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First Edition

TRANS HEALTH

A PRIMER FOR CANADIAN MEDICAL LEARNERS

The BIPOC Women's Health Network

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INTRODUCTION

Target Audience: Medical students and other healthcare learners situated across what is currently known as Canada.

Aim: An introductory resource for medical learners that covers the major topics in transgender (trans) health, specifically focusing on racialized and Indigenous trans and Two-Spirit people. This primer will act as an introductory guide to supplement gaps in the country's medical curricula.

Goal: Access to quality healthcare is not a specialty service thus, trans health should not be a "specialty service" but rather an integrated part of all health services offered by every physician. Our goal is to ensure that medical students are introduced to some fundamentals when working with diverse gender identities so they feel comfortable and competent in providing care to trans and non-binary patients, which will ultimately lessen the detrimental impacts of the healthcare system on our trans communities. Trans patients can often be lost in complex referral pathways and experience unacceptable wait times with specialists because general practitioners do not feel they are adequately trained to meet this population's needs. This can create a very large delay in accessing care.

Our goal with this primer is to supplement these gaps in knowledge and point you to further resources to increase your own education and training. While navigating the medical system, many trans people must advocate for themselves due to healthcare providers continually referring out to other practitioners or outright denying care for a number of reasons. Trans and gender diverse people are entitled to fundamental human rights both provincially and federally in Canada and the medical care that they receive should reflect that. Healthcare providers in Canada have a responsibility to educate themselves on the unique and diverse needs of trans people to ensure that their practice does not violate human rights legislation and the governing medical bodies they are bound to.

Scope: As a primer, the document aims to provide baseline knowledge about trans healthcare to be used in medical education training. Please note that it is not exhaustive by any means and serves to guide and direct students towards further resources so that we may all be competent working with trans patients and able to create safe healthcare spaces that our trans communities can trust. The guide is meant to help you develop an understanding for the cultural nuances and specific barriers faced by racialized and Indigenous trans and Two-Spirit communities. Through this primer, we aim to highlight the intersectional oppression faced by racialized and Indigenous trans and Two-Spirit communities and how we as healthcare providers can help our patients navigate complex systems of care.

INTRODUCTION

Limitations: As mentioned above, this introductory document is in no way meant to be comprehensive as trans health is a constantly evolving area of medicine. Moreover, although we group BIPOC (Black, Indigenous, People of Colour) under an umbrella as a means of acknowledging the intersectional oppression they face, this term does not account for the many cultural nuances that exist for each community. Every Indigenous community and community of colour is unique in the barriers it faces, and although the experience of racism, oppression and discrimination is shared, the way in which these factors manifest is very different. It is important as healthcare providers that we don't perpetuate stigma and stereotypes further by generalizing the experience of oppression and that we are able to contextualize and make an effort to understand the unique intersectional identities held by our individual patients. Additionally, although we are giving consideration to Indigenous communities in this primer, this is by no means as comprehensive as we would like. Please keep an open mind about the diversity of distinct Indigenous peoples. Coverage for various healthcare services also varies between different provinces and between First Nations, Inuit, and Métis peoples, as well as between individuals who are on-reserve versus off-reserve. These distinctions are not discussed in detail in this edition of the primer and will require research on your part, as a practitioner. Remember that although this primer outlines common procedures undergone by trans & Two-Spirit patients, the gender transition process is not a linear one and looks different for each patient depending on their goals. Work with your patient to assess their goals, what transitioning would look like for them.

This document focuses primarily on those who are over the age of majority and have completed puberty, as guidelines for trans and Two-Spirit children are still developing and changing.

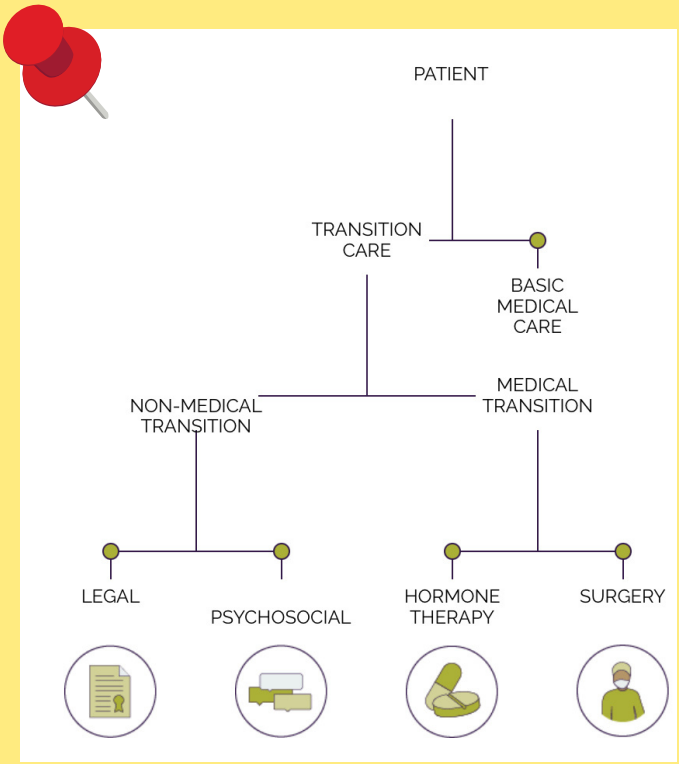


Diagram 1: Care pathways for transgender folks

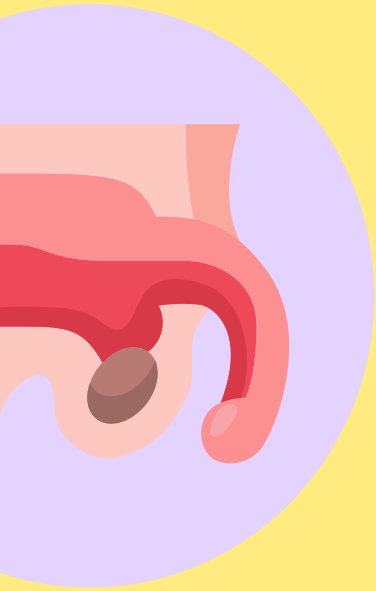
Taken from: https://www.rainbowhealthontario.ca/TransHealthGuide/intro-transition.html

Gender diversity is an area of medicine that is constantly evolving and guidelines for diagnosis and treatment are also changing.

We welcome feedback and critiques to help us improve this document and if you would like to pass on some of your feedback, feel free to email us at: bipocwhn@gmail.com.

GLOSSARY OF TERMS

Disclaimer: Remember that language and terminology is subject to change depending on cultural and societal influences. Adopting a life-long learning attitude will allow you to adapt to changing terminology throughout your clinical career. Terminology that is gender-affirming, respectful and aligns with the patient's self-identification can make a profound difference in the care you provide.



