Guidelines for Gender Affirming Healthcare in Aotearoa New Zealand

2025 edition

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PATHA

PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH AOTEAROA

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Nāu te rourou, nāku te rourou, ka ora ai te iwi.

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These guidelines reflect Aotearoa New Zealand's cultural context. They are holistic and reflect aspirations for a society where diversity in all forms is celebrated. They are a sum of the countless people who contributed to this work over many years, whether they are aware of it or not. These guidelines are indicative of what we know, and what we are learning, about how to do the best we can for the transgender population.

These guidelines are a road map towards Pae Ora for our transgender population. And these guidelines are a template for best practice healthcare that saves lives.

Mā whero, mā pango, mā uenuku!
Ka oti ai te mahi.

Description of front cover artwork

Tū Kaha Mokopuna —
Stand Strong Descendants/Grandchildren

Tū Kaha Mokopuna is a powerful expression of our transgender mokopuna, celebrating the vibrant identities within our takatāpui whānau. Pink and blue reflect the diverse experiences of our transgender population, while green and blue honour Papatūānuku and Ranginui – the Earth Mother and Sky Father.

This connection to Papatūānuku and Ranginui is vital. Takatāpui whakapapa traces back to these ancestral guardians, serving as a reminder that takatāpui and transgender whānau have always held a sacred place within Te Ao Māori, affirming their inherent mana and belonging.

At the centre of the artwork is a manaia encircling the genital region, symbolising strength and resilience. The manaia embodies two essential purposes: to offer guidance to whānau who are navigating the journey of gender affirmation, and to provide protection and aroha to those experiencing gender dysphoria.

The incorporation of Te Whatewha, a traditional weapon, further emphasises this spirit of empowerment and endurance. It stands as a bold declaration of the voices of transgender whānau. This piece embodies a powerful message of resilience and strength.

Introduction

These guidelines are about gender affirming healthcare for transgender and gender diverse people in Aotearoa New Zealand. A transgender person's gender does not match the gender they were assigned at birth. These guidelines use the term 'transgender' as an umbrella term for a wide array of gender identities and modalities.[a] This term includes people who are trans, non-binary, gender diverse; those who are agender or do not relate to a gender; culturally and linguistically specific identities that might not neatly align with Western understandings of gender; and other people for whom gender affirming healthcare is relevant. This includes some intersex people and people whose experience of transition is non-linear. The term transgender does not accurately describe everyone who might need gender affirming healthcare, but this shorthand is used here for readability.

Gender affirming healthcare is respectful and affirming of a person's unique sense of gender and provides support to identify and facilitate gender healthcare goals. These goals may include supporting exploration of gender, support around social gender affirmation, and hormone and/or surgical interventions. It may also involve providing support to whānau, caregivers or other supporting people.

The authors of this 2025 guideline acknowledge and are grateful for the *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand*, published in 2018 by Dr Jeannie Oliphant et al.[1]

The 2018 guidelines have provided the foundation for these guidelines, and contributed significantly to the whakapapa (genealogy/history) of gender affirming healthcare in Aotearoa New Zealand.

This 2025 guideline was developed by health professionals experienced in providing gender affirming healthcare and individuals with lived experience. It aligns with the *World Professional Association for Transgender Health (WPATH) Standards of Care Version 8*.[2] This 2025 guideline also recognises that all people have the human right to 'the highest attainable standard of physical and mental health'.[3]

Gender affirmation for people with innate variations of sex characteristics (IVSC – commonly referred to as intersex) are outside the scope of this guideline; however, some people with IVSC may present as transgender. There are unique considerations for transgender people with IVSC. Best practice guidelines for intersex wellbeing are being developed.

In the spirit of whakapapa, we acknowledge the transgender people who have passed on, many of whom endured a lifetime of hiding, denying, or fighting to be heard, seen, recognised and respected. We remember them and find solace in knowing that their wairua (spirit) lives on in this work. Moe mai rā, moe mai rā e hoa mā, ake ake ake.

[a] Gender modality is the way someone's gender relates to the sex they were assigned at birth. For example, transgender is a modality in which someone's gender is different to the sex they were assigned at birth.

Te Whare Takatāpui

These gender affirming healthcare guidelines utilise *Te Whare Takatāpui* as a framework. *Te Whare Takatāpui* is a conceptual model of wellbeing for takatāpui and Rainbow people that was developed by Professor Elizabeth Kerekere.[4]

'Te Whare' means 'the house' or 'the building'. 'Takatāpui' is a traditional Māori term meaning 'intimate companion of the same sex'. Takatāpui has been reclaimed to embrace all Māori with diverse genders, sexualities and innate variations of sex characteristics.[5]

'Rainbow' is a commonly used umbrella term in Aotearoa New Zealand to refer to people from all sexual and gender minorities, and people with variation of sex characteristics, for instance people who are transgender, lesbian, gay, bisexual or intersex.

Sir Mason Durie's Te Whare Tapa Whā[6] was foundational to the development of *Te Whare Takatāpui*.[4]

Te Whare Takatāpui is made up of six values that are important for transgender health metaphorically represented as different parts of a wharenui (ancestral meeting house): [4]

1. **Whakapapa (genealogy/history):** Represented by photographs on the back wall of the wharenui of those who have passed away. This section discusses the historical context, social determinants of mental and physical health (including minority stress theory), whānau considerations, and some considerations for gender affirming healthcare for older adults.

2. **Wairua (spirituality):** Represented by the whakairo (carvings) of transgender people's tūpuna (ancestors), kaitiaki (guardians) and tipua (shapeshifters). This section discusses creating inclusive healthcare environments for transgender people.

3. **Mauri ('life spark', identity):** Represented by the colour and patterns of the tukutuku (woven panels) inside the wharenui. This section discusses considerations in gender affirming healthcare for some sub-populations of transgender people, particularly priority groups.

4. **Mana (authority/self-determination):** Represented by the pou (posts) and tāhuhu (ridgepole) of the wharenui. The pou represent Mana Wāhine (the mana of women) and Mana Tāne (the mana of men). The tāhuhu represents Mana Tipua: the mana of transgender and intersex people based on their acceptance in traditional Māori society.[5] This section discusses informed consent and access to care.

5. **Tapu (sacredness):** Represented by healing places and the planting and preparation of healthy kai (food) and rongoā (traditional Māori medicines). This section discusses gender affirming medical care, fertility, sexual health, mental wellbeing, gender affirming surgery, and detransition and discontinuation of medical care.

6. **Tikanga (rules and protocols):** Represented by the paepae (the front threshold) and marae ātea (area in front of the wharenui) where the rituals of encounter take place. This section discusses health policy and strategy, workforce development and clinical governance.

Each section of these guidelines is classified as a *Te Whare Takatāpui* value and begins with more detail about this value.

Process for updating the guidelines

Background

In 2022, the *World Professional Association for Transgender Health Standards of Care Version 8 (WPATH SOC8)* were published. In 2023, the Professional Association for Transgender Health Aotearoa (PATHA) was contracted by Health New Zealand | Te Whatu Ora to update the 2018 *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand*. The 2018 guidelines had utilised the superseded *WPATH Standards of Care Version 7*.

The selection and composition of the guidelines update team

PATHA appointed a team of national experts in gender affirming healthcare to update the 2018 guidelines. The selection process ensured that the team included:

- A range of clinical specialisations in gender affirming healthcare
- A depth of experience and expertise in gender affirming healthcare
- A partnership between cisgender[b] and transgender people
- Access to relevant Māori cultural expertise
- Transgender population expertise
- Expertise in healthcare leadership.

The authors included 14 individual health sector professionals.

Clinical specialities amongst the authors included:

- General practice
- Paediatrics
- Adolescent health medicine
- Clinical psychology
- Neuropsychology
- Child and adolescent psychiatry
- Nursing
- Plastic and reconstructive surgery
- Sexual health medicine.

Allied health expertise in the team of authors included:

- Health systems navigation
- Health leadership
- Rainbow competency
- Māori cultural expertise
- Refugee and asylum seeker health.

Literature review

A broad literature review was completed. Smaller working groups reviewed academic literature within their field released since the publication of the WPATH SOC8.

Transgender population consultation

Multiple rounds of consultation were undertaken with transgender people across the country. In the first round, interviewers used strengths-based, narrative-building consultation techniques to gain quotes about what contributed towards positive healthcare experiences for the interviewees. The second round of consultation used individual interviews and community kōrero sessions with groups of transgender people to gather further quotes using open-ended questions.

Te Whare Takatāpui wānanga (training session)

A *Te Whare Takatāpui* wānanga (training session) led by Professor Elizabeth Kerekere guided participants through *Te Whare Takatāpui* and helped determine the structure of the guidelines. The wānanga was attended by 2025 guidelines authors, the Primary Care Workforce Development Group, other health professionals and transgender people, and people from different Rainbow groups across Aotearoa New Zealand.

The writing and review process

Areas of the 2018 Guidelines that either required updating or were missing were identified through consultation with health professionals and a review of the literature.

Each chapter was written and reviewed by professionals with expertise relevant to the chapter's subject matter. Forty nine people directly contributed to the writing and reviewing of the updated guidelines, including 14 individual authors and 35 external reviewers.[c] Together, approximately one-third of the authors and reviewers are transgender. Most of the transgender authors and reviewers are also clinically qualified.

Professor Elizabeth Kerekere continued to guide the authors' use of *Te Whare Takatāpui* to help structure the guidelines.

Draft chapters were reviewed within the guidelines update team, and then sent externally for peer review to people with relevant expertise.

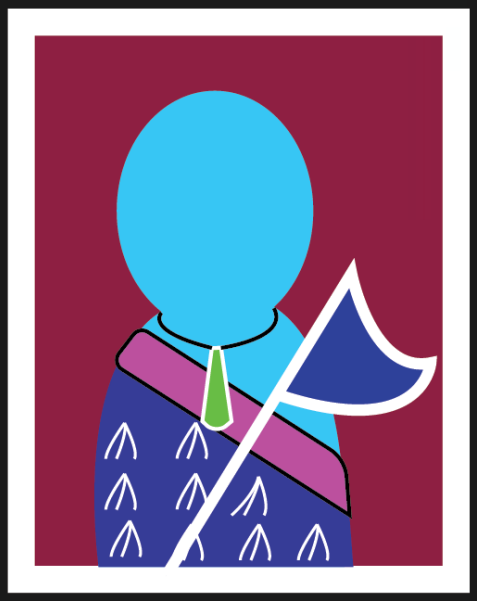
External peer reviewers included a wide range of health professionals and professionals with expertise in research, health systems navigation and educating health professionals, both within Aotearoa New Zealand and overseas.

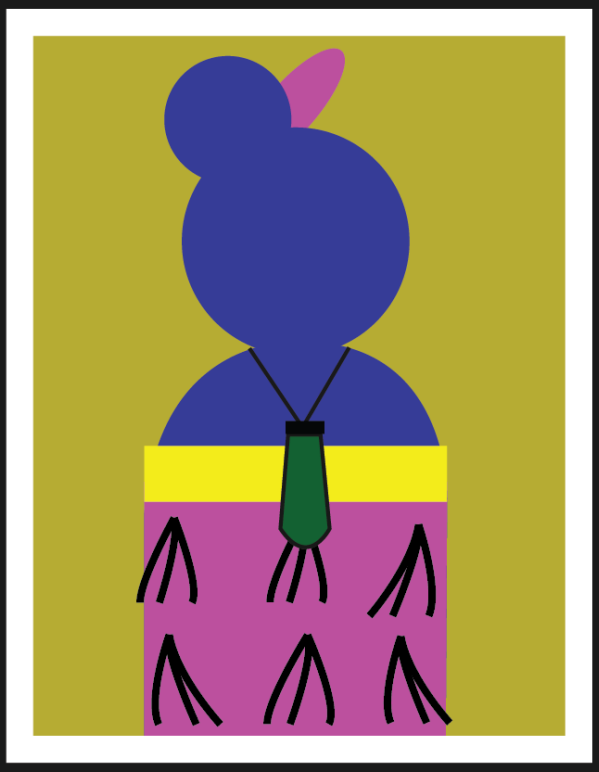
Clinical reviewers specialised in endocrinology, general practice, urology, sexual health medicine, obstetrics and gynaecology, fertility, paediatric medicine, adolescent health medicine, psychiatry, psychology, counselling and nursing.

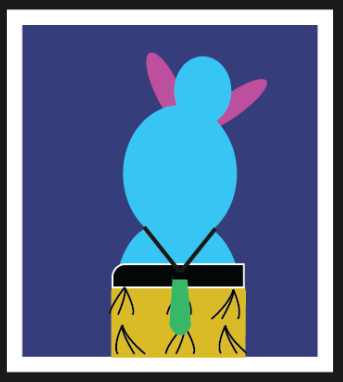
Reviewers also included individuals and organisations with knowledge regarding Māori, refugee and asylum seeker, Pacific and disabled people who may seek gender affirming healthcare.

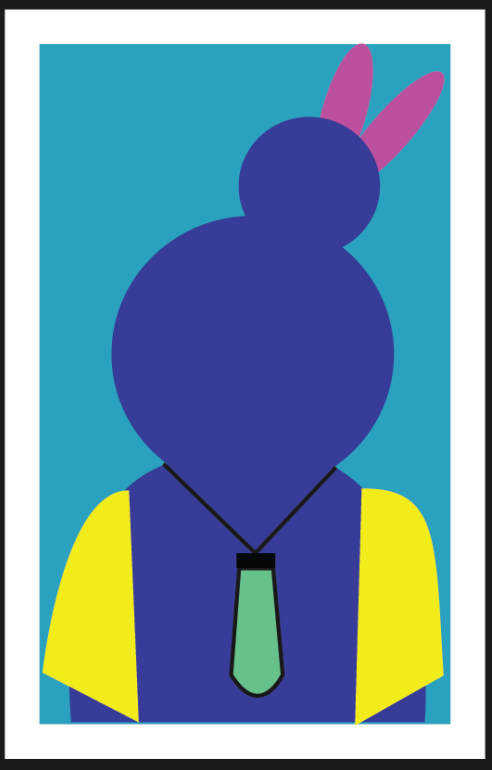
Reviewer feedback was considered and incorporated into the final draft before being approved by Health New Zealand | Te Whatu Ora's clinical governance group.

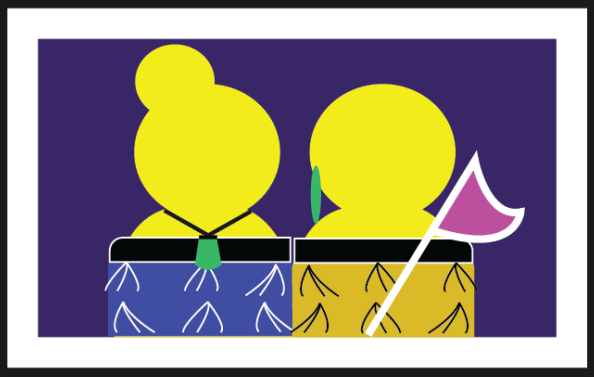
[b] A cisgender person has a gender that matches the sex recorded at their birth.
[c] Reviewers who were not authors of the updated guidelines.

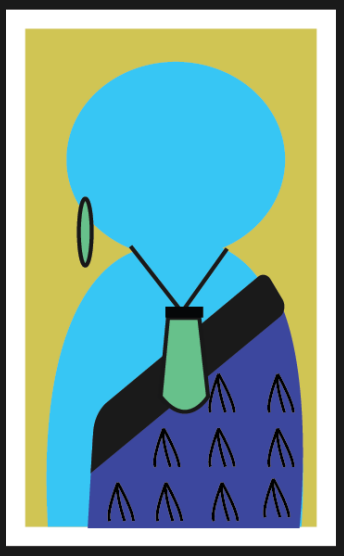












Whakapapa

Whakapapa refers to genealogy, all of the historical forces that have shaped a person in Aotearoa, and the whānau who support them. In *Te Whare Takatāpui*, whakapapa is represented by the photographs on the wall as transgender people remember and honour where they came from and all those who came before them. These guidelines outline appropriate gender affirming healthcare for people of different generations.

1. Historical context

What is conceptualised in Western cultures as gender diversity has existed globally throughout history, and has received different levels of acceptance and understanding, or stigmatisation and misunderstanding.[7]

Aotearoa New Zealand's approach has varied through history.

> *'As settler numbers and missionary influence increased, the systematic dismantling of Māori language and culture brought with it the British legacy of misogyny and homophobia. Its impact on the expression of Māori sexuality and gender fluidity was significant.'* [8]

In more recent years successive Governments have passed legislation to enable transgender people to affirm their gender and live healthily, including:

- In 2012, transgender New Zealanders became able to have 'X' (rather than male or female) listed as their sex on their New Zealand passport without also needing to change their birth certificate.[9]
- In 2021, Parliament unanimously passed the Births, Deaths, Marriages, and Relationships Registration Bill, making it easier for transgender New Zealanders to change their legal sex.[10]
- In 2022, the Conversion Practices Prohibition Legislation Bill passed with bipartisan support, helping to protect transgender people from conversion practices.[11]

Within healthcare, whilst gender diversity (or being transgender) has historically been theorised to be reflective of underlying psychopathology, this is no longer considered to be the case.[12] Conversion practices have been shown both to be unsuccessful[13] and to cause significant psychological harm to transgender people.[14, 15, 16]

Transgender identities have since been depsychopathologised (that is, recognised as normal) and, in reflection of this, diagnoses related to transgender identity have moved out of the 'Mental Health' chapter and into the 'Sexual Health' chapter within the ICD-11.[12]

2. Social determinants of mental and physical health

2.1 Overview

Transgender people have the same inherent potential to flourish and thrive as other people.

However, transgender people in Aotearoa New Zealand experience high rates of material deprivation and discrimination compared to the general population.[17] For instance, Stats NZ reports that, when adjusted for age, transgender people earn an average of $10,439 less per year than cisgender people.[18]

Transgender people also experience increased risk of psychological harm, rates of deliberate self-harm and rates of suicidal ideation. This is due to factors such as discrimination, social exclusion, bullying and assault, as well as institutional barriers such as difficulties accessing healthcare, bathrooms and appropriate legal identification.[19-22]

The additive effects of minority stress can result in mental health difficulties.[19, 21, 23-25] The contribution of stigma, marginalisation and discrimination to the burden of mental distress experienced by transgender people is acknowledged by professional bodies.[26, 27]

Transgender people in Aotearoa New Zealand also experience physical health disparities, such as increased rates of some cardiovascular diseases, with those experiencing more enacted stigma being more likely to experience these conditions.[28]

Some significant social determinants of poor health for transgender people in Aotearoa New Zealand include:[17]

- Experiences of discrimination and other mistreatment in healthcare, and in other settings
- Lower incomes than their cisgender peers, leading to material deprivation, inability to afford healthcare, and inability to change their name and gender on their identity documents
- Lack of transportation to get to healthcare appointments
- Avoidance of health professionals due to concerns about how they would be treated as a transgender person (the **Wairua** and **Mauri** sections of these guidelines may assist health professionals with this)
- Health professionals not having sufficient knowledge about transgender healthcare to assist them
- Lack of confidence and trust in health professionals
- Conversion practices to try to stop transgender people from being transgender
- Bullying at school
- Barriers to participating in sports and other physical activity
- Sexual violence being perpetrated upon them
- Homelessness due to violence from a partner or member of their whānau on the basis of them being transgender
- Long wait lists for gender affirming healthcare
- Not knowing where to go to access healthcare (including but not limited to gender affirming healthcare).

2.2 Multiple sources of marginalisation — compounding disadvantage

Transgender people who have multiple minority statuses, or other sources of marginalisation, can experience compounding disadvantage. They may have an even more heightened need for extra assistance to address social, economic and environmental determinants of poor health. Such factors may be barriers to their gender affirmation, and to a healthy, happy, meaningful life after this.

> Gender affirming health service design and delivery needs to take into account the inequities people with multiple minority statuses, or other sources of marginalisation, are more likely to experience.

Population groups experiencing poorer social determinants of health in Aotearoa New Zealand include, but are not necessarily limited to, Māori,[29] Pacific peoples,[30, 31] people with disabilities (Tāngata Whaikaha),[32] and refugees.[33, 34]

> The effects of compounding disadvantage are relevant to the healthcare of many transgender people. For instance, Stats NZ reports that 14.6% of Aotearoa New Zealand's adult transgender population is Māori, 6.7% are Pacific peoples, 16.2% are Asian, and 22.1% have a disability.[18]

Published research is limited regarding the social determinants of health for transgender people in Aotearoa New Zealand who have multiple minority statuses or other sources of marginalisation. However, some is available illustrating compounding disadvantage, for instance:

- **Māori:**
  - Rainbow Māori high school students have more housing insecurity and food insecurity compared with Māori students who do not have a Rainbow identity, and compared with Rainbow Pākehā (New Zealand European) students.[35]
- **Pacific peoples:**
  - Pacific peoples who responded to the 2018 Counting Ourselves survey (of transgender people in Aotearoa New Zealand) were more likely than the broader transgender population to report experiencing discrimination and unfair treatment in public places.[17]
  - Pacific Rainbow high school students were more likely to report experiencing discrimination in healthcare, and food insecurity, than Pākehā Rainbow students.[35]
  - Pacific Rainbow high school students were also less likely to report that they were accepted by their families for who they are, when compared with Pacific students who did not have a Rainbow identity, and when compared with Pākehā students who did not have a Rainbow identity.[35]
- **Disabled transgender people:**
  - Disabled transgender people report increased rates of discrimination and higher levels of material hardship compared with the general transgender population.[17]
  - Disabled transgender people have higher rates of suicide attempts, suicidal ideation and increased levels of psychological distress, compared with the broader transgender population.[17]
  - They also reported higher rates of being unable to afford GP appointments, experiencing discrimination when seeking healthcare, and lacking access to transport (compared with non-disabled transgender people).[17]
- **Asian transgender people:**
  - The Adhikaar Report[36] showed that Rainbow South Asians in Aotearoa New Zealand can experience racism from Rainbow communities, exclusion from ethnic communities, disbelief from their families about their gender or sexual orientation, and self-loathing due to their experiences of discrimination. They may lack access to information about transgender matters and have difficulty finding mental health services that are knowledgeable about their ethnicity and their Rainbow identity. Their families may experience stigma if they seek mental health assistance.
  - The 2018 Counting Ourselves survey showed that Asian transgender people were more likely than the broader transgender population to have been discriminated against in the last 12 months.[17]

[d] Research on the health, and social determinants of health, of transgender people in New Zealand often has small sample sizes, or groups transgender people together with other Rainbow population groups.

[e] Measured using the Kessler Psychological Distress [K10] scale.

2.3 Minority Stress Theory

'Minority stress' describes how identity-specific stressors can negatively impact the mental and physical health of marginalised groups including ethnic minorities, indigenous peoples and members of the Rainbow community.[37 38]

Minority Stress Theory utilises an engineering analogy to conceptualise stress as being 'a load relative to a supportive surface'.[39, 40] The 'supportive surface' represents the resilience of an individual (i.e. their ability to cope with stress), while the load represents any stimulus that adds to an individual's cognitive load or is perceived to have impaired their optimal cognitive functioning. Where the overall (cognitive) load exceeds the strength of the supportive surface (i.e. their resilience), the person is said to experience stress.

For transgender people, minority stress is best explained through the Gender Minority Stress Model.[24, 39] Gender minority stress can be defined as resulting from three categories of stressors:

- Distal stressors refer to experiences of gender-based victimisation, rejection, discrimination or non-affirmation,[39] all of which transgender people frequently report experiencing.[17, 41]
- Negative expectations refer to a minority individual's fear and/or presumption of negative incidents occurring in the future, such as fear of experiencing more discrimination or concern around a lower quality of life.[39]
- Internalised transphobia[39] refers to a transgender person internalising negative assumptions around transgender people and the psychological impact that holding these assumptions can have.[42]

The **working with minority stress** sub-chapter of the mental wellbeing chapter provides guidance on responding therapeutically to minority stress.

2.4 Social and community connections

A transgender person's increased sense of belonging to the transgender community is related to a lower likelihood of reporting mental health difficulties.[43] Peer support has also been shown to be significant in mitigating suicide risk amongst transgender people.[44]

2.5 School support

Feeling connected to school is associated with better mental health outcomes for transgender young people.[45, 46] Feeling safe at school, and having a sense of belonging to school, have also been associated with reduced rates of suicidality amongst transgender young people.[19, 47]

The Youth19 school survey found that while 74% of transgender young people felt part of their school community (87% for cisgender young people), 23% had been bullied at school weekly or more often in the last year.[48] This is much higher than for cisgender students, 5.1% of whom reported being bullied weekly or more in the last year.

Further issues that some transgender and gender diverse students may experience at school include:[49]

- Being unable to update school records to correctly reflect their gender
- Having staff disclose their gender to others without their consent
- Exclusion from activities such as joining sports teams
- Not having the option of wearing a gender-neutral uniform
- Lack of access to, or fear of accessing, changing rooms and toilets appropriate for their gender identity.

2.5.A Practice points for health professionals who work in, or with, schools

- Provide training on working with transgender and gender diverse students for all staff.
- Recommend clear policies and support available for transgender and gender diverse students, particularly those who experience bullying or discrimination from students or teachers.
- Connect with local health and social services in your area that specialise in working with transgender and gender diverse young people.
- Support students to establish a diversity group for transgender students (if the students want to do so).
- Encourage schools to enable students to participate in sports activities for people of their gender identity.

Schools have an obligation to provide a safe environment for their students.[50] There are a range of support materials available for schools, some of which are listed at the end of the Whakapapa section.

2.6 Workplace inclusion

Transgender people can experience stigma within the workplace throughout their careers.[51, 52] Unequal treatment of transgender employees is evidenced in recruitment, promotion, termination, pay disparities, job segregation and lack of inclusive policy.[53] This can impact negatively on income and general wellbeing.[52 54]

Other studies have also highlighted the role of positive workplace relationships and 'acts of oppositional courage' (i.e. acts of visible support of, or allyship toward, transgender people undertaken by cisgender colleagues), in promoting wellbeing of transgender employees.[53]

2.7 Sport

The benefits of exercise and participation in sports on mental and physical health are well established.[55-58]

However, as is seen internationally,[59] transgender people in Aotearoa New Zealand are less likely to participate in sports than their cisgender peers.[17] Fear of differential treatment and concerns about eligibility contribute to low rates of sports participation amongst transgender individuals.[17]

Sport participation is associated with a significant reduction in suicide attempts in the transgender population.[60] Meanwhile, transgender people report that exclusion from sport has had negative effects on their mental and physical health.[61]

Health professionals may wish to be aware of transgender inclusive sports clubs and organisations in their area so that they can make people aware of these as part of treatment plans.

Practice points

- Be mindful of the importance of connection and social support to the wellbeing of transgender people.
- Where appropriate, work with schools and workplaces to encourage the development of supportive, accepting and affirming environments for transgender people.
- Where appropriate, work with schools and workplaces to develop and implement policies that protect transgender people from discrimination or encourage inclusivity.
- Be aware of the benefits of exercise and sport as well as the barriers to participation faced by transgender people. Health professionals may wish to collate a list of local activity groups and sports clubs that are known to be accepting of, and safe for, transgender people in the interests of helping to reduce barriers to access.

3. Whānau

3.1 Whānau are self-defined

Whānau encompasses all significant individuals in a person's social network, extending beyond the confines of their immediate nuclear family structure.

> When discussing whānau and social support, work with the understanding that a person's whānau is defined by them, reflecting their self-determination.

Many people have chosen whānau members who may not be their biological relatives or those who raised them.

3.2 Levels of whānau support vary

Whānau support for transgender people can vary considerably. 57% of the 2018 Counting Ourselves survey respondents whose whānau knew they are transgender reported that most or all of their whānau were supportive of them.[17]

3.3 Māori – whānau considerations

Māori understandings of whānau can be broader than a person's immediate nuclear family.[62] A person's whānau may extend to other people connected through whakapapa (genealogy), and also extend to kaupapa whānau (other supportive social networks such as friends).[63]

65% of the Māori respondents to the 2018 Counting Ourselves survey whose whānau knew that they are transgender reported that most or all of their whānau were supportive of them.[63]

When providing gender affirming healthcare to someone who is Māori, involve the person's whānau in their care, if the person wants you to do this. Where needed and desired by the person, helping whānau to support their transgender whānau member may improve their wellbeing. Supportive relationships can benefit Māori transgender people's wellbeing.[63]

> *'[My whānau] gave me the courage and the strength to be who I am. And to pursue who I believe I am and go out there in the world and not worry what people say, you know, don't care about what people think' – takatāpui person*[64]

3.4 Pacific peoples – whānau considerations

> *'Family is key to wellbeing but also complex'* [65]

Include a Pacific person's whānau in their gender affirming healthcare if the patient or client wants this to occur and if it is possible. Just as whānau are important within Pacific cultures,[66] whānau are important to Pacific Rainbow+ peoples[f] in Aotearoa New Zealand.[67] The Ministry for Pacific Peoples provides some detail:

> *'[For Pacific peoples,] the family is the centre of the community and way of life. Every person belongs to a family, aiga*[g] *and kainga,*[h] *and every family belongs to a person. This brings identity and belonging. Ancestry and a sense of place involve a kinship with what and who has gone before.'* [66]

Some Pacific peoples seeking gender affirming healthcare may want their whānau to be involved in their gender affirming healthcare. Similar to the general transgender population in Aotearoa New Zealand,[17] the Manalagi survey found that 54% of Pacific Rainbow+ survey respondents reported that their whānau were 'supportive' or 'very supportive' of them being Rainbow+.[67]

[f] Pacific Rainbow+ people include those who are Rainbow, MVPFAFF+, or use any other identity label that indicates diverse genders, diverse sexualities, or diverse liminalities in Pacific communities. See the **Pacific peoples** chapter in the Mauri section for further details. Little data has been published specifically about Pacific peoples in New Zealand who seek gender affirming healthcare.

[g] Aiga – Samoan word for 'family'. [h] Kainga – Tongan word for 'family'.

'Being Sāmoan, gender fluidity is a lot more normal. We all know about fa'afafine, right? It helped me a lot because I already knew that different gender expressions were accepted in that culture' – parent[68]

While many Pacific peoples seeking gender affirming healthcare may benefit from whānau involvement, others may be vulnerable due to whānau responses. The 2018 Counting Ourselves survey found that:

- 33% of Pacific respondents had experienced violence from a member of their whānau for being transgender (compared with 9% of all respondents).
- 27% of Pacific respondents reported that they had been kicked out of their home for being transgender (compared with 8% of all respondents).

As with all people, it can help to assume that each Pacific person's life and whānau are unique. Through this, a person's existing support people can be included in their care (if the person wants this during their gender affirming healthcare) and any identified vulnerabilities can be better addressed.

Several organisations offer specialist support and other assistance to Pacific Rainbow+ people and their whānau. For a list of these organisations, see the **resources** chapter in the **Mauri** section.

3.5 Children and young people – whānau considerations

'I want everyone to feel safe. I wish I could have been safe in my transness as a child. Imagine the joy of a new generation of people who were safe and supported from day one regardless of their identity' – transgender person[49]

This chapter discusses whānau considerations for children and young people aged under 18 years. Some young people may benefit from extra support beyond the age of 18 due to the considerable variation in physical, emotional and cognitive development between adolescents.

3.5.A Whānau support aids children and young people's mental health

Research indicates that supporting a child or young person's gender leads to improved mental health outcomes,[69, 70] and that whānau support is highly protective for transgender children and young people.[45, 71, 72]

Studies indicate that transgender young people who report strong whānau connectedness exhibit significantly lower rates of mental health issues, even in the face of external stigma and discrimination.[45]

'Whānau support provides a place from which takatāpui rangatahi can draw strength and resilience to help deal with the challenges they face outside the whānau.' [8]

3.5.B Whānau support helps children and young people to explore their gender

It is important that children and young people feel supported to explore their gender, and that whānau are open to this.[45, 71, 72]

Helping children and young people feel supported to explore their gender usually involves assisting whānau to create an environment where their child or young person's gender can be freely expressed and explored over time. This might require:

- Providing education and support for families and schools to be able to support the child to navigate social gender affirmation
- Helping children and young people to develop coping skills to address any negative reactions that they might experience.

Children and young people can be very aware of disapproval of those around them and may try to hide their feelings about their gender.

3.5.C How whānau can support their transgender or gender diverse child/young person

Health professionals can facilitate whānau to support their child or young person by encouraging whānau to:

- Assure their child/young person that they have their unconditional love and support, or at least that they will commit to be alongside and support them. Support is invaluable even if the whānau doesn't fully understand everything that is going on for their child/young person.
- Encourage exploration of how the child/young person expresses themselves. It is important that children and young people have spaces in which they feel safe to explore their gender within the home, school or wider social settings.
- Use the pronouns and name that the child/young person wants and support others to do the same, if it is safe to do so.

3.5.D Common emotions of whānau of children and young people

Whānau report a range of emotions following a disclosure from their young person that they are transgender, including confusion, the need to have time to process, the need to grieve for the perceived loss of a son/daughter, fear for the future and acceptance of their young person.[73, 74]

Parents may worry that their child or young person might 'change their mind' and that supporting their current gender could later be seen as a mistake.

The young person is likely to have spent considerable time developing their understanding of self, while families may perceive the change as sudden and require time to adjust.[75]

3.5.E Needs of whānau of children and young people

Whānau may want support and information from health professionals or a parent support group to work out how to support their child or young person. This is particularly important if their child or young person is experiencing gender related distress. Speaking to whānau without their child or young person present can give them space to express their concerns and need for support. Some whānau find that joining parent support groups is beneficial for emotional[76] and practical support. If needed, health professionals can provide whānau with support, education around transgender identity and experiences, and facilitation of communication between whānau members.[74]

3.5.F Practice points

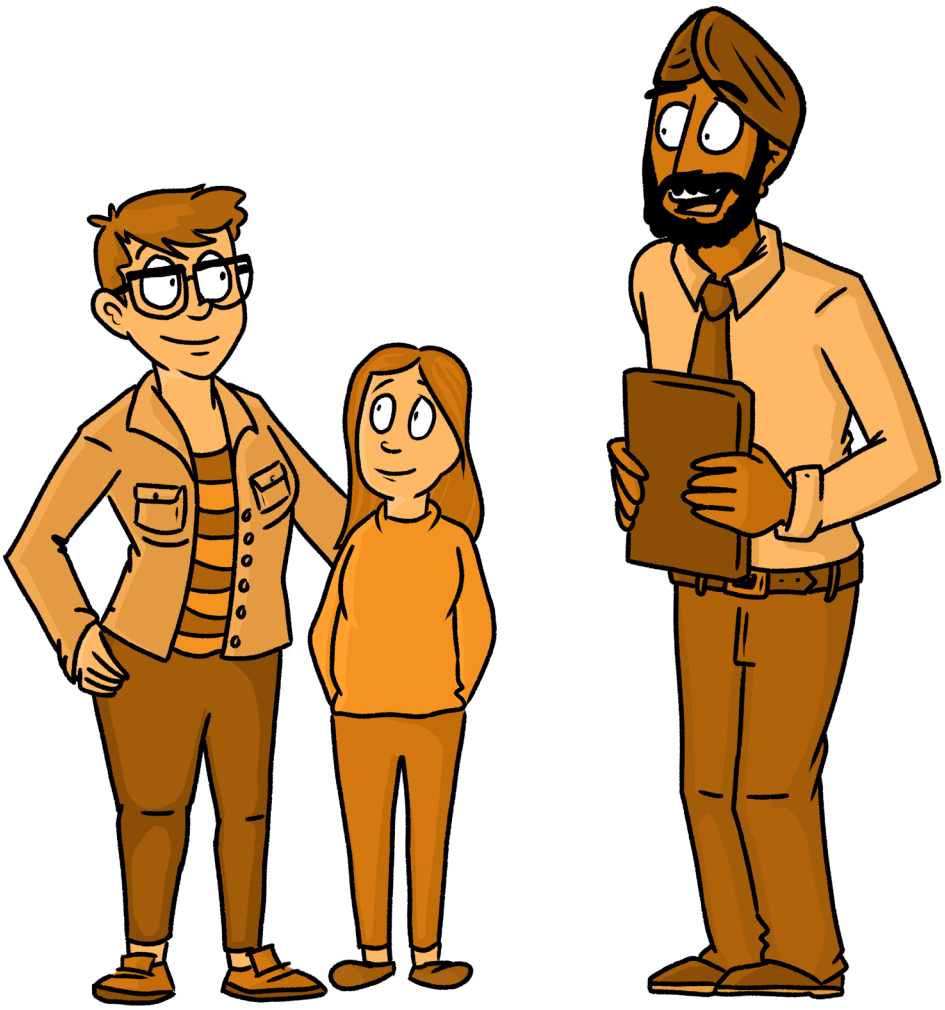
- Ask children and young people who is whānau to them. This allows the gathering of more comprehensive information about where social and familial support is available in the child or young person's life.
- Support whānau to support children and young people. Whānau support is highly protective for transgender children and young people.
- Make time to also see parents or guardians alone where possible, to give them the opportunity to talk openly and consider the best options for support. Lack of support by whānau often comes from a place of fear and love. Ask about any fears whānau may have.
- Be aware of the wider factors that can impact on families who are supporting a child to affirm their gender and the potential loss of significant relationships, e.g. partner, wider whānau, friends, church/faith or social activities, e.g. sports.
- Connect whānau to support groups where needed, and to resources about supporting and affirming the gender of the child or young person.

3.6 Adults – whānau considerations

For transgender adults, partner support can decrease suicide risk.[77] It can also protect against harassment and rejection exacerbating suicidality.[78]

Partners of transgender people may question their own identity, experience changes in their own relationships, and need support.[79] Where appropriate and wanted, offer support to the partners of transgender people seeking care. It may be helpful for partners to have their own support to process their feelings and/or to access relationship counselling to facilitate better communication.

