sexual implications – gender-affirming interventions often impact on sexual function and desire, and space should be made for these to be addressed. Impact on occupation/employment. Financial implications – for example, the cost of medical interventions, doctor's appointments, blood tests, transport to the clinic, etc. Legal ramifications – such as changing legal name and gender marker on ID documents.

Mental healthcare workers might also be requested to provide a referral for hormonal intervention.

4.2 Social Services

4.2.1 Taking a Social History

Social history is closely related to mental health and has a direct impact on trans wellness:

- The consideration of transgender people being considered a Key Population is problematic as it excludes people who do not fit into the psycho-socio-medical definition of "transgender", e.g. WSW, transgender men, non-binary and gender diverse people, especially those in rural South Africa. This plays an important role in the denial of basic human rights to transgender people while afforded to cisgender people (in general).
- If there are no psycho-social support services available at your location, or you cannot offer a referral to the appropriate services, asking questions about the patient's social situation may seem to be invasive and harmful.
- Be sensitive to the patient's circumstances. Do not make assumptions.
- Refer patients to trans organisations, and to online support if the patient has access to the internet, to get help about any trans-specific issues that may be impacting their psycho-social well-being. Transgender people are more likely not to have a good social support structure, including friends, family and other resources, and this may affect general health, mental health as well as ARV adherence.

Assess support structures e.g. friends, family, peer support groups. Pay attention to whether the patient has lost friends, family or acceptance in religious circles because of their gender identity and whether they have lost a job.

In addition to knowing about the trans patient's social support structures such as family and friends, it's also important to know the patient's social habits and behaviours, as these can impact on vulnerability to HIV and ARV adherence.

4.2.2 Social support services

Key to addressing the health needs of trans people, both psycho-social and biomedical, is community outreach and community engagement. This includes providing awareness training for healthcare workers and for police, as well as supporting the establishment of community-based services such as outreach programmes, engaging and training community outreach workers, and setting up drop-in or safe spaces for trans people.

When considering the social support needs of the transgender patient, the following need to be considered:

- Family relationships
 - Trans people are often not safe, even among their own family members.
 - Social services may be needed to work with the family.
- Experience of violence
 - May need support to escape the violence.
 - May need access to shelters.
 - May need help with accessing police protection, which is often denied to trans people.
- Employment
 - Discrimination occurs at all levels of the employment process. May need support in accessing training or work opportunities.
- Community outreach and community engagement
 - Providing awareness training for healthcare workers and for police. Supporting the establishment of community-based services such as outreach programmes. Engaging and training community outreach workers. Setting up drop-in or safe spaces for trans people.

Reminder: A list of Trans Community Organisations can be found at the end of this manual.

4.3 Accessing Psycho-social Support

4.3.1 Trans competent psycho-social services - referrals

With regards to referring the trans patient for further psycho-social support, is the place you are referring patients to:

- Trans competentWilling to consult with a trans patient?
- Aware of the unique psycho-social needs of the trans patientNot going to cause further trauma with regards to the trans person's healthcare experience?

Consider phoning ahead to brief the support resource on the needs of the patient as well as explain some of the basics of trans sensitivity if necessary.

Reminder: Refer to the list Trans Community Organisations at the end of this manual and ask for recommendations to find a trans competent MHCW or other social support in your area.

4.3.2 Resource Limited Settings

Access to mental health services and social services can be challenging or restricted for some patients. Factors like cost of accessing services and travelling distance need to be considered, among others.

Not all mental healthcare workers or social workers are knowledgeable about, or sensitive to, trans issues and identities. In some instances, peer support resources (like support groups or peer counsellors) might be more accessible and effective than formal mental health services.

Other services (especially gender-affirming services) should never be withheld because of limited access to mental health services.

Reminder: What can be done to help transgender people with limited resources to get the support that they need?

4.4 Summary: Psycho-social Support

APPLICATION EXERCISE 2.5



Test your own understanding. Answer the questions below. This is an individual activity.

5 minutes

1. Is gender dysphoria a mental illness?

2. Can gender identity be changed through psychotherapy?

3. If a transgender patient has a depressive disorder or an anxiety disorder, can they still receive hormone therapy?

[illegible]

MODULE 3: GENDER-AFFIRMING HEALTHCARE

MODULE 3: GENDER-AFFIRMING HEALTHCARE

INTRODUCTION

This module relates to the specific interventions that make up gender-affirming healthcare. Topics covered include: non-medical gender-affirming interventions, Hormone Replacement Therapy, information on surgical interventions, long-term general healthcare related to gender-affirming interventions, psycho-social support and referral pathways for interventions not offered at your healthcare setting.

Aims of the Module

The purpose of this module is to enable the healthcare worker to provide trans-competent general healthcare with gender-affirming aspects in mind, and to enable the healthcare worker to refer patients for further gender-affirming services, including mental health and surgical services.

Learning Outcomes

After completing this module, participants should:

- understand the role of primary healthcare workers in providing safe and affirming general healthcare for all transgender, and non-binary people.
- make HRT an accessible gender-affirming intervention for the transgender community.
- write a medical report to support the patient in changing their gender marker on their identity document.
- obtain informed consent from transgender patients for hormone therapy.
- take a comprehensive medical history before starting hormone therapy.
- do a full physical examination, and identify appropriate further investigations.
- counsel patients on the impacts of hormone therapy on fertility.

- explain to patients:
 - the basic components of the relevant hormone therapy regimens.
 - the expected effects of the hormones, the timeframe of these changes, and their reversibility or irreversibility.
 - the risks associated with feminizing and masculinizing hormone therapy.
- assess the patient's risk profile and modify the risk profile, if possible.
- identify referral pathways for further gender-affirming interventions.
- recognise different roles that a healthcare worker might play in providing gender-affirming healthcare services to transgender patients, and the essential knowledge required.
- know about the referral options and trans specific organisations that they could contact for both professional support as well as to support patients in accessing other gender-affirming interventions and support.

Resources

- PowerPoint slides.
- [Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html). (2016). New York (NY): United Nations Development Programme. Chapter 3, Section 3.3. <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>
- [Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html). (2016). New York (NY): United Nations Development Programme. Chapter 2, Section 2.2; Chapter 3, Section 3.3.10 and Chapter 4. <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>

Purpose and Learning Outcomes

1. The Components of Gender-Affirming Healthcare

Transgender people need a multi-disciplinary approach to their care in the same way that cisgender people do – e.g. if you have HIV you need counselling/psychological care, endocrinology, and access to ARVs.