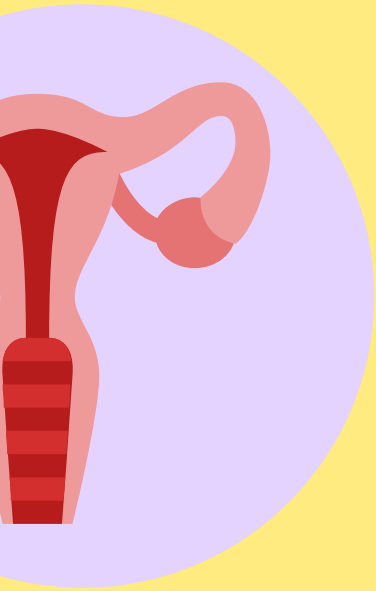


Table 2: Alternate, gender neutral terms

Use (less gendered language)	Instead of (gendered language)
People/folks who menstruate	Female, women
People/folks who are pregnant	Pregnant women
People/folks who produce sperm	Male, men
Not trans, non-trans, cisgender	Biologically male/female
Assigned male at birth	Biologically male
Assigned female at birth	Biologically female
Sexual or genital health	Women's/gynecological healthcare
External genitals, external pelvic area	Vulva, clitoris
Outer parts	Penis, testicles
GenitalGential opening, frontal opening, internal canal	Vagina
Outer folds	Labia, lips
Internal reproductive organs	Female reproductive organs
Internal organs	Uterus, ovaries
Internal gland	Prostate
Chest	Breasts*
Chest or breastfeeding*	Breastfeeding
Absorbent product	Pad/tampon
Internal condom	Female condom
Uterine bleeding	Period/menstruation
Parent or gestational parent	Mother
Hypothalamic pituitary gonadal - ovarian axis	Female gonadal steroid axis
Hypothalamic pituitary gonadal - testicular axis	Male gonadal steroid axis

**transfeminine patients may prefer the term breasts (ask your patients what they prefer!)*

Adapted from BIPOC Women's Health Network infographic & Krempasky et al. (2020)

This document (https://cyndigilbert.ca/wp-content/uploads/2020/05/Neutralizing-Clinical-Language.pdf) also contains more terms that can be used to neutralize the clinical language we use as healthcare providers.

Neutralized language is a step towards inclusivity and creating welcoming environments for all gender identities and sexualities.

GENDER IDENTITY & SEXUALITIES

GENDER

This is how we perceive our identity as woman, man, both or neither, regardless of our physical bodies.

SEX

The medical classification of people as male or female based on physical aspects of the body. It is usually assigned at birth.

INTERSEX

A person born with biological and/or physical characteristics t that are not easily characterized by medical definitions of male or female.

CISGENDER

A person whose gender identity is in alignment with their sex assignment at birth.

TRANSGENDER

An umbrella term referring to people with diverse gender identities and expressions that may differ from stereotypical gender norms.

NON-BINARY

Many people – including many transgender people – identify as man or woman. But some people choose to identify outside of the categories of "man" or "woman," or “male” or “female.” For example, some people have a gender that blends elements of being a man or a woman, or a gender that is different from either male or female. Some people don't identify with any gender. Some people's genders change over time.

People whose gender is not man or woman use many different terms to describe themselves, with non-binary being one of the most common. Other terms include genderqueer, agender, bigender, and more. None of these terms mean exactly the same thing – but all speak to an experience of gender that is not simply man or woman.

TWO-SPIRIT

> **Not all LGBTQ2SI+ Indigenous peoples identify as Two-Spirit, and not all Two-Spirit people identify under the LGBTQ2SI+ umbrella.**

Two-Spirit (Acronym - 2S) is a term specific to Indigenous Peoples (First Nations/Inuit/Metis) of Turtle Island (North America). While Two-Spirit people are not heterosexual and/or not cisgender, Two-Spirit is a term that is not meant to be synonymous with Indigenous LGBTQ2SI+ people.

Two-Spirit is a term coined by Indigenous peoples to find a common term in English that expresses various gender diversities throughout Indigenous cultures (as each language has its own way of describing those who don't conform to heterosexual and/or cisgender norms).

Historically, people who would be considered Two-Spirit today were celebrated for their identity and had important leadership roles in their communities, such as mediators, medicine people and had special roles in traditional ceremonies. The reclamation of Two-Spirit identity today is a means of dismantling the homo-, bi- and transphobia that was created by colonialism.

PRONOUNS

A pronoun is a word that refers to either the people talking (I or you) or someone or something that is being talked about (like she, it, them, and this). Gender pronouns (he/she/they/ze etc.) specifically refer to people that you are talking about.

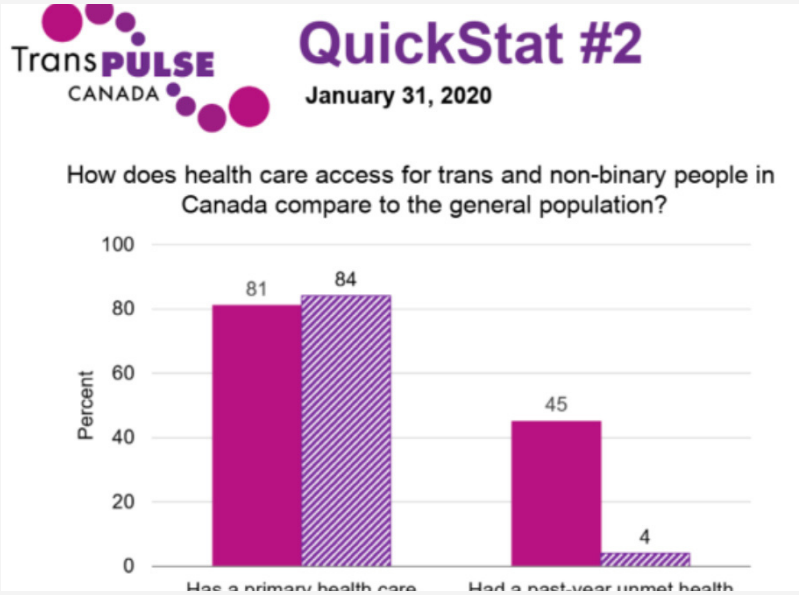
> Trans individuals often use pronouns different to their assigned sex, and it is vital to ask everyone their preferred pronouns. If a pronoun is used that is not an individual's preferred one, it is called misgendering, and can be harmful and invalidating. If this occurs, quickly correct yourself and apologize for the mistake.

HISTORICAL CONTEXT

Canada is well-known for its universal healthcare system but we must ask ourselves, who is it truly universal for?