Support from whānau of origin is also known to be protective against distress for transgender adults.[80]



4. Older transgender people

'It is my time to concentrate on the real me. I have lived a lovely life, but this has been missing. I will not tell my whole family, I know some of them will be upset. I don't want to upset people as I want it to be about what I need … life … was good. There was just this one thing I needed to do when the time was right' – 80 year old transgender person

As the Aotearoa New Zealand population continues to age,[81] the population of older transgender individuals is expected to grow. The oldest transgender person in the 2018 Counting Ourselves survey was 83 years old.[17]

Some transgender people wait for decades before they come out as transgender or decide to seek gender affirming healthcare.

Some of the reasons why a person may only affirm their gender later in their life include:

- The increased visibility of transgender people compared with when they were younger
- The increased social acceptance of transgender people compared with many decades ago
- More readily available information regarding transgender matters and gender affirming healthcare than in years past
- Greater accessibility of gender affirming healthcare
- Changes in personal circumstances, such as the death of a partner or whānau member to whom the person did not want to come out.

It can be advisable to suggest to older transgender patients that they obtain an enduring power of attorney for health and welfare, and a suitable advanced care plan. This is to ensure that their gender affirming healthcare needs continue to be met if, in future, another person is required to make medical decisions on their behalf.

For information about gender affirming medical and surgical treatment for older people see the **adult gender affirming hormone therapy** chapter, and **surgical gender affirmation** chapter, in the Tapu section.

'The rest home nurses have been amazing. Most of them come from cultures where gender diversity is normal. They took me shopping for dresses. It's been great.' – 70 year old transgender person

5. Resources for Whakapapa section

5.1 Schools

- InsideOUT Kōaro – a national charity working to make Aotearoa New Zealand safer for all Rainbow and takatāpui young people. They provide resources, networking, professional development, support for setting up school diversity groups and wider support to schools.
- Inclusive education: Supporting LGBTQIA+ students.

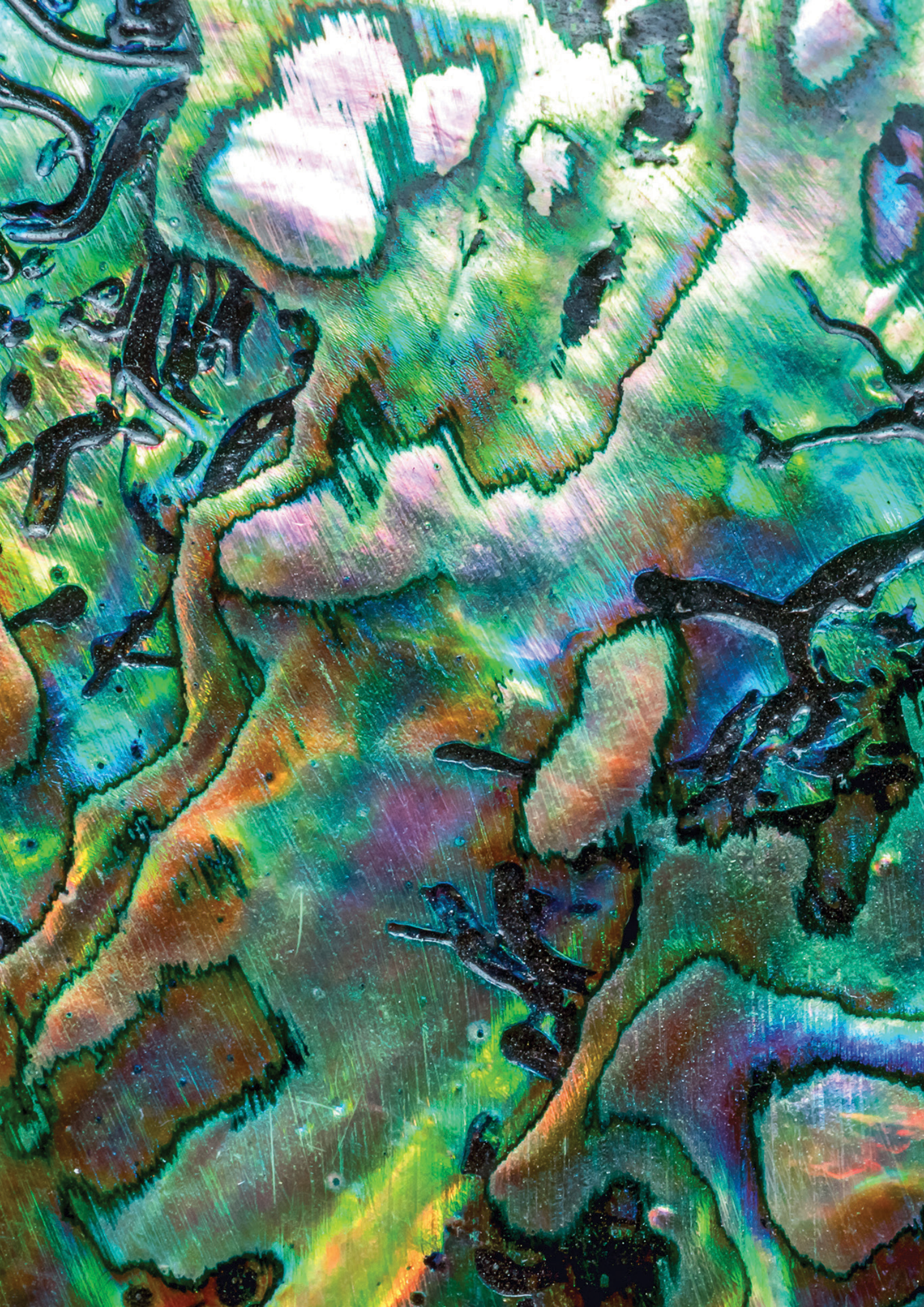
5.2 Whānau of transgender and gender diverse children/ young people

Gender Diversity in Children & Young People – KidsHealth – this has links to a range of resources for whānau and health professionals, including:

- Takatāpui: Part of the Whānau – a resource to support takatāpui identity and wellbeing
- Be There – a website to support families and whānau of transgender young people to be inclusive, affirming and safe
- Storm Clouds and Rainbows – provides insights from a parent perspective on how to support a transgender child
- Counting Ourselves Factsheet: Listening to and Supporting Trans and Non-Binary Young People
- Parents and Guardians of Gender Diverse Children in NZ – a parent-led group which provides support to other parents and caregivers.

5.3 Older people

- Gender and Sexual Minorities – New Zealand Dementia Foundation
- I Just Want To Be Me – Hospice UK
- Book: Trans and Gender Diverse Ageing in Care Contexts: Research into Practice. Toze M, Willis P, Hafford-Letchfield T (eds). Bristol University Press 2024



Wairua

Wairua refers to the spiritual dimension: the soul or essence that people are born with that connects people to the taiao (environment), deities (God/gods) and tūpuna (ancestors).

In *Te Whare Takatāpui*, wairua is represented by the whakairo (carvings) of tūpuna, kaitiaki (guardians) and tipua (shapeshifters).

We understand the impact we can make on transgender people from the moment they enter a healthcare setting. Recognising the pivotal role of language, imagery and our welcoming process, we cultivate a healthcare environment where the wairua of people seeking gender affirming healthcare can be tau (settled).

6. Creating inclusive clinical environments

'The comfort of trans people is as valid as the comfort of every other patient' – transgender person

Many transgender people in Aotearoa New Zealand have had negative experiences with healthcare providers.[17] The Counting Ourselves survey reported that over a third of participants had avoided seeing a doctor due to feeling worried about how they would be treated as a transgender person.[17]

Health services can take simple steps to create clinical environments that signal inclusivity and are welcoming towards transgender people.

6.1 Enrolment forms

Many health services require people to complete a form to provide their personal details on first attendance. Health professionals should ensure enrolment forms have spaces for people to give the name they would like used, their self-identified gender and their pronouns.

'You should have a preferred name in a GP [practice] that is used when speaking to a health professional … or receptionist and your government name is used only when absolutely necessary.' – transgender person

Some healthcare services may also need to identify the transgender person's sex assigned at birth so that the healthcare provided is both safe and appropriate (for instance appropriate health screening). It is recommended that an explanation is provided on the enrolment form about the reasons why your service asks for information regarding sex assigned at birth. Using a two-step process to collect sex and gender data is appropriate for a healthcare setting. Stats NZ has a useful guide to collecting sex and gender data.

6.2 Names and pronouns

'Let me use a preferred name and pronouns. Please affirm my identity without drawing attention to it. Don't call out my deadname[i] to the whole waiting room.' – transgender woman

Gathering information about a person's name/s and pronouns should be done in as confidential a manner as possible. Check which name and pronouns the person wants you to use on their records, and what names and pronouns they want used in the presence of others (for example when calling them from the waiting room). This is because the person may not have disclosed their gender, or their status as being transgender, to others.

'Please incorporate privacy measure[s] at receptions at GP offices. It is very traumatic to be deadnamed in a lobby at a GP practice.' – transgender person

6.3 Health records and IT systems

Health services should ensure they have processes to record people's self-identified pronouns and the name they want to be called in their health record to minimise the chance of misgendering someone or calling the wrong name from the waiting room.[82]

Setting an alert on the person's file may be a useful way to record their pronouns and the name they want to be called (their correct name). Register the person's self-identified gender on their clinical records and update the National Health Index (with discussion and consent from the person).

[i] 'Deadname' is a term used by some transgender people to refer to the name they were assigned at birth that they do not wish to use because it is of the wrong gender.

Primary healthcare services should ensure that recalls are set up so that transgender people are offered appropriate screening (such as mammograms and cervical screening) at appropriate intervals. This may not occur by default due to the patient's sex or gender being recorded differently on their NHI or patient file from their sex assigned at birth.

Many health IT systems are not linked, which means that laboratory forms, Work and Income New Zealand (WINZ) certificates, referrals and other correspondence may not reflect a person's correct gender or name. It may be helpful to explain this to your patient or client so that they understand why a form may not reflect accurate details.

It is helpful to be clear on a referral or form if the person uses a different name.

6.4 Visual cues

Q: 'Please mention anything that helps you feel comfortable to go to a healthcare service.'

A: 'Welcoming and authentic atmosphere, grounded in indigenous, bicultural, multicultural inclusive culture … gender affirming nametags on staff and signage … extended to advertising, PR and communications' – transgender person

Displaying the Rainbow, transgender or progress pride flag may improve perceived safety. Such visual cues can be displayed:

- Inside the health service
- On the health service's website
- In correspondence (such as newsletters) sent to service users
- On badges worn by staff.

'There's a trans flag hanging on the wall in the waiting room of my doctor's clinic … it really does help me feel more comfortable and safe.' – transgender person

Staff may also choose to wear pronoun badges or rainbow lanyards to signify their inclusivity.

'The pharmacist at the chemist where I go to pick up my oestrogen prescription wears a "she/her" badge on her shirt … She makes me feel really safe' – transgender person

Using posters and pamphlets that represent diversity can help people feel safe in a health service. Resources should ideally show the diversity of transgender people, such as ethnic diversity and people with disabilities. Having signs that welcome refugees in the waiting room and clinic rooms can give transgender refugees and asylum seekers visibility in healthcare spaces. Such measures can encourage all transgender people to feel safe and included.

'I think having pro-LGBT material [visible in a healthcare service] is actually quite important … I get a lot of anxiety about whether or not I belong, and whether my presence is desired, tolerated, or despised – and having clarity outside of human interactions is important to allow me to navigate that [dis]comfort without the potential for direct confrontation.' – transgender woman

If a health service displays visual cues of being safe for, and inclusive of, transgender people, it is important to ensure that this is backed up with staff training to avoid giving transgender people a false sense of security.[83]

6.5 Toilets

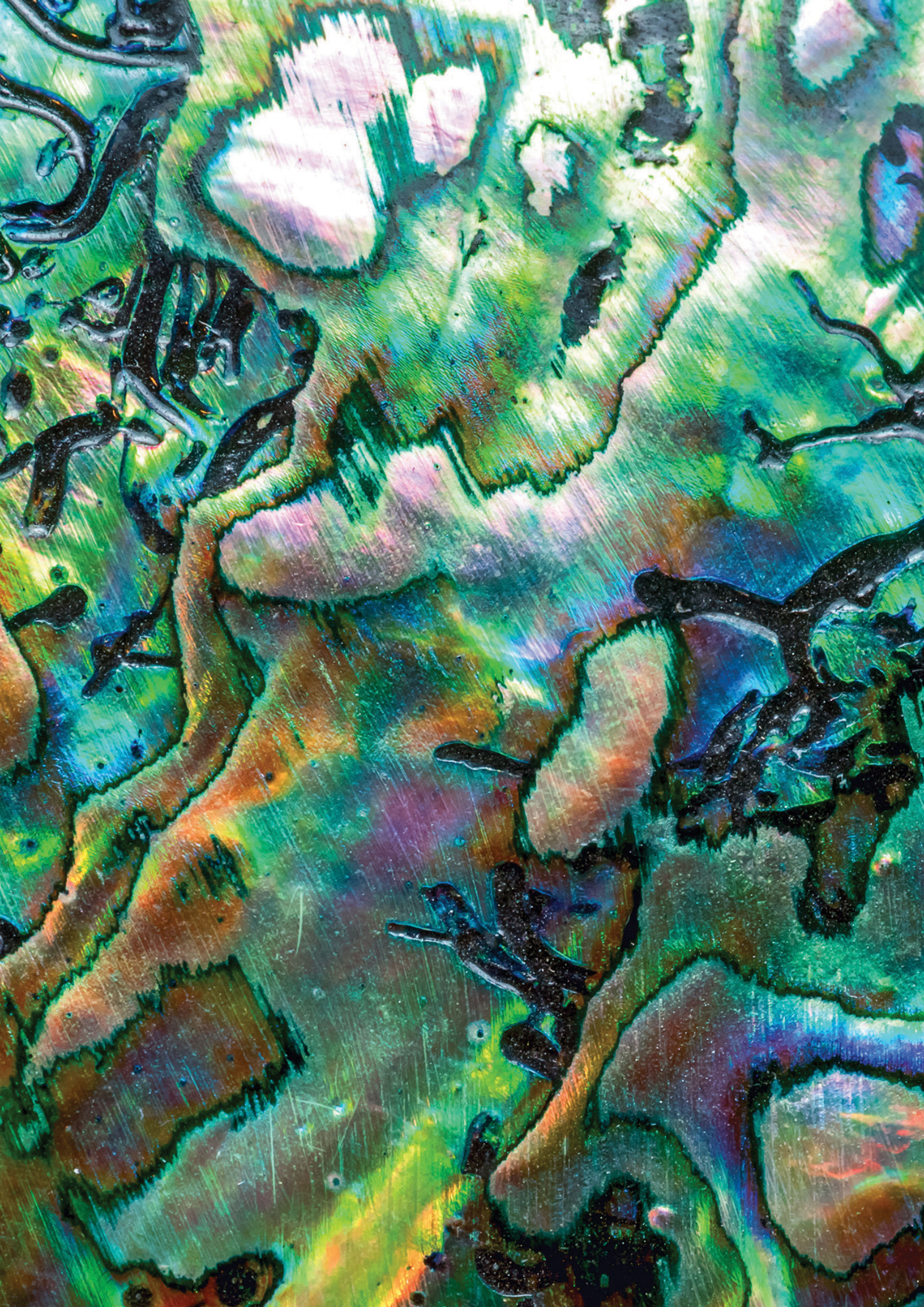
Having at least one non-gendered toilet helps to create a welcoming space for transgender people who are apprehensive about using a male or female toilet.

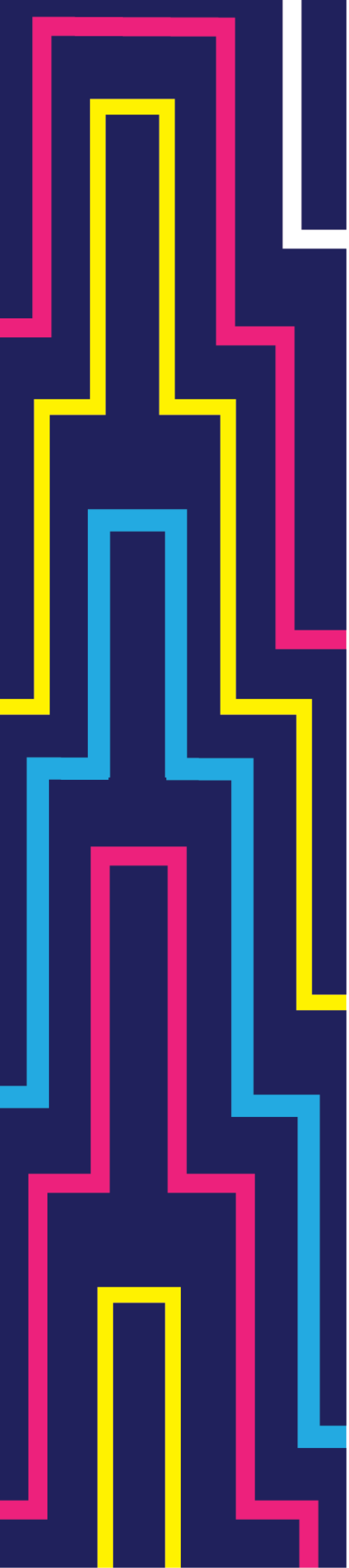
If all toilets are in separate cubicles, these can be labelled as 'toilet/wharepaku' without needing to add a gender label. Ensure there are sanitary bins in all toilets.

7. Resources for Wairua section

7.1 Posters and resources for clinic rooms and waiting rooms

- Aotearoa: we all belong – English Language Partners
- Posters in Population – Burnett Foundation Aotearoa
- Transgender posters – Gender Minorities Aotearoa
- Resources to help you in your practice
- Cervical screening: what you need to know – HealthEd
- Takatāpui posters





Mauri

Mauri is about our life spark – those essential qualities, skills and talents that are ours alone. In *Te Whare Takatāpui*, it is represented by the colour and patterns of the tukutuku (woven panels) inside the wharenui. As transgender people weave their unique stories, they are seen, recognised and valued. We acknowledge the unique mauri of each transgender person.

8. Interacting with transgender people

'Humanisation [sic] is respecting and using correct names, pronouns and identity' – transgender person

Accounting for each transgender person's unique identity holistically is as essential as it is for the rest of the population. As with the provision of healthcare to all people, when providing healthcare to a transgender person:

- Acknowledge and respect all aspects of the person's identity – for instance their ethnicity, religion and gender. This is also important when interacting with a transgender person's whānau, and any support people who accompany them.

  [Health professionals] … need to understand that every person identifies differently, diversity is vast, and they must communicate with the specific person they are dealing with to understand what that person needs.' – transgender person

- Regardless of what may be listed on a person's identity documents or health records, refer to, and address the person, using the name/s and the personal pronouns (such as he, she, they, or ia in te reo Māori) that they want to be used. The name and pronouns a person wants you to use may vary depending on context – for instance if the person has not disclosed their gender to others yet, they may want you to only use their 'new' name in a private setting (rather than a waiting room). Transgender people can face financial and other barriers to changing their name and sex on their identity documents. Some may not have had time to change their identity documents yet – for instance if they have only just disclosed their gender to others.

  'I would feel comfortable [to go to a healthcare service] with staff using gender affirming names and pronouns.' – transgender woman

- If you are unsure what pronoun or pronouns to use, politely ask the person, in as confidential a setting as possible.

  'Kia ora, my name is Dr Alex Smith, and my pronouns are he, him, and ia.

  Please could you tell me what pronouns are ok for our staff to use for you?'

- Language is constantly evolving. Transgender people also have varied perspectives about terminology and how they apply it to their own lives, bodies and identities. For instance, some transgender people may find that some terminology about their primary or secondary sex characteristics increases their gender dysphoria. Use terminology that your patient or client is comfortable with and that they understand.

  'It's important that we discuss how gender affirming hormones will and will not affect your body, including your genitals. What words would you like me to use to refer to your genitals when we talk about this?'

- Ask the person to tell you about what the term they use to describe their identity means to them if it is clinically relevant. Do this in as confidential a setting as possible.

  'Are there any particular words you use to describe your identity? Can you explain what that word means to you? Thank you for sharing this with me.'

9. Non-medical and non-surgical gender affirmation

Not all transgender people want, or need, gender affirming medical or surgical treatments. People may affirm their gender in ways that do not require input from health professionals. Everyone has the right to affirm their gender in the way that feels most authentic to them.

> Ensure that people seeking gender affirming healthcare are aware of all non-medical and non-surgical options they have, which may help them to affirm their gender or support their gender embodiment goals.

Recognising the self-determination of the person enables health professionals to respond flexibly and respectfully to the uniqueness of each person's journey.

Some transgender people may wish to delay non-medical or non-surgical steps until they have begun medical or surgical affirmation. Some may not wish to take steps outlined below at all.

> Non-medical gender affirmation options are as varied and as individual as the person.

9.1 Social affirmation

> Social affirmation describes many ways someone may affirm their gender in a way that does not require input from a health professional.

Social affirmation may include changing clothing, make-up or hairstyles, using a new name and/or pronouns, and telling friends and whānau.

Any of these steps can be taken at any time and can be supported by health professionals. For example, a primary care practice can offer to update a person's name, pronouns and gender in the practice management system (PMS) and NHI. There is no requirement for an ID document to be provided for someone's name or gender to be changed on their NHI.

The implications of changing a person's gender in the PMS can vary (for instance, whether the software will allow you to order a pregnancy test for someone listed as male). If you have difficulties, contact your PMS provider.

Correspondence between health professionals should use the transgender person's chosen name, pronouns and title.

9.2 Legal affirmation

Legal affirmation refers to the steps taken to align a transgender person's identity documents with their gender. This can include legally changing their name and sex, and acquiring identification that reflects these changes.

New Zealand law does not require a person to have any medical or surgical affirmation of their gender to update their name and sex on their New Zealand Government issued identification documents.[84]

Restrictions apply in some instances to whether a non-citizen can change their legal name and legal sex on their New Zealand Government identification. For information specific to asylum seekers and refugees please see the **asylum seekers and refugees** chapter.

Children and young people (aged less than 18 years) need an independent third party to provide a letter of support to change the sex on their birth certificate. Amongst others, a range of New Zealand registered health professionals with current practising certificates can provide this letter of support, such as doctors, nurses, nurse practitioners, psychologists, psychotherapists and some counsellors. For further detail see **Suitably qualified third parties – Department of Internal Affairs**.

9.3 Speech and language therapy

Gender affirming voice training, often provided by speech and language therapists, can help transgender people affirm their gender. This can help transgender people adjust their voice to sound more masculine, more androgynous or more feminine in accordance with their individual goals.

9.4 Hair removal

Transgender people assigned male at birth (AMAB) may desire hair removal, either via laser treatment or electrolysis. This is rarely funded in the public health system, but financial assistance may be considered by Work and Income New Zealand for those who meet the criteria for a Disability Allowance.

9.5 Chest binding

Transgender people assigned female at birth (AFAB) may wish to flatten the appearance of their chest. This is typically achieved with a chest binder – a specially designed piece of clothing that fits tight to the body and compresses breast tissue.

It is important that transgender people who bind do so safely, to prevent potential health risks such as bruising, stress fractures and rib restriction (impacting breathing). People who bind should be advised to use a purpose-made chest binder that does not fit too tightly, wear it for less than eight hours per day, and remove the binder before exercise or sleep. Some transgender people use larger binders, sports bras or swim binders for exercise.

Breathing and stretching exercises can help reduce these risks and make binding more comfortable. Some physiotherapists specialise in gender affirming healthcare and can assist.

9.6 Tucking and prosthetics

Some transgender people utilise specific pieces of clothing or prosthetics to help affirm their gender.

Those AMAB may use tucking gaffs, which are purpose-made underwear that help 'tuck' the penis to achieve a flattened appearance. They may also use breast prosthetics to achieve a fuller breast, shapewear to adjust the shape of their torso or padding to give the appearance of wider hips.

Some transgender people AFAB use packers (adding 'packing' to their crotch to achieve the look and feel of having a penis), which can include a prosthetic penis. Some of these are fitted with a mechanism that enables them to be used as a 'stand-to-pee' device.

9.7 Practice points

- People may choose to affirm their gender in ways that do not require input from health professionals. The steps people take and the timing of these is an individual choice, which varies widely between people.
- There is no requirement to take non-medical affirmation steps to access medical or surgical gender affirming healthcare.
- Examples of non-medical gender affirmation include changing clothing, hair, make-up, name, pronouns and legal identity documents.
- Gender affirming voice therapy can be provided by speech and language therapists.
- People AMAB may desire permanent hair removal. They may also use tucking, shapewear or prosthetics to change the appearance of their body.
- People AFAB may use tight fabric known as a binder to compress and flatten their breast tissue. They may also use a packer to give the appearance and feel of a penis.
- Using a chest binder can potentially lead to pain and breathing difficulties, so safety recommendations should be followed. Physiotherapists may be able to assist.

10. Māori

'Māori and diverse gender identities, sexualities and sex characteristics are not mutually exclusive … being diverse is part of being Māori.' [8]

'My hope is that one day … for Māori in particular, we look back and acknowledge how wonderfully our ancestors treated gender and sexually diverse individuals (pre-colonisation) and carry that on for future generations' – young person[49]

10.1 Belonging and relationships

'Acknowledge us as Māori first and then a[s] trans women.' – Māori transgender woman

For transgender Māori, feeling a strong sense of belonging to their ethnic group has been shown to be associated with a sense of 'life worthwhileness'.[63] Other identified protective factors for Māori transgender people's mental health (in terms of life satisfaction, gender identity pride and the sense that things that they do are worthwhile) include:[63]

- A belief that their friends are supportive of them
- A sense of belonging to the takatāpui community
- A sense of belonging at their workplace.

Relationships can be important to consider when providing gender affirming healthcare to Māori. This includes:

- Establishing trusting healthcare relationships. In addition to approaches that can help build trust with all transgender people (see the **Wairua** section and the **interacting with transgender people** chapter in the Mauri section), it may help for the health professional to practise in a manner that is culturally appropriate within Māori health more broadly.
- If the person seeking gender affirming healthcare uses culturally specific terms and pronouns to refer to their identity, address and refer to the person using these if they wish you to do so.
- Upholding the mana of the person and their whānau. A person's mana is their sense of authority, agency and power, and gives them the authority to have control over their own life and health. Part of upholding the mana of the person is empowering them to exercise informed self-determination (refer to the **informed consent in gender affirming healthcare** chapter in the Mana section).
- Taking into account the person's whānau-related needs, preferences and situation regarding their gender affirmation and healthcare. (Refer to the **whānau** chapter in the Whakapapa section for more information.)
- Assisting (where possible and appropriate) the person and their whānau to address any social needs that affect their health. For example, this could include connecting them and their whānau to culturally specific peer support groups (see the chapter titled **resources for Mauri section** in the Mauri section for more information).

10.2 Māori conceptualisations and models of health

Te Ao Māori conceptualisations and models of health involve multiple interrelated dimensions.[85] As with all people, it is helpful to be holistic, and consider all dimensions of health as interrelated. The **Whakapapa** and **Tapu** sections of these guidelines provide some assistance.

10.3 The pronoun 'ia'

In te reo Māori (the Māori language) personal pronouns are not gender specific. 'Ia' is the personal pronoun used when referring to a person in te reo Māori. 'Ia' is pronounced 'ee-a.'

10.4 Māori identity terms

'... my GP and the nurses always refer to me as takatāpui. It's so affirming! It tells me they understand how important my cultural identity is to me while also understanding I am gender diverse.' – patient

Addressing and referring to your patient or client using the identity term/s with which they are comfortable can help to build and maintain rapport.

Someone who is Māori may use words from one language, or more than one language, to describe their identity.

Within te reo Māori there are a range of terms that those seeking gender affirming healthcare may use to describe their identities. Professor Elizabeth Kerekere discusses some of these terms:

'Takatāpui is a traditional Māori term meaning "intimate companion of the same sex." It has been reclaimed to embrace all Māori who identify with diverse genders, sexualities and innate variations of sex characteristics. This includes whakawāhine (trans women), tangata ira tāne (trans men), irawhiti (all trans people), irarere (gender fluid), lesbian, gay, bi/pansexual, trans, non-binary, intersex, asexual, queer and questioning people. These are often grouped under the headings of "Rainbow people" or "Rainbow communities" in Aotearoa. Māori who are trans, non-binary or gender fluid may use these te reo (Māori language) terms as well as, or instead of, takatāpui.' [5]

Sometimes there is no direct translation of a te reo Māori identity term into English. For example, the term takatāpui can refer to an identity comprising matters that are inherently unitary and cohesive for the takatāpui person, but which may be regarded as separate and unrelated variables in English-speaking Western cultures:

'Takatāpui identity is related to whakapapa, mana and inclusion. It emphasises Māori cultural and spiritual identity as equal to – or more important than – gender identity, sexuality or having diverse sex characteristics.' [8]

The meanings and definitions that different transgender Māori attribute to some terms from te reo Māori also vary.

11. Pacific peoples

Life changing, I wouldn't be here today if it wasn't for gender-affirming medication.' – Pacific young person.' [49]

This chapter should be read alongside the **social determinants of mental and physical health** chapter and the **whānau** chapter. Both are in the Whakapapa section and contain further information specific to Pacific peoples.

11.1 Pacific peoples in Aotearoa New Zealand

The term 'Pacific peoples' is an umbrella term used to refer to people who have originated from the Pacific islands in the regions of Melanesia, Micronesia and Polynesia.[86] Around two-thirds of Pacific peoples in Aotearoa New Zealand were born here but have a genealogical link to the Pacific islands.[87] Around one-third of Pacific peoples in Aotearoa New Zealand have immigrated here.[87] The 2023 Census estimates that 8.9% of Aotearoa New Zealand's population are of Pacific ethnicity (as a component of, or their entire, ethnic identity).[88]

11.2 Pacific peoples are diverse

The cultures, nationalities, ethnicities and languages of Pacific peoples seeking gender affirming healthcare are diverse.

The Pacific islands include many different countries, territories, ethnicities, languages, cultures and histories. Around 41% of Pacific peoples in Aotearoa New Zealand also have more than one ethnicity.[87] Some people in Aotearoa New Zealand have a non-Pacific heritage as well as a Pacific heritage.

11.3 Cultural identity is important to many Pacific Rainbow+[j] peoples

A survey of Pacific Rainbow+ peoples in Aotearoa New Zealand found that 92% of respondents held their cultural identity as either important or very important to them.[67]

Acknowledge and take into account the cultures of Pacific peoples seeking gender affirming healthcare. It is helpful to provide culturally appropriate care for Pacific peoples and to facilitate self determination.

See the **Wairua** section and the **interacting with transgender people** chapter in the Mauri section for approaches that can help build trust with all transgender people.

11.4 Pacific conceptualisations of health

Many Pacific peoples conceptualise health as multidimensional – for instance including whānau wellbeing, physical health, mental health and environmental health – and understand these dimensions of health to be interdependent.[89] Take this into account when providing gender affirming healthcare to Pacific peoples.

Rainbow+ Pacific peoples in Aotearoa New Zealand often connect their own sense of wellbeing to the successes and hardships of their whānau.[67] Those who seek gender affirming healthcare can experience diverse responses to their identity from whānau.[67] See the **whānau** chapter in the Whakapapa section of these guidelines for information and guidance relating to the whānau of Pacific peoples.

[j] Pacific Rainbow+ people include those who are Rainbow, MVPFAFF+, or use any other identity label that indicates diverse genders, diverse sexualities, or diverse liminalities in Pacific communities.

11.5 Pacific identity terms

A Pacific person may describe their identity using English language terms (such as 'transgender'), terms specific to their own culture/s, or a combination of these terms.

Use the identity term/s with which the person is comfortable.

MVPFAFF+ is an acronym that was coined by Phylesha Brown-Acton in 2011.[90] The acronym MVPFAFF+ includes many diverse genders, sexualities and liminalities found within Pacific cultures:[67]

- Māhū (Hawai'i and Tahiti)
- Vakasalewalewa (Fiji)
- Palopa (Papua New Guinea)
- Fa'afafine and Fa'atama (Samoa and American Samoa)
- Akavaine (Cook Islands)
- Fakaleiti/Leiti (Tonga)
- Fakafifine (Niue)
- The '+' symbol acknowledges that there are other Pacific gender identities, sexualities and liminalities.

The glossary of the 2023 *Manalagi Survey Community Report* briefly describes each of the aforementioned MVPFAFF+ identities.[67]

Pacific identity terms do not always have an equivalent word in English.

The 'gender' term that a Pacific person may use to describe their identity can also incorporate other culturally specific aspects of their identity. For instance, a single Pacific identity term can concurrently relate to what in the English language might be referred to as gender, sexuality, familial roles, spirituality, social roles and cultural identity.[91]

11.6 Religion

Religion and spirituality have a 'central role in communal and family life' for many Pacific peoples in Aotearoa New Zealand.[92] Teariki and Leau explain that these two concepts are different:

'At its most basic, 'spirituality' could be interpreted as referring to Pacific peoples' high rate of affiliation with Christianity and the role of churches…[However,] 'spirituality' is much more than that. It is about deep spiritual connections with the natural world going back to ancient times, relational relationships, connections with ancestors and more, that go to the heart of cultural identity.' [89]

More than three-quarters (77%) of Pacific peoples in Aotearoa New Zealand report that they have a religion, and more than two-thirds (68%) report that their religion is Christianity.[87] Research relating to the religion-related experiences of Pacific people needing gender affirming healthcare in Aotearoa New Zealand was not available at the time of writing. However, the *Manalagi Survey Community Report of Pacific Rainbow+ people in Aotearoa New Zealand* (n=328) found that:[67]

- Religion was 'important' or 'very important' to nearly two-thirds (63%) of those who answered the question about the importance of religion to them
- More than three in five (61%) reported that religion had made their ability to live their life as a member of the Rainbow community(ies) 'somewhat difficult' or ' very difficult'.

'The advent of colonisation shifted many core and religious views regarding our Pacific Rainbow+ whānau … Colonial views expressed by many Pacific leaders in the past have served to marginalise Pacific Rainbow+ people in ways that have had a detrimental impact on our Rainbow+ whānau ability to experience optimal wellbeing outcomes.'
– Ministry for Pacific Peoples[66]

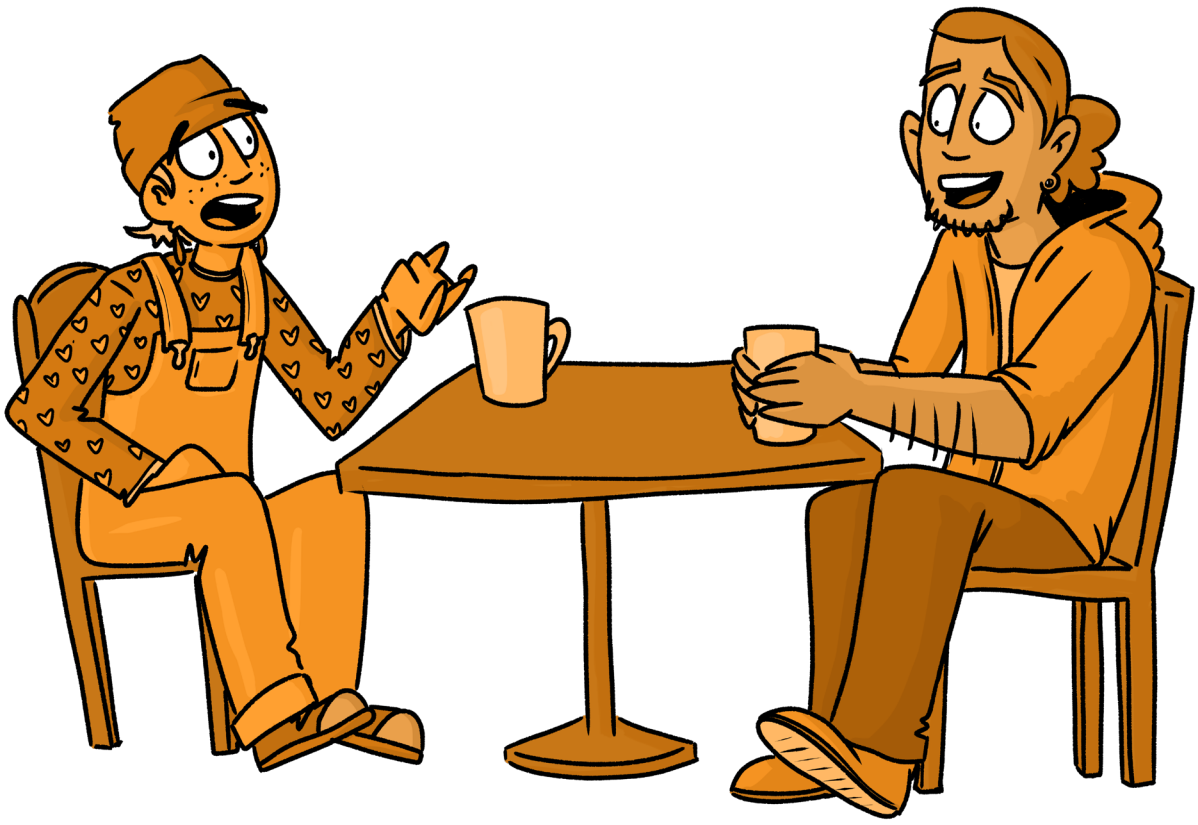
However, it may be helpful to know that there are still Rainbow+ Pacific peoples who hold roles of importance in their whānau, communities and cultures.[66]

11.7 Sources of affirmative assistance and connection

There are Pacific-run organisations across Aotearoa New Zealand that specifically assist Pacific Rainbow+ peoples, their whānau and their communities. A list is provided in the **resources for Mauri section** at the end of the Mauri section.

11.8 Self-determination

As with all Pacific Rainbow+ peoples,[66] it is helpful to engage with Pacific peoples who seek gender affirming healthcare in ways that facilitate self-determination through taking into account their aspirations.