Patients will not necessarily get all the care they need in one place, and healthcare workers should be able to refer the patient for further healthcare and support as is needed.

In this module, we will cover the following aspects:

- Writing medical reports required to change the gender marker on identity documents.
- Informed consent.
- History taking
 - assessing gender-related history
 - relevant medical history
 - relevant mental health history.
- Physical exam.
- Hormone Replacement Therapy (HRT).
- Non-medical gender-affirming support.
- Surgical interventions.
- Options for resource limited settings.

2. Medical Reports

Patients may require a medical report to apply for identity documents that accurately reflect their gender (***name changes do not require a medical report***). In such cases, the patient may ask for a medical report to give to the Department of Home Affairs (DHA) that states that they are undergoing gender-affirming interventions such as hormone therapy or gender-affirming surgery (***surgery is not a requirement for the patient to change the gender marker on their ID***).

The patient will require **two** medical reports:

- One letter from the Doctor prescribing HRT, or from the surgeon performing gender-affirming surgery.
- One support letter: If the patient is on HRT and about to undergo gender-affirming surgery, then the surgeon's letter counts as the support letter to the letter from the Doctor prescribing HRT.
 - Doctors who treat the patient for general healthcare can write this letter. Letters can also be written by local trans organisations, such as Gender DynamiX.
 - Note: Despite the law recognising the mandate of psychologists, counsellors, social workers or psychiatrists in writing the support letter, incorrect implementation of the law has led to some letters from the previously mentioned service providers not being recognised as a valid. While legally this is incorrect, be aware that getting a letter from one of these service providers may result in the application being rejected or the process being delayed.

Who qualifies for a gender change in an ID?

The Alteration of Sex Description and Sex Status Act [No. 49 of 2003] says the following:

*"... Any person whose sexual characteristics have been altered by surgical **or** medical treatment or by natural evolvment through natural development resulting in gender reassignment..."* (Act 49, 2003, Paragraph 1).

How does the law describe gender reassignment?

It *"...means a process which is undertaken for the purpose of reassigning a person's sex by changing physiological or other sexual characteristics, and includes any part of such a process..."*.

Make patients aware that this process could take a long time and that there are often administrative delays. Suggest that they change their name and gender marker at different times to ensure there are as few delays as possible.

For help with legal issues related to changing identity documents, refer patients to the list of Trans Community Organisations at the end of this manual.

.2.1 Sample medical reports

Please remember that these are layouts that are accepted for changing gender markers on identity documents. Bearing this in mind, the use of the terms 'male to female' and 'female to male' describe the change in gender marker not the gender of the transgender person.

At the time of compiling this document, non-binary gender markers are not an option for identity documents in South Africa and transgender people will have to choose either male or female for their legal documentation. The letter should be on an official letterhead that clearly displays the name, registration number, practice number, and contact details of the healthcare provider.

Male to female patients:

a) Male to Female - Only Hormones (no surgery)

To Whom It May Concern: Department of Home Affairs

MEDICAL REPORT on: XXXXXXXXXXXXX (legal name) ID No: XXXXXXXXXXXXXXX

In terms of the Alteration of Sex Description and Sex Status Act No 49 of 2003.

This is to certify that XXXXXXXXXXXXX is a patient of mine and has undergone medical gender reassignment. As a result of this medical gender reassignment, she now presents as female.

She has been a patient of mine since xxxx (date).

Please feel free to contact me at the above address if you have any further queries.

b) Male to Female – Hormones and some surgery

To Whom It May Concern: Department of Home Affairs

MEDICAL REPORT on: XXXXXXXXXXXXXXX (legal name) ID No: XXXXXXXXXXXXXXX

In terms of the Alteration of Sex Description and Sex Status Act No 49 of 2003.

This is to certify that XXXXXXXXXXXXXXX is a patient of mine and has undergone medical gender reassignment and has also had gender reassignment surgery. As a result of this medical gender reassignment and surgery she now presents as female.

She has been a patient of mine since xxxx (date).

Please feel free to contact me at the above address if you have any further queries.

Female to Male Patients:

a) Female to Male – Only hormones (no surgery)

To Whom It May Concern: Department of Home Affairs

MEDICAL REPORT on: XXXXXXXXXXXXXXX (legal name) ID No: XXXXXXXXXXXXXXX

In terms of the Alteration of Sex Description and Sex Status Act No 49 of 2003.

This is to certify that XXXXXXX is a patient of mine and has undergone medical gender reassignment. This has altered his sexual characteristics and he now presents as male.

He has been a patient of mine since xxxx (date).

Please feel free to contact me at the above address if you have any further queries.

b) Female to Male – Hormones and some surgery

To Whom It May Concern: Department of Home Affairs

MEDICAL REPORT on: XXXXXXXXXXXX (legal name) ID No: XXXXXXXXXXXXXXXX

In terms of the Alteration of Sex Description and Sex Status Act No 49 of 2003.

This is to certify that XXXXXX has undergone Medical Gender Reassignment and has also had gender reassignment surgery. As a result of this medical gender reassignment and surgery he now presents as male.

He has been a patient of mine since xxxx (date).

Please feel free to contact me at the above address if you have any further queries.

3. Initiating Gender-Affirming Healthcare

3.1 Assessment checklist

The following points must be covered as part of the pre-treatment assessment:

- Informed consent
- History taking
- Physical examination
- Baseline blood tests
- Fertility considerations

3.2 Informed consent

3.2.1 Dysphoria and gender dysphoria diagnosis

Dysphoria is a subjective feeling that can be related to how the person views their body, or how they feel about being gendered in a certain way in social interactions.

The term Gender Dysphoria, is a diagnosis found in the DSM-5.

- The problem with the DSM Gender Dysphoria diagnosis is: It categorises being transgender as a mental illness
 - It is often used to deny gender-affirming healthcare to transgender people because of healthcare workers expecting the patient to prove their gender. This causes unnecessary delays in accessing affirming care and can often be traumatic to the trans patient.