Many transgender (trans), non-binary and Two-Spirit people experience severe challenges accessing gender-affirming healthcare and the healthcare system has a long-standing history of discrimination and harmful practices towards trans communities (The Trans PULSE Canada Team, 2020). Moreover, several studies document significant health disparities in trans communities that can be attributed to healthcare accessibility issues, housing security, experiences of violence, and social marginalization among many other factors (The Trans Pulse Canada Team, 2020; Hughto et al., 2015). Historically, trans patients have had significant difficulties in accessing primary care physicians who are able to provide gender-affirming care (Bourns, 2019).

Diagram 2: Healthcare access in Canadian trans and non-binary people compared to the general population



Source: https://transpulsecanada.ca/wp-content/uploads/2020/03/National_Report_EN_2020-03-10_A.pdf

In a recent study conducted by Trans PULSE Canada on the health and wellbeing of trans and nonbinary people in Canada, the findings in the National report provide statistical data across the major provinces and territories. Of the 2873 respondents, roughly 1 in 10 participants were Indigenous. Additionally 14% of the sample were racialized people (those who identified as, or were perceived or treated as a person of colour). The study also provided useful information on unmet healthcare needs, gender affirming medical care status, mental health, suicidality as well as sociodemographic factors like age, gender, education, employment and income. While access to healthcare for trans and nonbinary people was fairly consistent with the general population, trans and nonbinary people were ten times more likely to have an unmet healthcare need compared to the general population.

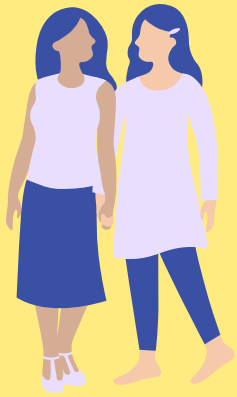
The table below, taken from The Trans Pulse Canada Team (2020), represents a recent survey of sociodemographics characteristics amongst trans and non-binary people. Trans & Two-Spirit communities experience significant amounts of discrimination, violence, harrassment and oppression but those who hold other intersectional identities (ie. race, disability, etc) may face additional barriers and oppression, in addition to higher rates of violence, harassment, and mistrust of law enforcement, which can be detrimental to their quality of life (Chih et al., 2020; Merasty et al., 2021). As healthcare providers, we must be aware of how different identities can impact each other and we must learn to practice medicine at this intersection.

	Canada n=2873		BC n= 538	AB n= 536	SK n= 95	MB n= 78	ON n= 1012	QC n= 369	NB n= 75	PE n= 14	NS n= 103	NL n= 36	YT,NT,NU [a] n= 12
	%	95% CI	%	%	%	%	%	%	%	%	%	%	%
Indigenous in Canada													
Indigenous in Canada	9	8 - 10	10	10	20	15	7	5	7	7	9	11	25
Not Indigenous in Canada	91	90 - 92	90	90	80	85	93	95	93	93	91	89	75
Racialization													
Racialized	14	13 - 15	13	13	15	15	19	9	8	0	5	0	42
Not racialized	86	85 - 87	87	87	85	85	81	91	92	100	95	100	58
Immigration history													
Newcomer (past 5 years)	3	3 - 4	6	2	0	1	3	4	3	0	2	0	0
Immigrant (non-newcomer)	9	8 - 10	14	6	5	1	10	6	5	14	5	3	9
Born in Canada	88	87 - 89	80	92	95	97	88	90	92	86	93	97	91
Urban / rural [d]													
Rural or small town	6	5 - 7	7	6	8	10	4	7	18	8	12	6	18
Not rural or small town	94	93 - 95	93	94	92	90	96	93	82	92	88	94	82
Disability identities (check all that apply) [b]													
Autistic	14	12 - 15	18	13	16	9	13	11	11	0	17	8	8
Blind	0.5	0.2 - 0.7	0.7	0.6	2	0	0.2	0.5	0	0	0	0	0
Crip	2	2 - 3	3	2	2	0	2	1	0	0	1	0	0
Deaf	1	0.6 - 1	1	0.8	0	1	0.7	1	1	0	3	0	0
Disabled or living with a disability	19	17 - 20	23	16	18	21	25	8	5	21	12	17	0
Chronic pain	21	19 - 22	26	20	22	19	22	14	17	7	18	19	33
Neurodivergent	30	29 - 32	33	32	32	33	31	25	21	7	21	31	17
Psychiatric survivor, mad, or person with mental illness	43	41 - 45	43	44	52	51	48	29	40	21	47	36	17
Other	7	6 - 7	9	8	9	4	6	4	3	0	4	8	0

Table 1: Socio-demographics among trans and non-binary people in Canada, by province/territory

Source: https://transpulsecanada.ca/wp-content/uploads/2020/03/National_Report_EN_2020-03-10_A.pdf

It's important to think critically about the impact of intersectional identities and reflect on how Eurocentric & Western world views of gender and gender transition have been problematic to many BIPOC communities. The Black trans history of Pride is a testament to how prolific racialized communities have been in pushing forward the 2SLGBTQ+ movement but how little recognition they have received in Western media for their activism and organizing efforts (Lora DiCarlo, 2020). Systemic inequities which impact BIPOC communities also manifest in gender diverse communities and as future practitioners, we must be aware of the dangerous history of healthcare institutions in perpetuating this violence.

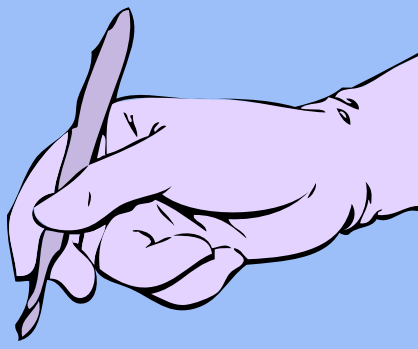


HISTORICAL CONTEXT

Historically, trans folks have been distrusted by the medical community. Even those who worked in trans healthcare often viewed trans folks as “shrewd, rehearsed, and thought to have ulterior motives” (Wills, 2020). Being a trans person was considered a profound psychological disorder. To treat this disorder, there were forms of conversion therapies used to attempt to change one’s gender identity to cis-gender, which have been associated with increased adverse mental health outcomes, including suicide attempts. This attitude of transness being a pathology to be fixed has been carried through research about the community, which only harms trans people (Turban et al., 2020). Conversely, providing support, resources and acceptance allows members of this community to thrive. Remember, trans identities are NOT a pathology and maintaining this attitude is harmful to patients and communities.

Internationally, a history of discrimination against trans people extended to fertility. In many countries, there is a history of requiring sterilization to legally change one’s gender if they identify as a trans person. Some even forbid freezing of sperm or eggs prior to transition surgeries, rendering creating biological children impossible (GlobalPost Reports, n.d.). Although this is not the case in Canada, we must remember this country’s shameful legacy of forced sterilization on Indigenous women and how this (along with an extensive colonial legacy and systemic erasure of Indigenous cultures) has created deep-seated medical mistrust between QTBIPOC (Queer, Trans, Black, Indigenous, People of Colour) communities and the medical system (Rasmussen, 2019).