12. Asylum seekers and refugees

Key tenets of gender affirming healthcare, such as honouring people's agency, autonomy and experience, and building respectful, trusting relationships, provide a strong foundation for providing care to people with a refugee background. However, it is important to understand and mitigate some of the unique barriers that refugees and asylum seekers may face in seeking gender affirming healthcare in Aotearoa New Zealand. It is not possible to cover all of these here; this section provides a brief introduction and overview.

12.1 Pathways to resettlement in Aotearoa New Zealand

People with a refugee background resettle in Aotearoa New Zealand through different pathways.

Some refugees, often referred to as quota refugees, obtain official refugee status overseas and resettle in Aotearoa New Zealand through an annual quota under the UNHCR (United Nations Refugee Agency) programme. Others make their own way to Aotearoa New Zealand and seek asylum here, either on arrival or at a later point. They are referred to as asylum seekers until they are recognised as a convention refugee, or protected person.

A third group are sometimes referred to as refugee-like migrants as they may have similar backgrounds and needs to (but often less support than) someone who arrived via the UNHCR quota.[93] Some examples include family members of refugees who have arrived via Refugee Family Support categories, or those arriving through the Afghan Emergency Resettlement Category and the 2022 Special Ukraine Visa.

12.2 Eligibility for healthcare

Access to resettlement support and gender affirming healthcare varies between quota refugees, asylum seekers and refugee-like migrants, creating disparities and inequities across these groups. Quota refugees are provided with an orientation to Aotearoa New Zealand, including a five weeks stay at Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre. They are granted permanent residency on arrival and are eligible for all funded healthcare. They also receive resettlement support for two years through a range of providers, depending on the region.

Regional refugee resettlement programmes

Reproduced with permission from the Refugee Health Handbook[34]

Region	Provider	
Auckland	Kāhui Tū Kaha:	kahuitukaha.co.nz
Hamilton	Hamilton Multicultural Services Trust:	hmstrust.org.nz
Palmerston North, Levin, Masterton, Wellington, Nelson, Blenheim, Dunedin, Invercargill	New Zealand Red Cross:	redcross.org.nz
Christchurch	Purapura Whetu Trust:	pw.maori.nz
Ashburton	Safer Mid Canterbury:	safermidcanterbury.org.nz
Timaru	Presbyterian Support South Canterbury:	pssc.org.nz

Asylum seekers are eligible for publicly funded healthcare once they have a letter from Immigration New Zealand confirming that their Confirmation of Claim form (INZ 1071) has been received and while this claim is being processed, including if an initial decision is appealed. However, this access is often delayed and not well understood by many healthcare professionals. Asylum seekers rely solely on community volunteers or independent non-government organisations (NGOs) such as the Auckland-based Asylum Seekers Support Trust and Rainbow Path to help them navigate health, legal, accommodation, employment, and social services.

Refugee-like migrants who do not apply for asylum may or may not be eligible for publicly funded healthcare and resettlement support depending on their immigration status. They will need to be considered on a case-by-case basis. For example, people who arrived via a Refugee Family Support Category or those on a work visa of two years or more are all eligible for funded health services.

It is important to check eligibility carefully and avoid making assumptions to ensure that people are not charged for funded healthcare that they are entitled to. For information on eligibility, see **Guide to eligibility for public health services**.

Asylum seekers and many refugee-like migrants may not have had comprehensive health screening on arrival or as part of the resettlement process and may have other unmet health needs along with their gender affirming healthcare needs. The Refugee Health Handbook provides detailed health screening guidance if this is needed.[34] If healthcare is not funded, whether for gender affirming healthcare or otherwise, only essential tests should be requested to avoid creating financial strain.

Once eligibility has been established, this should be clearly documented on the PMS. Asylum seekers and quota refugees can be classified as 'Eligible Non-New Zealand resident' and 'Eligible New Zealand resident' respectively so that this populates to clinical laboratory forms and ensures people are not charged incorrectly for requests. Adding an 'alert' in the person's notes can also serve as an additional reminder to health professionals and administration staff, reducing unnecessary confusion in the consultation and at the front desk.

12.3 Documentation

Transgender asylum seekers and convention refugees may have no overseas or New Zealand documents with a name, gender marker and photo that matches their gender identity and appearance.

Transgender people born overseas do not have the same access to processes to amend their name and gender marker in Aotearoa New Zealand as people born here. Some processes exclude anyone born overseas (such as amending a New Zealand birth certificate), while others are limited solely to permanent residents (for instance, legally changing your name) or to New Zealand citizens (for instance, obtaining a New Zealand passport).

This means the identity document most transgender asylum seekers and convention refugees use to prove their identity when accessing health services in Aotearoa New Zealand is either a passport from their country of origin, or a New Zealand issued Refugee Travel Document or Certificate of Identity. All of these documents are likely to have an incorrect, outdated name and gender.[94, 95]

However, all asylum seekers and refugees can choose the name and gender on their health clinic enrolment forms, the National Enrolment Service and their NHI number.

These details are not required to match the former name and gender marker on an overseas passport, even if those details are reflected on a Certificate of Identity or Refugee Travel Document issued in Aotearoa New Zealand.

Information about gender and immigration status should always be discussed in a private room or on forms and devices, as there are very real risks and fears about publicly disclosing sensitive information.[34]

In a private space, it can be helpful to check if the details in medical records are those that the person would like to use, and to explain that the details don't need to match what is on a passport or other legal documents from overseas.[34]

Many transgender asylum seekers and refugees also arrive without medical records or hormone documentation. They may have a long history of using hormones, including some not typically prescribed in Aotearoa New Zealand.

A longer appointment may be needed to collect information about previous hormone use, and to build trust or when using interpreting services.

12.4 Interpreting services

The right to effective communication in a form, language and manner that enables people to understand is established in right 5.1 of the Code of Health and Disability Services Consumers' Rights (1996). Local interpreting services are listed on Community Health Pathways, although access varies with different funding models and service providers across the country.[34]

Working with interpreters is a skill, and includes assessing need, modality (in person, video or telephone), language preferences, and whether the interpreter is the right person for the situation.[34] Many Rainbow asylum seekers and refugees do not feel safe having contact with others living in Aotearoa New Zealand who are from their country of origin or cultural background, including interpreters. Always gain consent to use an interpreter and, if needed, provide assurance that certified interpreters are bound by a confidentiality clause under a code of ethics.[34] Check whether telephone interpreting would provide more privacy, noting that some people may decline telephone interpreting if concerned the interpreter may misgender them by their voice.

More detailed resources for working with interpreters are listed at the end of this section. All health professionals are encouraged to utilise the training resources available.

12.5 Centring trust and relationships

As with all gender affirming healthcare, respectful trusting relationships are at the heart of good care for people with a refugee background.

A sensitive approach that honours people's agency, resilience and aspirations is essential.

Historically, many resettlement processes and organisations in Aotearoa New Zealand have been built around assumptions of psychopathology relating to pre-displacement trauma, post-traumatic stress disorder (PTSD), and the need for specialist intervention; this can compound stigma and mean that people's real needs are not well understood or properly met.[96]

Nevertheless, it is important to understand the specific challenges and intersecting forms of structural violence associated with refugee status and stigmatised gender.[97]

Many transgender asylum seekers and refugees have faced discrimination, violence, criminalisation and persecution in their country of origin or in transit countries where they sought asylum; even refugee camps may not have been safe.[98]

Some transgender asylum seekers and refugees have hidden their gender identity or expression, fearing exploitation or extortion, and discriminatory practices may have included conversion practices from health professionals.

Some people may never have had access to a health professional they could trust, or information about their general or gender affirming healthcare needs.[34] They may also have had to navigate normative categories built around colonial notions of gender that are used by many immigration systems and humanitarian organisations.[99]

On arrival, transgender asylum seekers and refugees may be especially isolated, encountering racism, xenophobia and Islamophobia, including from 'mainstream' Rainbow communities, but not knowing if it will be safe to seek support from their diaspora communities here.[36] Many have fled persecution from whānau members yet hope one day to reconnect with some they have left behind. It is important not to make assumptions about whether people have or want whānau support and/or support from the Rainbow community, and whether they want to be put in touch with support groups or agencies run by others from their country or cultural community, or who speak their first language. It may be helpful to reassure people they are safe and protected by laws in Aotearoa New Zealand.

Given the confusion that often surrounds access to healthcare and services, it is worth ensuring quota refugees and asylum seekers know they are eligible for all publicly funded healthcare and explaining other rights (for example, to ACC and to the minimum wage if they have a work visa).

12.6 Practice points

- There are a number of pathways through which people with a refugee background can settle in Aotearoa New Zealand – quota refugees, asylum seekers and refugee-like migrants. Access to support and healthcare varies, creating disparities between these groups:
  - Quota refugees have permanent residency and are eligible for all funded healthcare.
  - Asylum seekers are eligible for publicly funded healthcare once they have received a letter from Immigration New Zealand confirming receipt of their Confirmation of Claim (INZ1071) form.
  - Refugee-like migrants may or may not be eligible for funded healthcare depending on their individual immigration status.
- Inform people about their eligibility for healthcare.
- Include reception and support team staff in training, including to ensure eligibility for healthcare is correctly entered on a person's file.
- Reassure refugees and asylum seekers that they are safe and protected by laws in Aotearoa New Zealand and that you can connect them to confidential Rainbow organisations if they would like support.
- Ensure confidentiality, as there are very real fears and risks if a person's gender identity or refugee status is disclosed. Do not discuss someone's gender identity or immigration status in a public reception area. Collect any sensitive information in a private room or on forms or devices.
- Ask people what name and gender they would like on their health records, and then respect their chosen name and pronouns.
- Explain that the details don't need to match what is on their passport or other legal documents from overseas or their New Zealand-issued Certificate of Identity or Refugee Travel document. Check that any previous details you may have in your records are the ones they would like you to use.
- Ask whether they have or want whānau or community support.
- Ask whether they want to be put in touch with support groups or agencies run by others from their country or cultural community, or who speak their first language.
- If interpreters are needed, also offer interpreters from outside their cultural community or the region they come from overseas.
- Check whether phone interpreting may offer more confidentiality. However, some transgender people may be less comfortable using the phone if people misgender them based on their voice.
- Address isolation by connecting people to support services you know are competent in supporting transgender people who are asylum seekers or refugees.

13. Non-binary people

'There are more than two genders and people exist outside the binary' – transgender person

13.1 Definitions

Non-binary (NB or 'enby') is an umbrella term that encompasses diverse gender identities outside of the binary identities of woman/feminine/girl or man/masculine/boy. Te reo Māori has multiple words that non-binary people use to describe their identities, such as irarere and tāhine, though these words may have different definitions for different people.

Identities that can also be found under the non-binary umbrella include, for example: gender neutral, gender non-conforming, gender fluid, gender neutrois, agender, androgynous, multi gender, bigender and genderqueer. As individuals better understand themselves and their gender(s), their ability to explain their experience to others increases and new gender (and non-binary) identity terms may be coined.

Some (but not all) non-binary people identify as transgender. For brevity these guidelines use 'transgender' as an umbrella term to include non-binary people.

13.2 Prevalence

In the 2018 Counting Ourselves survey, 45% of the 1178 participants described themselves as non-binary.[17] Similarly, of the 32,000 people surveyed in the 2021 Household Economic Survey, non-binary people made up 43.5% of the transgender population.[k 18]

13.3 Pronouns

Non-binary individuals often use the pronouns they/them, she/they, and he/they; however, other pronouns may also be used.

'All the healthcare workers in my clinic really try to refer to me with my preferred pronouns. I know they/them is new for many of them, but they never stop trying and always correct themselves when they get it wrong' – non-binary person

13.4 Barriers to care

Non-binary people report higher rates of feeling 'uncomfortable' or 'very uncomfortable' discussing their gender with their general practitioner (GP) or a new doctor, compared with transgender people who have a binary gender identity (such as man, woman, boy or girl).[17]

'Being non-binary, I have been very scared of saying the wrong thing and then being locked out of help from doctors. It leaves me scared to say anything in front of most doctors or counsellors employed under doctors' – non-binary person[17]

Affirm a person's non-binary identity and don't assume that non-binary identities are a step towards a binary identity, as, for most individuals, this is their final gender expression.[100] However, there are some people who may utilise their non-binary identity to carefully support their social transition from cisgender to transgender.

[k] Non-binary was defined as 'people who do not identify exclusively as a man or a woman'.

13.5 Non-binary people have diverse gender affirming healthcare needs

'ALL trans people are individuals and present in different ways' – transgender person

Just as for binary transgender people, each non-binary person's gender affirmation needs are unique. Many non-binary people do not want medical or surgical care to affirm their gender, while for others, it is a crucial part of their gender embodiment.[101, 102]

The **non-medical and non-surgical gender affirmation** chapter provides details about non-medical ways that transgender (including non-binary) people may find it helpful to express and affirm their gender.

The aim of gender affirming treatment for non-binary people is the same as for any transgender person – to improve psychological wellbeing and quality of life.

Medical or surgical care for non-binary people is covered in the **adult gender affirming hormone therapy** chapter and **surgical gender affirmation** chapter.

14. Resources for Mauri section

14.1 Non-medical and non-surgical gender affirmation

- Gender Diversity in Children & Young People – KidsHealth
- Minus18: Your Guide to Socially Transitioning
- Identity documents – Gender Minorities Aotearoa
- Binding safety – Gender Minorities Aotearoa
- Naming New Zealand – RainbowYOUTH – Provides information to transgender, gender diverse and intersex youth to help them update their identity documents to correctly reflect their sex and gender information

14.2 Māori organisations and resources

- Nevertheless – A Māori, Pasifika and takatāpui Rainbow+ mental health non-profit organisation that supports the holistic wellbeing of individuals, whānau and aiga who are Takatāpui or Pasifika Rainbow+ communities
- Mana Tipua, Mana Ora – Enhances the hauora and mana of takatāpui. Based in Ōtautahi/Christchurch, Mana Tipua runs kaupapa Māori social groups, noho marae, individual wellbeing support and community advocacy for takatāpui/Māori LGBTQIA+ youth aged 12–25 years
- Takatāpui – Online resources for takatāpui and their whānau
- Tīwhanawhana Trust – Takatāpui community group based in Wellington
- Uplifting Takatāpui and Rainbow Elder Voices

14.3 Pacific organisations and resources

- F'INE Pasifika Aotearoa Trust (Auckland) – A Pacific LGBTQI+/MVPFAFF+ focused organisation that provides Whānau Ora navigational services
- Ngā Uri o Whiti Te Rā Mai Le Moana Trust (Porirua) – Dedicated to providing a safe environment for MVPFAFF+, Takatāpui and other people who identify as 'LGBTQiA+ of the Moana'. Provides awareness raising, assists other organisations that work with Pacific Rainbow people of all ages, and offers health workshops, arts and creativity initiatives, regular talanoa sessions, and parental related support and advocacy
- Manalagi (national resource) – An Aotearoa Pacific Rainbow LGBTQIA+ MVPFAFF+ health and wellbeing research project. Its website hosts numerous resources and research publications related to this
- Moana Vā (Canterbury) – 'Provides support, advocacy and mentorship of our Pacific Rainbow+ communities, and acknowledges the challenge of living in a region that is systemically conservative, enabling unconscious racial bias and stereotypes of our community members'
- Nevertheless (Hawke's Bay) – A Māori, Pasifika and takatāpui Rainbow+ mental health non-profit organisation that supports the holistic wellbeing of individuals, whānau and aiga who are takatāpui or Pasifika Rainbow+ communities
- Village Collective (Auckland) – Runs Rainbow Fale, which 'contributes to building supportive and safe environments for Pasifika rainbow young people. We equip and enable youth and young adults to achieve their goals; provide a platform for their voice, identify the issues and advocate for the elimination of stigma and discrimination'

14.4 Asylum seekers and refugees

Support and advocacy services

- Rainbow Path NZ – Connecting LGBTQIA+ Refugees and Asylum Seekers in Aotearoa New Zealand – Advocacy and peer support group for the rights of Rainbow refugees and asylum seekers living in Aotearoa New Zealand
- LGBTQIA+ people of colour community – Adhikaar Aotearoa – Advocacy group for all LGBTQIA+ people of colour, particularly South Asians
- Asylum Seekers Support Trust – Provides support to asylum seekers including limited emergency accommodation in Auckland, information and support around accessing entitlements, and advocacy

Note: more refugee-specific support services are on Community Health Pathways.

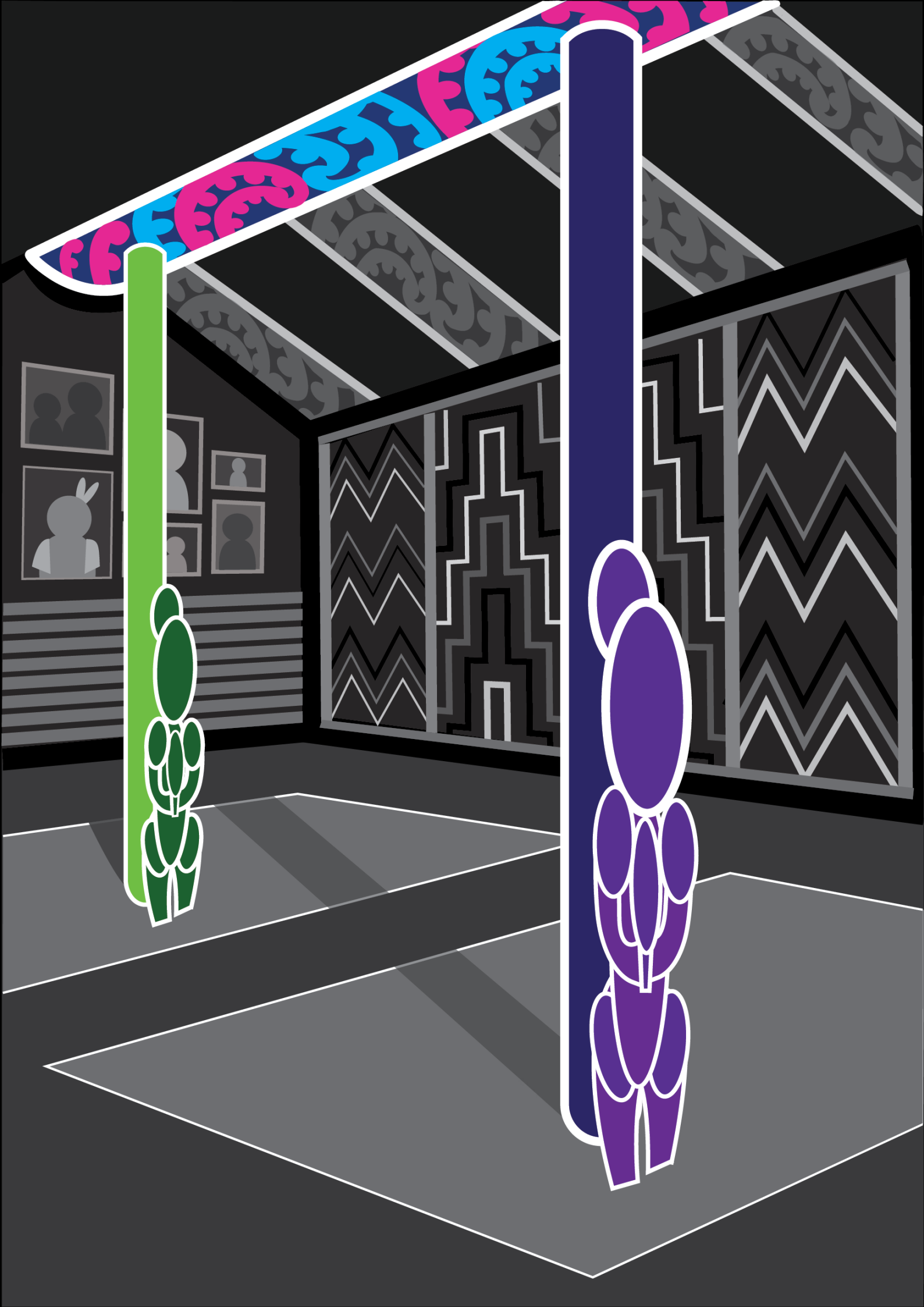
For generic health information in different languages, see Translations – Healthify.

Training resources for working with interpreters

- Cole's Medical Practice in New Zealand: Working with Interpreters – Medical Council of New Zealand
- Working With Interpreters for Primary Care Practitioners – University of Otago
- Cross Cultural Resources – eCALD

14.5 Non-binary people

- Book: Non-Binary Lives. An Anthology of Intersecting Identities. Twist J, Vincent B, Barker M-J, Gupta K. Jessica Kingsley Publishers, 2020, p. 133
- Book: Beyond the Gender Binary. Vaid-Menon A. Penguin Random House, 2020
- Book: How to Understand Your Gender. A Practical Guide for Exploring Who You Are. Iantaffi A, Barker M-J. Jessica Kingsley Publishers, 2017



Mana

Mana is about a person's sense of authority, agency and power, and gives them the authority to have control over their own life and health. In *Te Whare Takatāpui*, mana is represented by the pou (posts) and the tāhuhu (ridgepole) of the wharenui.[4] The pou represent Mana Wāhine (the mana of women) and Mana Tāne (the mana of men). The tāhuhu represents Mana Tipua: the mana of transgender and intersex people based on their acceptance in traditional Māori society.[5] These guidelines acknowledge the mana of people seeking gender affirming healthcare and whakamana (empower) them by providing relevant resources and information.

15. Informed consent in gender affirming healthcare

'The modern ethical and legal duty on practitioners to obtain informed consent marks a shift away from paternalistic medicine. Practitioners cannot dictate to patients how they will be treated. The principle [of informed consent] empowers competent patients to be confident to make informed health care choices …' [103]

'… meetings [with prescribers] can often feel like … the "right" behaviour has to be modelled to secure ongoing care and improvements. I have often worried attending appointments … [about] whether I dressed "femme" enough … Fundamentally – as the provider, they [prescribers] do have agency and control over prescriptions, and while I don't think that's inherently harmful, when they decide to leverage that authority over patients these appointments quickly become a place for gender performance, not gender discussion' – transgender woman

Informed consent processes should empower people within their gender affirming healthcare. Being transgender is not a mental illness,[12] and it does not impair capacity to consent to treatment.

'When I first started to talk to my doctor about gender affirming hormone treatment she never made me feel criticised for being trans, she just explained to me all the details of the treatment, made sure I knew exactly what choices I had, what changes I would see. She also asked me about any concerns I had. I felt cared for and capable of making my own decisions' – transgender person

These guidelines use the definition of informed consent used by the Medical Council of New Zealand at the time of writing.[104] Informed consent from a person:

- Is obtained after the person selects a treatment option, after they understand their treatment options, and the risks, benefits and potential outcomes of undertaking or declining these treatments
- Presumes that the person has the capacity to give informed consent unless it is established that there are reasonable grounds to believe otherwise
- Respects the person's autonomy, and their right to select a treatment option
- Is an interactive process of exchanging and discussing information, and shared decision making, rather than a one off 'event'
- May in some cases be only able to be obtained after the person seeking treatment has had access to relevant supports and aids to make an informed decision
- Also incorporates the requirement that a person should only be provided with a treatment if it is clinically indicated.[103]

In Aotearoa New Zealand, young people aged 16 years and older (or younger if deemed Gillick competent)[105] are considered competent to make decisions about their general medical care.[106, 107] The **children and young people's gender affirming healthcare** chapter, in the Tapu section, provides further detail about whānau involvement in relation to informed consent and Gillick competency for children and young people.

Regarding issues around capacity and cognitive impairment, as is found in other healthcare specialties, the majority of older individuals have the capacity to make decisions about their healthcare.

15.1 Access to care

'Mana is reciprocal. To gain mana, we must give it. … Mana (and consequently, well-being) cannot occur as an individual but only in the context of others.' [62]

People seeking gender affirming healthcare, and (where relevant) their whānau, need health professionals to:

- Inform them about all options available to them for their gender affirmation. This includes non-medical and non-surgical gender affirmation as well as medical and surgical care
- Provide them with sufficient information, communicated in a way that they understand, so that they can make informed decisions regarding any gender affirming medical or surgical care they decide to receive
- Provide clear pathways to gender affirming medical and surgical care so that they know where to access this care.

As with all kinds of healthcare, in some situations a person's visa status may affect their access to publicly funded gender affirming healthcare (noting that privately funding this healthcare may still be possible). For information relevant to refugees and asylum seekers, see the **asylum seekers and refugees** chapter in the Mauri section.

For information relating to other people from overseas, such as international students, see **Get publicly funded health services – New Zealand Government**.

Tapu

Tapu refers to a person, place, object or ritual that is sacred or forbidden in order to create safety. In *Te Whare Takatāpui*, tapu is represented by healing places and the planting and preparation of healthy kai (food) and rongoā (traditional Māori medicines). These guidelines emphasise the tapu nature of the tinana (body) and hinengaro (mind) of transgender people.

16. Children and young people's gender affirming healthcare

This chapter discusses people aged under 18 years.

This chapter is to be read alongside the whānau chapter in the Whakapapa section, and the informed consent chapter in the Mana section.

Please also refer to the following relevant chapters:

- Whakapapa section: **social determinants of mental and physical health** chapter
- Wairua section: **creating inclusive clinical environments** chapter
- Mauri section: **non-medical and non-surgical gender affirmation** chapter.

16.1 Introduction

Many children and young people explore gender identity and expression. Many will not want or need any medical support but for some it will be important for their wellbeing. These children are usually insistent, consistent and persistent in their gender identity and may exhibit distress or discomfort with their physical body.[108]

> Some young people present with a longstanding understanding of their gender diversity since childhood, while others find that adolescence is a crucial time for developing this understanding.[109]

All children and young people should be supported to safely express themselves in the way that feels most comfortable to them. Some transgender children are aware of their gender identity from a very early age, while others may take some time to figure it out or find a safe way to express it.[109]

The Youth12 study by the University of Auckland found that approximately 4 out of every 100 secondary school students reported that they were either transgender (1.2%) or that they were not sure of their gender (2.5%).[48]

Approximately half of the transgender students had wondered about being transgender before the age of 12, but only a third (34.8%) had disclosed that they were transgender to someone close to them.

Whānau support can be of benefit to transgender and gender diverse children and young people. Please see the **whānau** chapter of the Whakapapa section for further information.

> For those gender diverse or transgender children or young people who wish to live as a different gender, they and their parents report that the child/young person experiences decreased distress and improved mental health when their gender is accepted and socially affirmed.[69, 72 110-113]

16.2 Social affirmation and health education

> *'I hope that as a nation we can all come together and make the change that is needed to ensure that all the rainbow youth feel accepted, wanted and comfortable with being/expressing themselves. Seeing the changes so far from when I was at secondary school, I can see that there is some progress, however this is just the start to ensuring the safety of all gender diverse, trans, non-binary and intersex individuals have the same respect and life as a cis straight person does'*
> *– Identify Survey respondent*[49]

Social affirmation may include using a different name and pronouns to those assigned at birth, wearing differently gendered clothing and changes in hairstyle. No permission is required from a health professional for a child or young person to socially affirm their gender.

However, as discussed in the *World Professional Association for Transgender Health (WPATH) Standards of Care Version 8*,[2] supportive and accepting health professional involvement may benefit the child or young person through:

- Educating the child/young person and their whānau about the potential effects of social affirmation of gender, if the child or young person wishes to socially affirm their gender.
- Supporting the child or young person to explore their gender, and to socially affirm their gender if the child or young person wishes to do so
- Assisting whānau with managing situations relating to any social affirmation of gender
- Facilitating constructive communication and collaboration between whānau to assist with meeting the needs of the child or young person
- Providing education about gender development (to the child or young person and their whānau) if needed
- Providing therapy and consultation (with the child/young person and their whānau), if needed, to promote the child or young person's mental health
- Educating those approaching puberty about the effects of puberty
- Educating those of a relevant level of physical development, and their whānau, about gender affirming medical care options, their effects, and options for fertility preservation.

The **non-medical and non-surgical gender affirmation** chapter provides information regarding social gender affirmation. The **interacting with transgender people** chapter also applies to transgender children and young people and can help health professionals in responding supportively to transgender and gender diverse children and young people.

Access to further gender affirming healthcare should be considered for children and young people who experience distress or discomfort with their physical body, in relation to the prospect of pubertal changes. The **medical gender affirming healthcare for young people** part of this chapter provides information for those aged less than 18 years old.

'When my child was questioning their gender, it was a scary time. They were not happy. The counselling, the medication, and family support gave us all some time to breathe and enjoy life again' – parent of young person

16.3 Medical gender affirming healthcare for young people

This sub-chapter discusses care for people aged under 18 years.

Given the considerable variation of physical, emotional and cognitive development of young people during adolescence, extra support may benefit some young people beyond the age of 18 years.

This sub-chapter is to be read alongside the whānau chapter in the Whakapapa section, and the informed consent chapter in the Mana section.

Please also refer to the following relevant chapters:

- Whakapapa section: **social determinants of mental and physical health** chapter
- Wairua section: **creating inclusive clinical environments** chapter
- Mauri section: **non-medical and non-surgical gender affirmation** chapter
- Tapu section: **mental wellbeing**, **fertility**, and **adult gender affirming hormone therapy (GAHT)** chapters (some of the hormonal information in the **Adult GAHT** chapter is useful to read in addition to what is provided below).

This chapter should not be considered a stand-alone document on gender affirming medical care for young people. Anyone providing gender affirming healthcare to young people should be familiar with, and be utilising, the *WPATH Standards of Care Version 8* and the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*.[2, 75]

16.3.A Introduction

The term 'gender dysphoria' refers to the distress or discomfort many transgender and gender diverse people experience from the discrepancy between their gender identity and their sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Gender dysphoria may emerge during, or after, the onset of the physical changes of puberty.[114] Not all transgender children and young people experience gender dysphoria. The absence of gender dysphoria does not diminish the validity or stability of a person's transgender identity.

Encourage care providers and whānau to be open to supporting all gender trajectories and outcomes of a young person's exploration without constraint. Many children and young people explore gender identity and expression. Many will not want or need any medical support but for some it will be important for their wellbeing. A study of 317 young people who underwent social gender affirmation as children found that, in this group, detransitioning was infrequent. 115 More commonly, the young people who socially transitioned at early ages continued to identify that way.[115] A recent study found that 99% of young people who undertook gender affirming medical treatment from a Western Australian service did not 're-identify' with their birth-assigned sex during the study period.[116]

Supporting transgender and gender diverse children and young people requires a developmentally appropriate gender affirming approach.[108]

A holistic approach to supporting young people, which includes gaining a broad understanding of a young person's life, their supports, risks, resiliencies, health and wellbeing, is essential. The goal is to use a strengths-based approach which builds resilience and promotes positive youth development.

16.3.B Evidence to guide this chapter

There is a consistent and growing evidence base from observational studies around the world showing the benefits to psychological wellbeing of puberty suppression and gender affirming hormone therapy (GAHT) when used in line with current clinical practice and guidelines.[117–121]

Other forms of available evidence are generally limited due to the considerable ethical and methodological issues in conducting randomised controlled trials in this area,[122] and the small size of the transgender population. The New Zealand Ministry of Health evidence brief about the use of puberty blockers for gender affirming care discusses some of the limitations of the evidence in this area. The **evidence brief can be found here**.

A review in the United Kingdom (UK) has discussed a lack of a completely formed high-quality evidence base for gender affirming healthcare of those aged less than 18 years.[123] The UK review has been critiqued in depth internationally regarding a number of matters, including (but not limited to) for how it describes evidence quality, for disregarding the values and preferences of patients, and for the reasoning and justifications it uses to come to its recommendations.[124–126] However, the UK review does recommend individualised, holistic and comprehensive care for young people, which is developmentally informed,[123] and these Aotearoa New Zealand guidelines also recommend this.

In healthcare in general, it is not uncommon to provide treatments that lack high quality evidence of effectiveness. Practising medicine, and paediatric medicine in general (not just within gender affirming healthcare), often necessitates providing care without a high-quality evidence base.

> *'... parallels between [paediatric] gender-affirming medical care and other areas of pediatrics are abundant. All types of pediatric practices begin with a dearth of evidence and yet must deliver care to a heterogeneous population in need ...*
>
> *'The point is that careful use of the treatment options we have now, with the best evidence we have, defines pediatric care ... Children benefit from innovative medical treatments that improve their survival and quality of life. Pediatric care would all but cease if physicians denied treatments for which the evidence base is imperfect.'* [124]

In conjunction with the evolving evidence base, guidelines informing gender affirming medical care for young people rely on expert consensus, clinical experience, committee statements and clinical guidelines, particularly where quality evidence may be considered lacking.

In addition to research and international standards of care, this chapter draws on the clinical expertise and experience of clinicians nationally and internationally who have provided gender affirming healthcare to children and young people for many years. By supporting young people through their teenage years and into their early 20s, they have gained valuable insight into this care and the wellbeing of young people over time.

> Withholding gender affirming healthcare is not a neutral option.

Puberty blockers and gender affirming hormone therapy for transgender and gender diverse young people can positively impact mental health and wellbeing outcomes.[117-121]

As with paediatric and adult healthcare generally, gender affirming healthcare treatment decisions for those aged less than 18 years are made collaboratively by health professionals, patients and (as appropriate) their whānau, through a patient-and-family-centred process involving informed consent. This process ensures that people receive thorough information about their available treatment options and associated risks, benefits and alternatives, acknowledging what is and is not known. Such information is communicated in a patient-centred and understandable manner. This enables people to make voluntary and informed choices about their care relevant to their situation and sense of self.

Informed consent is a standard practice in healthcare. The **informed consent** chapter in the Mana section provides further detail about informed consent in Aotearoa New Zealand, and the **consent and whānau involvement** part of this chapter is also of relevance.

The consent forms in the **appendices** may be useful tools when obtaining informed consent.

16.3.C Mental health considerations

See also the **mental wellbeing** chapter (in the Tapu section) and **whānau** chapter (in the Whakapapa section).

> *Giving space and time, support and information to the child/young person and whānau are the most valuable mental health interventions.*

As a population, transgender young people have higher rates of depressive symptoms, self-harm and suicidality than their cisgender peers.[127] Good support is needed from whānau and often, but not always, from mental health professionals. Some of this distress may relate to minority stress (see the **social determinants of mental and physical health** chapter and **mental wellbeing** chapter).

> *Transgender children whose genders are socially affirmed, and who are supported in their gender identity, have only minimal elevations in anxiety, and developmentally normative levels of depression, suggesting that psychopathology is not inevitable within this population.*[69, 72]

Children

Supporting whānau to support children and young people cannot be overstated as a tool for improving their mental health and wellbeing (see the **whānau** chapter). Supporting children to connect with peers is also important so they know they are not alone in their experience. This may be through formal groups for younger children and their families or connecting with other families through the **Parents and Guardians of Gender Diverse Children in NZ** group. Providing support early can help to build children's self-esteem and comfort in exploring who they are.

Young people

The Youth19 survey[127] reported that more than half (57%) of transgender and gender diverse students reported significant depressive symptoms (compared with 25% of cisgender students), and an equal proportion (57%) reported they had self-harmed in the past year (25% for cisgender students). One in five (26%) transgender and gender diverse students reported that they had attempted suicide in the past year (compared to 6% of cisgender students).

Tools such as the Home, Education, Employment, Eating, Activities, Drugs and Alcohol, Depression and Suicide, Sexuality, Safety (HEeADSSS) psychosocial assessment can be used to facilitate understanding of the young person and to create a comprehensive plan of support and treatment.[128] Using risk and resilience models to promote a strengths-based approach to care can enhance the young person's connectedness, safety, and other positive outcomes.

Routinely assess risks, ask about abuse, bullying, drug and alcohol use, nutrition and unhealthy eating behaviours, sexual health, and any mental health concerns. It is useful to consider, and to explore with the young person, how their gender experiences may impact on and influence each of these areas, both now and in the future.

Confidentiality, being treated as autonomous individuals and concerns about acceptance from family, friends and health professionals are important for transgender youth.

Childhood trauma does not cause a person to become gender diverse,[129, 130] but can impact a person's experience and feelings about their body. Variations in gender identity are a normal part of human diversity.

There is an intersection between being transgender and being neurodivergent.[131] This is outlined in detail in the **mental wellbeing** chapter. Ask about communication and wider support needs for neurodivergent young people, e.g. use visual or pictorial tools, give them an opportunity to write answers, make fidget toys available, and consider the sensory environment and the need for breaks or to move around in the appointment.

16.3.D Consent and whānau involvement

Parent/guardian consent is required alongside the child's assent to access puberty blockers before having Gillick competency. Provision of gender affirming medical care for young people must be developmentally informed and usually requires whānau involvement. This is in line with WPATH SOC8 criteria for care for adolescents, which differs from an adult model of care.[2]

When discussing whānau and social support for children and young people, it is important to broaden the conversation beyond parents, guardians or caregivers to include other significant individuals in a person's life.

> Use non-specific terms when asking about whānau, e.g. 'who makes up your whānau?' rather than 'Mum and Dad'.

As outlined in the **whānau** chapter (in the Whakapapa section), whānau support offers significant benefits. However, some young people do not have this support. Lack of whānau support does not preclude older adolescents from accessing care; however, a complete lack of whānau support may pose significant risks to the wellbeing and safety of the young person.

It is best practice to take time to attempt to engage with whānau, where possible and when safe to do so, for all people under 18 years of age, or to seek appropriate wider adult support for the young person.

In most cases, it is recommended that the support of a parent or caregiver is obtained if gender affirming hormone therapy (GAHT) is being initiated for people under the age of 18 years.

16.3.E Recommendations for gender affirming medical care for young people

'Clinicians who initiate puberty blockers should be experienced in providing gender-affirming care and be part of an interprofessional team. In their assessment, clinicians need to consider the possible presence of other associated conditions. Young people who experience gender incongruence experience higher rates of anxiety, depression, and suicidal ideation. They should have timely access to therapeutic supports which meet their mental health needs.' Position Statement on the Use of Puberty Blockers in Gender-Affirming Care, Ministry of Health, 2024.