Language plays a big role in how people express their lived reality, and in the South African setting, many people may not even know what the word dysphoria means. It is more important to affirm the patient's lived reality than to expect that there will be a definite set of behaviours or experiences that will guide the healthcare worker to be able to diagnose gender dysphoria. Self-determination will allow a patient to ask for gender-affirming healthcare if that is what they want and feel would be of the most benefit to them. A diagnosis of gender dysphoria is not needed to access gender-affirming healthcare. Delaying or denying gender-affirming healthcare in order for the healthcare worker to document the patient's gender dysphoria may form an unnecessary obstacle, especially in the South African context where trans patients' access to healthcare facilities may include long waiting periods, significant travel time and cost, as well as leave taken from work.

Rather than the gender dysphoria diagnostic criteria, the informed consent model should be practised in any trans-competent facility when providing gender-affirming healthcare.

3.2.2 The informed consent model

Informed consent has two components: information and consent. Information:

- Risks of treatment.
- Benefits of treatment.
- Reversible and irreversible effects of hormone therapy.
- The impact of hormone therapy on reproductive capacity.

Consent:

- Must be given on a voluntary basis, without any coercion.
- It must be given by a patient who has the capacity to make a decision.
- In the above case, the patient must be fully informed regarding the decision made on their behalf.

Documenting consent:

- The best practice is to have printed handouts for patients that summarise the relevant information and have fields for signatures, names and dates.
- Keep a record of the signed consent form in the patient's medical file.
- Once the patient has signed, HRT may proceed.

An informed consent form for Masculinizing HRT and an informed consent form for Feminizing HRT can be downloaded from www.anovahealth.co.za

3.3 Additional History Taking for Initiating HRT

3.3.1 Assessing gender-related history

Take a history of the patient with regards to their transgender identity. (Remembering that transgender includes non-binary, and gender diverse patients).

This history has no textbook timeline and healthcare workers shouldn't anticipate that the patient will have a predictable set of key experiences or behaviours. (i.e. playing with specific toys or knowing that they were trans at a young age)

- Allow the patient to talk about their gender identity and their experience of discovering their gender. Begin by asking: "Could you tell me about significant events in your life with regards to understanding your gender?"
- Follow on with these, or some of these not answered by the above, if necessary:
 - How the patient became aware of these feelings.
 - How they interpreted them.
 - Childhood memories about gender.
 - School experiences about gender.
 - Response to puberty: the changing of their bodies.
 - Any experience of dysphoria that the patient may be able to identify, both past and present.
- *The focus of this history taking is not to unpack gender dysphoria but rather to allow the patient to express their gender journey in their own words.*

Reminder: Throughout this history taking, keep in mind the lessons learnt about being sensitive to the trans patient and the words that they use for themselves.

3.3.2 Relevant medical history

Ask about personal medical history, and specifically:

- Do you have any chronic illnesses (e.g. diabetes, epilepsy, asthma, or HIV)?
- Have you previously been diagnosed with or treated for any STIs?
- Are you allergic to any medicines, environmental allergens or foodstuffs?
- Have you been hospitalised before? If so, why, when and for how long?
- Have you had any surgical procedures? These can include general procedures or gender-affirming surgery.
- Do you have any of the following conditions
 - Coronary artery disease.
 - Deep vein thrombosis or pulmonary embolism.
 - Embolic stroke.
 - Liver disease.
 - Pituitary adenoma.
 - Uncontrolled hypertension.
 - Uncontrolled diabetes mellitus.
 - Breast or uterine cancer.
 - Erythrocytosis.
 - Kidney disease.
- Family history of: Cancer, diabetes, heart disease, hypertension, liver disease.
- Medication use: Do you take any medication on an ongoing basis (including hormone therapy)?
 - Prescribed? Over-the-counter? Herbal? Supplements?
 - Gym supplements, diet?
 - Medication from a traditional healer?
 - Have you recently been on any other medications or antibiotics?

- Silicone soft tissue filler use.
- Illicit drug use: What? How often? Use of needles?

Reminder: Some patients may self-medicate – e.g. Taking contraceptive pills as HRT, or taking testosterone not prescribed to them by a doctor.

Illicit drugs may include HRT purchased illegally, and that the use of needles is not limited to drugs, but used to inject testosterone.

3.3. 3 Mental health history related to gender-affirming healthcare

Mental health conditions that need to be screened for:

- Active psychosis.
- Cognitive impairment.
- Dementia.
- Suicidal or homicidal ideation or attempts.
- Depression and/or anxiety.

Patients who have a history of mental illness need more regular follow-ups to check for destabilisation of their pre-existing conditions. Patients with mental illnesses should not be precluded from beginning HRT simply because they have a mental illness.

Explain the risk of HRT to a patient with an existing mental illness.

4. Physical Exam

Conduct a full routine physical examination:

- General examination.
- Systems.
- Cardiovascular.
- Respiratory.
- Abdomen.
- Neurological.

- Musculoskeletal.
- Skin.
- Genitourinary.

Bear in mind that the chest/breast exam and genital exams should be undertaken with extreme sensitivity;

Patients might be uncomfortable with these exams and have the right to refuse them. If they do, please be understanding. Ask if they would prefer that someone else does the exam (if someone is available).

5. Hormone Replacement Therapy

5.1 Initiating Hormone Replacement Therapy

5.1.1 Clinical Guidelines

According to the World Professional Association for Transgender Health (WPATH) Standards of Care, Volume 7, the requirements for initiating hormone therapy are:

- The patient must have the capacity to make a fully informed decision and consent to treatment.
- The patient must be of legal age to make that decision and give consent to treatment.
- Any co-existing medical or mental health problems must be addressed, and be relatively well-controlled. Persistent, well-documented gender dysphoria.

However: These criteria are not absolute, and need to be assessed considering the South African context. They are flexible clinical guidelines to be adapted to individual cases.

For the South African context, the following is a more practical guideline:

- HRT for trans patients is approached using the informed consent model.
- The idea of requiring a patient to live in their identified role for a period before starting treatment ("real life experience") is outdated and no longer a requirement for beginning HRT.

- Psychotherapy is not a requirement for HRT, but it should be made available as an add-on to patients who might benefit from it, especially patients with a history of mental health issues.
- It is also important to note that HRT has effects not just on the patient's body, but on their mood as well, which is why referral to psycho-social support, if desired, should be facilitated, including for example, peer support groups.
- Harm reduction is also a consideration – for example, it is better to prescribe HRT for a patient if refusal to do so would lead to them self-medicating with illicit and potentially unsafe hormones.
- HIV, Hepatitis B and Hepatitis C infections do not preclude patients from being eligible for hormone therapy.