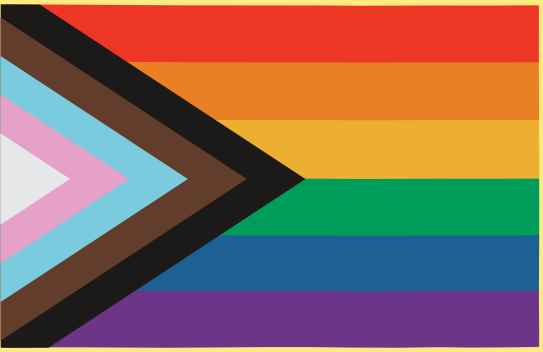
Remember that just as the successes of medicine are our victories, the dark history of our healthcare system is also a burden we must bear as future physicians; to engage meaningfully with BIPOC trans, non-binary and Two-Spirit communities, we must understand the context in which systemic inequities operate and work tirelessly to eliminate these disparities, human rights violations and inequities.



RACIALIZED TRANS HEALTH & INTERSECTIONAL OPPRESSION

Where do you go from here?

When discussing racialized people and these communities' various disparities, it is necessary to also underscore the concept of intersectionality. Intersectionality, first coined by Kimberlé Crenshaw, emphasizes the interconnected nature of identities such as race, class, and gender. These identities intersect synergistically to create different and distinct experiences of both privilege and systemic oppression for individuals (Crenshaw 1991). In particular, racialized trans individuals experience intersecting forms of social marginalization and barriers to healthcare, resulting in the disproportionately high health inequities that we see. For instance, a quarter of racialized trans individuals are also living with a disability, they are more likely to be earning less than $30,000/year and be under-employed despite being highly educated (Chih et al., 2020). This intersects with other social identities to create unique barriers when accessing healthcare. As healthcare providers, it is important to understand the intersectional oppression faced by racialized trans individuals to better understand and address the barriers they face in accessing healthcare.



Yet, there is a significant lack of data regarding the health of racialized trans individuals in Canada, and how it is impacted by the intersection of systemic racism and transphobia. In fact, the TransPULSE Canada report by Chih et al. (2020) represents the first and only quantitative all-ages data on racialized trans and non-binary people in Canada. The report highlights that racialized trans and non-binary individuals experience even higher levels of violence and harrassment.

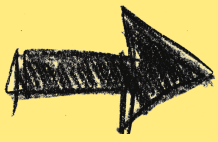
72% of individuals reported verbal harassment and 41% had been physically intimidated or threatened. Almost half of individuals experienced sexual harassment, and 1 in 3 had been sexually assaulted in the past 5 years. Despite similar access to healthcare as their non-racialized counterparts, racialized trans individuals rated their overall health more poorly. Notably, racialized trans individuals were also more frequently unsure or not planning to seek gender-affirming care.

RACIALIZED TRANS HEALTH & INTERSECTIONAL OPPRESSION

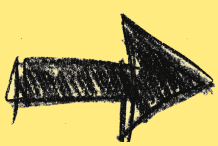
Stigma and discrimination based on one's actual or perceived identity—such as racism, ableism, or transphobia—can also intersect synergistically to exacerbate pre-existing structural inequities (Logie et al., 2011). For racialized and Indigenous trans and Two-Spirit individuals, this intersectional oppression and stigma they face also results in barriers to accessing the healthcare they need and deserve.

Throughout your career, keep in mind that concepts and systems of thinking around gender and sexuality (including trans identities) are fluid, flexible and differ from culture to culture.

Mistrust in the healthcare system due to previous trauma or negative experiences, historic discrimination and maltreatment by the healthcare system, and experiences of societal stigma can prevent individuals from seeking gender-affirming care.



It is the responsibility of all healthcare providers to actively practice cultural humility and understand the intersectional stigma and oppression experienced by each patient in order to recognize and mitigate the barriers they face.



It is the responsibility of healthcare professionals to create an inclusive and culturally-safe environment for all racialized and Indigenous trans and Two-Spirit individuals.

It is important to acknowledge that much of the current academic literature available to us in Canada is informed by Western ways of knowing and Eurocentric cultural beliefs. Not all trans people identify with Western portrayals of trans identities and as a practitioner, you should do your due diligence in exploring your patient's belief systems to help you understand what gender-affirming care would look like to them. Value all ways of knowing and learn to decentre yourself when working towards reaching your patient's goals.

MEDICAL CONTENT

Gender Dysphoria Diagnostic Criterial (DSM-5)

Transgender and gender diverse individuals may experience distress regarding their gender identity, known as **gender dysphoria**. Gender dysphoria is defined as a “marked incongruence between one’s experienced/expressed gender and their assigned gender, lasting at least 6 months.”

For adolescents/adults this is manifested by ≥2 of:

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

MEDICAL CONTENT

Gender Dysphoria Diagnostic Criterial (DSM-5)

For children this is manifested by ≥6 of:

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

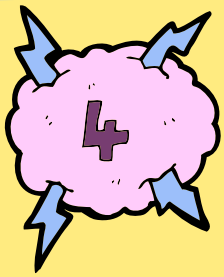
There also must be associated clinically significant *distress* or *impairment* in important areas of functioning (e.g. social, occupational)

The criteria listed on the previous page are controversial for a number of reasons:

Gender dysphoria's inclusion in the DSM has social implications for the trans community; pathologizing the identity

To meet the diagnostic criteria, functional impairment is required - not necessarily a feature of being trans, but due to anti-trans stigma and discrimination. The definition also includes feeling distress about one's gender identity, which may not be felt by all trans people.

The children's criteria are predicated on antiquated gender roles and stereotypes.



The definition of gender dysphoria is based on a binary view of gender, which may not apply to those who identify on a gender spectrum.

The failings of these criteria impact the trans community as they serve as the gatekeepers to medical intervention*

**Note: Many physicians now take a more nuanced approach to these criteria, the interpretation can be more fluid than one may realize.*

MEDICAL THERAPIES

Note: Not all trans folks want to medically transition. Those who do may not want both surgery and gender-affirming hormone therapy, or may want various combinations of medical therapies and procedures. Furthermore, people can change their minds over time.

01 Consider patient goals in starting hormone therapy

- Consider unique patient transition goals & understand where hormones can or cannot help meet these goals.
- Ensure patients understand contraindications and side effects to hormone therapy.
- Discuss risk mitigation (e.g. smoking cessation for estrogen therapy). Review understanding of hormone therapy effects and irreversibility of some effects.
- Consider how hormones affect fertility and explore fertility options with the patient.