A multi-disciplinary approach

- This care should be provided in the context of a multidisciplinary team (MDT) that includes access to medical and mental health professionals with knowledge of youth development and gender affirming healthcare. This applies to both initiating puberty blockers and hormone therapy. How an MDT may be configured, and operate, will depend upon which resources and health professionals are available. MDTs may be virtual and may involve correspondence.
- Health professionals who may be involved in the MDT assessment process include doctors, nurses, nurse practitioners, social workers, counsellors, peer support workers, psychologists, occupational therapists, youth workers and others.
- A comprehensive biopsychosocial assessment is recommended and further outlined in the box below.

Whānau support

- Work to bring whānau support into the young person's care, even if that means taking more time. This may not apply if their involvement is determined to be harmful to the young person or is not feasible. See the **whānau** chapter in the Whakapapa section.

Privacy and consent

- Discuss confidentiality with every young person, including privacy of health information. As is common in youth health, it is important to see adolescents on their own for at least part of the consultation. This allows space for a young person to talk about their gender identity.
- For those accessing puberty blockers at an age prior to having Gillick competency, parent/guardian consent is required alongside the child's assent.
- Obtaining informed consent, and assent, are collaborative processes between the young person and their health professional/s.

Health service and health provider expertise and support

- Ideally services working with young people would continue to provide care beyond the age of 16 years. This allows for support, continuity of care and recognition of the varying range of adolescent development over this time period.
- Health professionals involved require appropriate expertise in gender affirming healthcare for young people, and connections to peers. See the **clinical governance** chapter in the Tikanga section.

16.3.F Assessing young people for gender affirming medical care

MDT assessments are usually conducted over several appointments and include a mental health professional assessment/ review as part of the consent process.

Introduction and whakawhanaungatanga

- Welcome – introduce yourself with your name, pronouns and a bit about your clinical role and yourself.
- Invite whānau to share their name and pronouns if they are comfortable doing so.
- Offer karakia or ask if there is a specific way the whānau would like to start the consultation.
- Ask if there are any communication needs such as visual tools, breaks, fidget toys, change in lighting or a need to move around.
- Reassure and acknowledge that the young person is the expert on themselves. Explain that the health team is there to provide support and evidence-based information, and to help everyone understand the necessary information to make a fully informed decision as part of the consent process.
- Acknowledge the whānau's presence and their prior experience in supporting their child. Emphasise how important their support and care for their child is.
- Explain that health information (clinical notes) is shared within the health team and with their general practice.
- Discuss confidentiality and the limitations and exceptions to this.

Goals and history

- Establish the young person's and whānau's goals for the appointment.
- Explore gender history and experiences – the young person's awareness of gender diversity, whānau's awareness, and experiences to date.
- Ask about gender euphoria and/or dysphoria – what helps and what is challenging or distressing.
- Establish gender embodiment goals – acknowledge these may change over time.
- Take a medical and medication history, including any allergies. If considering puberty blockers, ask about previous fractures. Ask about needle phobia.
- Take a family history including risk of venous thromboembolism (VTE), osteoporosis, dyslipidaemia and sex hormone dependent cancers, e.g. breast cancer.
- Consider asking the young person or whānau if they have considered themselves to be neurodivergent. Provide information on self-understanding and management of neurodivergence if desired. Consider how this may impact on gender affirming healthcare, e.g. testosterone may result in different sensory experiences such as facial hair and clitoral growth.
- Developmental history – explore and screen for a history of neurodivergent traits and sensory sensitivities. If neurodivergent traits appear to be impacting on the young person's functioning, communication and/or distress, then consider if a formal diagnostic assessment and/or access to specialist support is needed alongside the young person's gender affirming healthcare.

Psychosocial assessment

- Use a youth appropriate assessment framework (such as the HEeADSSS psychosocial assessment)[128] to explore the impact of gender diversity across the domains in the HEeADSSS assessment such as home, education, employment, eating, activities, drugs and alcohol, depression and suicide, sexuality, and safety. Maintain a strong focus on support and resilience factors.
- Include a mental health screen – mood, self-harm, suicidal ideation, anxiety, disordered eating, bullying, drugs and alcohol, supports and safety. Find out if they are accessing mental health supports or services.

Physical examination

- Physical assessment – height, weight and blood pressure.
- Other physical examination when clinically indicated and with consent. This requires a careful explanation of what the examination involves and why it is needed. Allow a choice of who is present to provide support during an examination.

Health education and providing information

- Check whānau understanding and offer information about support. Include whānau peer connection opportunities.
- Discuss options and information around medical care if desired, e.g. menses cessation, puberty blockers, hormones.
- Discuss fertility preservation information (see **fertility** chapter).
- Provide written and/or online information.
- Explain what to expect in follow-up appointments, e.g. blood tests.
- Discuss and connect to mental health or counselling supports if needed.
- Discuss peer and school supports.

16.3.G Practice points

- For those accessing puberty blockers at an age prior to having Gillick competency, obtain parent/guardian informed consent alongside the child's assent.
- Use a youth appropriate assessment framework (such as the HEeADSSS psychosocial assessment: Home, Education, Employment, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality, Safety) to assess the young person's risk and resilience.
- Provide care in the context of strengths based, holistic care that is focused on more than just a person's sense of gender.
- Support young people to connect with supportive peer groups, including online groups.
- Counselling, primary mental health interventions, peer support and online apps can be useful in supporting development of skills for navigating emotions, nurturing resilience and dealing with distress.
- Consider additional support needed for neurodivergent young people.
- Where possible, find opportunities to speak with the young person by themselves. As with many other healthcare topics, some young people may be more comfortable discussing their experiences and needs without parents or caregivers being present.

16.3.H Puberty suppression using GnRH agonists

'Puberty blockers have meant we can slow down, and not rush into major changes. It's given my child time to get psychological assistance … It's provided him with mental stability, and there's nothing more important than that' – parent[68]

Puberty blockers are gonadotrophic releasing hormone (GnRH) agonists. They work by initially stimulating the hypothalamic-pituitary-gonadal (HPG) axis before switching it off. They halt the development of secondary sexual characteristics, such as breast growth or voice deepening, and can relieve distress associated with these bodily changes for transgender young people.[117, 121, 132, 133]

'Puberty blockers for my child was not about biding time, but ensuring irreversible puberty changes did not occur. Having gender dysphoria from preschool age it was essentially life-saving that she had access to the medicine she needed to prevent the dysphoria getting worse. She said: If I didn't have access to blockers, I wouldn't have made it' – parent[68]

Puberty blockers are considered to be largely reversible and have the benefit of allowing the young person time before making any decisions regarding starting on gender affirming hormone therapy (GAHT).[134] There is no good evidence to suggest that blockers impact negatively on cognitive and emotional development.[135, 136]

'Access to blockers early on in puberty allowed my son to focus on areas other than gender dysphoria in his life – things like getting an education, job, being a positive human being. He is a young adult who thrives and is succeeding in studying to be a social worker. He will make a strong contribution to New Zealand in future' – parent[68]

Criteria for puberty blockers

'Puberty blockers [have] given me the opportunity to be with my thoughts, rather than the terrifying (to me) onslaught of puberty. It had given me time to think about my future, and what that might look like for me' – young person[49]

The WPATH SOC8 provides internationally recognised standards and criteria for puberty blocking agents.[2]

WPATH SOC8 criteria for puberty blocking agents:

1. Gender diversity/incongruence is marked and sustained over time.
2. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care.
3. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
4. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
5. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.
6. Reached Tanner stage 2.

Puberty blockers can be prescribed from Tanner stage 2 to suppress the development of secondary sex characteristics. No medical interventions are indicated prior to this.

Puberty blockers alone are not thought to impact on long-term fertility;[137] however, some young people progress onto GAHT, which can have an impact on fertility. For this reason, future fertility considerations should be discussed with the whānau, and in a developmentally appropriate way with the child, before starting puberty blockers. See the **fertility** chapter for a discussion on fertility impact and preservation.

Identifying puberty/sexual maturity rating

The Tanner scale (see **Appendix A**) is a tool to determine pubertal stage. Some young people cannot tolerate an examination to assess Tanner staging due to gender dysphoria. In this case blood tests are useful to confirm the onset of puberty. Early morning LH >0.3 IU/L determines that biochemical puberty has started[138] but it may be months to years before physical changes start to occur. Indicators that show evolving puberty include growth velocity acceleration (>6cm/yr is suggestive), bone age > 12 years for those assigned male at birth or > 11 years for assigned females, and measurable daytime levels of testosterone or oestrogen.[139-141]

Self-report of Tanner staging using diagrams may be helpful for older adolescents in later puberty, but correlation is variable.[142] Physical examination of genitalia should only be done when it is deemed absolutely necessary to aid clinical care (e.g. informing decisions around when to start the puberty blocker, or to guide potential fertility preservation options) and then only with explicit consent.

For those assigned female at birth (AFAB), the first change that may be noticed by the young person is the development of breast/chest buds. For those assigned male at birth (AMAB) it is the increasing size of genitalia (penis/testes). Young people and parents can be informed of this, to empower them to inform their healthcare team if this has started, which may prompt a blood test for confirmation.

Puberty blockers for those assigned male at birth

For prepubertal young people AMAB who are moving into puberty, decision making around the optimal timing to start a puberty blocker is challenging. The goal is usually to prevent any unwanted testosterone-induced changes.

> Weighing up when to start a puberty blocker is an individualised decision for the health professional, young person and whānau to discuss.

Some young people feel distressed about the risk of any testosterone-related changes and feel more comfortable starting puberty blockers early, i.e. testicular volume 4 mls (Tanner stage 2) and/or early morning LH rise indicating biochemical puberty onset.

Waiting until Tanner stage 2–3 (testicular volume 6–8 ml) may allow for a shorter period off medication if sperm cryopreservation is desired in future. This would allow for more development of the scrotum and penis, which may also be helpful if gender affirming genital surgery is desired in the future.

However, significant penis growth is generally needed for penile inversion vaginoplasty,[143] which is unlikely to occur without experiencing other unwanted changes of puberty.

This potential benefit for future sperm cryopreservation needs to be balanced with the risk that some testosterone-induced physical changes may occur in this time. Decisions should take into consideration the distress level of the young person, who will require careful monitoring for physical changes. Sperm for fertility preservation can be found from Tanner stage 3 (testicular volume ≥10 ml)[144] and occasionally young people can get to this stage without much in the way of unwanted physical changes, but for others this will not be possible. Occasionally young people will tolerate some physical changes to prioritise fertility preservation. See **fertility** chapter in the Tapu section for further detail.

Based on knowledge from the treatment of prostate cancer in cisgender people, an initial testosterone rise following administration of goserelin may occur.[145] This may result in pubertal advancement. Puberty blockers may take 6–9 months for full effect and may require a change in dose if there is inadequate suppression at this stage.

Puberty blockers may still be a useful intervention for those AMAB presenting later than Tanner stage 2–3. While being taken they prevent ongoing irreversible masculinisation of the body and face that continues into the early 20s.[75] They may also be a necessary or preferred anti-androgen option for some adults.

Puberty blockers for those assigned female at birth

In those AFAB, puberty blockers can be prescribed from Tanner stage 2, which is the first signs of breast bud development. Early morning LH levels are advised to confirm pubertal onset and are occasionally needed to distinguish pubertal development from pseudogynecomastia, or if an examination is not possible due to gender dysphoria.

> Puberty blockers are most helpful if they are started prior to the onset of menses.

By this time significant breast development has usually occurred and the benefits of puberty blockers often do not outweigh the possible risks (i.e. hot flushes and a potential impact on long-term bone health). Usually at this later stage of puberty, menses cessation is what is most desired, and whilst puberty blockers are effective in this action, there are alternative well-established menses cessation options available. See the **adult gender affirming hormone therapy** chapter for a discussion of menses cessation options.

Puberty blockers may be considered beyond onset of menses if Tanner staging and family history suggest further breast development is likely, or if there is a significant thromboembolic risk with hormonal options for menses management.

Impact of puberty blockers on height

If puberty blockers are started prior to growth plate closure, final adult height may be taller than predicted mean parental height. This is due to the delay in growth plate closure and overall longer period of growth whilst on the blocker without sex hormones.[146] Therefore, regular monitoring of height is recommended. Height velocity commonly slows while on a puberty blocker and increases (a growth spurt) when hormones are commenced.[147, 148] Monitoring height velocity can be useful to help monitor pubertal suppression.

> Prior to starting a puberty blocker, a bone age (left wrist x-ray) may be helpful to establish if growth plates are still open.

Growth plates are commonly fused by 14 years of age in cisgender females and 16 years in cisgender males. Assessing if growth plates have fused may be important when considering timing and rate of hormonal induction, as this may also impact on final height. Monitoring bone age annually can be helpful to monitor pubertal advancement and the effectiveness of the puberty blocker.

People who are assigned female at birth who started puberty blockers prior to growth plate closure may seek to delay T-GAHT and consider a slow testosterone induction to promote maximal growth/height potential. Those AMAB considering E-GAHT may consider earlier hormone initiation and a faster induction to fuse growth plates with the aim of closing growth plates more quickly, to reduce adult height potential.[146, 149]

Although there is a need to balance this with the potential benefit of a low starting dose with incremental increases in oestrogen dose, this approach aims to mimic cisgender puberty, and is the standard protocol used for pubertal induction in the context of hypogonadism.[150]

Puberty blockers – bone density and bone health

In the Dutch Protocol, where early research on puberty blockers emerged, young people were on puberty blockers alone for four years, i.e. age 12–16 years.[151] If hormone therapy is started by age 16 years (for those who wish to start GAHT) this is likely to have the least impact on longer-term bone health. Staying on puberty blockers for prolonged periods (without hormone therapy) beyond the age of 16 years may have greater impact on long-term bone density, so the benefits and risks in this scenario need to be carefully considered. There may be situations where an older adolescent has not been on a puberty blocker for long, when it may be appropriate to remain on a puberty blocker alone beyond the age of 16 years, to allow more time for decision making around next steps.

Adolescence is an important time for bone density accumulation. Studies have shown a lack of bone accrual and may suggest a slight reduction in bone density when an adolescent is on a puberty blocker; however, this does not typically increase fracture risk during adolescence.[152-154] Studies have shown that bone density improves once an individual is on GAHT, with one study showing that gender diverse AFAB young people's bone density catches up to that of peers by three years on T-GAHT.[152]

For gender diverse AMAB young people, bone density is often lower than their cisgender peers prior to starting puberty blockers, suggesting other risk factors may be important in this group.[155, 156] Bone density appears to take longer to improve on E-GAHT compared to people on T-GAHT, and may remain lower than in their cisgender peers.[152, 157, 158] Transgender people who remain on E-GAHT lifelong will not experience the same reduction in bone density in their older years as cisgender women do at menopause.[152]

Bone density (DEXA) scans can be considered when clinically indicated, for example, when considering the length of time someone is on a blocker, or if there are additional risk factors for low bone density. Additional risk factors include very low BMI, anorexia nervosa, poor nutrition, low physical activity, gastrointestinal disorders such as coeliac disease and avoidant/ restrictive food intake disorder (ARFID). If there is an extended time on a puberty blocker (i.e. > 4 years), particularly if extending treatment beyond age 16 years, a DEXA scan may be indicated.

To optimise bone health in young people on puberty blockers it is considered good practice to discuss the role of weight-bearing exercise in improving bone density, consider regular vitamin D supplements (50,000 units monthly) if there is a risk of deficiency and recommend good dietary calcium intake (500–1000 mg daily).

Practice points

- For those who need them, puberty blockers (GnRH agonists) can have a positive impact on current and future wellbeing. Be mindful of the need to refer promptly and be aware of local referral pathways.
- It is essential to have a discussion regarding fertility before starting puberty blockers and again if continuing onto GAHT (see **fertility** chapter).
- It is recommended that initiation of puberty blockers is undertaken with whānau support and multidisciplinary team agreement.
- Puberty blockers can be initiated from Tanner stage 2–3. There are no medical interventions needed before this time.
- There are different considerations regarding puberty blockers for people presenting later than Tanner stage 2–3.
  - Alternatives to puberty blockers should be considered for young people AFAB presenting after menses has started.
  - Puberty blockers are a good option for those AMAB who are further through puberty, given that masculinising changes continue into their 20s. Oral anti-androgens may be considered as an alternative option in older adolescents (> 16 years old). Risks and benefits of the different options should be discussed.
- Puberty blockers are likely to affect final height if they are started prior to growth plate closure and this may influence the timing of starting GAHT.
- Bone density accrual is likely to be impacted while on puberty blockers (without sex hormones) and information about maintaining good bone health should occur prior to starting blockers.

Prescribing puberty blockers

Currently in Aotearoa New Zealand, goserelin SC implants have sole subsidy status, although leuprorelin IM injections continue to be fully funded for children and adolescents who are unable to tolerate administration of goserelin (when the prescription is endorsed accordingly).

Once started, puberty blockers should be continued until a decision is made regarding further treatment options.[2] This may include commencing GAHT, or if ongoing gender affirming healthcare is not desired, coming off puberty blockers to allow puberty to resume. Puberty blockers alone (without the addition of hormone therapy) should usually not be continued beyond 18 years of age.

Puberty blockers may take six to nine months to have their full effect. If oestrogen/ testosterone levels are suppressed prior to the next administration of a puberty blocker, this usually indicates adequate pubertal suppression, however if there is clinical concern that puberty is not adequately supressed (based on progression of Tanner stages, height velocity remaining elevated, bone age advancement), changing the dose or frequency may be required.

See appendices for puberty blocker consent forms.

Recommended investigations and suggested monitoring for GnRH agonists

Stage	Examination	Investigations
Baseline prior to suppression of puberty **Early morning LH/FSH, testosterone or oestradiol levels are usually recommended.**	Blood pressure Weight Height BMI Tanner stage[a]	FBC Electrolytes Creatinine LFT Lipids Hba1c LHb FSH Oestradiol and testosterone[b]
Other considerations	In younger adolescents consider annual x-ray of left hand and wrist for bone age, to assess if growth plates are closed and as a marker for good pubertal suppression. Consider Vitamin D levels or treat if there are risk factors for Vitamin D deficiency.	
General review 6 months after starting GnRH agonist. **Bloods taken 1–3 days prior to 3rd dose of puberty blocker.** Early morning LH/FSH, testosterone or oestradiol levels are usually recommended.	Blood pressure Weight Height BMI See below for information to cover during the consultation. Note – axillary and pubic hair will progress as these are adrenal androgen dependent.	FBC LFT Electrolytes Creatinine Lipids HbA1c LH FSH Oestradiol[b,c] or testosterone[b,c]
At 12 months and annually whilst on a GnRH agonist. Bloods taken 1–3 days pre-puberty blocker. Early morning LH/FSH, testosterone or oestradiol levels are usually recommended.	Review puberty blocker effect and side effects as per the box below.	FBC LFT Electrolytes Creatinine Lipids HbA1c LH FSH Oestradiol[b,c] or testosterone[b,c]

[a] Physical review of Tanner staging may not always be possible and should only be done with explicit consent. Self-reported Tanner stage may be helpful if examination is not possible. See the **appendices**.

[b] Early morning LH/FSH, testosterone or oestradiol levels are usually recommended.

[c] Aim for oestradiol <50 pmol/L and testosterone <2 nmol/L – this means the testosterone or oestradiol level is suppressed prior to the puberty blocker being given but does not necessarily mean full suppression. One hour post puberty blocker LH (aim for <2–5 IU/L) has been thought to be useful in assessing full HPG axis suppression, 159 but is not a standard recommendation in most guidelines.

Additional reviews may be required if there are concerns about inadequate pubertal suppression or side effects.

Information to cover at review appointments
– Document any positive impact of the puberty blocker – has the puberty blocker been helpful, and if so, in what way? – Document any unwanted effects or side effects, e.g. hot flushes, fatigue. – Ask about any pubertal progression – most young people prefer to self-report any changes, but some may be reassured by a physical examination to review Tanner staging/pubertal progression. Only examine genitalia if clinically indicated and with full consent. – Do they have any concerns they wish to discuss? – Do they want to stay on the puberty blocker?

GnRH medication dosing (given at or after Tanner stage 2)

Medication	Usual dose
Leuprorelin*	11.25 mg 10–12 IM weekly.
or	
Goserelin	10.8 mg SC implant insertion into lower abdomen every 10–12 weeks.

* Endorse leuprorelin prescription 'unable to tolerate goserelin' and 'only to be given by a health professional'.

If someone is not suppressed adequately, consider changing the frequency of the dose, e.g. leuprorelin 11.25 mg to 10 weekly or leuprorelin dosing to 22.5 mg IM 12 weekly or trialling 10.8 mg subcutaneous goserelin 10–12 weekly. For some people goserelin can be more effective. If 22.5 mg of leuprorelin is required, this can be prepared individually as two doses and then mixed in one syringe for administration. If there are ongoing issues with a painful local reaction with leuporelin, consider changing to goserelin as it may be less painful and better tolerated.

16.3.1 Gender affirming hormone therapy (GAHT) for young people

This sub-chapter refers to gender affirming hormone therapy (GAHT) prescribing for people **under the age of 18 years**. Use the **adult gender affirming hormone therapy** chapter for those over 18 years of age. The adult chapter contains important information about GAHT which should be read alongside this section.

Approach and supported decision making

The guidance in the **assessing young people for gender affirming medical care** sub-section of this chapter outlines the points to cover in an assessment of adolescents for gender affirming medical care.

> These guidelines recommend an MDT approach which includes medical and mental health professionals who have knowledge and experience in young people's development and gender affirming healthcare.

It is important to take time for this supported decision making, due to the irreversible effects which come with taking GAHT. Capacity, maturity in decision making and whānau (or other adult) support should all be taken into consideration.

> Prior to starting GAHT discuss physical effects and the timing of these changes, permanency of these effects, side effects and risks, impact on fertility, and fertility preservation options.

Information on these topics is found in the **adult gender affirming hormone therapy** chapter, **fertility** chapter, and in the consent forms in the **appendices**.

Suggested points to encourage young people to think about and discuss as part of their decision making for medical care:

- In what ways do you think hormone therapy will help you in your life (this may include changes in your body and/or changes in how other people perceive you). Are there any downsides to taking hormones for you, or any changes you do not want?
- Sometimes other factors can amplify feelings of gender dysphoria and influence decision making about hormones. Think about whether this may be the case for you and how this may affect your decisions, ways your body may be feeling, how you will cope with changes, the best way to understand information. Think about whether the hormones will give you the changes you are seeking to feel better.
- Consider all the non-medical options available to support gender embodiment goals. Not everyone who is transgender needs or wants medical affirmation. See **non-medical and non-surgical gender affirmation** chapter for more details.
- Think about what supports you have in place. There are likely to be challenges along the way, and good support is important. How does your whānau feel about this?
- Are you in a good place physically and mentally to cope with change and stress? What coping skills do you have? Do you need more support before starting hormones?
- Are your expectations for the effects of hormones and the time frame for changes realistic? What do you understand about the changes that will happen and what will not change?
- Do you understand which effects are permanent (i.e. will not change even if you come off hormones in the future)?
- Could starting hormones impact on your safety, living situation, relationships, schooling or finances?
- Have you thought about the possibility of wanting to stop hormones in the future? People stop hormones for all sorts of reasons, including not liking the effects, not feeling they have resulted in enough effects, feeling like you have had all the changes you want, whānau pressure and difficulty accessing care, and sometimes people change their mind and regret their decision. Have you read about or met anyone who has experienced this?
- Is anything else impacting decision making that you may wish to discuss?
- Take the time you need to make this decision, so that you can look back and feel that you had the time and information you needed. No-one can predict how you will feel in the future but thinking about things carefully and ensuring you have good support is important.

WPATH SOC8 recommended criteria for hormonal treatments for adolescents

A. Gender diversity/incongruence is marked and sustained over time.
B. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care.
C. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
D. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
E. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.
F. Reached Tanner stage 2.

Refer to the **fertility** chapter for details of fertility considerations.

Parent/guardian support

For individuals under 18 years of age who want to start GAHT, parent/guardian or caregiver support is recommended.

Taking the time to assist the whānau is strongly advised, even if it extends the process, as the benefits of parental support are widely acknowledged.[71]

Prioritise the safety of the young person, recognising that it may not always be possible to attempt to engage with and include whānau members.

Some young people may be living independently of their whānau and in this case, it is considered best practice to explore other avenues of support, such as other trustworthy adults who can support the young person, if their parents are not supportive.

Support young people to talk to their whānau before starting GAHT (if this is safe for them to do), and to take time for their support people to come on board.

There are many considerations to take when a young person does not have whānau support. Potential outcomes of them starting GAHT, such as the risk of losing housing, financial support and whānau relationships, should be considered.

Most young people are financially reliant on their whānau and identifying potential financial support options in case of whānau estrangement is essential. Understanding the time frame for the visibility of hormone effects, particularly distinguishing between the effects of oestrogen and testosterone, is important. For example, the physical effects of testosterone are apparent to others much sooner and in a more apparent way than those of oestrogen. These are important discussions to have prior to consideration of starting GAHT.

If an adolescent is starting GAHT without whānau support, a clear safety plan is needed to ensure they have the necessary resources and systems in place, in case the young person needs to leave the whānau home. For many health professionals this may mean that, in discussion with the young person, they choose not to start hormones until later.

Oestrogen based gender affirming hormone therapy (E-GAHT) for young people

Introduction

See the **adult gender affirming hormone therapy** chapter for full information to support E-GAHT prescribing including effects, risks and side effects. See **appendices** for consent form.

Ensure young people have up-to-date information to ensure realistic expectations and to support the consent process.

E-GAHT consists of oestradiol and an anti-androgen.

This sub-chapter outlines the different dosing recommendations for adolescents under the age of 18 years, which aim to mimic puberty, and differ from adult hormone initiation protocols.

There is limited research around outcomes of pubertal induction in relation to different hormone formulations, optimal starting doses, and rate of dose increase for transgender young people. Regimens have traditionally been based on those developed for hypogonadal young people.

Examinations and investigations for adolescents < 18 years starting and continuing on E-GAHT

Stage	Examination	Investigations
Baseline (prior to starting E-GAHT)	BP Height Weight BMI Tanner stage (consider whether an examination is necessary or whether self-report is sufficient)	FBC Electrolytes LFT Lipids HbA1c LH FSH Testosterone Oestradiol For fertility preservation ensure that Hepatitis B, HIV and Syphilis screening is completed prior to referral for sperm storage. Consider: bone age (x-ray left wrist) if questioning whether growth plates are open or to monitor pubertal suppression.
6 monthly after starting oestradiol or after a change in oestradiol dose	If headaches or migraines develop, consider changing to oestradiol patches. BP Height and weight	FBC Electrolytes LFT Lipids HbA1c Oestradiol Testosterone LH/FSH
12 monthly once on a stable oestradiol dose	As above	FBC Electrolytes LFT Lipids HbA1c Oestradiol Testosterone LH/FSH

For those on cyproterone or spironolactone as an anti-androgen – see **adult gender affirming hormone therapy** chapter for monitoring advice.

See box on page 82 for further detail of what to cover in each review appointment.

Aim for a well suppressed testosterone level in the cisgender female range and oestradiol levels within cisgender female range (below 750 pmol/L).[134] Oestradiol levels are used mainly to ensure levels are not supraphysiological, as they are very variable and not indicative of hormonal effects. It is important to explain this to the person you are prescribing for, otherwise people can feel that higher levels need to be reached.

Oestradiol

Suggested oestradiol regimens for commencing E-GAHT in adolescence

	Oral oestradiol valerate	**Transdermal oestradiol patch** Apply new patch (or portion of a patch) every 3.5 days.
Step 1 **Starting dose for those on puberty blockers started at Tanner stage 2–4.** Increase oestradiol dose 6 monthly and continue GnRH agonist.	0.5 mg daily (or 5 mcg/kg/day)* Hard to cut into smaller doses. Lower doses are best achieved with patches.	12.5 mcg/24 hours Patches can be cut to achieve desired dose.
Step 2 **Start here if post pubertal (or if puberty blocker was started post puberty).** Start a GnRH agonist or oral anti-androgen. Increase oestrogen dose at around 6 months.	1 mg daily (or 10 mcg/kg/day)*	25 mcg/24 hours
Increase at around 6 months.	2 mg daily (or 15 mcg/kg/day)*	25–50 mcg /24hrs hours
Increase at around 6 months (if needed – for some people, remaining on a lower dose of oestrogen, alongside a GnRH agonist, will be sufficient)	3 mg daily (consider splitting the dose if possible, i.e. 2 mg mane and 1 mg nocte to maintain steady levels). (or 20 mcg/kg/day)*	50–75 mcg/24 hours
Common maintenance dose Aim for lowest dose with good effect	2–4 mg/day (consider splitting dose once >2 mg if possible, i.e. 2 mg BD, although OD dosing is more practical)	100–150 mcg/24 hours Dosing of >100 mcg/24hrs can be obtained by cutting patches and giving more frequent scripts.

* Endocrine society guideline suggested dose for those blocked in early puberty.

Oestradiol dosing – further notes

Commonly GAHT regimes for adolescents start at lower doses, gradually increasing the dose every six months over a two- to three-year period, until adult dosing is reached, to best mimic pubertal progression:

- Aim to use the smallest dose of oestradiol that gives a good effect.
- Increasing the oestradiol dose slowly is theoretically suggested to achieve optimal breast development (based on protocols for treating hypogonadal cisgender children).[150]
- A faster increase in oestradiol dosing (e.g. four monthly) can be considered in older adolescents, if there are concerns about final height and growth plates that have not yet fused, or if there are significant side effects related to testosterone suppression (e.g. hot flushes, fatigue) or risk factors for osteoporosis.
- Higher hormone levels are associated with quicker growth plate closure.

Experience suggests that high oestradiol doses or higher oestradiol levels do not necessarily equate to more feminisation. Health professionals should ensure standard dosing is used so as not to increase risks with no added benefits.

Transdermal oestradiol patches can be cut, which allows for lower, more gradual oestradiol increases. Transdermal oestradiol is considered the safest option with no (or very low) venous thromboembolism (VTE) risk. A transdermal oestradiol 25 mcg/24 hours patch is thought to be equivalent to or a slightly lower dose than oestradiol valerate 1 mg.

Anti-androgen use

See **adult gender affirming hormone therapy** chapter for oral anti-androgen dosing.

Which anti-androgen to prescribe

An anti-androgen needs to be given alongside oestrogen.

Puberty blockers can be continued as the anti-androgen choice alongside oestradiol treatment, but it is important that injections are given on time to ensure ongoing effect:

- If leuprorelin 11.25 mg is not sufficient to suppress the HPG axis, consider switching to goserelin rather than increasing the dose of leuprorelin. Goserelin can be continued long term (including in adulthood) as an anti-androgen, or later changed to an oral anti-androgen.
- Those on leuproprelin who choose to remain on this as their anti-androgen will need to change to goserelin in late adolescence, as it is only subsidised for adolescents.

Some young people may prefer to change to an oral anti-androgen and should be counselled around the side effects and risks of available options (cyproterone and spironolactone) when making this decision.

Inform young people on E-GAHT about the importance of taking an anti-androgen consistently alongside their oestradiol therapy, given the changes that will occur if they do not have effective ongoing androgen suppression to ensure HPG axis suppression.

Whilst there is no evidence to suggest either oral anti-androgen has significant benefits over the other when used for adults, this may not be the case for adolescents where good androgen suppression is needed to prevent further masculinisation that continues into the 20s.

Oral anti-androgens

Cyproterone may be beneficial if there are adherence issues, as there will be less impact on testosterone levels if doses are missed. Testosterone levels can be measured to ensure effective testosterone suppression, which may be reassuring to some young people. Cyproterone is associated with a risk of benign meningioma which increases as the cumulative dose rises. This has been found at daily doses of 25 mg per day and above.[160, 161] It is not known whether long-term use of low doses carries this same risk. For this reason, cyproterone may not be the best option for very long-term use i.e. > 5 years, in someone not planning to have an orchiectomy. Other potential side effects and risks include VTE, depression, weight gain, fatigue and breathlessness.[162] Hepatotoxicity has been reported with very high doses.

If someone has commenced on cyproterone, continue to discuss risks, review evidence, and use the lowest effective dose.

Spironolactone is considered potentially safer than cyproterone with regards to its side effect profile. It must be taken daily for good effect, so may not be as effective as other anti-androgens for adolescents, if adherence is not good. It is not clinically useful to monitor testosterone levels, as it works by blocking the effect of testosterone at the tissues, rather than blocking its release. Potential risks and side effects include hyperkalaemia, gastrointestinal side effects, hepatotoxicity, lethargy, hypotension and urinary frequency.[162]

If an individual ends up having an orchiectomy as an adult, puberty blockers/anti-androgens can be stopped.

Information to cover at E-GAHT review appointments for young people

- Ask about the positive effects and side effects prior to each dose increase.
- Discuss with the person their wish to continue GAHT and inform them that hormones can be paused or stopped at any time.
- Continue to ask about and support broader adolescent health considerations, such as sexual health and contraceptive needs. This can be an opportunity to screen for STIs if indicated.
- Discuss the importance of attending routine future screening, e.g. breast, noting that routine reminders may not occur if their gender has been changed on medical records.

Testosterone based gender affirming hormone therapy (T-GAHT) for young people

'I am much more comfortable in my body. every change that happens feels like something I chose for myself. I love my acne, my weight gain, my voice cracks, my coarse hair, because they are all part of my trans pride. People tell me I seem happier, brighter, more at ease, more myself. I feel more happy and safe in my own skin every day and my mental health is consistently more positive than its ever been even though I still have a ways to go' – transgender young person[49]

Introduction

See **adult gender affirming hormone therapy** chapter for information to support T-GAHT prescribing including effects, risks and side effects.

See also the **appendices** for information presented in a consent form. Ensure young people have up-to-date information to ensure realistic expectations and to support the consent process.

This sub-chapter outlines the different dosing recommendations for young people under the age of 18 years, which aim to mimic puberty, and differ from adult hormone initiation protocols.

There is limited research around outcomes of pubertal induction in relation to different hormone formulations, optimal starting doses, and rate of dose increase for transgender young people. Regimens have traditionally been based on those developed for hypogonadal young people.

Examinations and investigations for adolescents commencing or already on T-GAHT

Stage	Examination	Investigations
Baseline (prior to starting T-GAHT)	BP Height Weight BMI	FBC Electrolytes Creatinine LFT Lipids HbA1c Oestradiol Testosterone* LH/FSH
6 months after starting T-GAHT or before a change in dose	BP Height and Weight	FBC LFT Testosterone*
6–12 monthly once on a stable testosterone dose	As above	FBC Electrolytes LFT Lipids HbA1c Testosterone* LH

* The time of day the blood test is taken is not relevant (i.e. a morning blood test is not needed). Instead, timing should be based on the testosterone formulation: for Sustanon and Depo-testosterone (both IM and SC) this is measured mid-way between doses (this gives an average level, noting that the peak is 1–2 days after administration). For Reandron measure a trough level, just before injection is due. For Testogel measure in the morning prior to applying the dose or 4–6 hours after applying, but from the opposite arm as topical testosterone at the site of venepuncture can result in a falsely elevated level.

Note: norethisterone can falsely elevate testosterone levels.

See box on page 81 for recommendations of what to discuss during review appointments.

T-GAHT prescribing

Dosing regimens for those who have been on puberty blockers prior to menses onset (Tanner stage 2–4) are based on a gradual increase of testosterone every six months to mimic puberty.

> *AFAB individuals who have been on a puberty blocker prior to menses onset should remain on puberty blockers whilst the testosterone dose is increased up to a maintenance dose and testosterone levels are consistently in the usual male adult range, for at least 6–12 months.*

This is necessary to ensure HPG axis suppression to prevent further breast or other pubertal development and to support ongoing amenorrhoea. It is important to ensure testosterone injections are given on time.

If puberty blockers are only being used for menses cessation, the puberty blocker can usually be stopped earlier, i.e. after six months of testosterone and having reached near to full maintenance dosing.

There is no evidence around the best dosing regimens to achieve maximal height for those commencing testosterone prior to fusion of growth plates.

The dosing tables that follow discuss Sustanon and Depo-testosterone but other formulations of testosterone also exist – please see the 'Testosterone Formulations' text that immediately follows the dosing tables for relevant information.

T-GAHT pubertal induction for those blocked prior to menses onset or on puberty blockers (based on Endocrine society guidelines)[134]

	Sustanon 250 mg/ml IM 3 weekly	Depo-testosterone (testosterone cypionate) 1 g/10 ml IM 2 weekly
Starting dose	0.125 mls/m2	25 mg/m2
After 6 months	0.25 mls/m2	50 mg/m2
Next increase	0.375 mls/m2	75 mg/m2
Next increase	0.5 mls/m2	100 mg/m2
Common adult maintenance dose	0.75–1 ml	100–200 mg

T-GAHT initiation for adolescents who have not been on puberty blockers (Tanner stage 4–5)

	Sustanon* 250 mg/ml IM 3 weekly	Depo-testosterone* (testosterone cypionate) 1 g/10 ml IM 2 weekly
Starting dose	0.25 mls	25–50 mg
Increase at 3–6 months	0.5 mls	50–100 mg
Increase at 3–6 months (if needed)	0.75 mls	100–150 mg
Increase at 3–6 months (if needed)	1 ml	150–200 mg
Common adult maintenance dose	0.75–1 ml	100–200 mg

* Depo-testosterone and Sustanon can both be self-injected.

Some people report symptoms related to a drop in testosterone levels at the end of dosing, so dosing may need to be a little more frequent (but within the recommended 2–4-weekly dosing interval), which is likely to be easier if someone is self-injecting.

There is no target dose of testosterone to administer, even for those who wish to be on a 'standard/full' dose. Instead, dosing is based on an individual's preferences, the changes they are experiencing, any adverse effects (e.g. a dose reduction may be required if haematocrit is raised), and to maintain testosterone levels in the physiological male range.

Some young people may wish to start at even lower doses and increase more gradually. Some people prefer to stay on a low dose. Testosterone dosing is discussed further in the adult gender affirming hormone therapy chapter, including in its testosterone based gender affirming hormone therapy (T-GAHT) sub-chapter, and its non-standard gender affirming hormone therapy regimens sub-chapter.