5.1.2 Informed consent: Fertility considerations

Patients must be counselled on the effects of HRT on fertility, and should also be informed that they can seek cryopreservation of sperm or ova before they start therapy to preserve their reproductive options in the future. Note that these options will need to be pursued in private and at the patient's own cost.

Hormone therapy often leads to infertility in transgender patients. Fertility will, in some cases, return if HRT is withdrawn. In some individuals, infertility will be irreversible.

HRT should not be used as a contraceptive – other means are still required.

Effective contraception methods include:

- Condoms
- An IUD can be used in conjunction with testosterone therapy for people who have a uterus and ovaries.

5.1.3 Hormone therapy basics

The use of HRT for gender reassignment is off-label. There is a wealth of clinical experience that supports the safety and efficacy of HRT.

Not all transgender patients will want to go on HRT, for varying reasons – this is a decision that should always be respected. Remember that the decision belongs to the patient – it is their body, and they have the right to decide what happens with it.


Patients with non-binary identities may also want HRT, and their access to it should be facilitated. Hormone therapy is not reserved exclusively for trans men or trans women.

Patients do not need to suffer from a specified degree of dysphoria to be eligible for hormone therapy.

Patients who are already on HRT – whether they have self-medicated, or received it from other avenues – should always be continued on HRT, as a means of harm reduction. Perform appropriate assessments and adjust medication, but do not withdraw (or threaten to withdraw) HRT from them.

5.1.4 Summary: Initiating HRT

APPLICATION EXERCISE 3.1

	Complete the Quick Quiz below to check your own understanding.	5 minutes	
The decision to start hormone therapy should be made by the healthcare worker, and not by the patient.	TRUE	FALSE	
Patients need to live as their identified gender for a set period of time ('real life experience') before they can be allowed to start hormone replacement therapy.	TRUE	FALSE	
HIV, Hepatitis B, and Hepatitis C infection are all factors that make patients ineligible for hormone therapy.	TRUE	FALSE	
Patients on hormone therapy do not need contraceptives as they are all infertile.	TRUE	FALSE	
Assessing a patient for hormone therapy requires a physical examination	TRUE	FALSE	
To initiate hormone therapy there should be there should be a diagnosis of gender dysphoria or the presence of dysphoria.	TRUE	FALSE	

5.2 Investigations: Baseline Blood Tests

5.2.1 Baseline tests for feminizing regimen

Recommended Panel						Limited Resource Settings					
Baseline	3 Months*	6 Months*	12 Months*	Yearly	PRN	Baseline	3 Months*	6 Months*	12 Months*	Yearly	PRN
Urea, Creatinine (GFR) and potassium						Creatinine (GFR) and potassium (if on Spiro)					
X	X	X	X	X	X	X	X	X	X	X	X
Glucose, HBA1c (only if indicated by medical history)											
					X						
Liver enzymes: AST and ALT (if oral oestrogen is used)						Liver enzymes: AST and ALT (if oral oestrogen is used)					
X		X			X	X		X		X	X
Fasting lipogram (only if indicated by medical history and oral oestrogen is used)						Fasting lipogram (only if indicated by medical history and oral oestrogen is used)					
X		X		X	X	X		X		X	X
Sex hormone levels: Estradiol (E2)											
	X	X			X						
Sex hormone levels: Total Testosterone											
	X	X	X		X						
Sex hormone levels: SHBG											
	X	X	X		X						
Prolactin (only if signs of prolactinoma)											
					X						
Offer STI screen: Hepatitis and Syphilis						Offer STI screen: Hepatitis and Syphilis					
X					X						
Offer HIV counselling and testing						Offer HIV counselling and testing					
X					X						

* in the first year of HRT

Source: Overview of feminizing hormone therapy. <http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy>

If circumstances allow, do the full recommended panel of tests for all patients: Urea, Creatinine (GFR) and potassium.

- Fasting lipogram.
- Sex hormone levels: E2, testosterone, SHBG (assessed against standard hormonal levels of the population that corresponds to the hormone panel).
- Offer STI screening.
- Offer HIV counselling and testing.

In resource limited settings, these are the minimum required investigations –

- Fasting lipogram – if oral oestrogen will be used.
- Potassium and creatinine – if Spironolactone will be used.
- Transaminases – if oral oestrogen will be used.

5.2.2 Baseline tests for masculinizing regimen

Recommended Panel						Limited Resource Settings					
Baseline	3 Months*	6 Months*	12 Months*	Yearly	PRN	Baseline	3 Months*	6 Months*	12 Months*	Yearly	PRN
Haemoglobin and Haematocrit						Haemoglobin and/or Haematocrit					
X	X	X	X	X	X	X	X	X	X	X	X
Glucose, HBA1c (only if indicated by medical history)											
					X						
Fasting lipogram						LDL and HDL					
X		X			X	X		X		X	X
Sex hormone levels: Estradiol (E2)											
					X						
Sex hormone levels: Total Testosterone											
	X	X	X		X						
Recommended Panel						Limited Resource Settings					
Sex hormone levels: SHBG											
	X	X	X		X						
Offer STI screen: Hepatitis and Syphilis						Offer STI screen: Hepatitis and Syphilis					
X					X						
Offer HIV counselling and testing						Offer HIV counselling and testing					
X					X						

* in the first year of HRT

Source: Overview of masculinizing hormone therapy. <http://transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy>

If circumstances allow, do the full recommended panel of tests for all patients: Full blood count – or haematocrit and haemoglobin.

- Fasting lipogram.
- Sex hormone levels: E2, testosterone, SHBG (assessed against standard hormonal levels of the population that corresponds to the hormone panel).
- Offer STI screening.
- Offer HIV counselling and testing.

In limited resource settings, these are the minimum required investigations: Haemoglobin.

- LDL and HDL.

5.3 Oestrogen based hormone therapy: Feminizing regime

The components of the feminizing regimen are:

- Anti-androgens (oral).
- Oestrogen (oral)
- Oestrogen is also available as a transdermal (patch). The patch is unfortunately expensive, may cause skin irritation, and some patients find that they struggle to reach their target hormone levels. Although it may be a good option for patients who have issues with liver function.