02 Conduct a physical & mental health assessment

- Rule out or address medical or mental health conditions that may be affected by hormone therapy or should be stabilized before starting hormone therapy. Conduct baseline blood work, review health records, and perform physical exams as appropriate.
- Discuss psychosocial implications of transitioning & what community supports are available.
- Assess the World Professional Association for Transgender Healthcare (WPATH) Hormone Readiness Guidelines (WPATH, 2012).

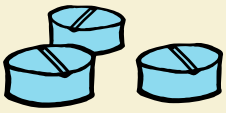
03 Identify a provider to prescribe & decide on a long term care plan

- Obtain informed consent from the patient and use a “checklist” to help patients understand the process/procedure. Examples available in Checklist for Healthcare Providers section of this document & can also be located in the (Saskatchewan Trans Health Coalition, 2019)

Table 3: Types of Hormone Therapy

Note: initiate a conversation with your patients on side effects. Many can be managed & screened for.

Hormone	Description	Types	Effects	Levels	Coverage
Anti-Androgens	• Blocks the effect of testosterone • Can be used alone to reduce testosterone-induced characteristics or used in conjunction with estrogen. • Can discontinue post-gonadectomy • Keep in mind estrogen cannot work if testosterone is present	**Spironolactone** • Oral pill • 50mg-400mg /day **Cyproterone** • Oral pill • 12.5mg-50mg/ day **Finasteride*** • Oral pill • 2.5mg-5mg /day **Dutasteride*** • Oral pill • 0.5mg/day **Can be teratogenic in pregnancy*	• Slows facial & body hair growth • Slows balding • Breast development with spironolactone • Decrease testicle size • Decrease sex drive **Side Effects** • Spironolactone can decrease blood pressure and cause hyperkalemia • Decrease kidney function • Infertility (although not reliable as contraception) • Increase osteoporosis risk when taken without a steroid hormone (such as estrogen)	Goal is to maintain testosterone < 2.0 ng/dL	$20-80/month • Generally covered by health plans (NIHB, OHIP+, Fair PharmaCare, etc) • Patch or gel covered by some private plans

Hormone	Description	Types	Effects	Levels	Coverage
Estrogen	• Works directly on targets and through suppression of testosterone • Sublingual, patch, and gel forms are available. • Oral routes or patch forms are preferred to limit effects on the liver • Transdermal patch indicated if age > 40 with risk factors such as smoking • Cannot create a high pitched voice	**Oral Estradiol** • Oral/Sublingual pill • 1mg-6mg/day **Transdermal Estradiol** • Skin Patch/ cream • 0.1mg-0.4mg / 24h, 2x/week **Intramuscular Estradiol Valerate*** • Injectable liquid • 5mg-10mg / 1-2 weeks **Only available at some pharmacies*	• Breast development • Redistributing fat to hips & thighs • Softening skin • Emotional changes	Goal is to maintain estradiol 300-800 pg/mL 	$20-80/month (oral) $140-280/month (injectable or patch) • Generally covered by health plans (NIHB, ODB with EAP request, OHIP+, Fair PharmaCare, etc) • Patch or gel covered by some private plans
Progesterone	• Generally not recommended • Can be prescribed to aid breast & nipple development, to supplement estrogen if the maximum dose is reached, or if patient is unable to take estrogen	**Medroxyprogesterone** • Oral pill • 5mg-30mg/day **Micronized Progesterone** • Oral pill • 100-400mg/day	• Breast development • Increase nipple size, increase areola size, and darken areolas • Emotional changes 		$2-30/month (medroxyprog-esterone) • Generally covered by health plans $40-160/month (micronized progesterone) • Covered with special permission
Testosterone	• Works directly on targets and through suppression of estrogen • Keep in mind excess testosterone converts to estrogen. High testosterone doses can cause estrogenic effects	**Injectable Testosterone** • Intramuscular Injection or subcutaneous • 25mg/wk-100mg/wk **Transdermal Testosterone*** • Skin patch, gel, or cream • 2.5g-10g/day **Must be careful not to rub off & transfer onto children or pregnant individuals	• Stops menstruation (although not reliable as contraception) • Redistributing fat to stomach and away from hips & thighs • Deepen voice • Increase facial and body hair • Increase muscle mass • Increase clitoris size • Vaginal atrophy/ dryness • Emotional changes	Goal is to maintain testosterone <30 ng/dL 	$12-70/mo (injectable) $80/month (topical gel) • Generally covered by health plans (NIHB, ODB with EAP request, OHIP+, Fair PharmaCare, etc) • Gel covered by some private plans
GnRH Analogues	• Works to suppress puberty hormones • Effects are fully reversible. Upon stopping GnRH analogues, puberty would resume as if puberty suppressing 	**Lupron** • Injection • Every 4 or 12 weeks	• Limits growth spurt • Reduces sex drive development • Limits fertility • Decreases bone Ca2+ accumulation **When blocking testosterone:** • Reduces facial & body hair • Limit voice deepening • Reduce growth of adam's apple, testes, & penis • Reduce broadening of shoulders **When blocking estrogen:** • Decrease breast development • Reduce broadening of hips • Limits menstruation		$387 per 7.5mg (injection) • Generally covered by health plans (NIHB, OHIP+, Fair PharmaCare, etc)

(Saskatchewan Trans Health Coalition, 2019)

Table 4: Effects & expected time course for hormone therapy

Hormone	Effect	Expected Onset	Expected Maximum Effect
Feminizing Hormones	Body fat redistribution	3-6 mo	2-5 years
	Decreased muscle mass/strength	3-6 mo	1-2 years
	Softening of skin/decreased oiliness	3-6 mo	unknown
	Decreased libido	1-3 mo	1-2 years
	Decreased spontaneous erections	1-3 mo	3-6 mo
	Male sexual dysfunction	variable	variable
	Breast growth	3-6 mo	2-3 years
	Decreased sperm production	variable	variable
	Thinning & slowed growth of body/facial hair	6-12 mo	>3 years
	Male pattern baldness	No regrowth, loss stops 1-3 mo	1-2 years
Masculinizing Hormones	Skin oiliness/acne	1-6 mo	1-2 years
	Facial/body hair growth	3-6 mo	3-5 years
	Scalp hair loss	> 12 mo	Variable
	Increased muscle mass/strength	6-12 mo	2-5 years
	Body fat redistribution	3-6 mo	2-5 years
	Cessation of menses	2-6 mo	n/a
	Clitoral enlargement	3-6 mo	1-2 years
	Vaginal atrophy	3-6 mo	1-2 years
	Deepened voice	3-12 mo	1-2 years

(WPATH Standards of Care V7, 2012)