Testosterone formulations

Depo-testosterone (testosterone cypionate)

Can be given weekly intramuscularly (IM) at half of the recommended standard doses. It can also be given subcutaneously (SC) usually at a dose of 50 mg weekly. The SC route uses a smaller needle, so may be preferred by some. There is little research regarding the use of SC testosterone (as opposed to IM testosterone) for gender affirming healthcare,[163] but it is widely used this way. Depo-testosterone comes in reusable vials which can be re-accessed for a 28-day period.

Sustanon

Contains arachis oil and should be potentially avoided in those with peanut allergies. If there is a peanut allergy or a local reaction with Sustanon, consider using alternatives, e.g. Depo-testosterone.

Testosterone gel (testogel 1.62%)

May be a useful option for people who are needle phobic or who prefer a topical option. See **adult gender affirming hormone therapy** chapter for more details, and the Australian standards of care for dosing recommendations for pubertal induction.[75] Note: the strength of gel is higher in Aotearoa New Zealand (1.62%) than in Australia – i.e. 1 pump = 20.25 mg of testosterone, therefore lower dosing may be harder to achieve.

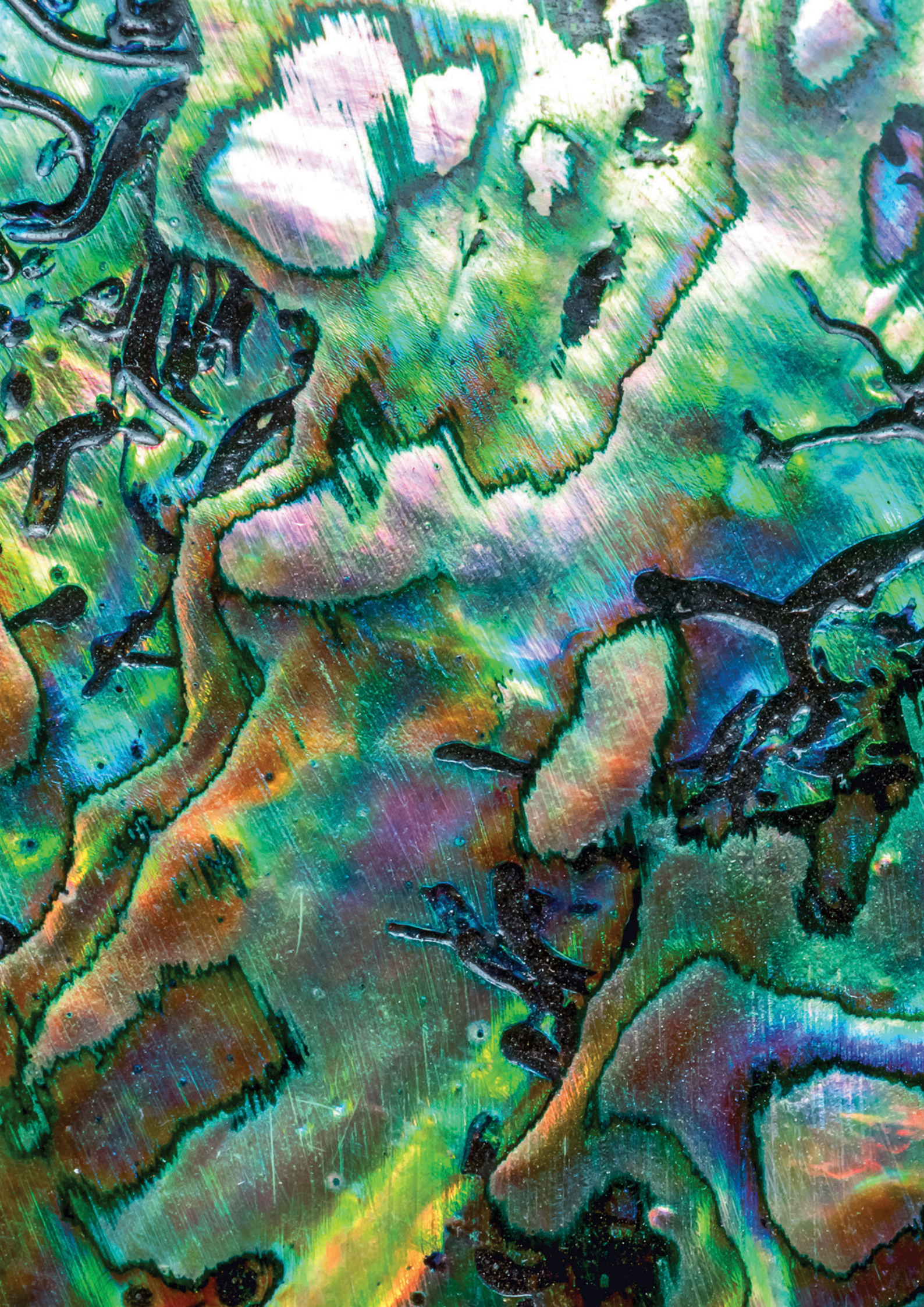
Reandron

Has a long half-life and is usually used once young people are used to the effects of testosterone, i.e. they have reached the adult maintenance dose of Sustanon or Depo-testosterone and are happy with the effects. The usual dosing for Reandron (1 g/4 ml) is 1000 mg every 12 weeks, with a dose range of 750–1000 mg, 10–14 weekly. Reandron must be given by a health professional, with oxygen available on site, due to the rare risk of a pulmonary oil microembolism.[164] It is advised to give it slowly over 3–5 minutes to reduce pain (your patient can guide you as to what feels most comfortable). The second injection is given 6 weeks after first to achieve steady state testosterone levels more quickly, then 10–14 weekly thereafter, based on testosterone levels. If reducing the dose, use 500–750 mg every 10–14 weeks.

T-GAHT review appointments

Information to cover at T-GAHT review appointments for young people

- Ask about any positive effects and side effects prior to each dose increase.
- Discuss with the person their wish to continue GAHT and inform them that hormones can be paused or stopped at any time.
- Continue to ask about and support broader adolescent health considerations, such as sexual health and contraceptive needs. This can be an opportunity to screen for STIs if indicated.
- Discuss the importance of attending routine future screening, e.g. breast and cervical, noting that routine reminders may not occur if their gender has been changed on medical records.



17. Adult gender affirming hormone therapy (GAHT)

'Gender affirming hormones are life changing. They have changed how I think, how I feel, and how I look – and my only wish is that I had taken them sooner and that someone, anyone, had told me that this was an option … GAHT is treated with such worry – breast development with oestrogen, vocal cords for testosterone, and yet this is often what we want. These aren't irreparable scars, but marks of progress … I'm seeing my face soften and round, my hip-waist ratio changing … My body is finally becoming the person I am inside, and when I dress and present the way I want, I see myself as I am, a woman' – transgender woman

'Hormones … changed my life for the better and I finally find joy in existing. Forming relationships is easier and living life means something for once' – transgender man

This chapter refers to treatment in adults (over 18 years of age). See the **children and young people's gender affirming healthcare** chapter for those under 18 years of age.

17.1 Introduction

'[Gender affirming hormone treatment] … literally completely changed my life. I definitely would have ended my life if I wasn't able to fully transition and pass as a male … Before medically transitioning I hated every part of my life and couldn't even attend school. I now have graduated school, university and have a very successful career' – transgender man[49]

Many, but not all, transgender people wish to access GAHT. The 2015 US Transgender Survey of 27,715 transgender people reported that 78% wanted to receive GAHT.[41] The 2018 Counting Ourselves survey of 1178 transgender people in Aotearoa New Zealand found that 67% of participants wanted GAHT to affirm their gender.[17]

Oestrogen (together with an anti-androgen), or testosterone, can be used to feminise or masculinise a person's appearance. This occurs by inducing the onset of secondary sexual characteristics of the desired sex, and/or by reducing secondary sex characteristics associated with one's assigned sex. Some effects of these medications are irreversible, whilst others are reversible to some degree.[75]

The decision to start GAHT should be individualised to each person.

It is important to appreciate the considerable variation of physical, emotional and cognitive development of young people during adolescence, and extra support may benefit some young people beyond the age of 18 years. Please see the **children and young people's gender affirming healthcare** chapter for further details.

17.2 Initiating gender affirming hormone therapy for adults

'… long-term outcomes [of GAHT] for me is I just get to live my life. I get to get my hormones in a way that make my body feel like my body. I get to be, my existence doesn't give me the ick anymore. And that's a really beautiful thing going forward. Like, you know, I'm gonna get married in a month, and I'm just getting married as me' – transgender person

These guidelines utilise the Medical Council of New Zealand's definition of informed consent. Please read the **informed consent** chapter of these guidelines alongside this chapter.

Most medications in Aotearoa New Zealand are prescribed without mandated prior assessment by a mental health professional and without referral to secondary or tertiary care specialists.

Being transgender is not a mental illness,[12] and it does not impair capacity to consent to treatment. If a doctor or nurse practitioner has sufficient knowledge, skill and professional scope to initiate GAHT in an adult patient:

- There is no requirement for all people to be assessed by a mental health professional prior to starting GAHT
- For many transgender adults, GAHT can be initiated in primary care, without the involvement of secondary or tertiary care.

These guidelines provide health professionals in both primary and secondary/tertiary care with the information to safely and appropriately provide gender affirming healthcare in Aotearoa New Zealand.

17.3 Additional support for primary care health professionals

There are general practitioners (GPs) and nurse practitioners (NPs) who appropriately initiate GAHT in primary care without routine referral to secondary care. Prescribing ongoing GAHT is already a part of everyday general practice.

The **Aotearoa Primary Care Gender Affirming Hormone Therapy Initiation Guidelines** have been endorsed by the Royal New Zealand College of General Practitioners (RNZCGP) and provide additional information for primary care health professionals regarding GAHT initiation in primary care. Please refer to the document for a more detailed outline of an approach to initiating GAHT in primary care beyond what is contained in this chapter.

A sample patient questionnaire can be found in the **appendices**. This questionnaire can be used to gather information before an appointment to help save time. The consent forms in the **appendices** can be utilised as both patient information sheets and consent forms.

Anyone working in primary care can access training on gender affirming healthcare and GAHT prescribing through the **national workforce development programme**.

17.4 Involving other health professionals prior to initiating gender affirming hormone therapy for an adult

Ideally GAHT would be accessed through primary care providers in most situations. The following section outlines the clinical indications for involving professionals outside of primary care in GAHT initiation. We recognise that the GAHT initiation process does not fit easily into the current GP/NP appointment model without extra cost to the patient. Other barriers to primary care GAHT initiation may include prescribers' lack of knowledge, confidence and/or time to learn about and initiate GAHT. It is anticipated with access to guidelines, training, professional support and funding that initiating GAHT will become part of standard primary care practice.

Factors indicating that involvement of a mental health professional, or another health professional (for instance in secondary/tertiary care), may be clinically indicated prior to initiating GAHT include:

1. **Capacity to consent issues:** Where there are reasonable grounds to believe that an adult seeking GAHT may lack capacity to provide informed consent, prescribers are advised to request assistance or assessment from an appropriate health professional.[104] Conditions which might diminish capacity include:
   a. Cognitive impairment (e.g. intellectual disability, dementia, sequelae of head injury)
   b. Current psychosis
   c. Manic episode.
2. **Specific communication challenges:** It is advisable to seek appropriate communication-related assistance from relevant professionals if, due to specific communication challenges involving a person's disability, health condition or neurodivergence, the prescriber is unable to do any or all of the following in a timely manner without this assistance:
   a. Gather relevant information from the person, or
   b. Communicate relevant information to the person in a manner that the person understands, or

c. Assess the person's capacity to consent, or
d. Assess the person's understanding of relevant GAHT related information conveyed to them.

Examples of situations in which these communication challenges may arise include: an autistic adult who is non-verbal, a person suffering from expressive aphasia, or a person who has cerebral palsy that causes them to have difficulties with speech. When considering referral to a relevant health professional due to communication challenges, ensure communication challenges are not solely a result of:

a. Language differences that can be sufficiently addressed using an interpreter or using other appropriate and available means.
b. Other communication challenges that can be addressed or sufficiently mitigated using a sign language interpreter or accessible communication tools.
c. The adult seeking GAHT not feeling comfortable to sufficiently engage with the treating health professional.

3. **Specific pharmacological issues:** Seek relevant assistance if there are potential pharmacological interactions between GAHT and the person's medication regimen or substance use that are outside your knowledge or scope to assess, resolve or manage.

4. **Specific health issues:** Seek assistance from a relevant specialty if:
   a. The person has one or more health issues that are reasonably likely to interact adversely with GAHT (or the prescriber is unable to sufficiently determine how likely it is that an adverse interaction may occur), and
   b. It is outside of the prescriber's knowledge or scope to assess, resolve or manage all relevant aspects of this potential adverse interaction between GAHT and the health issue.

17.5 Recommendations prior to starting hormone therapy

- Confirm the person meets WPATH SOC8 criteria for hormone therapy.[2]
- Discuss gender history and impact of any gender dysphoria.
- Discuss goals, expectations and desired outcomes for GAHT.
- Discuss non-hormonal options to support gender embodiment goals, e.g. voice therapy, laser hair removal, breast forms, etc. (see **non-medical and non-surgical gender affirmation** chapter).
- Take a past and current medical history (including mental health), family and social history.
- Consider sexual health needs, e.g. contraception, STI screening, HIV PrEP (see **sexual health** chapter for more details).
- Consider a psychosocial assessment, especially in younger people over 18 years old, such as the HEeADSSS assessment (this is an acronym for a comprehensive psychosocial assessment tool identifying risk and protective factors).[1] It can be a useful way to develop an effective therapeutic relationship with your patient or client.
- Assess support needs and/or referral for peer support.
- Consider psychological support if relevant or requested by the individual.
- If there are concerns about capacity to consent, then refer for capacity assessments and support to plan next steps.
- Ensure fertility options are discussed, and any appropriate referrals made (see **fertility** chapter).
- Obtain recommended blood tests (see tables in relevant hormone section later in this chapter).
- Provide hormone information and discuss this to ensure understanding. Give the patient sufficient time to consider the information provided. This includes a clear discussion of irreversible changes. Obtain informed consent (see **informed consent** chapter). Consent forms and information sheets are available to support this process (see **appendices**).
- Discuss other relevant health needs – e.g. surgery (see **surgical gender affirmation** and **post-operative care** chapters).

17.6 Criteria for gender affirming hormones

The *World Professional Association for Transgender Health Standards of Care Version 8* (WPATH SOC8) provides internationally recognised standards and criteria for gender affirming hormone treatment.[2]

WPATH SOC8 Criteria for Hormones

a. **Gender incongruence** is marked and sustained.

b. Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment in regions where a diagnosis is necessary to access health care.

c. Demonstrates capacity to consent for the specific gender-affirming hormone treatment.

d. Other possible causes of apparent gender incongruence have been identified and excluded.

e. Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed.

f. Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.

While many transgender people may also experience gender dysphoria (discomfort or distress with their body or gender roles associated with their sex assigned at birth)[2] this is no longer a requirement to access GAHT. Many transgender people describe gender euphoria, because they confidently affirm their gender, and are accepted and supported in their identity. But they still experience gender incongruence and seek to physically affirm their gender.

Medical or mental health concerns should generally not prevent the initiation of gender affirming hormone therapy. Instead, an individualised approach is recommended where these concerns are addressed concurrently alongside gender affirming healthcare.[2] This may mean involving health professionals from other disciplines such as endocrinology, sexual health, psychology or psychiatry.

A careful balance of risks and benefits may need to be considered, utilising a harm minimisation approach. This is in recognition that, for those who want GAHT, not prescribing GAHT is not a neutral action. GAHT may relieve a transgender person's gender dysphoria and improve their mental health.[165, 166 167]

17.7 Monitoring of hormone therapy

Monitoring and follow up of gender affirming hormone therapy is appropriately done in primary care as part of the patient's overall care. Appointments may include:

- Assessment of the effects of taking hormones on both physical and emotional health
- Checking with the person if they wish to continue with GAHT. This is advised to support any person that may have doubts, as it gives them permission that it is okay to stop GAHT if they are unsure and to not feel pressure that they must continue; encourages an open and honest dialogue with the prescriber; and allows health professionals not to assume that they want to continue
- Review of doses and desire for change
- Presence of side effects
- Support with reproductive or contraceptive needs, as these can change
- Current social supports and need for further support
- Lifestyle factors such as nutrition, exercise and smoking
- Monitoring of blood pressure and BMI
- Monitoring blood tests
- Referrals for gender affirming surgeries if desired.

Note: Some people plan to only remain on hormone therapy temporarily before stopping. This may be to achieve specific and permanent gender embodiment goals (e.g. deep voice) whilst avoiding lifelong hormone therapy.

17.8 Older adults

There is no upper age limit for gender affirming hormone therapy.[2] Most research about initiating GAHT focuses on younger transgender individuals, making it difficult to generalise findings to older people. As there are no specific guidelines for GAHT in older adults, informed consent should acknowledge the limited evidence base in prescribing GAHT in older adults, with the understanding that in general most risks may increase with age.

Individuals who have been on hormones for many decades may wish to consider a reduction in hormone doses as they age.[168] Hormone therapy may increase the risk of issues which are already more likely in older individuals, such as medication interactions, CVD or a change in blood pressure. There is limited data on cancer effects of hormone use in transgender people. Ensure screening for relevant hormone-dependent cancers is up to date and inquire about any cancer symptoms. Ensure the person understands the limited data regarding screening in the transgender population. Consider investigations if there are concerns. Screening protocols for transgender people should be based on the anatomy/organs that are present.

17.9 Non-standard gender affirming hormone therapy regimens

Health professionals report an increase in non-binary people seeking individualised, non-standard gender affirming treatments.[169, 170] Research on non-standard GAHT and its efficacy and possible risks is lacking.[170] Individualised protocols require an understanding of hormonal actions, efficacy and safety, along with adequate discussion of reversible and irreversible changes. Health professionals may want to seek advice from those who regularly practise in this area for guidance on novel regimens to ensure safety and to address the person's goals. There are no clinical guidelines or evidence to guide non-standard hormone prescribing for non-binary people.

17.9.A Low doses of GAHT

Some non-binary people who are seeking medical affirmation of their gender request low doses of GAHT. This is often referred to by transgender people as 'microdosing'.

While lower hormone doses may result in a more gradual onset of changes, all physical effects, including permanent effects, will still occur with ongoing treatment.

It is not possible to predict the physical effects of a specific dose or duration of treatment with GAHT. It is essential to discuss all the physical effects the hormone will result in, just as you would when initiating GAHT using a standard dosing protocol. There is no guarantee that effects will be more gradual as this is based solely on anecdotal evidence, and people respond to medication in individual ways.

Extrapolating from the adult cisgender population it is known that low levels of sex hormones carry health risks, such as depression, reduced bone density and cardiovascular disease.[171-174]

Using an androgen blocker or a GnRH agonist in adults without adding any sex hormones is not safe due to the impact on bone mineral density and cardiovascular disease risk. It is not known what lower limit of oestrogen or testosterone is required to reduce health risks.

17.9.B Short-term GAHT

Short-term use of GAHT can be considered if the person desires some, or all, of the permanent effects but does not wish to remain on long-term hormone therapy, for example, achieving a lower voice with intermittent or short-term testosterone use. It is possible to take testosterone or oestrogen for a period of time and then stop to allow gonadal hormones to return. The patient needs to understand the permanent effects which will remain even once GAHT has been stopped. Measuring reproductive hormone levels after someone stops GAHT is recommended to ensure they have returned to levels typical for the sex assigned at birth.

17.10 Oestrogen based gender affirming hormone therapy (E-GAHT)

See appendices for consent form.

Oestrogen based gender affirming hormone therapy (E-GAHT) may be desired by people who are seeking to embody and affirm their gender.

> As part of the informed consent process, transgender people should understand the effects of E-GAHT, including the benefits and risks, reversible and irreversible effects, realistic expectations, and alternative options to medications to meet gender embodiment goals.

This process may take time and require several appointments. Those working in primary care can refer to the *Aotearoa Primary Care Gender Affirming Hormone Initiation Guidelines* for a detailed approach to GAHT initiation.[175]

Please refer to the **fertility** chapter for detailed discussion on fertility preservation and fertility impacts of E-GAHT. This must be discussed prior to starting E-GAHT.

Oestradiol is usually started at a low dose and increased over time. Doses are usually increased every 3–6 months, based on clinical effect. Transdermal oestrogen is recommended for those aged > 45 years, with raised body mass index (BMI) or any increased risks for thrombosis (including venous thromboembolism (VTE), cardiovascular or cerebrovascular thrombosis).[176, 177] The different oestrogen formulation options should be explained, and an individualised discussion of the risks and benefits carried out, so that people can engage in shared decision making.

Oestradiol is started in conjunction with an anti-androgen (spironolactone or cyproterone) or added to a GnRH agonist (leuprorelin/goserelin).[134] A discussion of the mechanism of action, risks and side effects of each is required, and these are outlined later in this section.

Goserelin can be used for people who cannot tolerate oral anti-androgen agents. Anti-androgen agents can be ceased if orchiectomy or gender affirming genital surgery is performed.

17.10.A Potential risks and side effects of oestradiol therapy[162]

- Headache and migraine – consider using patches in someone with a history of migraine with aura
- Nausea (usually transient)
- Breast tenderness
- Venous thromboembolism:
  - Particularly if aged > 40 years
  - Most common in first two years of treatment
  - No increased risk on transdermal oestrogen
  - If aged > 40 years or other DVT risks, recommend switching to transdermal oestrogen
- Cardiovascular disease (CVD) – adverse lipid profile, hypertension (with oral oestrogen)
- Liver dysfunction
- Gallstones
- Mood changes
- Reduced libido
- Small risk of breast cancer[178] (more than prior to E-GAHT but less than cisgender women)
- Rarely hyperprolactinaemia.

Risks may be higher in those who smoke, have a family history of CVD or VTE, or have other CVD risk factors.

17.10.B Potential risks and side effects of anti-androgens[162]

Potential for bone loss.

Cyproterone

- VTE (contraindicated with a history of thromboembolic disorders)
- Low mood (contraindicated in severe depression)
- Weight gain
- Fatigue
- Breathlessness
- Meningioma[160, 161] – risk increases as the cumulative dose rises. This has been found at daily doses of 25 mg per day and above. It is not known whether long-term use of low doses carry this same risk
- Hepatotoxicity – jaundice, hepatitis and hepatic failure have been reported with very high doses.[179]

Spironolactone

- Hyperkalaemia – monitor electrolytes and watch for drug interactions
- Gastrointestinal side effects
- Hepatotoxicity
- Lethargy
- Hypotension
- Urinary frequency.

17.10.C Factors that may increase risks from E-GAHT[134]

Some physical health conditions may be worsened by E-GAHT. None of these conditions are considered absolute contraindications. Seek appropriate specialist advice if you have concerns. Complex risk/benefit ratios may need to be discussed with the patient, being aware that most information is from studies in older postmenopausal cisgender women and has been extrapolated to those taking E-GAHT.

Factors which have the potential to increase risks include:

- Current or recent smoker
- Heart failure, cerebrovascular disease, coronary artery disease, atrial fibrillation
- Personal or family history of VTE including deep vein thrombosis (DVT) – not an absolute contraindication but specialist advice may need to be sought. Oestradiol patches may have a lower VTE risk than oral oestrogen
- Cardiovascular risk factors – BMI > 30, hyperlipidaemia, hypertension, diabetes
- Migraine with aura – the risk of stroke is raised with migraine with aura and is further increased with the use of the oral contraceptive pill and with smoking, thus transdermal oestrogen is recommended. Discussion with relevant specialists and explaining risks and unknowns to the patient is advised
- Personal history of hormone-sensitive cancers, e.g. breast, prostate, testicular – seek specialist advice before commencing hormones
- Possible drug interactions (check the New Zealand Formulary[180] for an individual's potential drug interaction)
- Age over 45 years: Based on evidence in cisgender women, it is recommended that oestradiol patches rather than oral oestrogen tablets be used after 45 years of age, to further reduce the risk of VTE.[176] Spironolactone is typically preferred as the anti-androgen choice, as it often helps control hypertension without the adverse liver effects and VTE risk which can happen with cyproterone.[168] However, potential interactions should be considered, and potassium and creatinine levels should be monitored more closely than in younger individuals.

17.10.D Emotional effects from E-GAHT

There is evidence for reduction in symptoms of depression or distress associated with gender dysphoria.[167] Some people may experience mood swings and emotional imbalances, but increased emotional insight and expressiveness is also reported.[167] If there are any concerns regarding impact of E-GAHT on mood, this should be closely monitored.

17.10.E Prescribing E-GAHT

Detailed discussions need to take place before initiating E-GAHT. A consent form and GAHT questionnaire can be found in the **appendices**.

Recommended medical examination and investigations prior to starting E-GAHT

Physical examination	Investigations
Blood pressure Height Weight* BMI Note: genital examination is NOT required.	Liver Function Tests Lipids (if indicated due to risk factors) Electrolytes (if starting spironolactone) Oestradiol Testosterone HbA1c (if indicated due to risk factors)

* Be sensitive when asking to weigh someone and consider whether it is clinically indicated.
Some people prefer not to be told their weight, and some will decline to be weighed. This should be respected.

Oestrogen formulations and dosing [2, 134]

Oestrogen formulation	Starting dose	Maintenance dose range	Notes
Oestradiol valerate Progynova)	1–2 mg daily	4–6 mg daily	Increasing by 1–2 mg every 3–6 months is generally recommended.
Oestradiol patch (Estradot)*	25–50 mcg patch twice weekly	100–200 mcg patch twice weekly	Increasing by 25–50 mcg every 3–6 months is generally recommended. Lower VTE risk than oral oestrogen.
Oestradiol gel (Estrogel)	1 pump daily	2–4 pumps daily	Increasing by 1 pump every 3–6 months is generally recommended. Lower VTE risk than oral oestrogen.

* PHARMAC subsidy is only available for 2 patches/week, independent of doses.

Anti-androgen formulations and dosing [2, 134]

Note: The anti-androgen can be stopped following an orchiectomy.

Anti-androgen	Starting dose	Maximum dose
Spironolactone*	50–100 mg daily	200 mg daily
Cyproterone**	12.5 mg daily or alternate days	12.5 mg daily or alternate days. A twice weekly dose is adequate and can be convenient when combined with oestrogen patch dosing.
Goserelin	10.8 mg SC implant insertion into lower abdomen every 12 weeks	

* Use with caution in the elderly.

** Use the lowest effective dose and consider reviewing appropriateness every 5 years. See below for an outline of risks.

17.10.F Effects of E-GAHT

Adapted from The Endocrine Society Guidelines 2017[134] and The Royal Children's Hospital Standards of Care.[75]

Effect of oestrogen and anti-androgen	Expected onset	Expected maximum effect	Reversibility
Redistribution of body fat	3–6 months	2–3 years	Likely
Decrease in muscle mass and strength	3–6 months	1–2 years	Likely
Softening of skin/decreased oiliness	3–6 months	Unknown	Likely
Decreased sexual desire	1–3 months	3–6 months	Likely
Decreased spontaneous erections	1–3 months	3–6 months	Likely
Breast growth	3–6 months	2–3 years	Not possible
Decreased testicular volume	3–6 months	2–3 years	Unknown
Decreased sperm production	unknown	> 3 years	Unknown
Thinning and slowed growth of body and facial hair	6–12 months	> 3 years*	Possible
Voice changes	None**		

* Complete removal of hair requires laser treatment.

** E-GAHT does not affect voice. Gender affirming voice therapy can be provided by speech and language therapists.

17.10.G Monitoring on E-GAHT

Blood test monitoring is recommended 3–6 monthly in first year and thereafter 1–2 times per year, or as clinically indicated.

Physical examination	BP Consider BMI especially if interested in future surgery
Blood tests	Electrolytes (potassium) – if on spironolactone Liver Function Tests HbA1c – if risk factors suggest indicated. Lipids – if risk factors suggest indicated. Oestradiol – avoid supraphysiological levels (target < 750 pmol/L)*. Testosterone – aim for level < 2 nmol/L if on cyproterone or goserelin (if desiring more sexual function consider a higher target level). There is no need to measure if on spironolactone, as this medication blocks the effect of testosterone on the tissues rather than its production.
If major risk factors for osteoporotic fracture	Consider bone density scan (DEXA).

* Experience suggests that oestrogen levels or dose do not correlate well with physical effects or self-reported satisfaction with E-GAHT, and exogenous oestrogen is not well measured in the serum. Do not adjust oestrogen doses based on blood levels that are within the normal reference range. Dose change should be with regard to physical effects and in keeping with standard recommended doses (and should be reduced if levels are supraphysiological).

17.10.H Other medications which may be asked about as part of E-GAHT

Injectable oestrogen

Injectable oestrogen is not funded in Aotearoa New Zealand but is included in the endocrine society guidelines.[134] Guidance on dosing regimens and monitoring is lacking.

Progesterone

There is ongoing debate regarding the inclusion of progesterone in E-GAHT regimens. Anecdotally, some transgender people report improved breast and/or areolar development, mood, sleep or libido with the use of progesterone, although these findings have not been supported by the limited studies available.[181, 182] Progesterone is responsible for lobular alveolar development to facilitate lactation, but not pubertal breast development in cisgender women.[183]

There are no studies assessing whether or not progesterone has potential for harm in the context of GAHT; however, data from cisgender women suggests harm associated with extended progestin exposure.[2] The Women's Health Initiative study involving post-menopausal cisgender females reported a potential increased risk of cardiovascular disease (CVD) and breast cancer when medroxyprogesterone acetate was used in combination with oral oestrogen.[184] Potential risks may include CVD, breast cancer, bone loss and VTE.[2, 134, 184, 185] We acknowledge that micronised progesterone is used by some transgender people. Although generally well tolerated, progesterone can cause weight gain, fatigue, irritability and low mood.[186] Utrogestan may be associated with a better side effect profile than older progesterones.[187] Further randomised studies on the role of progesterone in gender affirming therapy are under way, and results will inform future practice.[188]

Selective oestrogen receptor modulators

Sometimes people request medications in addition to GAHT in the hope that this will minimise a hormonal effect that is undesired. Some degree of breast growth is unavoidable when using E-GAHT. There is no evidence that selective oestrogen receptor modulators prevent this, and their use is not recommended due to serious safety concerns with long-term use.[189]

17.10.1 Practice points

- E-GAHT consists of an oestrogen and an androgen blocker.
- Oestrogen can be given as tablets, patches or gel. Topical oestrogen (patches and gel) carry a lower risk of thrombosis[176, 177, 190] and hepatic dysfunction.[191]
- Oestrogen is started at a low dose and gradually increased over time.
- The usual choice of anti-androgen is spironolactone or cyproterone. Each carries different risks and side effects which need to be discussed with the patient.
- The anti-androgen can be stopped if the person has an orchiectomy.
- The feminising effects on the body are slow and gradual.
- E-GAHT does not change voice, bone structure or laryngeal prominence.
- Fertility discussions are essential as E-GAHT can result in permanent infertility.
- GAHT monitoring should take place 3–6 monthly during the first year and thereafter 1–2 times a year.

17.11 Testosterone based gender affirming hormone therapy (T-GAHT)

See appendices for GAHT questionnaire, consent form, and patient information sheets about clitoral growth and testosterone gel.

Testosterone based gender affirming hormone therapy (T-GAHT) may be desired by people who are seeking to embody and affirm their gender.

> As part of the informed consent process, patients should understand the effects of T-GAHT, including the benefits and risks, reversible and irreversible effects, realistic expectations and alternative options to medications to meet gender embodiment goals.

This process may take time and require a number of appointments. Further detail can be found in the introduction to hormone therapy and in the consent forms in the **appendices**. Those working in primary care can refer to the *Aotearoa Primary Care Gender Affirming Hormone Initiation Guidelines* for a detailed approach to primary care GAHT initiation.[175]

Please refer to the **fertility** chapter for detailed discussion on fertility preservation and fertility impacts of T-GAHT. This must be discussed prior to starting T-GAHT.

17.11.A Potential risks and side effects of T-GAHT

- Polycythaemia – If severe, increases risk of thrombotic event
- Adverse lipid profile
- Mood changes
- Increased libido
- Obstructive sleep apnoea
- Acne
- Pelvic pain
- Breakthrough bleeding
- Vaginal dryness – may require topical oestrogen treatment
- Small increased risk of VTE in first 6 months
- Small risk of liver dysfunction, insulin resistance, cardiovascular disease.

17.11.B Factors that may increase risks from T-GAHT[162]

Some physical health conditions may be worsened by T-GAHT. None of these conditions are considered absolute contraindications. Seek appropriate specialist advice if you have concerns. Factors which have the potential to increase risks include:

- Current or recent smoker
- Heart failure, CVD, coronary artery disease, atrial fibrillation
- History or family history of VTE
- Cardiovascular risk factors – BMI > 30, hyperlipidaemia, hypertension, diabetes.
- Personal history of hormone-sensitive cancers. Seek specialist advice before commencing hormones
- Possible drug interactions
- Sleep apnoea.

Testosterone therapy carries little risk regarding CVD or cancer, but a reduced dose may be prudent in cases of high haematocrit or cardiac insufficiency.[168]

17.11.C Emotional effects from T-GAHT

There is evidence that AFAB transgender people with distress about their sex characteristics may have reduced depressive symptoms and reduced distress about their body when on T-GAHT.[167] Some transgender people may also notice:[167]

- A reduction in anxiety
- An overall dampening of their emotions, both positive and negative ones
- They are more likely to express their anger when taking testosterone; but the intensity of this feeling may not change.

If there are any concerns regarding impact of T-GAHT on an individual's mood, this should be closely monitored.

17.11.D Menstrual cessation and contraception

Testosterone does not provide contraception. Pregnancy can occur even if testosterone has resulted in amenorrhoea. Testosterone is contraindicated in pregnancy, and it is important to avoid pregnancy whilst on T-GAHT as this is harmful to a developing fetus.

Discuss contraception requirements with everyone who is starting T-GAHT. Continue to ask about this over time as this need can change (noting that T-GAHT may increase libido).

Progesterone based long-acting reversible contraception (LARCs) such as Depo-provera®, Jadelle® or IUDs (Mirena®)/IUCDs are suitable options for contraception, while condoms provide additional protection against sexually transmitted infections.

The combined oral contraceptive pill can also be used but may not be the preferred option for some transgender people.

Insertion of an IUD may be more painful and technically more challenging in someone who has a degree of vaginal atrophy from testosterone therapy and who may be experiencing dysphoria. Mirena/Jaydess placement before starting testosterone can give relief from breakthrough and monthly bleeding common when starting T-GAHT. Consider topical oestrogen for 2 weeks before IUD insertion for those on testosterone to reduce discomfort. Some regions may have capability to do these procedures under general anaesthetic if desired.

People seeking T-GAHT may be experiencing distress or dysphoria relating to menstruation. Menstrual cessation options can be offered to assist with this.

Some people may choose to start this alongside the process of starting T-GAHT, as testosterone takes time to result in menstrual cessation, or someone may choose only menstrual cessation options if they are not yet decided about whether testosterone is right for them. The choice of medication used will be dependent on whether contraception is required.

- Primolut® (norethisterone)* po 5 mg bd, increase to 10 mg bd for 1 week if breakthrough bleeding, then reduce.[192] Sometimes higher dosing is required longer term. Norethisterone is partially metabolised to ethinylestradiol in the body, which at these high doses is equivalent to levels in the combined oral contraceptive. This is likely to convey additional thromboembolic risk
- Provera® (medroxyprogesterone)* po 10 mg tds or 20 mg nocte
- Combined oral contraception – continuous active pill taking to avoid menstruation (note: some people may not be comfortable with being prescribed oestrogens, although this would not affect the outcome from T-GAHT)
- Depo-provera® (medroxyprogesterone acetate) 150 mg IM every 12 weeks
- Mirena® (levonorgestrel) – intrauterine device.

For those who started on a GnRH agonist (puberty blocker) in early adolescence it is recommended to continue menstrual cessation medication whilst the testosterone dose is being increased, to allow time for testosterone to achieve HPG axis suppression. This usually occurs when someone has been on full dose testosterone for around 6 months to 1 year (with adequate testosterone levels).

If a GnRH agonist was used later in puberty for menses cessation, this can be stopped once the person has been on testosterone for 6 months.

17.11.E Irregular menstruation – prior to testosterone

Whilst some transgender people who are experiencing amenorrhoea or irregular menstruation may be relieved by this, it is important in these situations to review for polycystic ovarian syndrome or other causes of irregular menses or amenorrhoea. If menstruation occurs < 3 monthly and the person is > 2 years post menses onset, progesterone (e.g. norethisterone 5 mg or 2 noriday tablets per day) is recommended for endometrial protection (if not contraindicated).

* Not considered effective contraception.

17.11.F Prescribing T-GAHT

Detailed discussions need to take place before initiating T-GAHT as outlined earlier in this chapter. Consent forms can be found in the **appendices**.

Recommended medical examination and investigations prior to starting T-GAHT

Physical examination	Investigations
Blood pressure Height Weight* BMI	Liver Function Tests Full Blood Count Lipids Oestradiol Testosterone** HbA1c (if indicated due to risk factors) Urine/serum HCG*** (if appropriate)

* Be sensitive when asking to weigh someone and consider whether it is clinically indicated. Some people prefer not to be told their weight, and some will decline to be weighed. This should be respected.

** Testosterone levels can appear falsely raised in patients on norethisterone.

*** Testosterone is contraindicated in pregnancy.

For older adolescents and adults, the usual starting dose is half of the full/maximum dose. This can be increased to the maximum dose after 1–3 months depending on the patient's response and wishes. In younger adolescents the dose should be increased more gradually. See the **children and young people's gender affirming healthcare** chapter for more details.

Some people choose to start on a much lower dose, and either remain on this or increase very gradually. For more discussion about low doses of testosterone see the **non-standard gender affirming hormone therapy regimens** sub-chapter within this chapter.