5.3.1 Feminizing effects

EFFECTS OF FEMINIZING REGIMEN			
Effect	Onset	Maximal effect	Reversibility
Body fat redistribution	3-6 months	2-5 years	Reversible
Decreased muscle mass and strength	3-6 months	1-2 years	Reversible
Softening of skin and decreased oiliness	3-6 months	Unknown	Reversible
Decreased libido	1-3 months	1-2 years	Reversible
Decreased spontaneous erections	1-3 months	3-6 months	Reversible
Breast growth	3-6 months	2-3 years	Irreversible
Decreased testicular volume	3-6 months	2-3 years	Reversible
Decreased sperm production	Variable	Variable	May be irreversible
Thinning and slowed growth of body and facial hair	6-12 months	>3 years	Reversible
Halted alopecia androgenetica	1-3 months	1-2 years	Reversible

5.3.2 Risks of feminizing regimen

Feminizing HRT increases a patient's risk of: Venous thromboembolic disease.

- Weight gain.
- Cardiovascular disease, especially if additional risk factors are present (e.g. smoking).
- Hypertriglyceridemia (clinically significant).
- Gallstones.
- Elevated liver enzymes.

- Hypertension.
- Hyperprolactinaemia (usually in the first year of treatment, highly unlikely after three years).
- Type 2 Diabetes Mellitus, if additional risk factors are present (e.g. Metabolic syndrome).

5.3.3 Risk profiling and reduction for a feminizing regimen

The risk profile is based on the initial workup done as part of the assessment for hormone therapy.

Absolute contraindications to oestrogen therapy are: (Make the patient aware of these, but it is still the patient's decision to begin HRT if they are fully aware of the risks involved):

- Previous venous thromboembolic event or a hypercoagulable state.
- History of an oestrogen sensitive cancer.
- Advanced chronic liver disease.

Other risk factors that should be considered are: Modifiable factors, e.g. smoking, weight, diet, untreated hepatitis.

- Unmodifiable factors, e.g. age (above 35 years), family history (e.g. of cardiovascular disease).

Patients should be counselled on modification of risk factors (smoking cessation, lack of exercise, overweight or obesity).

5.3.4 Basic oestrogen replacement regimen

A basic, commonly used feminizing regimen for patients starting on HRT is: 17-Beta-oestradiol (Estrofem® or Estropause®).

- Spironolactone (Aldactone®).

Primary healthcare:

- Conjugated equine oestrogen (Premarin®).
- Spiro on request.


	Low Initial Dose ¹	Initial Dose	Maximum Dose ²	Post-Orchidectomy	Comments
Oestrogen:					
17-beta estradiol (Estrofem®)	1mg/day	2-4mg/day	6-8 mg/day	1-2 mg daily	Most commonly prescribed oestrogen HRT because it is bio-identical and has a more favourable risk profile compared to conjugated oestrogen.
OR Conjugated equine oestrogens (Premarin®)	1mg/day		5mg/day	0.625-1.25mg/day	Commonly prescribed in public health clinics because it is accessible and well known, however of all the oestrogen HRT options, conjugated oestrogen has the highest rate of thrombogenicity and increased cardiovascular risk. HRT with this form of oestrogen results in an inability to accurately measure blood hormone levels.
Anti-androgen:					
Spirolactone (Aldactone®)	25mg at bedtime	50mg twice daily	200mg twice daily	N/A	Often not prescribed in public health unless specifically requested.

1. For patients who require gradual changes, or gender-affirming option for non-binary transgender people
2. Maximal effect does not necessarily require maximal dosing; maximal doses do not necessarily represent a target or ideal dose. Dose increases should be based on patient response and monitored hormone levels

Source: <http://transhealth.ucsf.edu/trans?page=guidelines-feminizing-therapy>

5.3.5 Summary: Oestrogen based HRT

APPLICATION EXERCISE 3.2

	<p><i>In your groups, answer the questions below. You may refer to your manual.</i></p> <p><i>This is a race! The first group to finish will be awarded a prize!</i></p>	<p><i>7 minutes</i></p>
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1. Name two components of a feminizing regime.

2. Name six feminising effects of the feminizing hormones.

3. Name one irreversible effect of the feminizing regime.

4. Name six risks of the feminizing regime.

5. Name three absolute contraindications to oestrogen therapy.

5.4 Testosterone-based hormone therapy: Masculinizing regimen

The masculinizing regimen consists of testosterone only. It may be given as:

- Injectable – most common method in South Africa.
- Transdermal.
- Gel/Cream (not readily available in South Africa).
- Oral (very seldom used; potentially dangerous side effects, and not as effective as other forms).

Most commonly, long-acting, injectable testosterone is used.

5.4.1 Masculinizing effects

EFFECTS OF THE MASCULINIZING REGIMEN			
Effect	Onset	Maximal effect	Reversibility
Skin oiliness/acne	1-6 months	1-2 years	Reversible
Facial/body hair growth	3-6 months	3-5 years	Irreversible
Scalp hair loss	>12 months	Variable	Irreversible
Increased muscle mass/strength	6-12 months	2-5 years	Reversible
Body fat redistribution	3-6 months	2-5 years	Reversible
Cessation of menses	2-6 months	n/a	May be irreversible
Clitoral enlargement	3-6 months	1-2 years	May be irreversible
Vaginal atrophy	3-6 months	1-2 years	May be irreversible
Deepened voice	3-12 months	1-2 years	Irreversible

5.4.2 Risks of masculinizing regimen

Masculinizing hormone therapy increases a patient's risk of: Hyperlipidaemia.

- Polycythaemia, including DVT.
- Weight gain.
- Acne.
- Androgenic alopecia (male pattern baldness).
- Sleep apnoea.
- Elevated liver enzymes.
- Destabilisation of certain psychiatric disorders, if additional risk factors are present.
- Cardiovascular disease, if additional risk factors are present.
- Hypertension, if additional risk factors are present.
- Type 2 Diabetes Mellitus, if additional risk factors are present.

5.4.3 Risk profiling and reduction for a masculinizing regimen

The risk profile is based on the initial workup done as part of the assessment for hormone therapy.

Absolute contraindications to testosterone therapy are: Pregnancy.

- Unstable coronary artery disease.
- Untreated polycythaemia with a haematocrit of > 55%.
- If there is a history of oestrogen-dependant cancer, refer to an oncologist.

These contraindications should not prevent hormone treatment if the patient is aware of the risks, the complications and still chooses to start HRT.

Other risk factors should be assessed:

- Modifiable: Smoking, weight, diet, untreated hepatitis.
- Unmodifiable: Family history (e.g. of cardiovascular disease).
- Patients should be counselled on modification of risk factors (smoking cessation, exercise, weight loss).