Table 5: Risks of hormone therapy

Risk	Feminizing Hormones	Masculinizing Hormones
Likely increased risk	• Venous thromboembolic disease ***** • Hypertriglyceridemia ***** • Gallstones • Elevated liver enzymes • Weight gain	• Polycythemia ***** • Weight gain • Acne • Androgenic alopecia (balding) • Sleep apnea
Likely increased risk with presence of other risk factors	• Cardiovascular disease	
Possible increased risk	• Hypertension ***** • Hyperprolactinemia or prolactinom	• Hyperlipidemia ***** • Elevated liver enzymes
Possible increased risk with presence of other risk factors	• Type 2 diabetes *****	• Destabilization of certain psychiatric disorders ***** • Cardiovascular disease ***** • Hypertension ***** • Type 2 diabetes *****
No increased risk or inconclusive	• Breast cancer *****	• Breast cancer ***** • Cervical cancer ***** • Ovarian cancer ***** • Uterine cancer ***** • Loss of bone density

***** = *clinically significant*
(WPATH Standards of Care V7, 2012)

Table 6: Common comorbidities to assess for

Hormone Therapy	Goals	Baseline Investigations	Investigations to Follow	Subjective Areas for Review	Objective Areas for Review
Estrogen & Anti-Androgens	• Maintain hormone levels in the cis female range • Induce changes at expected rates • Minimize side effects	**Repeat q6-12 months** • Testosterone • Prolactin • TSH • CBC • Fasting glucose & lipids • ALT • GFR • Electrolytes	• Testosterone level • Estrogen level • ALT • Electrolytes	• Physical and emotional effects of hormones • Desire for dose change • Side effect concerns • Mental health (including mood, body image, and libido) • Social situation (including significant others, support, acceptance, safety, housing, finances)	• Blood pressure • Weight • Cardiovascular exam • Abdominal exam • Mental status
Testosterone	**Request the lab to report male reference ranges** • Maintain hormone levels in cis male range • Induce changes at expected rates • Minimize side effects	**Repeat q6-12 months** • Testosterone • TSH • CBC • Fasting glucose & lipids • ALT	• Testosterone level • CBC • ALT		

INJECTION TIPS

These can be important to address as patients may be acquiring underground sources of hormone therapy out of financial constraint, due to not being taken seriously by physicians, or out of desperation. Address injection safety for patients who are injecting hormone therapy without a provider to ensure safe practices. (*Adapted from Transgender Health: Injection Guide, 2020)*

Testosterone can be administered intramuscularly or subcutaneously depending on patient preference.

Intramuscular Injections

- Use two different needle tips for drawing and injecting.
- Rub injection site with palm before sterilizing to warm up the muscle and keep it relaxed.
- Let the skin fully dry from the alcohol swab before injecting.
- Pinch around the site of injection about 1 inch in diameter when inserting the needle and let go after the needle is in the muscle.
- Testosterone can be very viscous and difficult to inject. Make sure to insert the needle straight into the skin and pull it out without wiggling or deviating the needle

Subcutaneous Injections

- Subcutaneous (SubQ) injections are often preferred by patients as they are much less painful compared with intramuscular injections.
- SubQ injections target the subcutaneous fat directly under the skin and medications are absorbed more slowly than intramuscular injections.
- SubQ injections are given at a 45 degree angle. Needles are usually 25-26 gauge and ⅝’ in length. Sites for SubQ injections include the side or backs of the arm, the front of the thighs, abdomen, or gluteus maximus.

Preventing Infection

- Wash your hands
- Clean the rubber stopper of the vial with an alcohol swab and let it air dry. Swab the skin before injecting.
- Do not use the syringe if the package has been open or damaged. Do not let the needle touch any surfaces. Never reuse needles!
- Check the expiration date on the vial. Do not use if there are visible particles or if the medication is discoloured.

Navigating Hormone Shortages

- Injectable testosterone often faces manufacturer supply shortages, which can lead to anxiety and frustration for patients.
- Try calling different local pharmacies or considering a temporary switch to another form.
- Enanthate and cypionate formulations have a different base and concentration, but deliver the same testosterone and can be swapped if there is a shortage.

Safe Disposal

- Purchase a home sharps container from your local pharmacy and dispose at community drop-off locations.
- Note: Some provinces provide free sharps containers at pharmacies. In many cases physicians can write a prescription for a home sharps container which means they can be covered by some drug plans.

Ask about injection practices!

- Note any infections and ask about injection practices.
- Again, inquire about any potential use of underground sources!

GENDER-AFFIRMING SURGERIES

Requirements for care

WPATH criteria outlines the requirements for transition-related surgery: “While the SOC [standards of care] allow for an individualized approach to best meet a patient’s health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of hormone therapy and one year of continuous living in a gender role that is congruent with one’s gender identity” (WPATH, 2012).

Detailed criteria for surgery is provided in Tables 7 and 8.

Steps for accessing surgeries are province-dependent. For example, in AB, a psychiatrist is (still) required to make a diagnosis of gender dysphoria and apply for surgical funding on their patient's behalf, even for masculinizing chest surgeries performed in province. Bottom surgeries require two psychiatrists' letters and are performed out of province.

Steps to access in-province surgery:

1. Patient makes the decision to seek the surgical intervention.
2. Physical and mental health assessment:
   a. Rule out or address medical contraindications: does the patient have any medical conditions that a major surgery may negatively affect?
   b. Rule out or address mental health issues: does the patient have any mental health concerns that should be stabilized before surgery?
   c. Discuss and address psychosocial implications of transitioning
   d. Ensure patients meet the WPATH Criteria for Surgery (WPATH, 2012)
3. The doctor who conducted the physical and mental health assessment refers the patient to a surgeon.
4. Surgical date is scheduled.

Note: While many trans and non-binary individuals find comfort with their gender identity and gender expression without surgery, surgery is medically necessary to alleviate gender dysphoria for many trans people (Hage and Karim, 2000).

Steps to access out-of-province surgery:

1. Patient makes the decision to seek the surgical intervention and talks to a doctor (probably a GP) about accessing the surgical intervention, who will then refer them to a recognized authority for a first assessment.
2. Primary Assessment and Referral Letter
   a. Primary assessment must be completed by a recognized authority
   b. Ensure patients meet the WPATH Criteria for Gender Dysphoria (WPATH, 2012)
   c. Ensure patients meet the WPATH Criteria for Surgery (WPATH, 2012)
   d. The service provider will then refer patients to a second provider
3. Secondary Assessment and Referral Letter; second opinion to ensure patients meet the readiness criteria.
   a. Note: While the WPATH stipulates that a “qualified mental health practitioner” can do this, who the government allows to provide these letters varies from province to province. Ex. In Saskatchewan the current criteria is a “designated approved” (in-province family physicians or out-of-province psychiatrists) and one psychiatrist. In Ontario & British Columbia, this differs as nurse practitioners, more family physicians, and masters-level social workers may be able to provide these letters. Please ensure that you are aware of your own province’s regulations surrounding the provision of these letters.
4. Funding Approval
   a. Once the patient has been assessed by two providers, their application is forwarded to the Ministry of Health. This is typically done by the doctor who made the initial referral, or one of the psychiatrists.
   b. The Ministry of Health then forwards the application to the clinic where the surgery will take place (typically GRS Montreal) - the clinic will follow-up with the patient to gather additional information.
   c. NOTE: Patients must cover their own travel costs. Patients can apply for travel funding from hopeair.ca
5. Surgical date is scheduled.