T-GAHT formulations and dosing [2, 134]

Testosterone formulation	Usual maintenance dose (adults and older adolescents) The usual starting dose is half of the full/maximum dose
Depo-testosterone (testosterone cypionate)	100–200 mg IM every two weeks or 50 mg* SC weekly (suitable for self-injection)
Sustanon® ** (testosterone esters)	250 mg/ml IM every 3 weeks (suitable for self-injection)
Reandron® (testosterone undecylate)	750–1000 mg IM every 10–12 weeks (second dose at six weeks to achieve steady state) Not suitable for self-injection due to risk of oil embolism
Testogel* **	2 pumps/actuations mane (can be increased up to 4 pumps if required based on levels)

* Some guidelines recommend a maximum dose of 100 mg weekly SC.

** Sustanon contains arachis oil and should be potentially avoided in those with peanut allergies.

*** Close skin-to-skin contact can result in the testosterone gel being transferred to the other person and should be avoided. For more details about application and precautions when using Testogel see patient information sheet in the appendices and the New Zealand Formulary.

Note: Testosterone patches are no longer funded by PHARMAC, but if used, a dose of 7.5 mg daily is the usual maintenance dose. Skin irritation is common with their use.

Sometimes people request medications in addition to GAHT in the hope that this will minimise a hormonal effect that is undesired. In theory the use of finasteride, which blocks the conversion of testosterone to 5α-dihydro-testosterone, may limit clitoral growth in people taking T-GAHT, as well as potentially limiting facial hair growth and scalp hair loss, but there are no well-designed studies to demonstrate the effect of finasteride in this context. A careful discussion is required prior to consideration of prescribing finasteride to mitigate the undesired effects of T-GAHT, as there is no guarantee that it will have the desired effect, and the usual effects of T-GAHT may still occur. Finasteride carries risks and side effects,[193] and it is not known if long-term risks relating to its use apply to transgender people AFAB as no studies have been carried out.

17.11.G Effects of T-GAHT

Adapted from The Endocrine Society Guidelines 2017[134] and The Royal Children's Hospital Standards of Care.[75]

Effect of testosterone	Expected onset	Expected maximum effect	Reversibility
Skin oiliness/acne	1–6 months	1–2 years	Likely
Facial/body hair growth	6–12 months	4–5 years	Unlikely
Scalp hair loss	6–12 months*	Variable	Unlikely
Increased muscle mass/strength	6–12 months	2–5 years	Likely
Redistribution of body fat	1–6 months	2–5 years	Likely
Cessation of periods	1–6 months		Likely
Clitoral enlargement**	1–6 months	1–2 years	Unlikely
Vaginal atrophy	1–6 months	1–2 years	Unlikely
Deepening of voice	6–12 months	1–2 years	Not possible
Increased sexual desire	None	Variable	Likely

* Highly dependent on age and inheritance; may be minimal.

** See **appendices** for drawings of this to help you and the person you are prescribing for, know what to expect.

17.11.H Monitoring on T-GAHT

Blood tests and blood pressure monitoring are recommended 3–6 monthly in the first year and 1–2 times per year thereafter, or as clinically indicated.

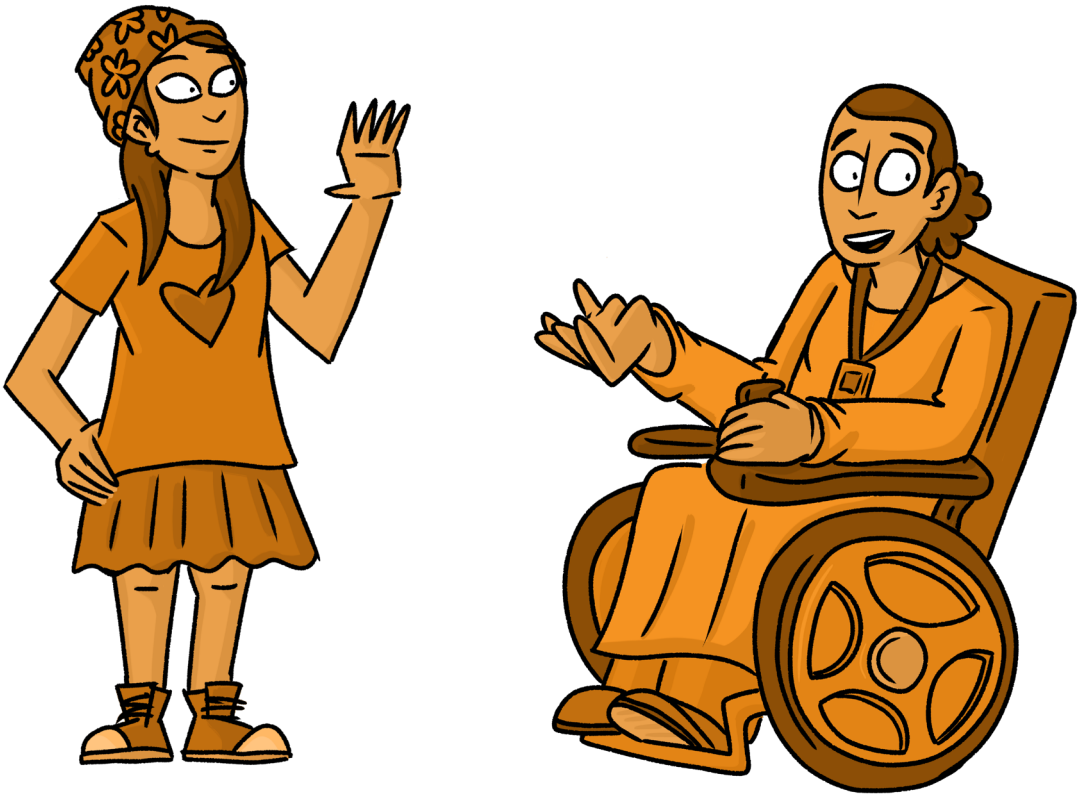
Physical examination	BP Consider BMI especially if interested in future surgery
Blood tests	Full Blood Count* Liver Function Tests Lipids HbA1C (if risk factors) Testosterone** (aim for male reference range)

* Polycythaemia risk. Consider testosterone dose reduction or change of formulation if Hct > 0.52. Use male reference range when interpreting results.

** Testosterone should be measured midway between injections for depo-testosterone or Sustanon, and immediately prior to an injection for Reandron. For Testogel measure in the morning prior to applying dose, or 4–6 hours after application on the opposite arm.

17.11.1 Practice points

- Testosterone can be given as an injection or a topical gel.
- Permanent effects of T-GAHT include facial and body hair growth, deeper voice, clitoral growth, potential scalp hair loss.
- There are unknown effects on fertility, and this should be discussed with the patient.
- Most people experience amenorrhoea on testosterone, but menstrual cessation options may be appreciated and should be offered while waiting for this to occur.
- Contraception is required if having any sexual contact that could result in pregnancy. Testosterone is teratogenic and does not provide contraception.
- Monitoring should be undertaken 3–6 monthly in the first year and 1–2 times yearly thereafter.
- When measuring testosterone levels, the timing of the blood test varies depending on the formulation being used.



18. Fertility

Future fertility and fertility preservation options must be discussed prior to starting puberty suppression, gender affirming hormone therapy (GAHT) or undergoing some gender affirming surgeries.[134]

It is a criterion of the WPATH SOC8 that transgender people have been informed of the effects of medical and/or surgical treatment on fertility, and have considered reproductive options in their decision making.[2]

Gonadotropin releasing hormone (GnRH) agonists are largely reversible and once stopped should not affect long-term fertility, although fertility may take some time to resume.[194] Gender affirming hormone therapy (particularly E-GAHT) can have permanent effects on fertility, as outlined later in this chapter.

Gender affirming surgery that includes removal of the gonads (e.g. orchiectomy, oophorectomy and gender affirming genital surgery) has irreversible effects on fertility. Reproductive options and fertility preservation must be discussed prior to surgery.

Prior to starting GAHT, adolescents are often reluctant to cease GnRH agonists in order to undergo fertility preserving interventions.[75] For younger adolescents, a discussion focusing on the practicalities of preserving gametes may be more developmentally appropriate than discussing a potential desire for future fertility or children.

For example:

'No-one can know for sure how they will feel in the future about whether they want children or not. Do you think you would be able to go to the clinic and try to provide a sperm sample? That is the only decision you need to make right now. That way you leave your options open for whatever you may decide in the future. Your future self may be grateful that you kept that door open.'

Encourage young people to involve their whānau in these discussions and decisions. There may be cultural elements for some people to explore in their decision making. There are many ways to have a whānau, but for some people having children biologically related to them is important. Some people will have strong feelings about whether they do or do not want to have children in the future. Discussions can include encouraging people to envisage future scenarios which differ from how they feel now, for example meeting a partner who really wants to have children. Give people time to make these decisions and revisit this over time.

Fertility Associates provide fertility services for most of Aotearoa New Zealand, with Fertility Plus also providing services in the Auckland region. It is recommended that all young people are provided with information about fertility preservation options, and if desired a referral to a fertility service.

18.1 Sperm cryopreservation

Discussion about impacts on fertility should take place prior to starting GnRH agonists, and this should always be reviewed and discussed again prior to commencing hormones. E-GAHT is expected to have a permanent impact on future fertility, and it is essential to discuss this prior to prescribing E-GAHT for the first time.

Everyone should be offered the opportunity to store sperm prior to starting E-GAHT.

Sperm cryopreservation is funded for people under the age of 40 years, who have not previously had children, who are starting E-GAHT or undergoing surgical removal of gonads. A referral usually requires accompanying screening blood test results for Syphilis, HIV, Hepatitis B and C.

18.2 Early adolescence (Tanner stage 2)

For those in early adolescence (Tanner stage 2: testicular volume <10 mL) there is currently no good option for fertility preservation. Cryopreservation of testicular tissue obtained via biopsy is considered experimental as it has not yet successfully resulted in offspring.[195] It is likely that in the future this tissue may be able to re-implanted into the same individual's body to allow sperm production but this would mean that GAHT would need to be paused or ceased. It is hoped that tissue obtained via biopsy could be used to produce sperm outside of the body.

The decision about whether to store sperm may be a particularly difficult decision for those assigned male at birth, who started GnRH agonists early on in puberty, as they would then need to allow further pubertal changes to occur to allow sperm maturation in order to store. For many, significant gender dysphoria would likely be a barrier, and they may feel that they do not have an easy option available to them. In such cases, referral to a fertility specialist to discuss options is recommended, but people should be aware that current options are extremely limited when GnRH agonists are commenced early in puberty.

18.3 Adults and adolescents at or above Tanner stage 3

Sperm cryopreservation is likely to be possible from Tanner stage 3 (testicular volume 10mL).[144] It is recommended that all patients at this stage are offered and consider sperm cryopreservation.

To ensure optimal chances for future successful assisted reproductive technologies (ART), multiple masturbatory samples are recommended. We acknowledge that this process is daunting to most people. Those who are unable to provide a masturbatory sample can be considered for testicular sperm extraction (TESE), although this is not available in all centres and travel may be required to access this. Genital tucking (pushing testicles into the inguinal canal or securing the scrotum and penis between the legs) should be discouraged for 3 months prior to sperm cryopreservation as it may negatively impact semen quality.[196-199]

The Human Assisted Reproductive Technology Act 2004 (HART) limits initial storage of sperm to a maximum of 10 years before the sample is destroyed.[200] Storing sperm for longer than this requires an application to the Ethics Committee for Assisted Reproductive Technology (ECART). It is important that contact details are kept up to date to ensure fertility centres can review the need for ongoing storage and support applications to the ethics committee if desired.

Of note, while there is publicly funded storage of sperm for up to 10 years, depending on the person's circumstances there may be additional future costs for assisted reproductive technologies such as IUI or IVF. Frozen thawed sperm often has reduced motility and due to sperm preparation required prior to treatment, and clinic regulations for this use, self-insemination is not an option with this cryopreserved sperm. There is the option of transporting this sperm to another clinic in Aotearoa New Zealand if the person moved away from where it was frozen, and there are options for shipping to an overseas clinic if required in the future.

18.4 Sperm cryopreservation after starting E-GAHT

It is not known whether fertility can be retained after taking E-GAHT or how often this may occur. Early research suggests subfertility increases with early puberty blocking, early oestrogen administration and longer duration on E-GAHT.[201, 202] A person's decision about fertility preservation can change over time. Pausing GnRH agonists or E-GAHT for a period of time to enable sperm storage can be considered, although this can be challenging to navigate as it is not known how long medication needs to be stopped for mature sperm to be present, or if it will be successful.

There is emerging research indicating that restoration of spermatogenesis in people on E-GAHT who have paused hormones may be possible. The prevailing view that E-GAHT inevitably leads to permanent infertility is being challenged,[203, 204] though more studies are needed.

18.5 Egg or ovarian tissue storage

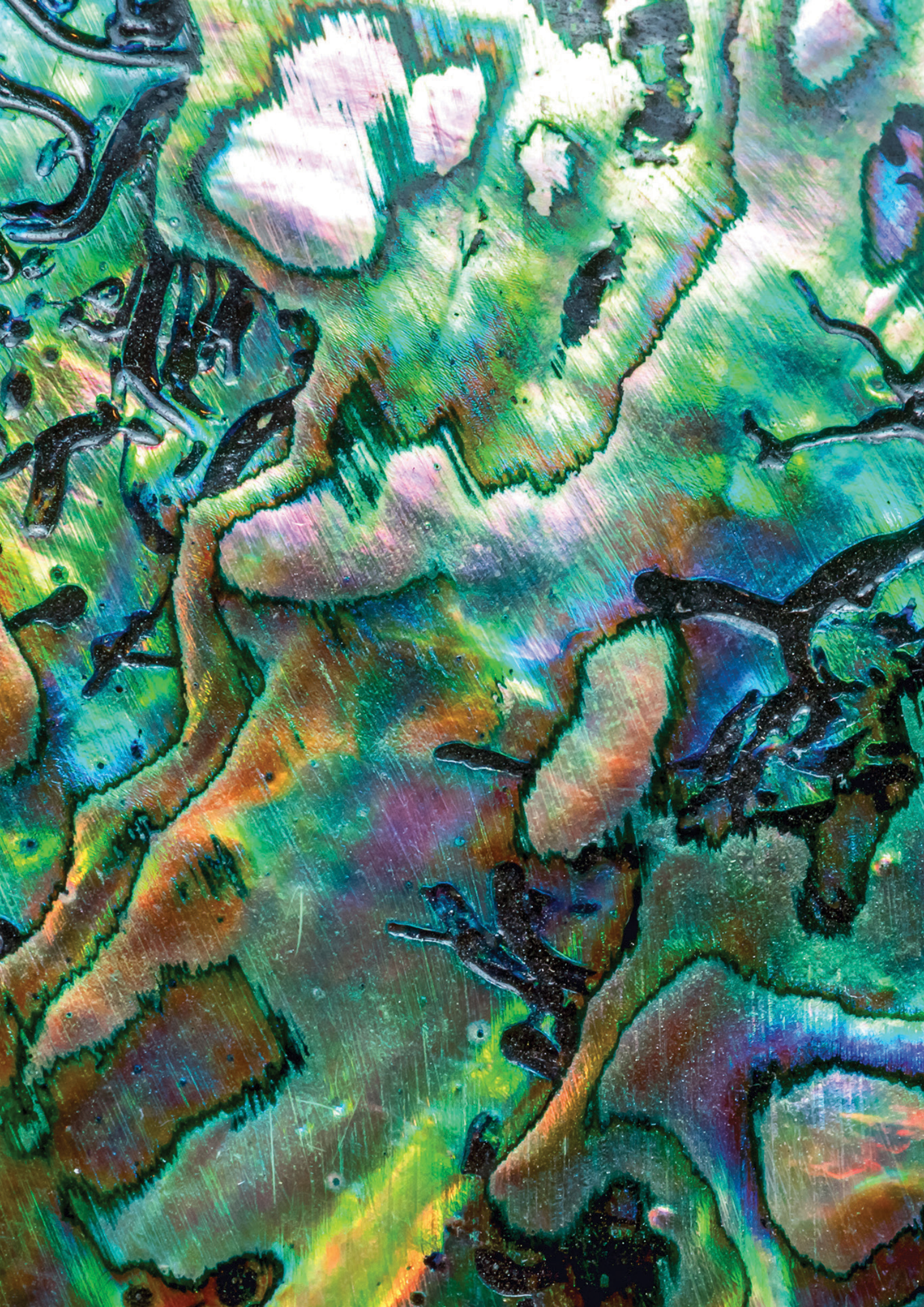
T-GAHT usually causes ovarian suppression. This may be reversible on stopping testosterone, which may result in a return of spontaneous fertility.[205-207] People need to understand that if a future pregnancy is desired it will mean stopping testosterone (as it is a teratogen) and may require fertility assistance in the form of egg harvesting. There is little research to inform people about whether being on T-GAHT affects the likelihood of success of egg harvesting.

There are many reports of transgender people who have been on T-GAHT having successful pregnancy outcomes after stopping testosterone for the purposes of conception. However, there are uncertainties in this area and further research is needed. The option of egg or ovarian tissue storage should be discussed, recognising that this involves invasive procedures that are not publicly funded unless reproductive organs are being removed.

There are case studies of young transgender people who started GnRH agonists in early Tanner stages (prior to full breast changes and menses initiation) having successful egg harvest for storage. This is following stimulation, designed with the goal of minimal progression through puberty, and prior to commencing testosterone.[208, 209] Letrozole can be used at the same time as ovarian stimulation medication to minimise the oestradiol rise and the changes associated with this.

18.6 Practice points

- A discussion about the impact on fertility and fertility preservation options is essential prior to any gender affirming medical or surgical intervention.
- Consider a referral to a fertility specialist for young people starting GAHT or undergoing surgical removal of gonads.
- GnRH agonists do not have a permanent impact on fertility, but hormones can. This can lead to challenging decisions about pausing GnRH agonists to preserve fertility prior to commencing GAHT.
- E-GAHT is likely to result in permanent infertility and sperm cryopreservation should be offered to everyone prior to commencing it.
- Sperm cryopreservation can occur from Tanner stage 3 (testes 10 ml).
- Fertility may return on stopping T-GAHT, allowing pregnancy to occur. If pregnancy is desired, T-GAHT must be stopped prior to conception due to the teratogenic effects of testosterone.



19. Sexual health

19.1 Sexual health check-up

In the 2018 Counting Ourselves transgender health survey 89% of participants had ever had a partner. However, 58% of people had never received any transgender-specific information about prevention of sexually transmitted infections (STIs) and 29% indicated that they would like to receive information. Only 9% had received any information from healthcare providers.[17]

Transgender people have all kinds of sex with all types of bodies and (like all people) for a range of reasons including pleasure, reproduction and money. The only way to find out what sexual health tests are needed is to respectfully ask.

Who people have sex with (sexual orientation) is very different to a person's gender identity. While it is important to ask about sexual contacts, it is equally important to only ask medically necessary questions and to explain why you're asking. Questions that cross the line from being necessary to being about one's own personal interest are inappropriate. Intrusive questions about personal lives that people feel are irrelevant to why they have sought out medical care are distressing for the person. Always frame questions with explanations of why they are needed.

> *'Before we get started, I'm going to need to ask some questions about your sexual contacts to make sure that we do the right tests. Do you have any words you prefer to use for your body or genitals so that I can help you feel comfortable?'*

The parts and practices model focuses on the body parts a person has and what they are doing with them, rather than making assumptions based on gender, sexuality or reproductive ability.[210]

> *'Do you have sex with people with a penis, people with a vagina or both?'*

> *'Is there any risk of pregnancy for any of the sex that you're having?'*

STI testing (as per New Zealand STI guidelines)[211] should be offered based on anatomy, sexual practices and the person's preference. Self-collection of samples is appropriate for asymptomatic STI testing but examination is required for people with symptoms.

Use of hormone therapy does not affect STI screening, but T-GAHT can affect the vaginal microbiome[212] and the interpretability of vaginal microscopy to investigate a vaginal discharge.

People with a neovagina (post gender affirming genital surgery) should be offered first-void urine testing in addition to a neovaginal swab.[211] The suitability of requesting neovaginal tests is dependent on the type of tissue present in the neovagina (penile skin, bowel, peritoneal) and seeking advice from a sexual health specialist is recommended.

19.2 Genital examination

'I am extremely uncomfortable about my body. In a physical examination please take care and understand, if I seem distant or if I make awkward comments, I'm just trying to get through it' – transgender person

If an examination is indicated, then explain to the person what is and is not required before starting. Transgender people can experience dysphoria related to their genitals and may find genital examinations very challenging.

If a genital examination is indicated, psychological trauma also should be considered.

Participants in the 2018 Counting Ourselves survey (of transgender people in Aotearoa New Zealand) reported high rates of being sexually assaulted, with 32% of those aged 16–74 years reporting that, since the age of 13 years, someone had had sex with them against their will.[17] This is nearly five times the rate of experiencing non-volitional sex that 16–74-year-olds in the general population reported in the 2014/15 New Zealand Health Survey.[213]

Disabled transgender people in Aotearoa New Zealand reported even higher rates of being forced to have sex than the broader transgender population. 49% of disabled Counting Ourselves 2018 survey participants aged 16–74 years reported that, since the age of 13 years, someone had had sex with them against their will.[17]

It is critical that health professionals recognise the potential for distress and provide a trauma-informed and sensitive approach to genital examinations. Collaboration, allowing people's voice and choice to be central, are key to trauma-informed care.[214] Respect personal autonomy by providing options including: the timing of procedures, having a support person present, and seeking permission to start examinations and allowing control over stopping examinations at any time. The option of self-inserting a speculum may provide some people with a greater sense of control. The new human papillomavirus (HPV) primary screening in Aotearoa New Zealand allows for the option of a self-taken vaginal swab for those eligible.[215]

As T-GAHT can cause vaginal dryness,[212] use of extra lubrication and a small speculum may decrease discomfort during an examination. Topical vaginal oestrogen cream applied each night for approximately two weeks prior to a speculum examination may also be helpful prior to a planned procedure such as cervical cancer screening.

If examination of a person's neovagina is recommended, consider an initial digital exam using a single digit to assess the length and path of the neovagina. Using an anoscope instead of a speculum may facilitate visual examination.

19.3 STI treatment

Provide STI treatment in accordance with the New Zealand STI guidelines.[211] Symptomatic bacterial vaginosis in people with a vagina on T-GAHT requires treatment, but the possibility that symptoms may be related to atrophic vaginitis secondary to T-GAHT[212] should be considered and the option of topical oestrogen discussed. Provide reassurance that this will not affect the outcomes of T-GAHT.

19.4 HIV PrEP

> 'Do you or any of your partners have sex with gay, bisexual or queer cis-men?'

HIV pre-exposure prophylaxis (HIV PrEP) should be offered for eligible people as per Aotearoa New Zealand guidelines.[216] While HIV incidence for transgender people in Aotearoa New Zealand appears low,[217] risks are likely to be higher for people whose sexual networks include cisgender men who have sex with cisgender men (MSM).[216] The risk of HIV acquisition is higher with anal intercourse but for people on T-GAHT there may also be increased risk with vaginal (frontal) sex due to a decrease in natural lubrication and the effect of testosterone on vaginal tissue.[212]

Daily dosing is currently the only recommended HIV PrEP regimen for people on GAHT. While being on HIV PrEP does not affect E-GAHT, oestrogen may reduce the efficacy of tenofovir, so event-driven HIV PrEP is not currently recommended. Daily dosing is also the only recommended option for anyone having frontal sex.[216]

19.5 Doxy-PEP

Post-exposure prophylaxis with doxycycline (Doxy-PEP) has been shown to significantly decrease the risk of syphilis and chlamydia acquisition for MSM, and for transgender people AMAB, whose sexual networks put them at increased risk of these infections.[218] Consider discussing this as part of combination STI prevention, including condom use, as per the New Zealand consensus statement.[219]

19.6 Pleasure

Transgender people's sexual function and/or desire may change throughout their life (as it can for all people). This can be for a range of reasons, including from the effects of GAHT and how comfortable people feel in their bodies at different points in time. Checking in with people about whether they have anything related to sexual function that they want to address can be a helpful way to open a space to talk if needed.

If people are unhappy with where they are at, it may be helpful to have a conversation about what they want and how to achieve this. The use of lubrication may benefit people on T-GAHT.

If there is a concern regarding lack of erectile function for people on E-GAHT, then reviewing the dose and choice of anti-androgen may be helpful. Also consider the potential impact of other medications. A trial of a different anti-androgen may be of benefit, such as switching from cyproterone to spironolactone. Alternatively reducing doses could be considered. Cyproterone doses can be adjusted down to 12.5 mg every second day or twice weekly as needed. Review the need for lifestyle changes or counselling and consider medication. The PDE5 inhibitors, e.g. sildenafil/tadalafil, can be used with any feminising hormone regimen.[220]

20. Mental wellbeing

This chapter is to be read alongside the social determinants of mental and physical health chapter, and the whānau chapter, both of which are in the Whakapapa section.

20.1 Mental health inequities

Transgender people rate their mental and physical health as poorer than cisgender people,[17] with this finding replicated in numerous international studies over the last decade.[221-225]

International studies have shown higher rates of anxiety, depression, substance misuse, neurodivergence, eating disorders and risk for PTSD amongst transgender people.[226-230] In Aotearoa New Zealand, a survey of nearly 1200 transgender people showed that more than half (56%) had seriously thought about attempting suicide in the last 12 months.[17] Almost two in five respondents (37%) reported having attempted suicide at some point, and 12% reported having had attempted suicide in the last 12 months.[17] Stats NZ also reports that transgender adults in Aotearoa New Zealand experience more frequent anxiety and depression than their cisgender counterparts.[18] Please see the **social determinants of mental and physical health** chapter, in the Whakapapa section, for relevant further details.

However, transgender people have the same inherent potential to flourish and thrive as other people. Evidence suggests that the burden of minority stress contributes to their mental health inequities.[19, 21, 23-25] Please see the **Minority Stress Theory** sub-chapter within the **social determinants of mental and physical health** chapter, in the Whakapapa section, for more details, as well as additional information later in this chapter.

20.2 The goals and mental health impacts of gender affirming healthcare

> *'[Gender affirming medical treatment] … has been the single best decision I have ever made for my mental health' – transgender adult.*[49]

Being transgender can be, but may not always be, accompanied by gender dysphoria: a person's discomfort or distress with their body or gender roles associated with their sex assigned at birth.[2] Everyday activities that remind a transgender person of the difference between their body and/or gender role, and their identity, can exacerbate this distress, for instance showering, dressing, and interacting with people who misgender them.

> Increasing evidence demonstrates that supportive, gender affirming healthcare for transgender people significantly improves gender dysphoria and mental health and wellbeing outcomes.[2, 166, 231, 232]

The *World Professional Association for Transgender Health Standards of Care Version 8* (WPATH SOC 8) explains that the goal of gender affirming healthcare is to safely and effectively provide transgender people with 'lasting personal comfort with their gendered selves with the aim of optimizing their overall physical health, psychological wellbeing, and self-fulfillment'. [2] Mental health may improve because of gender affirming healthcare. For example, a systematic review of 46 studies indicated stronger evidence for a decrease in psychological distress and depressive symptoms, and weaker evidence for an increase in quality of life.[167] Observational studies have shown decreases in depression, suicidality and sometimes anxiety.[165, 233] However, improved mental health cannot be guaranteed as an outcome, and is not necessarily the sole or primary goal.

20.3 Best practice approach to gender affirming healthcare

Current best practice for gender affirming healthcare is built on the principle that a person is the expert in their own gender, and that they should be able to access treatments which help them find comfort in their own body and identity on the basis of informed consent.[2] The **informed consent** chapter (in the Mana section) should be read alongside this chapter.

Input from a mental health professional is not routinely indicated prior to gender affirming medical care for adults in Aotearoa New Zealand – please see the **adult gender affirming hormone therapy** chapter. There is no evidence showing that universal mental health 'gatekeeping' prerequisite requirements are necessary or helpful,[234] and evidence suggests they cause harm and distress through unnecessarily delaying access to care[235] and perpetuating stigma.[236]

20.4 Practice points

- Transgender identities are a part of normal human diversity and are not inherently negative or pathological.
- A transgender person should be considered the expert in their own identity, gender(s) and needs.
- Being transgender may or may not be associated with gender dysphoria. The absence of gender dysphoria should not be considered a barrier or contraindication to someone being able to access gender affirming medical or surgical treatment(s).
- Gender affirming healthcare should be provided on the basis of informed consent.
- As with any other person over the age of 16 (or who is deemed to be Gillick competent),[237] and with any other medical treatment, transgender people should be assumed to have capacity unless there is reason to believe otherwise. Assessment by a mental health professional is not routinely indicated and having blanket requirements of this nature has been shown to be harmful.
- Transgender people have been shown to experience higher rates of a range of mental health conditions and report higher levels of mental distress when compared to the general population.

20.5 Supporting self-exploration of gender

Much like other forms of identity formation,[238] people come to understand their gender through a process of self-guided experimentation and self-discovery.[109, 239] This is an important facet of the healthy development of a person's identity and understanding of self. Transgender people who have been supported in expressing their identity have better mental health outcomes.[240]

20.5.A Support the person

> *'I basically came in ready to fight, ready to fight off intrusive questions, all that sort of stuff. I met with a psychologist who basically immediately asked me, she came into the waiting room and she was like "hey, lovely to see you" like super super nice. She just had a really good vibe. I went into a room, had my partner with me, and we sat down and there was a big comfort sort of soft toy on the couch and she offered that to me and I was like "yes please, that'll help a lot." So it immediately made me very comfortable and just treated me as very human throughout the whole process in a way that like, I hadn't experienced very much' – transgender person*

Mental health professionals should provide people who are questioning their gender with space to explore and come to their own conclusions about how they identify. All genders are an equally valid and positive outcome. The individual should lead, dictate the direction and set the pace of this self-exploration.

> The key is not presupposing an outcome, but instead supporting the person's journey.

Practitioners may then facilitate access to any treatments and interventions chosen by the individual, as opposed to taking a 'conveyor belt' or one-size-fits-all approach to gender affirmation.[2]

> Effective gender affirming healthcare is done with the individual rather than done to the individual.[235] It is about sharing knowledge and empowering individuals to make informed decisions about their body and their wellbeing, rather than expecting individuals to fit rigid gender roles.[241, 242]

When a person understands and accepts their gender, they may realise that they are transgender or cisgender (not transgender). Those who engage in gender affirming healthcare, only to conclude that they are cisgender, or do not want further gender affirming healthcare, still may report that this journey was nevertheless helpful in terms of both reducing psychological distress and giving a stronger sense of self.[243-245]

Many people have started questioning their gender months or years prior to disclosing this to family, and prior to presenting to health professionals for support.[246] Health professionals should be mindful that a person's understanding and acceptance of their gender is not static and changes over time, and may do so more rapidly during the earlier phases of gender exploration.[247] Someone's pronouns, name or the way they describe or explain their gender identity may change and evolve as they go through this process.[109, 248-250] This does not invalidate their gender, nor should it be seen as a contraindication to the person receiving other forms of gender affirming healthcare. Change is often reflective of a healthy, ongoing and self-guided process of exploration of gender identity, and of experimentation with gender expression.[109]

Whilst many transgender (and gender questioning) people feel able to engage in exploring their gender themselves, some people may present to healthcare services requesting additional psychological support to assist with this process.[251] The need for this should always be identified by the individual. Counselling or therapy should not be a blanket mandatory prerequisite for supporting social affirmation or access to other forms of gender affirming healthcare.[2]

20.5.B Who can support self-exploration of identity

Support for self-exploration of gender can often be provided in a primary care or community setting by counsellors, peer-support workers, transgender or Rainbow community organisations, transgender peer support groups, psychologists, or other individuals and organisations with relevant experience. A referral to secondary mental healthcare may only be warranted if there are other complex or severe mental health issues.

20.5.C Be affirming, and empower self-exploration and self-expression

When providing support to those who are questioning their gender or identity it is important to be affirming in one's practice.[252] At the most basic level, this includes using the pronouns and name chosen by the individual at that point in time (see the **interacting with transgender people** chapter, in the Mauri section). It also includes, with patient consent, updating health records and computer systems to ensure records are correct and reflect that person's identity (see the **creating inclusive clinical environments** chapter, in the Wairua section).

> Health professionals are encouraged to exercise cultural humility, and so consider each person to be the expert in their own gender and sense of identity.

Empower people to express their gender in the way which feels most authentic (or most comfortable) to them at that point in time. This may include experimenting with dress and presentation, trialling the use of different pronouns or identity labels, trying binding, tucking or packing, speaking at a different pitch or resonance, or asking to be called by different names. This list is non-exhaustive. There are many ways people can explore and express gender identity, beyond and often prior to seeking medical or surgical treatments. The **non-medical and non-surgical gender affirmation** chapter, in the Mauri section, provides useful further information.

20.5.D Information and connections to assist with identity exploration

Practitioners may help facilitate gender exploration by:

- Signposting gender-exploring people to transgender and/or Rainbow community organisations, or
- Informing gender-exploring people about spaces (both physical and online) where they can access peer support from other gender-exploring and transgender people.

Such connections have been shown to reduce self-stigma, reduce the burden of psychosocial stress associated with gender-exploration, and improve psychological wellbeing.[253, 254]

It can also be helpful to provide people with information about gender identity and exploration, being transgender, and/or gender affirming medical and surgical options for the future.

20.5.E Practice points

- Self-exploration of gender can be an important, normal and healthy part of identity formation, which should be supported and encouraged by health professionals.
- Acknowledge that transgender people are the experts of their own sense of personal identity, both with regards to their gender and other areas.
- Transgender people being connected with transgender community support can have a positive impact on an individual's wellbeing.
- Take a holistic approach when caring for transgender people. Consider the individual alongside their social and cultural contexts and how these contribute to their mental health.
- Psychotherapeutic support and/or counselling is not mandatory to obtain gender affirming healthcare but may be helpful when sought or requested by an individual.
- Self-exploration of gender does not routinely require input from a secondary mental health professional. For many who need support, it can be provided in primary care and community settings by a wide range of professionals.

20.6 Considerations for therapy providers

20.6.A Introduction

At times, people may be confronted with concerns that they are unable to resolve by themselves. In these instances, therapeutic support may be helpful. This should never be mandatory and should instead be offered and provided on the basis of it being sought by the patient with mutually agreed treatment goals. There is international expert consensus that psychotherapy should no longer be a compulsory prerequisite to access other forms of gender affirming healthcare.[2]

20.6.B Gender affirming vs non-affirming modalities

There is a long history of therapeutic interventions being provided as a 'treatment' to 'cure' gender incongruence.[255] Psychological interventions may be helpful in addressing internal conflicts or the impact of minority stress, or for treatment of mental health issues.[256] However, there is no evidence that any form of psychological therapy can change a person's gender identity, or make a person no longer be transgender. Please see the **conversion practices** sub-chapter within this chapter.

Exclusively using psychotherapy to 'treat' a person for gender dysphoria – whilst suspending the administration of any gender affirming hormone treatment – is considered to be a 'risky and unproven strategy'.[257] Professional organisations have recognised that cessation of gender-related treatment, not through patient choice, is usually inappropriate and is highly distressing for the transgender person.[26]

Conversely, taking a gender affirming approach is likely to enhance rapport with transgender people[235] and lead to improved outcomes in other areas of treatment. For guidance on how to affirm a person's gender during mental health appointments please see the **interacting with transgender people** chapter.

20.6.C Choice of affirming modality

In recent years, the uses and potential benefits of specific psychological therapy approaches to relieving psychological distress amongst transgender people have been reported,[76, 246, 256, 258-261] and some models have been developed specifically for working with transgender individuals.[262] However, there is no strong evidence suggesting a particular psychotherapeutic modality should be preferred or recommended over another when working with transgender people.[263] Systematic reviews have noted the sparsity of evidence and the developing nature of this field and stressed the need for additional high quality research.[76, 256]

A recent systematic review identified several approaches that may be useful in supporting transgender people.[256] These include:

- Building Awareness of Minority related Stressors + Transgender Affirmative psychotherapy (BAMS + TA).[258] Alongside taking a transgender affirming approach, this model incorporated elements of psychoeducation around the experience of minority stressors and prompted participants to discuss these experiences in therapy
- A modified version of the Releasing Internalized Stigma for Empowerment (RISE) model[264]
- Transgender Empowerment by Texting (TExT) – a cognitive behavioural therapy (CBT)-informed approach delivered through cellphone messaging[265]
- Incorporating elements from positive psychology[266]
- The Transgender Resilience Intervention Model (TRIM) identifies factors that are useful in combating the negative impacts of minority stress and guides mental health professionals on how to address them when working with clients.[262]

20.6.D Therapeutic rapport

Whilst some transgender people report therapy as being beneficial, others report having negative experiences of psychological interventions,[267, 268] and may have reservations about engaging in therapy. These reservations may present challenges to the therapeutic relationship, particularly if the therapy providers goals are not collaborative, and/or the transgender person views the therapy provider as a 'gatekeeper' to accessing gender affirming healthcare.[269] To address this, demonstrate awareness and empathy around transgender experiences, and engage in practice based on cultural humility and cultural safety.

20.6.E Use a holistic approach

Health professionals should take a holistic view and think broadly in supporting people. Māori health frameworks have laid the foundation for holistic care in Aotearoa New Zealand, such as Tā Mason Durie's Te Whare Tapa Whā model[270] and Rose Pere's Te Wheke.[271]

For these guidelines, we are using Kerekere's *Te Whare Takatāpui* model.[4] It is useful for mental health professionals to utilise the information in the following parts of these guidelines within their practice:

- The **historical context**, **social determinants of mental and physical health**, and **whānau** chapters in the Whakapapa section
- The **creating inclusive clinical environments** chapter in the Wairua section
- The **Māuri section** about how to interact with transgender people, including those with particular identities and backgrounds.

Holistic mental healthcare could include measures such as offering interventions to help resolve familial conflict where it has arisen. Where there are conflicts between identity exploration and religious beliefs, it may help to signpost people to Rainbow-safe places of worship. Where attitudes at school or work are unsupportive, it may be appropriate to consider contacting these institutions to advocate for the person, with the person's consent and involvement. There are many other examples.