- Testosterone administration is not contraindicated in the presence of PCOS, but patients should be monitored for hyperlipidemia and diabetes.
- These risk factors should not prevent hormone treatment if the patient is aware of the risks, the complications and still chooses to begin with HRT.

5.4.4 Basic testosterone replacement regimen

A basic, commonly used masculinizing regimen for patients starting on testosterone HRT is:

- Nebido® (very expensive and not readily available in primary healthcare) Depo-testosterone® Sustanon® (this is not readily available, and is in most cases illegally obtained).

After two years, dosages may need to be reduced to stay within the typical male range for serum testosterone.

Reminder: Reassess the osteoporosis risk if adjusting the hormone dosage, as sex hormones are necessary for bone health.

Depo-Testosterone® is readily available in primary healthcare, while Nebido® is extremely expensive and not readily available in primary healthcare. The form of testosterone HRT that will be available is dependent on the area and supply chain of the particular clinic.

	Low Initial Dose ¹	Initial Dose	Maximum Dose ²	Comments
Testosterone Cypionate (Depo-Testosterone®)	20mg/week IM/ SQ ³	50mg/week IM/ SQ	100mg/week IM/ SQ	If an injection is given every two weeks instead of weekly, then double the dosage per injection.
Testosterone Undecanoate (Nebido®)	N/A	1000mg IM, repeat in 6 weeks, then every 10-14 weeks	N/A	
Sustanon®	Sustanon® 250 is a blend of four esterified testosterone compounds. It is not readily available in South Africa and is in most cases illegally obtained.			
Testosterone topical cream	Topical cream needs to be ordered from a compounding pharmacy. Dosage dependant on the testosterone percentage of the cream.			

¹ For patients who require gradual changes, or gender-affirming option for non-binary transgender people.

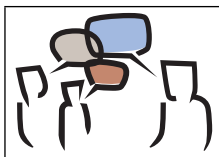
² Maximal effect does not necessarily require maximal dosing; maximal doses do not necessarily represent a target or ideal dose. Dose increases should be based on patient response and monitored hormone levels.

³ While Depo-Testosterone® is labelled for use intramuscularly, it can be given as a subcutaneous inject which some patients find preferable and minimises the risks of long-term IM injections.

Source: <http://transhealth.ucsf.edu/trans?page=guidelines-masculinizing-therapy>

5.4.5 Summary: Testosterone based HRT

APPLICATION EXERCISE 3.3



In your groups, answer the questions below. You may refer to your manual. This is a race! The first group to finish will be awarded a prize!

7 minutes

1. Name the component of a masculinizing regime.

2. Name six effects of the masculinizing regimen.

3. Name three irreversible effect of the masculinizing regime.

4. Name six risks of the masculinizing regime.

5.5 Monitoring and maintenance of hormone therapy

Follow-up visits should be scheduled at: One month.

- Three months.
- Six months.
- Thereafter, six-monthly, unless the patient experiences symptoms that might be the effect of HRT. Explain this to patients.

5.5.1 Follow-up consultations

A complete physical exam should be done, with special attention to:

- Blood pressure.
- Weight (keeping in mind that patients on testosterone will put on muscle mass, even without exercise).

Ask the patient about:

- Effects they are happy about, and effects that they are concerned about.
- Feminizing hormones: Most commonly nausea, headache, mood changes.
- Testosterone: Most commonly acne, headache, mood changes.

5.5.2 Follow-up investigations

For the schedule for follow-up blood tests, refer to the tables found earlier in this section

- For patients on oestrogen: Measure the prolactin level annually.
 - If it remains normal at three years, no further testing is needed.
- For patients on testosterone: Be sure to check the serum testosterone as close to the day before the next dose is due. This is especially important for Nebido where the trough level needs to be measured, before the next dose is administered.
 - Haematocrit must be monitored regularly, i.e. 6-12 monthly.
 - If the patient is on Nebido, check the trough level (just before the next dose is due).

5.6 Non-Binary Gender-Affirming Care

Non-binary gender

Some transgender people conform to the gender binary and are either male or female, others do not.

Some examples of non-binary genders are:

Having a neutral gender (neutrois).

Not having a gender (agender)

A gender identity that shifts (genderfluid)

A non-conforming gender identity (genderqueer)

The regimens detailed above include an initial low-dose HRT option which may be a good starting point for people who desire less extreme changes or who have non-binary identities.

For less intensive changes, the following can be considered –

- AMAB patients:
 - Use of an anti-androgen alone can be used for a short-term intervention but due to the long-term risk of osteoporosis, additional oestrogen supplementation is strongly advised.

- Use of an anti-androgen with low-dose oestrogen (e.g. half of the usual starting dose).
- AFAB patients:
 - Interventions to suppress menstruation (e.g. IUD, endometrial ablation).
 - Low-dose testosterone (e.g. half of the usual starting dose). It needs to be explained to the patient that each body reacts differently to testosterone, and they might not achieve some of the effects they desire, and might experience effects they do not want.
- Assess the patient's wishes and expectations, and adjust the management accordingly.
- Remember to review this at appropriate intervals.

6. Non-medical Gender-Affirming Support: Binding and tucking

Reminder: Not all gender-affirming care needs to be medical (HRT and related medical histories and treatments) or surgical. There are other gender-affirming ways to help trans patients that they may not be aware of such as binding, packing, and tucking.

Packing refers to placing an object or purpose-made prosthesis in the underwear to replicate the bulge of a flaccid penis under the clothing. We have not discussed packing in this manual, however there are many online resources, and packers are sometimes imported by lranti.org (details in the Trans Community Organisations list).

6.1 Binding

Binding refers to flattening the chest by means of compressing breast tissue beneath tight garments or other forms of strapping. It is usually done by AFAB patients who want a flatter chest. It might be done by AMAB patients who have grown breast tissue that they wish to hide for various reasons.

6.1.1 Unsafe binding

Unsafe binding, though often tempting, can lead to irreparable damage to the skeleton, soft tissues, and the lungs themselves. Patients must be discouraged from using any of these unsafe techniques for chest binding. Remember to provide alternatives for patients that are safe and sustainable.

Unsafe methods include:

- Using elastic bandages.
- Wrapping the chest with Glad Wrap.
- Using duct tape.

The risks with these methods include: Restricted breathing.