(Saskatchewan Trans Health Coalition, 2019)

SURGERY COVERAGE

Standard Coverage

Gender affirming surgeries are medically necessary. Individuals with provincial healthcare coverage are eligible for certain transition-related surgeries covered by the province. Coverage of surgeries depends on each province. Other surgeries that are not covered by the province are available, but require out-of-pocket payment.

Coverage for Newcomers

The Interim Federal Health Program (IFHP) includes basic, supplemental, and prescription coverage for: resettled refugees, certain people protected under asylum claims, refugee claimants (including those awaiting decision or whom have been rejected), victims of human trafficking, and those detained under the Immigration and Refugee Protection Act. In most cases, the IFHP covers primary care and doctor's visits, including mental health doctors, for up to three months, and medications and prescriptions for up to 12 months (Sherbourne Health, 2020).

Coverage for Indigenous Peoples

Each provincial government provides basic medical benefits. For people registered under the Indian Act ("Status Indians") and to Inuk people recognized by an Inuit land claims organization, the Non-Insured Health Benefits Program provides coverage for meals, accommodation and transportation. An eligible recipient for the Non-Insured Health Benefits Program must be identified as a resident of Canada and one of the following: a) Registered according to the Indian Act; b) An Inuk recognized by one of the Inuit Land Claim organizations; or c) An infant less than one year of age, whose parent is an eligible recipient. When recipients are eligible for benefits under a private health care plan, or public health or social program, claims must be submitted to these plans and programs first before submitting them to the Non-Insured Health Benefits Program. Non-status First Nation and Métis people do not receive any health care benefits from the federal government (Alberta Health Services, n.d.).

RISKS OF SURGERIES

General Surgical Risks

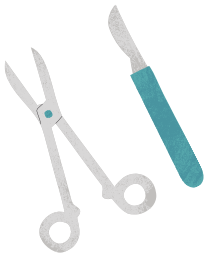
- Bleeding, if excessive may require blood transfusion
- DVT, PE (blood clots in legs, lungs)
- Injury to surrounding anatomical structures (organs, nerves, blood vessels)
- Hematoma (collection of blood)/seroma)
- Infection/abscess (collection of pus)
- Wound dehiscence (wound opening), delayed healing
- Nerve damage, loss of sensation, hypersensitivity, neuropathic (nerve) pain
- Chronic pain
- Scarring (can be prominent especially if history of keloid)
- Dissatisfaction with appearance/function
- Need for revision(s)
- Post-operative regret [Note: this is a very low risk as less than 1% experience this (Narayan et al., 2021)]

Top Surgery-Specific Risks

- Scar tissue formation. This can become uncomfortable or change the shape of the breast.
- Implants that leak or rupture - must be removed.
- Changes in how the nipple feels.
- Nipple graft loss (a risk in transmasculine chest surgery).
- Need for revisions if breasts are lopsided or wrinkled.

General Anesthetic Risks

- Respiratory failure
- Cardiac failure/arrest
- Death
- Damaged teeth
- Aspiration pneumonia
- Nausea/vomiting

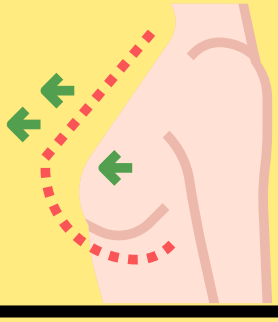
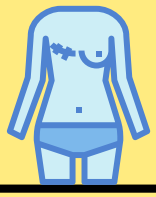


Bottom Surgery-Specific Risks

- Fistula (an opening that forms between the rectum and the vagina).
- A breakdown of the tissue used to create the vagina.
- A narrowing or closure of the vagina or urethra.
- Sagging or drooping of the top of the vagina into the vaginal canal or outside of the vagina.
- A vagina that's too small or short for vaginal intercourse.
- Bladder infections or other bladder problems.
- Flap loss (a risk in phalloplasty)

Healthwise, 2020; Sherbourne Health Centre, 2016)

TABLE 7A. TOP SURGERIES

	Surgery	Description	WPATH Requirements has to be from a qualified professional (the designation of a "qualified professional" varies from province to province as mentioned above). (WPATH 2012)	Where it's provided	Where it's covered
Feminizing procedures	Breast augmentation	Insertion of silicone or saline implants to enlarge breasts (sometimes described as 'feminizing' the chest). 	1. Persistent, well-documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country (if younger, follow the SOC for children and adolescents); 4. If significant medical or mental health concerns are present, they must be reasonably well controlled. *Recommended that patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.	BC (*approval required) Alberta (*approval required) Manitoba (*approval required) Newfoundland Nova Scotia NWT	BC Alberta Manitoba Ontario Quebec (Centre de Chirurgie, Montreal) Nova Scotia
Masculinizing procedures	Double mastectomy * some patients may prefer the term chest surgery or upper surgery	Removal of the breast tissue to flatten the chest. This procedure typically does not include liposuction, although it may be included by some surgeons on a case by case basis. 	1. Persistent, well-documented gender dysphoria; 2. Capacity to make a fully informed decision and to consent for treatment; 3. Age of majority in a given country (if younger, follow the SOC for children and adolescents); 4. If significant medical or mental health concerns are present, they must be reasonably well controlled. *Hormone therapy is not a prerequisite	BC Alberta Saskatchewan Manitoba (*approval required) Ontario Quebec Newfoundland New Brunswick Nova Scotia PEI NWT	BC Alberta Manitoba Saskatchewan Ontario Quebec (Centre de Chirurgie, Montreal) Nova Scotia By select local plastic surgeons.
	Chest contouring	Surgery that entails additional sutures, incisions, and/or liposuction to alter the appearance of the chest and give it a "V" shape (sometimes described as 'masculinizing' the chest).	1. Persistent, well-documented gender dysphoria; 2. Capacity to make a fully informed decision and to consent for treatment; 3. Age of majority in a given country (if younger, follow the SOC for children and adolescents); 4. If significant medical or mental health concerns are present, they must be reasonably well controlled *Hormone therapy is not a prerequisite	Manitoba Newfoundland New Brunswick Nova Scotia PEI	BC Alberta Manitoba Quebec (Centre de Chirurgie, Montreal) Nova Scotia 

*In certain provinces, additional criteria not recommended by WPATH are imposed on the approvals process for breast surgery. For example, in AB, approval for breast augmentation for transfeminine people is usually only granted when patients are determined to have little to no breast growth on HRT as determined by their surgeon. Otherwise, these surgeries are designated as "cosmetic" procedures and are not covered.