20.6.F Professional competency

Please see the **clinical governance** chapter in the Tikanga section for relevant information.

20.6.G Mis/dis-information

Aetiology

There is no convincing evidence that being transgender – or questioning gender over an extended period of time – arises solely due to psychological trauma, other adverse life experiences, neurodivergence or peer influence.[129, 272]

The suggestion that transgender identities arise as sequelae of trauma has been recognised as a 'misleading and unfounded narrative' by professional bodies such as the American Psychological Association.[129]

In recent years, concerns have been raised around some people's experience of transgender identity being (supposedly) caused by peer influence rather than innate understanding of their own experience.[273] Methodological and ethical concerns have necessitated major revisions to[274] or withdrawal of[275] papers proposing that

expressions of gender diversity in young people may be the result of social contagion, and that this group may experience harm from gender affirming healthcare. Comprehensive scholarly critiques of these papers have been published,[273, 276, 277] and the papers are widely considered as debunked amongst experts within the field of transgender health.[2] The proposed social contagion concept has been condemned by a range of medical professional organisations.[278-281]

Increased demand for gender affirming healthcare

The increased prevalence of known gender diversity, and associated increased demand for gender affirming healthcare, is widely considered to have arisen due to societal changes.[282]

> Increased social discourse about transgender people, in conjunction with de-stigmatisation and depsychopathologisation of transgender experiences, has given people the language to explore, explain and understand personal experiences that historically may have been suppressed or left unexplained.

There is also a greater awareness of options for gender affirmation. The increased visibility and acceptability of gender affirming health services has led to more people seeking gender affirming healthcare where they may have previously seen such support as inaccessible or unavailable. The increase in gender diversity and demand of gender affirming healthcare among youth likely reflects the increased social visibility, allowing people to access gender affirming healthcare at an earlier age (when they would have previously struggled with distress relating to gender and being unaware of, or unable to access, gender affirming healthcare).

Conversion practices

Conversion practices are defined as any practice, sustained effort or treatment that is directed towards an individual because of the individual's sexual orientation, gender identity or gender expression and is done with the intention of changing or suppressing the individual's sexual orientation, gender identity or gender expression.[283]

These have caused, and continue to cause, significant harm when enacted on transgender individuals.[14]

> Encouraging people who identify as transgender to suppress their gender identity and to take on a gender role that is in accordance with their sex assigned at birth has been shown both to be ineffective and to increase gender-related distress.[13, 16]

It is illegal to perform conversion practices on someone under the age of 18 or on someone who lacks decision-making capacity under New Zealand law.[283] In many instances, it is also an offence to perform conversion practices on someone 18 years or older where that causes serious harm.[283]

Professional organisations and statutory regulators covering various mental health-related disciplines have released statements recognising the harm of conversion practices, opposing them, and/or confirming that they lie outside of their ethical standards.[26, 27, 284-288]

There is significant variability between mental health professionals in how specific psychotherapies (e.g. psychodynamic psychotherapy; Narrative Therapy; cognitive behavioural therapy, etc) are practised. This is in part due to how these are subjectively interpreted and adapted based on the therapist's own teaching, values and clinical experience. While psychotherapies are not conversion practices by default,[26] psychotherapies have the potential to be used as conversion practices, depending on how these are interpreted and enacted by a provider, and the school of thought – and underlying assumptions – on which the therapy is based (e.g. 'Gender Exploratory Therapy' and related practices).[289]

Psychotherapy is not ethical by default, but rather is determined by the actions, conduct and intentions of the practitioner, including whether it upholds the relevant ethical standards of that profession.[290] Some statutory bodies have taken care to emphasise the particular importance of ethical codes when providing care to transgender individuals.[26, 27]

20.6.H Practice points

- There is no blanket requirement for all transgender people to undergo psychological assessment or therapy to access gender affirming medical interventions.
- There is a lack of evidence supporting specific psychological interventions as applied to transgender individuals.
- Be mindful of misinformation and disinformation relating to transgender people.
- Many conversion practices targeting gender identity are illegal in Aotearoa New Zealand.

20.7 Supporting neurodivergent transgender people

For brevity and readability, the terms 'neurodivergent' and 'autism' are used as umbrella terms throughout this section. We have used the terms 'Autistic Spectrum Disorder' (ASD) and 'Attention Deficit Hyperactivity Disorder' (ADHD) for clarity. Whilst we acknowledge that some people may disagree with the terms ASD and ADHD, or their categorisation as 'disorders', we use them as they are standard diagnostic terminology in the DSM-5 and ICD-11.

Whether a transgender person is neurodivergent or neurotypical, they have potential to benefit from appropriate gender affirming healthcare if they wish for it. A diagnosis of neurodivergence should not prevent a person from accessing medical or surgical gender affirming healthcare.[2, 75, 291]

This sub-chapter focuses on considerations relating to the assessment, diagnosis and treatment of transgender people with potential neurodivergence.

20.7.A Terminology

Neurodivergence is an umbrella term that covers a wide range of neurodevelopmental variations including ADHD and ASD.

Some people find neurodivergence labels such as autism or ADHD to be useful in explaining their own lived experiences.[292-294] However, these labels are Western constructs and may not fully capture the lived experiences of both those within a Western culture and those who are outside of it.[295]

Within Te Ao Māori there are many diverse understandings of people who would be considered to have autism in Western culture.[296] Some Māori have stated that they do not think the label of autism should be used, as people with these experiences would be a normal part of Te Ao Māori.[297] Others have proposed a more culturally appropriate term, 'Takiwātanga', which is derived from the term 'tōku/tōna anō takiwā' which means 'my/their own time and space'.[298] Takiwātanga is seen as a more mana-enhancing rather than deficit-opposed term, focusing on the gifts that people with these experiences bring.[297]

While these guidelines continue to use the Western concepts to communicate information in language that health professionals are familiar with, we also acknowledge the limitations of these labels and how others may have different ways of conceptualising these experiences.

20.7.B Co-prevalence

A substantial proportion of transgender people have neurodivergent variations.[131] ASD has an estimated prevalence of 1–2% in the general population, with research indicating that transgender individuals are 3.03 to 6.36 times more likely to be autistic than the general population.[131] Research indicates that ADHD is 1.72 to 7.21 times more prevalent among transgender individuals than in the general population.[131]

Whilst there are many theories proposed to explain the increased prevalence of neurodivergence amongst transgender populations,[299] there is no evidence to suggest gender diversity is a manifestation of neurodivergence.[129]

20.7.C Assessment considerations

Accommodating neurodivergence

Any service provided for transgender people should accommodate neurodivergence. Health professionals are encouraged to consider and enquire about neurodivergence, what this may mean for the transgender person, and what it might mean for them in terms of gender. Some transgender people may already have a formal diagnosis of ASD or ADHD, others may be self-diagnosed or suspect they are neurodivergent, and others may not have considered this or be unaware they have some neurodivergent traits. Regardless, it is important to check if the individual has any specific needs which may need accommodations. These may include:[291, 297]

- Accommodating sensory sensitivities (e.g. using low level lighting)
- Making adjustments for social differences (e.g. minimising number of people in assessment)
- Accounting for cognitive rigidity (e.g. providing a clear and transparent overview of processes, time frames, and what to expect)
- Providing additional time to accommodate verbal communication difficulties (e.g. alexithymia, executive dysfunction).

Informed consent

Being neurodivergent does not routinely impact on an individual's capacity to give informed consent. Informed consent for transgender people is discussed in detail in the **informed consent in gender affirming healthcare** chapter (in the Mana section).

For informed consent, health professionals can consider accommodating different learning styles by providing information in audiovisual formats and pictures, as well as written text. When providing informed consent education and discussion be aware that some individuals may appreciate repeated shorter appointments rather than fewer long appointments.

The applicability of psychometric tools

Be aware of the limitations in the applicability of psychometrics to transgender people. Psychometric tests tend to employ gendered norms and the limitations to this are discussed in Anderson et al. 2022.[300] There is currently no evidence indicating whether it is more valid to use an individual's stated gender or their sex assigned at birth when scoring a psychometric tool that uses gendered norms, and no clear clinical consensus about which approach may be more accurate.

There is widespread understanding that under-diagnosis of ADHD and ASD exists, particularly among adults, and especially in women.[301-304] Long-established psychometric tools used in the diagnosis of these conditions have been criticised for being based in a male-phenotype of neurodivergence. There is a lack of research about their applicability to the transgender population.

Where these are available, health professionals may wish to consider using psychometrics that include non-binary population norms, such as the Camouflaging Autistic Traits Questionnaire (CAT-Q).[305] Another option is to take the approach of double scoring and making an assessment on the basis of considering scores in the context of both gendered norms, or scoring on the basis of the patient's preference.[300]

Psychometrics used in the diagnosis of neurodivergent conditions often require feedback from multiple responders related to the patient. The following may lead to added challenges in gathering this information about transgender people:

- Transgender individuals are more likely to experience bullying and discrimination at school, and are less likely to feel they are cared about by education providers.[17] This may impact on attendance and the likelihood of remaining within a given school, and makes gaining accurate feedback from educational settings more challenging.
- As transgender individuals are significantly more likely to be estranged from whānau[17] it may not be possible to gain collateral information or assess developmental history.
- Gaining a true sense of functional impact on employment may also be challenging. Transgender individuals are more likely to experience workplace discrimination.[17, 229]

Health professionals may need to exercise additional flexibility when assessing for neurodivergence among those with transgender identities, and take into account the limitations of psychometric testing in the process of assessment.[306]

20.7.D ADHD prescribing considerations for people who are on puberty blockers

As is the case with a number of psychiatric medications, GnRH analogues (also known as puberty blockers) are associated with QT prolongation.[307] Whilst there are no reported cases of QT prolongation in young people secondary to these medications, data remains limited. Prescribers should exercise clinical judgement when considering whether additional cardiac monitoring (e.g. serial ECGs) or advice from a cardiologist might be warranted when starting new medications.[308]

Appetite suppression is a common adverse effect of a number of ADHD medications, particularly with stimulants.[309, 310] While recent longer-term evidence has been reassuring,[311-313] there is a concern that poor diet from appetite suppression may exacerbate the impact of puberty blockers on bone density.[306]

When prescribing for ADHD to young people who are on puberty blockers, provide education about good nutrition. It may also be helpful to use the strategy of encouraging young people to consider 'eating as a gender affirming treatment' in itself by highlighting the need to have adequate caloric intake to allow the building of muscle mass in transmasculine individuals, or feminine fat deposition and/or breast development in transfeminine people.[306] There may also be benefit in encouraging young people on puberty blockers to take part in physical activity to benefit their bone density and overall health.[306] For more information regarding physical activity and transgender health, please see the **sport** sub-chapter, within the **social determinants of mental and physical health** chapter.

20.7.E Practice points

- A significant proportion of transgender people are neurodivergent, and their needs should be accommodated by gender affirming healthcare providers.
- Health professionals working with transgender people should consider and enquire about potential neurodivergence.
- Health professionals specialising in the administration of standardised questionnaires and psychometrics s hould consider the use of measures that accommodate transgender and non-binary individuals. Alternatively, health professionals may consider scoring psychometrics using both sets of gender norms.
- Prescribers should be aware that loss of appetite associated with ADHD medications has the potential to compound bone density concerns for young people on puberty blockers. Advice around lifestyle measures, including physical activity, should be provided.

20.8 Working with minority stress

Minority stress, which is discussed in the **social determinants of mental and physical health** chapter, can be a useful framework to consider when working with transgender individuals. It can be used to guide a holistic approach to care that does not focus solely on gender affirmation but considers the person – and the context they live in – as a whole.

Some might consider manifestations of minority stress to be akin to experiences of trauma, but for many transgender people minority stress is ongoing, repeated, pervasive and a current experience. Acknowledgement of this opens the possibility to seek to address, and reduce, minority stress actively, and not merely seek to change how it is perceived, weighed or carried retrospectively (as might be the case with a historical trauma).

> Minority stress might be considered clinically as an additional therapeutic target, working from a systemic perspective.

Transgender people have the same potential to benefit from care-as-standard for common mental health conditions as other people. The guidance which follows should be considered 'in addition to' rather than 'instead of' such approaches.

20.8.A Maladaptive coping mechanisms

Additional indirect harm may arise from chronic exposure to stress by the development of behaviours that may be used as (maladaptive) coping mechanisms. Amongst transgender people, research has shown that there is an association between chronic stress and maladaptive coping mechanisms, for example restricted eating[314] or drug and alcohol misuse.[315]

Transgender people have high rates of deliberate self-harm (DSH),[17] which is a maladaptive coping mechanism. Rates of DSH and suicidal ideation have been shown to correlate to experiences of transphobia,[316, 317] felt stigma,[318, 319] victimisation[19, 47] and gender dysphoria.[318]

Indirect harm may also be incurred by individuals avoiding or delaying seeking healthcare due to concerns about experiencing discrimination.[320]

20.8.B Emotional regulation and stress management

Adverse life experiences are more common among transgender young people than cisgender young people.[321] When experienced in childhood and adolescence, these may negatively impact on their subsequent emotional regulation.[322]

Other transgender people may have great resilience and be highly skilled at stress management and emotional regulation but still experience difficulties in coping effectively due to the magnitude of the additional burden they face because of gender minority stress.

20.8.C Risk reduction

When looking at interventions to address escalated rates of suicidal ideation and attempts,[317] there is evidence that cognitive behavioural therapy (CBT)-based interventions and Attachment Based Family Therapy can be useful in youth populations.[323]

Minority stress, internalised transphobia, expectations of rejection and concealment of transgender identity can exacerbate suicidal ideation in transgender people.[317] Given the relationship between these stressors and suicidal ideation, interventions to address these stressors, such as the previously discussed BAMS + TA and RISE models, may be useful in reducing suicidal ideation.[256]

More conventional treatments for suicidal behaviour such as CBT, Dialectical Behavioural Therapy (DBT), Mentalisation-Based Therapy, Emotion-Regulation psychotherapy, Psychodynamic therapy and problem-solving therapies may also be useful in addressing suicidal risk.[323]

20.8.D Practice points

- Mental health professionals are encouraged to consider minority stress as a useful framework when working with transgender individuals. This can be used to guide a holistic approach to care that does not focus solely on transition or gender affirmation, but considers the person, and the context they live in, as a whole.
- Chronic stress can lead to maladaptive coping mechanisms, and difficulties with emotional regulation and stress management.
- Addressing stressors specific to transgender people may reduce suicidal ideation.

20.9 Connection to whānau and peers

20.9.A Whānau

The **whānau** chapter in the Whakapapa section discusses the importance of whānau support, some social dynamics that can be present in whānau, and how health professionals can assist transgender people and their whānau.

20.9.B Social media

For transgender people, social media can have both positive and negative impacts on mental health. Many transgender people report accessing useful information,[324, 325] or that accessing internet communities has helped with validation of identity, isolation, bullying or other adversities.[254, 326] Connection with online communities is a valued means of peer support and identity exploration and for some people it is their only source of information and support.

At the same time, there has been a significant amount of transphobic discourse in social media over the last few years.[327] This is problematic as exposure to online hate speech has been shown to have negative consequences, causing negative mood states like loneliness, anger or fear.[328]

It can be useful to discuss social media use with transgender people. This might include asking how frequently they use social media, if they are aware of negative media representations, and if this has any impact on their wellbeing.

It may be helpful to discuss steps to mitigate negative impacts of social media use. This might include taking steps to reduce their exposure to negative social media sources (e.g. unfollowing accounts, blocking certain users), increasing exposure to positive supports and role models (i.e. finding healthier alternative content), reducing screen time generally, or engaging with alternate forms of support (whether digital or face-to-face).

20.9.C Practice points

- Connection and social support are important to the wellbeing of transgender people.
- Social media has been shown to have the potential for both positive and negative impacts on transgender mental health. It may be beneficial to discuss taking steps to mitigate exposure to psychologically harmful content.

21. Surgical gender affirmation and post-operative care

21.1 Introduction

Some transgender people are comfortable with the expression of their gender without any form of surgery and for others surgery is essential to alleviate their gender incongruence or dysphoria and/or to live fully and authentically in their gender.

There is no expectation or requirement for surgery for gender affirmation, but for those who do desire it, current literature supports the benefits of gender affirming surgery in reducing dysphoria and improving quality of life.[329]

> Gender affirming surgery has a low incidence of regret.[330-332]

Gender affirming surgeries are not offered in an equitable manner across regions. This is sometimes known as the 'postcode lottery'. Availability and funding are significant issues within Aotearoa New Zealand.

Please read this chapter in conjunction with the **fertility** chapter.

21.2 Overview of gender affirming surgical procedures

Gender affirmation surgeries can help to either reconstruct sex characteristics and/or remove reproductive organs. Each has different considerations for psychological and physical surgical preparedness.

21.2.A Alignment of sex characteristics

Surgeries that reconstruct external sex characteristics include facial, chest, truncal and genital modification. Individuals are consulted on their specific aesthetic and functional goals. Dependent on the technique and complexity of reconstruction, patients may be recommended physical preparations and advice to optimise their health and support environment to improve surgical outcomes.

A psychological assessment with a mental health professional trained in gender affirming surgery is usually required due to the complex nature of these reconstructive procedures. It is important to have a good support network and coping skills for stressful situations.

21.2.B Removal of reproductive organs

Orchiectomy

From a medical perspective, an orchiectomy allows an individual to stop anti-androgen medication, thereby removing the need for lifelong medication, with its associated risks and side effects. Other benefits include being able to wear tighter fitting clothes.

People undergoing this procedure need to consider the impact on fertility and the need for lifelong hormone supplementation.

Hysterectomy

A hysterectomy is less often indicated as part of gender affirming healthcare, as benefits such as cessation of menses can usually be achieved using medical options (see **adult gender affirming hormone therapy** chapter). In the first instance these should be discussed and offered (noting that testosterone usually results in menstrual cessation). However, some transgender people report experiences of gender dysphoria from knowing that they have a uterus, and some people struggle with ongoing bleeding despite medical therapies.

If an individual does undergo a hysterectomy, careful consideration should be given to whether an oophorectomy is necessary. In most cases it is advisable to retain the ovaries to allow for future fertility options, and to retain the ability to produce endogenous hormones. Some people decide to stop T-GAHT, and if the ovaries are not present, they would need to take oestrogen supplementation to maintain bone and cardiovascular health.

A psychological assessment with a mental health professional who is knowledgeable about relevant gender affirming surgery matters is recommended to explore the irreversible nature of these procedures, the impact on fertility and implications for long-term medical care.

Anyone undergoing surgical removal of gonads should have fertility implications and reproductive options discussed as part of the consent process. See the **fertility** chapter for further detail.

21.3 Feminising surgical procedures

These include:

- Facial feminisation surgery, which commonly includes tracheal shave, brow reduction, rhinoplasty and genioplasty (chin)
- Minimally invasive facial procedures including hair removal, dermal filler or hair transplant
- Voice/pitch surgery
- Breast augmentation – as breasts proliferate with oestrogen, it is recommended that for optimal aesthetic outcomes, women achieve stable breast growth (usually at least one year of being on oestrogen) before planning for breast implants
- Lipocontouring of body – hips/buttocks
- Orchiectomy
- Vaginoplasty – minimal or full depth vaginoplasty.

21.4 Masculinising surgical procedures

These include:

- Chest masculinisation/mastectomy – as testosterone does not shrink breast tissue, being on hormones is not a necessary prerequisite
- Lipocontouring of the body – hips/flank
- Hystero-oophorectomy
- Genital masculinisation:
  - Metoidioplasty with or without urethral lengthening
  - Phalloplasty with or without urethral lengthening.

Note: A vaginectomy is necessary for urethral lengthening. People who plan for urethral lengthening therefore require a hysterectomy (including removal of the cervix) prior to vaginectomy and urethral lengthening.

21.5 Referral processes

Referrals for locally provided procedures (hysterectomy, orchiectomy, chest surgeries) should go to the appropriate local hospital provider. These are usually represented in a health pathway. Each regional pathway has its own surgical criteria to optimise wound healing and anaesthetic risk. Some gender affirming surgeries are only offered in the private sector and only in some regions.

Gender affirming genital surgery is publicly funded with a national waiting list for a first specialist assessment (FSA) which is managed by Health New Zealand | Te Whatu Ora. Referrals can be made by a hospital referrer or an authorised GP (at the time of writing the only districts with authorised GPs are Wellington and Christchurch). All referral information can be found on the **service website, including referral criteria and referral forms**. Up-to-date information about a person's physical and mental fitness to undergo a lengthy and highly complex reconstructive surgery is required. This is usually in the form of a psychological assessment.

Mental health specialists completing such assessments are advised to be in communication with the surgeon, or have a clear understanding of their requirements, pathway, and the surgical procedure. This will allow for the assessment to support decisions regarding informed consent, the timing of surgery, ensuring the individual's expectations are realistic and achievable, that they are able to engage in a shared decision-making process with the surgical team, they have adequate post-operative support plans in place, and managing mental health issues if these are experienced by the individual undergoing surgery.[2]

I was warned about the level of disruption and post operative recovery that was needed for genital surgery. I was very glad I had all my supports in place and had taken care of my general health, because it required lots of energy to keep my recovery on track' – patient

21.6 Surgery for older people

When considering surgery for older transgender individuals, it is important to recognise that complications may be more pronounced with ageing. However, there is no upper age limit for gender affirming surgeries.[2] The evaluation process should mirror that of cisgender older individuals, with careful attention to physical health conditions, the ability to rehabilitate after surgery, availability of support at home, and mental health considerations.

21.7 Gender affirming surgeries without hormone therapy

Some people seek gender affirming surgeries without wishing to be on GAHT, as taking hormones is not consistent with their embodiment goals.[102] Gender affirming surgical access criteria should recognise that not all transgender people want or need GAHT. The *WPATH Standard of Care Version 8* recommends that GAHT should not be required prior to gender affirming surgery for those who do not desire GAHT, and for those for whom GAHT is medically contraindicated.[2]

If a surgical intervention removes a person's testicles or ovaries, hormone therapy would be necessary to prevent the negative consequences of hypogonadism, especially on bone and cardiovascular health.

21.8 Overseas surgery

Due to the existing barriers in accessing gender affirming surgeries in the public health system and the high cost of accessing this care in private, some people go overseas to access surgery. People doing so should be aware that appropriate follow-up care can be challenging to access, as it is not usually covered in the public pathway or by ACC. Follow-up for complications of surgery should remain with the surgeon who did the initial surgery or via referral to the appropriate specialist, which is unlikely to happen with overseas surgeries.

21.9 Surveillance and follow-up

Cancer screening should be undertaken based on the anatomy present. People are encouraged to discuss these surveillance requirements with their surgeons prior to discharge back to their GP or primary care NP.

For those assigned male at birth:

- If an anti-androgen is being used, this should be stopped immediately or soon after orchiectomy.
- The prostate gland remains post vaginoplasty.
- Breast screening should occur according to the recommended breast screening programme.

For those assigned female at birth:

- Medication for menses cessation or contraception can be stopped post hysterectomy/oophorectomy.
- Mammography may still be required following certain chest masculinisation techniques.
- If the cervix is still present, cervical screening should be undertaken.

21.10 Practice points

- Gender affirming surgery can be to align secondary sex characteristics or to remove reproductive organs. These have different considerations which should be reflected in any psychological assessments performed.
- Psychological assessments to support people undergoing surgery, if required, should occur in the context of communication with the surgeon. This allows for assessments to be specifically tailored to meet the needs of the individual, the specific surgical procedure, surgical pathways, and the decision-making process between the individual and their surgeon and surgical team. Removing reproductive organs is irreversible and has impacts on future fertility.
- Gender affirming genital surgery is funded nationally with all referrals going through the Health New Zealand | Te Whatu Ora referral process. All other surgical referrals should follow regional health pathways, and will depend on local referral criteria, capacity and services.
- The Health New Zealand | Te Whatu Ora website contains comprehensive information regarding the Gender Affirming (Genital) Surgical Service, including how to make a referral, travel assistance, patient information and wait times for FSA. See **The Gender Affirming (Genital) Surgery Service**.
- Gender affirming genital surgeries are extraordinarily complicated procedures, often involving multiple steps and surgeries, and commitment from individuals in an extended post-operative period. People should be in the best possible physical and mental health before the surgery.
- Health professionals should counsel patients that seek overseas surgeries that ACC treatment injury claims and public care is unlikely to meet all their needs on their return and this may have both mental and physical health outcomes.
- Surveillance and cancer screening should be undertaken based on the anatomy present.

22. Detransition and treatment discontinuation

There is no agreed universal definition or terminology to use when people who have affirmed their gender socially, legally, medically or surgically stop or reverse the process. Detransition is a common umbrella term, but other terms such as retransition, non-linear transition or discontinuation are also used. For simplicity we have used the term detransition here, but we recognise this term does not fit for everyone.

> Some people who stop hormones or reverse surgeries re-identify with their gender assigned at birth, but many people who detransition still identify as transgender, non-binary or gender diverse.[248, 333]

Detransition and treatment discontinuation are complex and nuanced phenomena. No two people's experiences are the same, and one cannot make assumptions about a person's gender, or feelings about their gender affirming healthcare choices, based on their detransition or treatment discontinuation.

There are many reasons why an individual may discontinue or seek to reverse gender affirming hormones or surgeries. Detransition is not synonymous with regret,[334] but for those who do experience regret it can be a difficult time and accessing care can be challenging due to lack of health professional knowledge and experience, and potentially the feelings of the person seeking care.

> It is important to let patients/clients know that gender related care and support is available no matter their gender trajectory.

Current research on detransition rates is not very reliable or accurate, due in part to the wide range of definitions used for detransition, the assumption that detransition equates to regret, inconsistency of terms, very small numbers, poorly designed studies and the nuanced reasons behind detransition.[335, 336] Most existing research shows that detransition is infrequent.[337-340]

These studies are from overseas contexts which may differ from Aotearoa New Zealand, where local data on detransition rates is lacking. Gender affirming surgery has a much lower regret rate than many other surgical interventions.[331, 341]

There are different ways to embody and express gender without hormones or surgery. Non-medical options that may help people to reduce or address their dysphoria should be discussed. These may include changes in clothing, hairstyle and chosen name (see **non-medical and non-surgical gender affirmation** chapter for more detail). However, for many transgender people these non-medical and non-surgical options may not be sufficient to relieve their dysphoria.

> The fact that a small number of people may later detransition does not change the fact that it is essential to maintain access to gender affirming healthcare in a way that respects people's bodily autonomy and utilises the principles of informed consent.

When providing gender affirming healthcare, an important part of informed consent and supported decision making is to include a discussion about possible detransition and/or future regret, as well as the possibility of gender fluidity.

'Some people decide to come off hormone therapy in the future. It is fine for you to do this at any time, but it is important that you understand which hormone effects are permanent and therefore will not reverse if you stop this treatment. I am here to support you whatever decisions you make about this in the future and hope that you feel able to come and discuss this with me at any time.'

Reasons for detransition or discontinuation of treatment are multiple, varied and complex.[335] Exposito-Campos described core/primary detransition as being primarily motivated by the cessation of transgender identity, whereas non-core or secondary detransition is influenced by other factors, but with a continuation of identifying as transgender.[333]

Whilst regret may be an experience for either group, this is not necessarily the case, even in primary detransition. A study of 16-25 year olds who detransitioned found that for those research participants experienced regret, it was almost always mixed with aspects for which the person was grateful.[248] Regret and feelings of satisfaction can co-exist.[248]

22.1 Primary detransition

This is when an individual re-identifies with their gender assigned at birth and chooses to discontinue medical treatment and/or seek reversal of surgical interventions. Whilst good quality research is lacking in this area, what is available suggests that this is uncommon and that rates of regret are low.[338-340] Supportive, non-judgemental and accessible support is essential and is outlined further later in this chapter.

22.2 Secondary detransition

This is when detransition or discontinuation of medical treatment occurs, but the individual still identifies as transgender.

A number of studies have identified external factors as a driver for detransition,[248, 342] including a secondary analysis of a large US transgender survey, which found that 82.5% of the small percentage of those who detransitioned reported at least one external driving factor.[334] These factors include: pressure from whānau, friends, employers or health professionals; societal stigma; cost of healthcare; insufficient support or information; medical reasons; minority stress; discrimination; social reasons (risk of losing job or whānau); difficulty finding employment; and difficulty accessing hormones.

Internal factors that may lead someone to discontinue treatment whilst still identifying as transgender include: changed perspective over time, transition objectives achieved, change in gender identity without regret (e.g. transgender woman/man to non-binary), transition not relieving dysphoria, or finding alternative ways to manage dysphoria.[248, 334, 342]

A good discussion of what hormones can and cannot do may support people to have realistic expectations from the outset. People may be experiencing dysphoria about physical aspects which hormones will not change, which can lead to later dissatisfaction and stopping hormone therapy, due to the medication not relieving their dysphoria.

There are others who from the outset only plan to remain on hormone therapy for a certain length of time before stopping. This may be to achieve specific and permanent gender embodiment goals (e.g. deep voice) while avoiding lifelong hormone therapy. This group may be captured in detransition statistics due to stopping gender affirming hormone therapy, when in fact they have not detransitioned. The only reason this group is mentioned here is that they may be incorrectly included in detransition statistics in some research.

22.3 Implications for healthcare

Internationally the media often frames detransition as an outcome to be avoided and uses this to suggest that access to gender affirming healthcare should be restricted.[343] Fears of detransition also feed into actions overseas to restrict or ban gender affirming healthcare.[344, 345]

> Instead of restricting access to gender affirming healthcare, we require a deeper understanding of detransition so that access to gender affirming healthcare is maintained for those who need it, and support is provided to those who decide to stop or reverse medical or surgical interventions.

There may be anxiety from health professionals about whether the informed consent process for physical gender affirmation is robust, or if processes involving gender assessments are more appropriate. People have a right to change their mind and a decision to stop medication is not a failure of the informed consent process.

> Health professionals can be assured that there is no evidence that psychological gender assessments can reliably predict or reduce detransition or prevent regret.[234]

In fact, when people feel they need to overcome obstacles (in the way of rigid assessments) to access the care they need, they are less likely to be open and honest, instead feeling as though they need to say 'the right thing to pass a test' in order to access care.[235, 346]

It is possible that this could lead to people making less considered decisions or feeling the need to present as a man/woman rather than feeling comfortable to express and explore their non-binary or gender fluid embodiment goals.

It is important to acknowledge that some people who detransition, later retransition – seeking gender affirming healthcare again in the future.[338]

22.4 Approach to support people who detransition[335]

Support for people who detransition or discontinue hormones needs to be individualised, as the underlying reasons are so varied. When seeing someone who has stopped hormones or wishes to reverse a surgery, start by asking more about this in an open manner without making assumptions. Some people may not want to share this information with you, but by creating a non-judgemental and supportive consultation environment this becomes more likely, either on the first visit or in the future. Some people may be feeling external pressure to detransition, and understanding this can help to tailor your support to the individual.

- Listen to the individual in front of you – no two people are the same. Do not make assumptions about how they are feeling or their reasons for detransitioning or discontinuing treatment.
- Be supportive, non-judgemental and open to listening.
- Validate people's feelings and experience.
- Offer psychological support if appropriate. People may require support to cope with dysphoria, social and physical changes, loss of friendships, rejection, and talking to whānau.
- Address medical needs – if hormone therapy has been discontinued it may be useful to check that reproductive hormones return to the levels of their sex assigned at birth.
- Arrange follow-up to allow further opportunity to connect with and support the person.

If there is a return to a cisgender identity with or without regret:

- If there is regret, give the person space to grieve what may have been lost. Recognise that this can also result in dysphoria.
- If a person regrets a gender affirming surgery, explore options for reversal.
- Support people to move towards self-acceptance.
- Discuss non-medical options for managing gender dysphoria. Some people may wish to access voice therapy, hair removal, binders etc.

22.5 Practice points

- Reasons for detransition are complex, varied and nuanced. People who detransition do not necessarily regret their transition or return to a cisgender identity.
- Health professionals should let people know that they will be supported regardless of the trajectory of their transition, including detransition. It is important to pre-empt this as people who detransition are often reluctant to seek further healthcare support.
- Health professionals and health services should offer support for people who detransition. These may include psychological, medical, social and legal support options.
- Detransition should not be seen as contraindication to someone seeking gender affirming care again in future.

23. Resources for Tapu section

23.1 Adult gender affirming hormone therapy (GAHT)

Appendices:

- Consent forms
- Patient information sheet showing drawings of clitoral enlargement
- Testosterone gel patient information sheet

Other:

- Primary Care Gender Affirming Hormone Therapy (GAHT) Initiation Guidelines
- Testosterone injection administration guidance
- Visual timeline of GAHT effects:
  - E-GAHT
  - T-GAHT

23.2 Fertility

- Hauora Tāhine has an example of fertility information that might be provided for those starting E-GAHT (scroll down to documents at end of page)
- Transgender fertility – Fertility Associates

23.3 Sexual health

- STI Guidelines
- Sexual Health – TransHub
- The transgender guide to sex and relationships: online course – Gender Minorities Aotearoa

23.4 Surgical gender affirmation

- Transgender and gender diversity – Health New Zealand | Te Whatu Ora
- Transgender services – Health New Zealand | Te Whatu Ora
- The Gender Affirming (Genital) Surgery Service – Health New Zealand | Te Whatu Ora – has a wealth of information about referral processes and patient information leaflets about the procedures available
- Position Statement: Overseas Plastic Surgery/Medical Tourism – New Zealand Association of Plastic Surgeons

23.5 Detransition and treatment discontinuation

- Detrans Support

Tikanga

Tikanga means the right way to do things based on the mātauranga (knowledge) that we have. In *Te Whare Takatāpui*, it is represented by the paepae (the front threshold) and marae ātea (area in front of the wharenui) where the rituals of encounter take place. In these guidelines tikanga is the right way to work with transgender people specifically when it comes to clinical governance, policies and procedures, leadership and staff training.

24. Clinical governance

24.1 Definition of clinical governance

These guidelines are written with consideration of the principles of clinical governance as defined by the Health Quality and Safety Commission (HQSC).[347] Healthcare services that provide gender affirming healthcare should be applying all principles of clinical governance within their practice as much as possible. This chapter contextualises how specific principles should be applied within gender affirming healthcare.

24.2 Clinical effectiveness

The HQSC states that Aotearoa New Zealand's health services should 'use evidence-based, effective interventions and treatments based on the principles of good practice', and should 'include consumers/patients in the process of determining which outcome measures are reported and how the information is presented'.[347] As with other fields of healthcare, some important strategies and actions for health professionals and services providing gender affirming healthcare include:

- Patient-centred, evidence-based care: Prioritise gender affirming healthcare service users' stated needs, values and preferences within their healthcare, in addition to the best available clinical evidence.
- Policies and procedures: Health service policies and procedures should reflect current evidence-based, patient-centred best practice to facilitate health professionals providing such care.
- Clinical audit: Health services involved in gender affirming healthcare should transparently review their clinical outcomes, using measures that are patient-centred and evidence-based. This should be used to drive quality improvement and assist with decision making and planning.

24.3 Health service user engagement and participation

The HQSC states that Aotearoa New Zealand's health services should be partnering and engaging with health service consumers within service design, service delivery and protecting service consumers' rights.[347] Just like any other field of healthcare, provisions within gender affirming healthcare should include, as much as possible:

- Consumer participation: Health professionals should empower service users to be involved in decisions about their gender affirming healthcare (see the **informed consent in gender affirming healthcare** chapter).
- Co-design: Gender affirming healthcare services should be designed collaboratively by gender affirming healthcare consumers, their health professionals and other relevant experts using co-design principles.
- Consumer engagement: Healthcare services should gather feedback from their service users and be appropriately responsive to this feedback.
- Consumer experience: Healthcare services should have readily available feedback processes for their service users. Healthcare professionals should be forthcoming with information about these processes.

24.4 Continuous quality improvement

All healthcare services in Aotearoa New Zealand should have quality of care and consumer safety as top priorities.[347] In relation to gender affirming healthcare, priorities should include:

- Auditing: Healthcare services should document wait times to access gender affirming healthcare, any excessive staff workload, and any other issues identified by staff and gender affirming healthcare consumers. Quality and safety issues should be addressed in a timely manner.
- Responsiveness to consumer feedback: Healthcare services should continuously seek and utilise service user feedback about their gender affirming healthcare to improve service provision.

24.5 Engaged and effective staff

The HQSC states that all healthcare workforces in Aotearoa New Zealand should work in partnership with health service users and their whānau, and should participate in an ongoing process of peer and self-review.[347]

There is increasing recognition of the lack of training provided to healthcare professionals both in and outside of Aotearoa New Zealand pertaining specifically to transgender people and their healthcare needs.[348–352] Given the recognised gaps in health professional education on transgender related topics, health professionals should exercise caution in assuming or asserting transgender health expertise based solely on their qualifications.

In relation to gender affirming healthcare in Aotearoa New Zealand, measures to ensure engaged and effective staff include:

- Professional development: Health services ensuring that health professionals involved in gender affirming healthcare have ready access to up-to-date quality information regarding gender affirming healthcare for their induction and continuing professional development (CPD). Just like any other field of healthcare, health professionals practising in gender affirming healthcare should undertake regular CPD on this topic. Important topics for all health professionals involved in gender affirming healthcare to understand include:
  - Ways to interact respectfully with people seeking gender affirming healthcare.
  - Unconscious bias.
  - Transgender identities and terminology, including for different ethnic groups and cultures in Aotearoa New Zealand.
  - Social determinants of health for transgender people and gender diverse children, including for different subpopulations such as culturally and linguistically diverse populations, transgender refugees and asylum seekers, those with disabilities, and people with different transgender identities (for instance non-binary people).
  - Topics specific to one's clinical specialty.
- Ensuring training is undertaken in gender affirming healthcare specific to the population the health professional cares for, for example children and young people.
- Training all staff who interact with service users about how to ask about gender identity in a manner that is respectful and safe for transgender people. A workforce development programme for primary care can be found at **Supporting Aotearoa's primary care workforce**.
- Peer support and review: There are resources and networks across Aotearoa New Zealand designed to support health professionals working in gender affirming healthcare. Health professionals providing gender affirming healthcare should access peer support and review from colleagues as needed.
- Supervision: From professionals with expertise and experience with working with transgender people.
- Undergoing exploration of their own gender (or reflection upon their own gender and underlying beliefs shaping their experience of gender) prior to undertaking this work.
- Due to the high prevalence of neurodivergence in the transgender population, it is also recommended that mental health professionals seek additional training in neurodivergence and working with neurodivergent clients.