- Severe and debilitating back pain.
- Muscle damage.
- Long-term use may deform the structure of the chest wall, or cause rib fractures.
- Lung damage, such as lung contusion.

6.1.2 Safe binding

Safer methods for binding include:

- Use of a purpose-made chest binder, a garment designed specifically for binding (which is available in South Africa but quite expensive at about R400 per binder, but much cheaper than ordering one from overseas).
- Wearing sports bras: Sports bras flatten the breasts and give more support. Wearing multiple sports bras in layers may improve the effect.
- Layered clothing, e.g. a tight undergarment, with layers of progressively looser garments on top.
- Athletic compression shirts available at some sports outlets. (These are cheaper than binders, but still expensive).

Precautions to be taken when binding:

- Make sure the garments are not too tight. Resist the temptation to take a smaller size than you need.
- When binding, ensure you can breathe comfortably.
- Start with short periods of wear, and gradually build up.
- Try not to bind for longer than 6 to 8 hours at a time.
- Try not to bind when exercising, as this exacerbates the risk factors and damage caused.
- Do not sleep in your binder.

Reminder: There is a contact for South African made binders in the list of Trans Community Organisations at the end of this manual.

Some online resources with more information on binding are:

<http://www.ftmguide.org/binding.html>

<http://www.idontdoboxes.org/your-friendly-neighborhood-binding-safety-guide/>

<http://transhealth.vch.ca/social-transition-options/binding-packing-tucking/binding>

6.2 Tucking






Tucking is a gender-affirming practice used by AMAB patients. This refers to hiding the genitalia so that they will not be visible beneath tight fitting clothing.



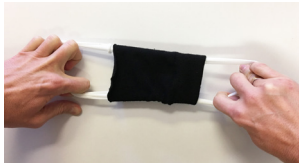

Techniques for tucking: Pushing the genitalia back in between the legs, and securing this arrangement by wearing tight fitting underwear or panties.

- Tucking into the inguinal canal.
- The testes can be lifted into the scrotum and gently pushed through the inguinal ring.
- This is easier if the patient lies on their back.
- The scrotum may be secured in place with medical tape.
- Special undergarments called a "gaff", designed specifically for tucking, may be used. These are difficult to source, but many AMAB people make their own, using stockings.

How to make a Gaff Diagram.

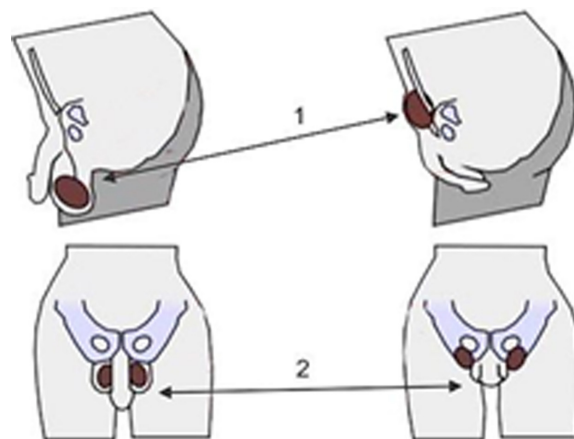
The following diagram demonstrates how to make an affordable Gaff, which is a tucking device:

<p>Step 1.</p> <p>You will need a sock with a longish neck (shorter "sport" socks won't work).</p>	
<p>Step 2.</p> <p>You will need a pair of full pantyhose.</p>	
<p>Step 3.</p> <p>You will need a sharp pair of scissors.</p>	
<p>Step 4.</p> <p>Using the scissors, cut the elasticated band off the legs of the pantyhose.</p>	
<p>Step 5.</p> <p>The elastic waist of the pantyhose is what you will be using, not the legs.</p>	

<p>Step 6.</p> <p>Take the scissors and cut off the top neck of the sock from the foot.</p>	
<p>Step 7.</p> <p>The remaining piece of the sock should resemble an elastic tube.</p>	
<p>Step 8.</p> <p>Place the cut pantyhose elastic waistband through the sock neck.</p>	
<p>Step 9.</p> <p>Place each of your legs in the pantyhose elastic with the sock neck between your legs.</p>	
<p>Step 10.</p> <p>Pull up your gaff and tuck.</p>	

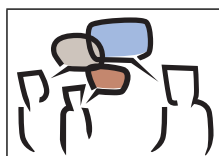
6.2.1 Precautions when tucking

- Tucking may be easier if the area is shaved, especially if using tape.
- The patient must go slowly, and stop immediately if any pain/nausea/discomfort occurs.
- Caution should be exercised when sitting down to avoid undue pain.



6.3 Summary: binding and tucking

APPLICATION EXERCISE 3.4



In your groups, answer the questions below

5 minutes

1. What is 'binding'?

2. Is it safe to bind with elastic bandages? Why?

3. What methods of binding are safe, if done properly?

4. What is 'tucking'?

5. What precautions should be taken to ensure safe tucking?

7. Surgical Interventions

Reminder: Surgery for trans patients is effective in treating gender dysphoria and is medically necessary and NOT a cosmetic endeavour.

7.1 Top surgery

Top surgery includes:

- Mastectomy for AFAB patients.
- Augmentation mammoplasty for AMAB patients.

AMAB patients should ideally not pursue top surgery before being on hormones for one to two years, as the results of the surgery improve if maximal natural breast growth has already been achieved.

AFAB patients can have top surgery done sooner.

Both procedures are commonly performed procedures for indications other than trans healthcare (e.g. breast augmentation for cisgender women is a common procedure).

7.2 Bottom surgery

- AFAB patients:Metoidioplasty.
 - Phalloplasty.
 - Scrotoplasty.
 - Hysterectomy.
 - Salpingo-oophorectomy.
- AMAB patients:Orchidectomy.
 - Vaginoplasty.
 - Labioplasty.

7.3 Other surgery

AMAB:

- Facial feminisation surgery.
- Tracheal shave.
- Vocal cord surgery.

AFAB:

- Pectoral implants.

7.4 Follow-up care

Transgender patients should have access to lifelong holistic follow-up care that should include general healthcare, gynaecological care, and psycho-social support.

As applicable to the general (cisgender) population, this includes regular check-ups, screening tests, and vaccinations as appropriate.

Special consideration should be given to patients with the following conditions that might be influenced by hormonal therapy:

Cardiovascular disease or risk factors

Osteoporosis

Gynaecological care should include:


AFAB patients who have not had bottom surgery may develop vaginal atrophy, with pruritus and burning that should be addressed to prevent deterioration.