25. Policy, procedures and strategy

Health service policies, procedures and strategies relevant to implementing quality gender affirming healthcare also include:

- Policies, procedures and strategies that help make gender affirming healthcare accessible, including to transgender people who face multiple sources of inequity. Such inequities need to be considered in healthcare service design, healthcare service delivery and any fee structures used.
- Policies and procedures regarding the recording, management and updating of transgender service users' data, particularly in relation to names, pronouns, gender and sex.

26. Leadership

Some healthcare professionals in Aotearoa New Zealand become official or unofficial local 'champions' for gender affirming healthcare as their expertise increases. They may support other health professionals in their area with relevant professional development, service and pathway development, and answer queries to support best practice.

27. Primary care

'It's that long-term relationship. You're not just going there for access to something. She's like alongside us, with us, as we try to get what we need. So that's like the beauty of GPs, isn't it? That you have that, that they know, ideally, they know you better' – patient

'... they [primary care] know us best. That's why. Whenever we go in there for anything, me and my whānau, our GP always says, like, "kia ora, team." And just even how she says team, it makes you feel like you are on her team' – parent of transgender child

Primary care is the ideal place for meeting many of the healthcare needs of transgender people, including many aspects of gender affirming healthcare. This is because primary care teams can work with patients as collaborative partners within long-term holistic healthcare relationships.

As well as providing general primary care, primary healthcare professionals with sufficient knowledge can provide gender affirming healthcare directly in the form of initiating, continuing and monitoring hormone therapy, administering injections, and referring for allied healthcare (e.g. voice therapy) and surgical care.

An aim of these guidelines is to help provide the knowledge primary care health professionals need to provide gender affirming healthcare. A primary care-based approach to gender affirming healthcare can involve many specialties in primary care teams, such as general practitioners (GPs), nurse practitioners (NPs), practice nurses and health improvement practitioners.

Glossary

Note: Language is constantly evolving. Transgender people also have varied perspectives about different terminology and how they apply it to their own lives. Take into account the perspectives your transgender patients or clients have on these words.

Cisgender

A cisgender person has a gender that matches the sex recorded at their birth.

Clinical governance

These guidelines define clinical governance as per the Health Quality and Safety Commission:[347]

'Clinical governance is an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation. In practice, it requires clinicians to be engaged in both the clinical and management structure of their health organisation to contribute to the mission, goals and values of that organisation. It is also about managers engaging more with clinicians and enabling them to be involved.'

Come out (as transgender)

When a person discloses to one or more other people that they are transgender.

Disability

These guidelines define disability as per a definition provided by the United Nations:[353]

'long-term physical, mental, intellectual or sensory impairments which, in interaction with various attitudinal and environmental barriers, hinders their full and effective participation in society on an equal basis with others.

However, this minimum list of persons who may claim protection under the [United Nations] Convention [on the Rights of Persons with Disabilities] does not exhaust the categories of the disabilities which fall within … it nor intend to undermine or stand in the way of wider definition of disabilities under national law (such as persons with short-term disabilities). It is also important to note that a person with disabilities may be regarded as a person with a disability in one society or setting, but not in another, depending on the role that the person is assumed to take in his or her community. The perception and reality of disability also depend on the technologies, assistance and services available, as well as on cultural considerations.'

Gender affirming hormone therapy (GAHT)

Hormone treatment that helps to affirm a transgender person's gender, rather than the gender they were assigned at birth. Gender affirming hormone therapy may help to at least partially alleviate any gender dysphoria a transgender person experiences.

This guideline uses the following terminology and abbreviations in relation to hormone therapy:

- E-GAHT: Oestrogen based gender affirming hormone therapy
- T-GAHT: Testosterone based gender affirming hormone therapy.

Gender

Gender refers to someone's social status and personal identity as a man, woman, or another gender or genders that may be non-binary. A person's gender may differ from the sex recorded at their birth and may differ from what is indicated on their current legal documents. Some people may not identify with any gender.

Gender affirmation (or transition)

Gender affirmation (also known as transition) is the process through which someone goes from living as their gender assigned at birth to living according to another gender or genders. Every person's gender affirmation, or transition, is unique to them and depends upon what their identity, goals, circumstances and available resources are. A person may utilise social, medical, surgical and legal aspects to affirm their gender or genders. Social aspects may include, for example, a person affirming their gender by using a different name and pronouns to those assigned at birth, wearing differently gendered clothing, and changes in hairstyle. Medical and surgical aspects of affirming a person's gender may include, for example, hormone medications, surgery, or both. Legal aspects of gender affirmation may involve, for instance, a person changing their legal name and the sex on their birth certificate.

Gender affirming healthcare

Healthcare that is respectful and affirming of a person's unique sense of gender and provides individualised support to identify and facilitate a person's gender healthcare goals. These goals may include supporting exploration of gender, support around social transition, hormone and/or surgical interventions. It may also involve providing support to whānau, caregivers or other significant supporting people.

Gender diverse

Gender diverse is an umbrella term sometimes used to refer to people whose gender expression or gender identity is outside of common expectations for the gender they were assigned at birth. Not all gender diverse people identify as transgender and vice versa.

Gender dysphoria

Distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). This is also a diagnostic classification in DSM-5.[354] Everyday activities that remind a transgender person of the difference between their body and/or gender role, and their identity, can exacerbate this distress, for instance, showering, dressing, and interacting with people who misgender them.

Gender embodiment

Embodied gender encompasses the shape and appearance of one's body, the feeling of one's body and the behaviour enacted by one's body.[355]

Gender expression

A person's presentation of their gender through physical appearance (including dress, hairstyles, accessories, cosmetics), mannerism, speech, behavioural patterns, names and personal references. Gender expression may or may not conform to a person's gender identity.

Gender identity

Gender identity refers to a person's internal and individual experience of gender.

Gender incongruence

These guidelines define gender incongruence as per their definitions in the World Health Organization's International Classification of Diseases, 11th revision:

'**Gender Incongruence of Adolescence and Adulthood** is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to "transition", in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.'[356]

'Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.'[12]

Innate variations of sex characteristics

Natural variations of genetic, hormonal, or physical sex characteristics that are regarded within biomedicine as atypical for female or male bodies. There are a wide spectrum of innate variations relating to people's sex hormones, sex chromosomes, genitals and reproductive organs. Some other terms used to describe being born with innate variations of sex characteristics are intersex person, a person with an intersex variation, or Differences of Sex Development (DSD). 'Intersex' is a reclaimed umbrella term which is used within Rainbow communities to include all people with innate variations of sex characteristics. However, people with innate variations of sex characteristics may or may not personally identify as intersex or a member of Rainbow communities. Intersex is not a gender but is often incorrectly conflated with that.

LGBTQIA+

An acronym which stands for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Intersex, Asexual or Ace. The + recognises there are further identities not listed, and while the order, combination and number of letters varies, the LGBTQIA+ acronym is well recognised.

Non-binary

Non-binary (NB or 'enby') is an umbrella term that encompasses diverse gender identities outside of the binary identities of woman/feminine/girl or man/masculine/boy.

Pākehā

Te reo Māori word for a New Zealander of European descent.

Pronouns

Pronouns are referential markers that people use to refer to themselves and others. Common pronouns are she/her/hers, he/him/his, and they/them/theirs.

Rainbow

An umbrella term used in Aotearoa New Zealand to refer to people from all sexual and gender minorities, and people with variation of sex characteristics, for instance people who are transgender, lesbian, gay, bisexual and intersex.

Sex

A person's physical sex is based upon their sex characteristics, such as their genitalia, chromosomes, reproductive organs and secondary sex characteristics. A person's physical and legal sex is typically based upon the sex characteristics observed and recorded at birth or infancy. New Zealanders can change their legal sex without changing their physical sex.

Sex assigned at birth

The sex a baby is assigned (or presumed to be) at birth, usually determined by a visual observation of external genitalia. A person's gender may or may not align with their sex assigned at birth.

Sex characteristics

A person's observable features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, hormones, and secondary physical features emerging from puberty.

Takatāpui[5]

'Takatāpui is a traditional Māori term meaning "intimate companion of the same sex." It has been reclaimed to embrace all Māori who have diverse genders, sexualities and innate variations of sex characteristics.' This includes whakawāhine (transgender women), tangata ira tāne (transgender men), irawhiti (all transgender people), irarere (gender fluid), lesbian, gay, bi/pansexual, transgender, non-binary, intersex, asexual, queer and questioning people. In Aotearoa New Zealand, these are often grouped under the headings of 'Rainbow people' or 'Rainbow communities'. 'Māori who are transgender, non-binary or gender fluid may use these Te Reo (Māori language) terms as well as, or instead of, "takatāpui."'[5]

Te Reo Māori

The Māori language.

Transgender

A transgender person's gender does not match the gender they were assigned at birth. In this document, the authors use the term 'transgender' as an umbrella term for a wide array of gender identities and modalities.[m] 'Transgender' includes people who identify as trans and non-binary; those who identify as agender or don't relate to a gender; culturally and linguistically specific identities that might not neatly map onto Western understandings of gender; and other people for whom gender affirming healthcare is relevant, including some intersex people and people whose experience of transition is non-linear. The authors recognise that 'transgender' does not accurately describe everyone who might need gender affirming healthcare, but use this shorthand for readability.

Transition (also known as gender affirmation)

See 'Gender affirmation'.

Whānau

Family. A word from the Māori language. Pronounced 'far-no'.

For further definitions of Rainbow-specific terminology or concepts please refer to **Stats NZ concept and classification management system**.

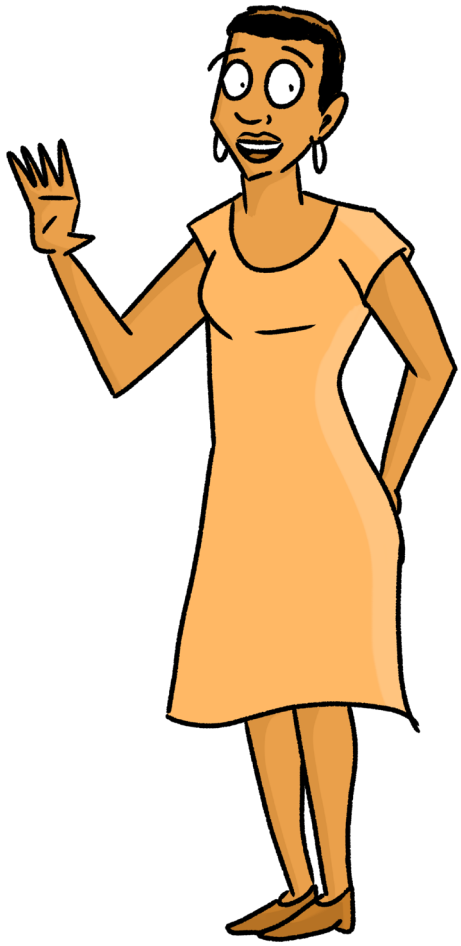
[m] Gender modality is the way someone's gender relates to the sex they were assigned at birth. For example, transgender is a modality in which someone's gender is different to the sex they were assigned at birth.

Acronyms and abbreviations

See glossary for definitions

ACC	Accident Compensation Corporation
ADHD	Attention deficit hyperactivity disorder
AFAB	Assigned female at birth
AMAB	Assigned male at birth
ASD	Autistic spectrum disorder
BMI	Body mass index
BP	Blood pressure
CBT	Cognitive behavioural therapy
CPD	Continuous professional development
CVD	Cardiovascular disease
DSH	Deliberate self-harm
ECG	Electrocardiogram
E-GAHT	Oestrogen based gender affirming hormone therapy
FBC	Full blood count
FSA	First specialist assessment
FSH	Follicle-stimulating hormone
GAHT	Gender affirming hormone therapy
GnRH	Gonadotrophic releasing hormone
GP	General practitioner
HEeADSSS	A psychosocial assessment covering home, education, employment, eating, activities, drugs and alcohol, depression and suicide, sexuality, safety.
HPG	Hypothalamic-pituitary-gonadal
ICD-11	International Classification of Diseases, 11th revision
IVSC	Innate variations of sex characteristics
LFT	Liver function tests

LH	Leutinising hormone
MDT	Multi-disciplinary team
MVPFAFF+	An acronym which includes many diverse genders, sexualities and liminalities found within Pacific cultures (this is detailed in the **Pacific peoples** chapter)
NHI	National Health Index
NP	Nurse practitioner
PMS	Practice management system
PrEP	Pre-exposure prophylaxis (for HIV)
PTSD	Post-traumatic stress disorder
STI	Sexually transmitted infection
T-GAHT	Testosterone based gender affirming hormone therapy
VTE	Venous thromboembolism
WPATH SOC8	*World Professional Association of Transgender Health Standards of Care Version 8*



Appendices

Appendix A
Tanner stages

For breast development:

1. Prepubertal
2. Breast and papilla elevated as small mound, areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour.

For penis and testes:

1. Prepubertal; testicular volume, <4 ml
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 ml
3. Penis longer, testes larger (8–12 ml)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 ml), scrotum dark
5. Penis adult size; testicular volume, 15 ml.

Appendix B

Consent form for GnRH agonists ('puberty blockers') for blocking oestrogen

This consent form outlines important information you might want to talk to your health team about before starting puberty blockers to block oestrogen. The information provided is based on current available evidence. It is important to be aware that this may change over time.

Leuprorelin acetate injections or goserelin acetate implants (puberty blockers) work by blocking the production of oestrogen in the ovaries.

The puberty blockers are given every 10–12 weeks and will reduce the level of oestrogen in the body. It is important that the puberty blocker is given on time.

Puberty blockers are considered to be a largely reversible medication used to stop the physical changes of puberty. It can be started in early puberty (Tanner stage 2–3). If started then, puberty blockers will usually stop significant breast development and further pubertal changes such as starting periods. Puberty blockers will stop periods but may take up to 3–6 months to do so. There are other good options for the cessation of menses.

Starting puberty blockers can improve psychological distress associated with having the unwanted effects of an oestrogen induced puberty. This allows time and maturity to develop before consideration of further care choices e.g. stopping the puberty blocker or considering testosterone.

Common side effects

- Hot flushes
- Mood swings/low mood
- Fatigue
- Headache

Side effects may be more likely in older adolescents. Side effects may settle over time. Allergic reactions can happen but are rare. Please tell your health team if you have any problems or concerns.

Potential risks of puberty blockers

- Increased height

Whilst height velocity typically slows whilst on a puberty blocker, if starting a puberty blocker in early puberty, there is potential for increased final height. Final adult height is influenced by many factors such as parental stature, nutritional status and age of onset of puberty.

- Impact on bone density

Puberty is a time of increased calcium uptake, growth of bones and increase in bone density (bone strength). Puberty blockers impact on bone density development in the short term due to suppression of sex hormones. Therefore, it is important to look after your bones while on the blockers by keeping active and having enough calcium and vitamin D (sun exposure). It is not known if being on a puberty blocker during puberty significantly increases the risk for osteoporosis (thinning of bones) in older age.

Fertility

Fertility (ability to get pregnant) is likely to be affected whilst on the puberty blocker, but this is not guaranteed. Contraception will be needed if there is any sexual contact that may lead to pregnancy. It is important not to get pregnant while on blockers as it may be harmful to the pregnancy.

If deciding to stop puberty blockers it is not expected that there will be any long-term impact on fertility, but periods may take time to return to normal.

Your doctor will discuss future fertility considerations relating to gender care treatment options, e.g. future testosterone.

Sexual health

Being on puberty blockers may lower sex drive and impact on sexual experiences. It may cause the vagina to become drier. This increases the risk of sexually transmitted infections (STIs), including HIV, if having any sexual contact with this part of the body. Condoms provide good protection against STIs and lubricant helps to prevent any discomfort.

Decision making

The decision to use a puberty blocker is a collaborative process typically including the young person, whānau supports and healthcare team.

This includes considering the risks and benefits of both using and not using a puberty blocker.

The impact of not using a blocker may include additional distress and irreversible unwanted physical changes.

The health team

Keeping in touch with your health team for regular check-ups and blood tests is an important part of your care and will reduce the risks of being on puberty blockers.

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

For many different reasons, people may question whether they want to continue to be on puberty blockers. This can be a normal part of the journey. Please feel free to discuss this with your prescriber before stopping medications. Come and talk – your health team is always ready to listen.

I wish to start puberty blockers _____

Name _____

Signature _____ Date _____

Parent/caregiver

Name _____ Relationship _____

Signature _____ Date _____

Prescribed by:

Name _____

Signature _____ Date _____

Appendix C

Consent form for GnRH agonists ('puberty blockers') for blocking testosterone

This consent form outlines important information you might want to talk to your health team about before starting puberty blockers to block testosterone. The information provided is based on current available evidence. It is important to be aware that this may change over time.

Leuprorelin acetate injections or goserelin acetate implants (puberty blockers) work by blocking the production of testosterone in the testes.

Puberty blockers are given every 10–12 weeks and will reduce the level of testosterone in the body. It is important that the puberty blocker is given on time.

Puberty blockers are considered a largely reversible medication used to stop the physical changes of a puberty. It can be started in early puberty (Tanner stage 2–3). If started then puberty blockers will halt the testosterone induced puberty changes such as voice changes, facial and body hair growth, enlargement of penis and testicles.

Puberty blockers can also be started later in puberty, which may prevent further testosterone induced changes including facial changes. It may slow down facial and body hair growth and decrease muscle bulk but will not reverse other changes that have already happened.

Starting puberty blockers can improve psychological distress associated with having the unwanted effects of a testosterone induced puberty. This may allow time and maturity to develop before consideration of further choices, e.g. stopping the puberty blocker or considering oestrogen.

Common side effects

- Hot flushes
- Mood swings/low mood
- Fatigue
- Headache

Side effects may be more likely in older adolescents. Side effects may settle over time. Allergic reactions can happen but are rare. Please tell your health team if you have any problems.

Potential risks of blockers

- Impact on height

Whilst height velocity typically slows whilst on a puberty blocker, if starting a puberty blocker in early puberty, there is potential for increased final height. Final adult height is influenced by many factors such as parental stature, nutritional status and age of onset of puberty.

- Impact on bone density

Puberty is a time of increased calcium uptake, growth of bones and increase in bone density. Puberty blockers impact on bone density development in the short term due to suppression of sex hormones. Therefore, it is important to look after your bones while on the puberty blockers by keeping active and having enough calcium and vitamin D (sun exposure). It is not known if being on a puberty blocker during puberty significantly increases the risk for osteoporosis (thinning of bones) in older age.

Fertility

Fertility (ability to get someone pregnant) is likely to be affected whilst on the puberty blockers, but this is not guaranteed. Contraception will be needed if there is any sexual contact that may lead to pregnancy.

For those starting on a puberty blocker in Tanner stages 3–5, storing sperm is an option to preserve fertility before starting treatment.

For those starting on a puberty blocker in early puberty, sperm storage may not be possible. Fertility information will be discussed and decisions around this can be revisited again at any point before starting on hormone therapy. If the puberty blocker is stopped it is not expected that there will be any long-term impact on fertility.

Sexual health

Being on puberty blockers may lower sex drive and impact on sexual experiences. It may stop erections or make them less hard. It can decrease the size of testicles over time. If puberty blockers are stopped then puberty changes should resume but may take time to do so.

Decision making

The decision to use a puberty blocker is a collaborative process typically including the young person, whānau supports and healthcare team. This includes considering the risks and benefits of both using and not using a puberty blocker. The impact of not using a puberty blocker may include additional distress and irreversible unwanted physical changes.

The health team

Keeping in touch with your health team for regular check-ups and blood tests is an important part of your care and will reduce the risks of being on puberty blockers.

I wish to start puberty blockers _____

Name _____

Signature _____ Date _____

Parent/caregiver

Name _____ Relationship _____

Signature _____ Date _____

Prescribed by:

Name _____

Signature _____ Date _____

Appendix D

Patient questionnaire for gender affirming hormone therapy (GAHT)

Thank you for taking the time to complete this patient questionnaire to support your appointment for gender affirming hormone therapy (GAHT).

Our staff respect that your gender is self-determined. It takes time to work through the informed consent process for starting GAHT. By providing this information in a written form, you will help speed up the process.

This form is intended to be used for people aged over 18 years of age.

Your health professional follows the recommendations as per the WPATH 2022 **Standards of Care for the Health of Transgender and Gender Diverse People, Version 8** and the Guidelines for Gender Affirming Healthcare in Aotearoa New Zealand, 2025 edition.

Please try to answer the questions as fully as possible, but please note that you don't need to answer any questions you don't wish to.

If you don't wish to complete this questionnaire, or any part of it, that will not affect your access to gender affirming healthcare. Your responses will be discussed during your appointment.

Your completed patient questionnaire will be stored on your general medical file.

Your details:

Title	☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other:
First name/s & Last name	
Previous name/s (if still used on medical records or legal documents)	
Ethnicity	
Date of birth (DD/MM/YYYY)	
Ethnicity	
NHI Number (if known)	
Pronouns	☐ Masculine (he/him ☐ Feminine (she/her) ☐ Gender neutral (they/them) ☐ Other:
Gender	☐ Man ☐ Woman ☐ Another gender *(please specify)*
Sex assigned at birth	☐ Male ☐ Female ☐ Another term *(please specify)*
Hormones you are seeking	☐ Oestrogen-based gender affirming hormone therapy (E-GAHT) ☐ Testosterone-based gender affirming hormone therapy (T-GAHT)
Contact email	
Contact phone number	

Health Questions:

Your doctor/GP's name **Name of clinic/surgery/ medical centre**	
Do you have any physical or mental health issues? ☐ **Yes** ☐ **No**	If yes, please describe:
Are you taking any medications? ☐ **Yes** ☐ **No**	If yes, please list prescribed and non-prescribed medications, dose and frequency:
Do you use nicotine (e.g., smoke cigarettes or vape)**?** ☐ **Yes** ☐ **No**	If yes, please describe: *(Please be specific, how much, how often, etc)*
Do you drink alcohol? ☐ **Yes** ☐ **No**	If yes, please describe: *(Please be specific, type of alcohol, how much, how often, etc)*

Gender Questions:

This appointment is due to you seeking gender affirming hormone therapy (GAHT) for your body to better align and become congruent with your gender. Please take the time to help us understand your gender experiences, hopes and expectations from GAHT.

Please describe your experiences of gender so far:

For example, when and how you came to realise you are trans or non-binary, how you experience this in day-to-day life, how you came to realise that gender affirming hormone therapy (GAHT) would be helpful, any experiences of gender euphoria, etc.

Have you taken any steps towards affirming your gender socially?

For example, pronouns, appearance, etc. (please note, this is not a requirement for GAHT)

Have you taken any steps towards affirming your gender legally?

For example, name and/or gender updated on passport, birth certificate, driver licence, etc. (please note, this is not a requirement for GAHT)

What do you hope gender affirming hormone therapy (GAHT) will achieve?

For example, describe your goals, including any goals about your body, social and family life, emotions, and spirituality.

Gender affirming hormone therapy (GAHT) can cause changes that you may not want; how will these affect you?

How will starting GAHT affect your relationships?

For example, whānau/family, friendships, partner/s, or at school/study/work

Physically affirming your gender with GAHT can be a challenging time. What supports do you have to assist you moving forward?

For example whānau/family, friends, partner/spouse, work, study, spirituality or religion, self-care, and coping skills.

What do you understand about the effects of GAHT on fertility?

For those assigned male at birth (AMAB):

Are you aware that gamete (sperm) preservation is funded for 10 years, if you are going to take E-GAHT, are under 40 years old, and have not had a biological child?

- ☐ Yes
- ☐ No
- ☐ Not applicable, I am assigned female at birth (AFAB)

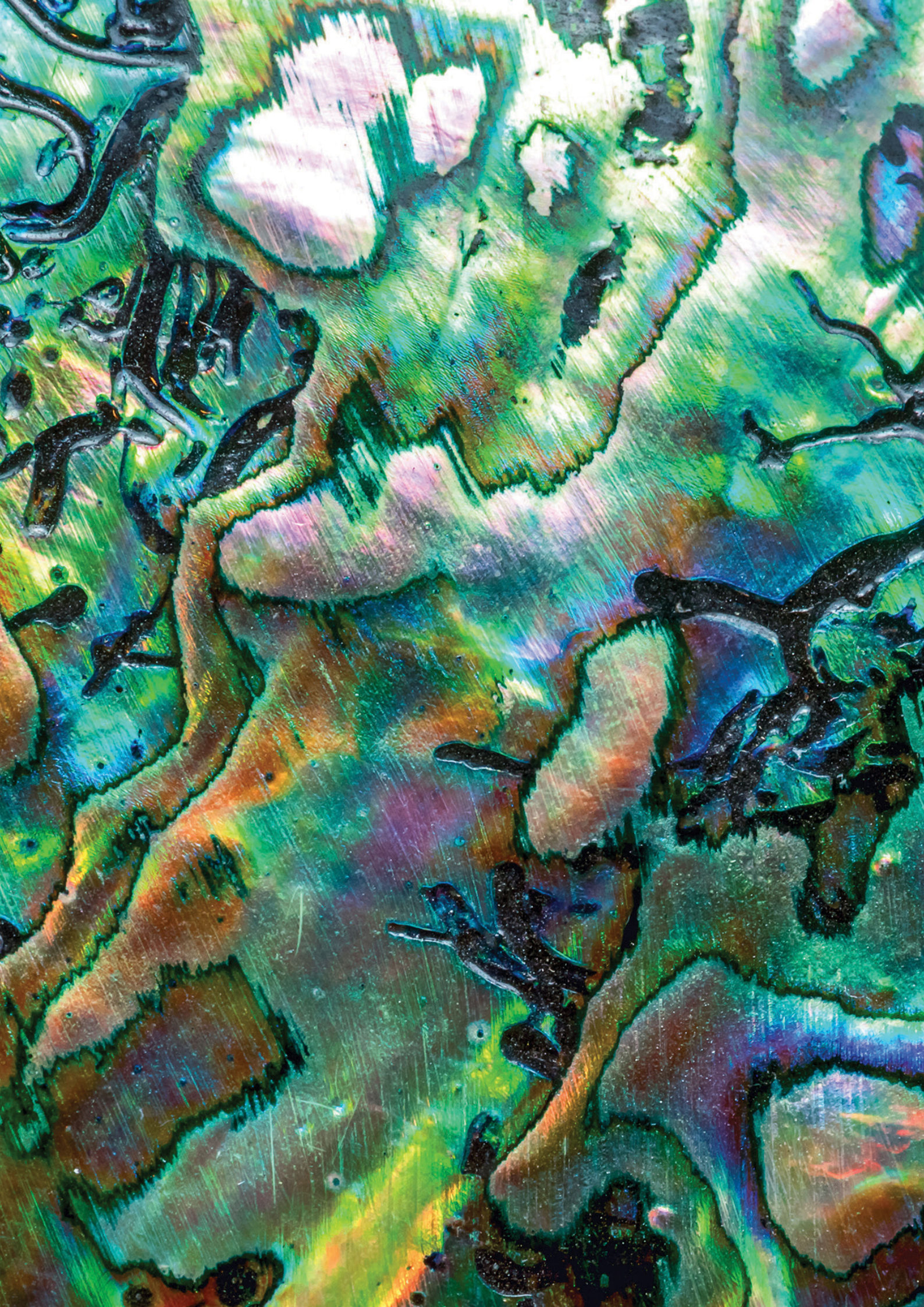
Please discuss with your GP a referral to fertility services if you wish to store before starting oestrogen-based gender affirming hormone therapy (E-GAHT)

Note: This is a recommendation; this is not a requirement to start E-GAHT

What do you understand about the effects of GAHT on sexual function?

Do you have any questions about gender affirming hormone therapy (GAHT) and/or gender affirming services in your area?	
Date completed form *(DD/MM/YYYY)*	

Thank you for completing this questionnaire.



Appendix E

Consent form for oestrogen gender affirming hormone therapy (E-GAHT)

It is important to understand the benefits and risks of oestrogen and testosterone blockers, have realistic expectations, and understand alternative options to medication to meet gender embodiment goals. This consent form outlines important information you might want to talk to your health team about. Please let us know what further information you may need.

Oestrogen tablets or patches provide the feminising hormone oestrogen. **Testosterone blockers** are also needed unless an orchiectomy (testes removal) has occurred.

- Oestrogen tablets/patches will gradually change the body and usually take 3–5 years to have maximal effect.
- Gradual increase of oestrogen dose is recommended as this may be beneficial for breast development.

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

- Breast growth – this occurs gradually over 2–3 years
- Likely infertility (see next section)
- Shrinking of the testicles

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

- Softer skin
- Decreased muscle mass
- Less body hair (but hair growth does not stop completely)
- More fat on buttocks, hips and thighs

Things that don't change much:

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

If you stop taking your hormones some body changes stay but other changes will slowly reverse.

Fertility

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

Sex

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

Emotions

You may notice a reduction in symptoms of depression or distress associated with gender dysphoria. Some people may experience mood swings and emotional imbalances. Others feel this increases their emotional insight and expressiveness. The effects of hormones on the brain are not fully understood. Medically affirming your gender can be a stressful time and many people need some help adjusting to the physical and emotional changes. It is important that you let your health team know if you are having problems so that they can help you access the support you need.

Side effects

- Common: Tender breasts
- Less common: Nausea, headaches, weight gain

Please tell your health team if you have any side effects, especially headaches or migraines.

Potential risks of oestrogen

The full medical effects and risks of taking hormones may not yet be known. The potential risks of taking oestrogen must be weighed against the benefits that hormones can have on your health and quality of life.

Likely increased risk

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

Possible increased risk

- Increased blood pressure
- Liver dysfunction
- Increased prolactin and rare risk of prolactinoma (benign pituitary tumours)

Possible increased risk if you have extra risk factors

- Heart disease
- Diabetes

Unknown risk

- Oestrogen may increase the risk of breast cancer. Everyone with breasts is advised to follow the standard breast screening advice. Some of these risks e.g. blood clots are reduced by using oestrogen patches instead of tablets.

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

- A swollen painful leg
- Chest pain or difficulty breathing
- Vision or speech problems

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

The risk of having a blood clot is much higher if you use nicotine or are overweight. Please ask if you would like help to quit smoking or vaping. Blood clots are more common as you get older. Stopping oestrogen before and after some surgeries can help reduce the risks of blood clots around this time.

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

Are there any other questions you want to ask?

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

Additional considerations *(prescriber to complete)*:

Sometimes people decide to pause or stop oestrogen. There are many reasons for this. Some people feel they have developed the permanent effects they desired and want to avoid lifelong medication; others don't like the effects they are experiencing. It is always best to pause oestrogen if you are unsure about developing further changes. It can always be restarted again in future. Please come and talk to us if this happens for you. We are here to listen to you and support you regardless of whether you take hormones or not.

I wish to start oestrogen hormone therapy. Name _____

Signature _____ Date _____

Prescribed by _____ Date _____

Appendix F
Consent form for starting testosterone based gender affirming hormone therapy (T-GAHT)

It is important to have a good understanding of the benefits and risks of testosterone, and realistic expectations, as well as awareness of alternative options to medication to meet gender embodiment goals. This process may take time. This consent form outlines important information you might want to talk to your health team about. Please let us know what further information you may need.

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

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

- Deeper voice
- Increased growth of body hair – with thicker hairs on arms, legs, chest, back and abdomen
- Gradual growth of facial hair
- Hair loss at the temples – possibly becoming bald with time
- Genital changes – clitoral ('bottom') growth (typically 1–3 cm) and vaginal dryness. If you would like to see a drawing of what clitoral growth can look like, please let your health team know

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

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

Things that don't change much:

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

Fertility

While it is not known what the long-term effects of taking testosterone are, some people find that if they stop testosterone, they will become fertile again and can get pregnant. There are no guarantees for anyone, and it is probably harder to get pregnant the older you are and the longer you have been on testosterone. Testosterone is dangerous for the developing fetus – you must not get pregnant while you are on testosterone. Even after your periods stop you might still be at risk of getting pregnant. If you are having any sexual contact that puts you at risk of pregnancy you must talk to your health team about contraception options.

Sex

Taking testosterone causes your vagina to become dryer and more fragile. This increases the risk of sexually transmitted infections (STIs), including HIV, if you are having any sexual contact with this part of the body. Condoms provide good protection against STIs and lubricant helps to prevent any discomfort. If this area becomes uncomfortable in general please talk to your healthcare team who can provide treatment such as a cream.

Emotions

You may notice taking testosterone reduces symptoms of depression or distress associated with gender dysphoria. Some people notice a reduction in anxiety. Others may notice an overall dampening of their emotions, both positive and negative ones. Some people notice they are more likely to express their anger when taking testosterone; but the intensity of this feeling does not change.

The effects of hormones on the brain are not fully understood. Medically affirming your gender can be a stressful time and many people need some help adjusting to the physical and emotional changes.

It is important that you let your health team know if you are having problems so that they can help you access the support you need.

Potential risks of testosterone

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

Likely increased risk

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

Possible increased risk

- Changes to lipids (may increase risk for heart disease)
- Liver problems – rare with injectable testosterone
- Very small increase in risk in the first 6 months of blood clots – deep vein thrombosis (DVT)

Possible increased risk if you have additional risk factors

- Diabetes
- Increased blood pressure

No increased risk or unknown

- Breast cancer
- Cervical, ovarian, uterine cancer

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

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

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

Are there any other questions you want to ask?

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

Additional considerations *(prescriber to complete)*:

Sometimes people decide to pause or stop testosterone. There are many reasons for this. Some people feel they have developed the permanent effects they desired and want to avoid lifelong medication, others don't like the effects they are experiencing. It is always best to pause testosterone if you are unsure about developing further changes. It can always be restarted again in future. Please come and talk to us if this happens for you. We are here to listen to you and support you regardless of whether you take hormones or not.

I wish to start testosterone hormone therapy. Name _____

Signature _____ Date _____

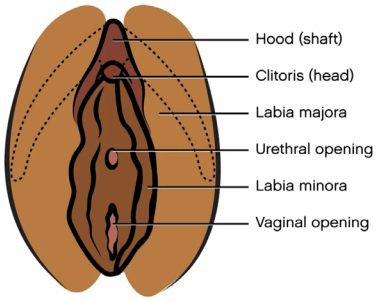
Prescribed by _____ Date _____

Appendix G

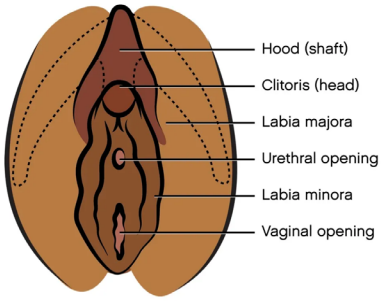
Clitoral ('bottom') growth (drawings)

Thanks to FOLX Health (folxhealth.com) for permission to reproduce the following drawings.

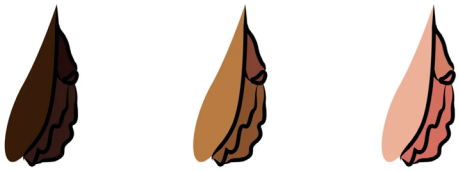
Ex. pre-testosterone



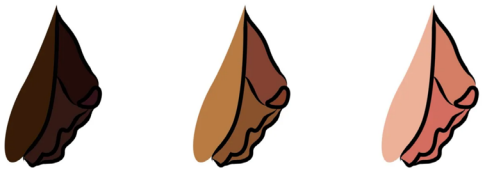
Ex. bottom growth from testosterone



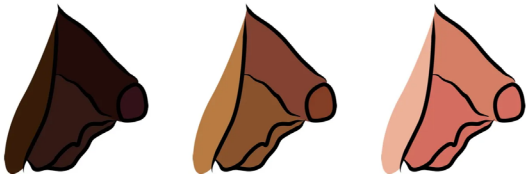
Ex. pre-testosterone



Ex. unaroused and/or low dose



Ex. aroused and/or high dose



Appendix H

Testosterone gel

Testogel 1.62% is fully funded in New Zealand. There are different types and strengths of testosterone gel available overseas – the doses are not interchangeable.

Testogel comes in a pump bottle. The usual standard dose is 2 pumps once a day in the morning, but your dose may be slightly lower or higher depending on when you started, your prescriber's advice and your individual needs and blood levels.

Instructions for use

Each new Testogel pump bottle must be primed before first use by pressing the plunger down 3 times (discard this gel); the pump will not need to be primed again.

Apply:

Apply dose as a thin layer to clean, dry, healthy skin on shoulders or upper arms (or abdomen). Do not apply to chest or genitals.

Wash:

Wash hands with soap and water after application. Ideally avoid washing the treated area for at least 6 hours. Wash application site before any direct skin-to-skin contact with another person.

Cover:

Allow skin to dry for 3 to 5 minutes before covering with clothing (to avoid accidental transfer to other people – especially children and those who are pregnant). Avoid any contact of the gel with others, especially women and children.

Checking testosterone levels on a blood test

If you are having a blood test to check your testosterone levels, please do this either:

- In the morning before you put that day's gel application on,

OR

- 4–6 hours after gel application (have the blood taken from the opposite arm from the one you apply the gel to).

Testosterone may be transferred to others during close skin contact with the gel application area.

This can cause the other person to show signs of increased testosterone such as hair growth and a deeper voice. This can be avoided by covering the site in clothing and showering before any skin-to-skin contact. This is especially important before coming into contact with women and children.

For further information see **Testogel – Healthify**.

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