Recommendations are the same as post-menopausal vaginal care and include use of extra lubrication during penetrative sex. For AMAB patients who have had bottom surgery, considerations include:

- Genital hygiene.
- Sexuality and sexual intercourse.
- Infections.
- Regular dilation or penetration to maintain patency of the neovagina.

7.5 Summary: Surgical interventions

APPLICATION EXERCISE 3.5

	<i>Complete the Quick Quiz below to check your own understanding.</i>	<i>5 minutes</i>	
Trans people only require surgery and hormones as part of their transition.		TRUE	FALSE
Top surgery' and 'bottom surgery' are the only kinds of operations trans people might have as part of their transition.		TRUE	FALSE
AMAB patients should not pursue top surgery before being on hormones for one to two years.		TRUE	FALSE
Top and bottom surgery are cosmetic.		TRUE	FALSE
AFAB patients who have transitioned don't need a pap smear.		TRUE	FALSE

8. Module Summary



Write down the most important things you learnt in this module

5 minutes

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CONCLUSION

CONCLUSION

1. Closing the Loop

Refer to the expectations you listed at the beginning of the training. Think of the questions that you had in mind to which you wanted answers.

- Have you found the answers to your questions?
- Have your expectations been met?
- What other questions do you have?
- What else would you like to know?

Please use the opportunity now to ask any questions or clarify any concerns that you have.

2. Key Learning Points

We focused on the following:

In Module 1:

We established that trans-competent healthcare is essential as it is a human right enshrined in our Constitution.

- We saw the key differences between the medical, psycho-social and legal view of trans people and the difficulties trans people face in accessing healthcare where they expect discrimination.
- We discussed how to treat trans patients sensitively, without assumptions and stereotypes, through the understanding of the institutionalised transphobia and discrimination trans people face. We clarified the importance of names, pronouns, transgender terminology, how trans people refer to their own anatomies and how using that language and the language of the patient is at the centre of trans-affirming healthcare.
- We spoke about making our healthcare facilities a safer space for trans patients through transforming the way we go about standard procedures, by using affirming and non-judgemental language and attitudes when taking relevant general healthcare and gender-affirming healthcare histories.

In Module 2:

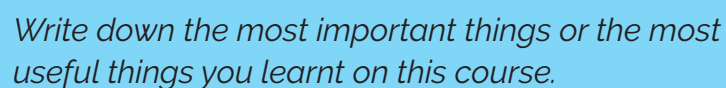
We zoomed in on trans-competent healthcare, standard history taking and how to transform this history taking into trans-competent and trans-sensitive history taking.

- We focused on sexual health in trans patients emphasising HIV, ARV adherence, and the additional risks trans patients face compared to cisgender patients, when it comes to exposure to HIV and the lack of adherence that is more prevalent in the trans population.
- We clarified the specific language to avoid and the language to use when referring to trans bodies and trans people's sexual behaviour, emphasising the importance of following the patient's lead in this language.
- We introduced the psycho-social treatment of trans patients in relation to history taking.

In Module 3:

We went into specific detail about trans-competent healthcare and the contexts, increased risk factors and gender-affirming treatment of trans patients. We mentioned how primary healthcare clinics play an important role in providing access to HRT and counselling services.

- We went into more detail about history taking, especially in relation to mental health assessment as it relates to gender-affirming treatment in the form of hormone therapy, as well as the risks and benefits of this therapy.
- We spoke about mental health services, social services, social support structures and surgical interventions.
- We ended off with the reality of the majority of the trans population in limited resource healthcare settings and how we as healthcare practitioners need to work together with other health practitioners as well as the trans community in enabling trans patients to access resources that we as health practitioners cannot provide.



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Please complete the Course Evaluation Form that your facilitator will hand out. Your honest feedback is important to us and can help us to improve the course. It can also inform us what we are doing well and should continue to do!

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Transgender People and HIV/AIDS, Avert. www.avert.org

Transgender Women and Pre-exposure Prophylaxis for HIV Prevention: What We Know and What We Still Need to Know, National Center for Innovation in HIV Care, <http://careacttarget.org>

Trans community organisations

Organisation	Services	Area	Website / Contact
Access Chapter 2	<ul style="list-style-type: none"> Legal support services 	Gauteng	http://www.ac2.org.za/ Tel: +27 12 430 3272
Anova Health Institute	<ul style="list-style-type: none"> Health services Healthcare training 	National	www.anovahealth.co.za Tel: +27 11 581 5000/1
CtrlAltGender	<ul style="list-style-type: none"> Peer support 	Gauteng	Facebook: ctrlaltgender
Cross-University Trans Collective	<ul style="list-style-type: none"> Advocacy Research 	National	Facebook: transfeministcollective transfeministcollective@gmail.com
Gender Dynamix	<ul style="list-style-type: none"> Advocacy Legal support services Community support Healthcare training 	Western Cape	www.genderdynamix.org.za Tel: +27 21 447 4797
Iranti-org	<ul style="list-style-type: none"> Advocacy Community support 	Gauteng	www.iranti-org.co.za Tel: +27 11 339 1476 Tel: +27 11 339 1468
S.H.E , Social Health and Empowerment feminist collective of transgender and intersex women of Africa	<ul style="list-style-type: none"> Advocacy Research Community support Healthcare training 	Eastern Cape	transfeminists.org Tel: +27 43 722 0750
Sistaazhood	<ul style="list-style-type: none"> Advocacy Peer support 	Western Cape	www.facebook.com/SistaazHood
Thea van Steenderen	<ul style="list-style-type: none"> Chest binders 	Eastern Cape – delivers nationally	http://www.healingwiththea.co.za/ +27 72 607 3465 nasturtium1@gmail.com
TIA - Transgender and Intersex Africa	<ul style="list-style-type: none"> Advocacy Community support Healthcare training 	Gauteng – Tshwane	transgenderintersexafrica.org.za Tel: +27 81 313 5306
Trans Wellness Project	<ul style="list-style-type: none"> Advocacy Research Community support Healthcare training 	Western Cape	Facebook: transwellnessproject Tel: +27 73 636 7470
Triangle Project	<ul style="list-style-type: none"> Peer support Telephonic helpline Health services Healthcare training 	Western Cape	triangle.org.za Tel: +27 81 257 6693 (Counselling) Tel: +27 21 712 6699 (Helpline)