(Table 7A & 7B Source: Saskatchewan Trans Health Coalition, 2019; WPATH, 2012; Sherbourne Health Centre, 2016; Saskatchewan Trans Health Coalition, 2019; Klinic Community Health, 2021; Sante Trans Health, 2020; Government of Newfoundland and Labrador, 2019; Government of New Brunswick, 2021; Government of Nova Scotia, 2020; Government of Prince Edward Island, 2019; Government of Northwest Territories, 2020; Government of Yukon, 2021)

TABLE 7B. BOTTOM SURGERIES

	Surgery	Description	WPATH Requirements Two supporting assessments: 1 assessment from a qualified Physician or NP AND 1 assessment from a qualified Physician, NP, Psychologist or Registered Social Worker with a Masters	Where it's provided	Where it's covered
Feminizing procedures	Vaginoplasty (with or without vaginal canal)	Removal of the penis and testes; and creation of a vulva and vagina. Vaginoplasties may be done with or without a vaginal canal. If the vaginoplasty is done without a vaginal canal, penetration will not be possible.	1. Persistent, well-documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country (if younger, follow the SOC for children and adolescents); 4. Significant medical or mental health concerns are present, must be reasonably well controlled. 5. 12 mo of hormone therapy (contraindications are exempt); 6. 12 mo of living in a gender role that is congruent with their gender identity. *Recommended that patients also have regular visits with a mental health professional.	BC Alberta Saskatchewan Manitoba Ontario Quebec Newfoundland New Brunswick Nova Scotia PEI NWT	BC Manitoba Ontario Quebec (Centre de Chirurgie, Montreal). *Currently, only GRS Montreal is accepting out-of-province patients (so Toronto is for Ontario-only patients, and Vancouver is for BC-only patients).
	Orchiectomy	Removal of the testes.	1. Persistent, well documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country; 4. If significant medical or mental health concerns are present, they must be well controlled; 5. 12 mo of hormone therapy as appropriate to the patient's gender goals (contraindications are exempt). *The aim of hormone therapy is to introduce a period of reversible E or T suppression, before patient undergoes irreversible surgery. *Criteria don't apply to gonadectomy for indications other than gender dysphoria.	BC Saskatchewan Manitoba Newfoundland New Brunswick Nova Scotia PEI NWT	Manitoba Quebec (Centre de Chirurgie, Montreal) Nova Scotia
Masculinizing procedures	Hysterectomy +/- oophorectomy	Removal of the uterus +/- ovaries.	1. Persistent, well documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country; 4. If significant medical or mental health concerns are present, they must be well controlled; 5. 12 mo of hormone therapy as appropriate to the patient's gender goals (contraindications are exempt). *The aim of hormone therapy is to introduce a period of reversible E or T suppression, before patient undergoes irreversible surgical intervention. *Criteria don't apply to gonadectomy for indications other than gender dysphoria.	BC Alberta Saskatchewan Manitoba Ontario Quebec Newfoundland New Brunswick Nova Scotia PEI NWT	Alberta Manitoba Saskatchewan Ontario Quebec Nova Scotia By select local gynaecologists.
	Metoidioplasty	Lengthening of the clitoris and urethra, creation of the scrotum, and insertion of testicular implants.	1. Persistent, well-documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country; 4. If significant medical or mental health concerns are present, they must be reasonably well controlled. 5. 12 mo of hormone therapy (contraindications are exempt); 6. 12 mo of living in a gender role that is congruent with their gender identity. *Recommended that patients also have regular visits with a mental health professional.	BC Saskatchewan Manitoba Ontario Quebec Newfoundland New Brunswick Nova Scotia PEI NWT	BC Quebec (Centre de Chirurgie, Montreal). *GRS Montreal accepts out-of-province patients whereas many other centres do not.
	Phalloplasty	Creation of a phallus from skin of the forearm, abdomen or thigh; grafting of the new penis onto the groin; and possible implant of pump to make penis erect.	1. Persistent, well-documented gender dysphoria; 2. Capacity to consent for treatment; 3. Age of majority in a given country; 4. If significant medical or mental health concerns are present, they must be reasonably well controlled. 5. 12 mo of hormone therapy (contraindications are exempt); 6. 12 mo of living in a gender role that is congruent with their gender identity. *Recommended that patients also have regular visits with a mental health professional.	BC Alberta Saskatchewan Manitoba Ontario Quebec Newfoundland New Brunswick Nova Scotia PEI NWT	BC Quebec (Centre de Chirurgie, Montreal)

TABLE 8. OTHER PROCEDURES

*Many of these procedures are deemed "cosmetic" by provincial governments and are not publicly funded anywhere. Patients who can afford to pay for these procedures may still access them, but there isn't a pathway for those who can't afford it to get them funded

	Procedure	Description	Where it's provided	Where it's covered
Feminizing procedures	Body sculpting procedures	May include hip, buttock implants, liposuction, and other procedures.		
	Facial feminizing procedures	May include changes to nose, brow, jawline, lips, and other facial features.		
	Facial hair removal	*Electrolysis:* Inserting a needle into individual hair follicles and applying a charge to kill the root. Considered 'permanent' hair removal by FDA. *Laser Hair Removal:* Bursts of focused light that burn & kill hair follicles in the growth stage. Not considered 'permanent' hair removal by FDA.	Manitoba	Manitoba
	Laryngeal chondroplasty	Shortens vocal cord length, resulting in a higher vocal pitch. - 1 in 5 patients report 100% satisfaction - 3 in 5 patients say they notice changes - 1 in 5 patients say they noticed no change		
	Tracheal shave	Reduction of Adam's apple through the excision of thyroid cartilage.		
	Voice therapy	Speech therapy to alter the pitch, tone, and timbre of the voice.	Saskatchewan Manitoba Yukon	Manitoba (Deer Lodge Centre, Winnipeg) Ontario (Toronto) Out of country
Masculinizing procedures	Voice therapy	Speech therapy to alter the pitch, tone, and timbre of the voice.	Saskatchewan Manitoba Yukon	Manitoba (Deer Lodge Centre, Winnipeg) Ontario (Toronto) Out of country

(Source: Saskatchewan Trans Health Coalition, 2019; WPATH, 2012; Sherbourne Health Centre, 2016; Saskatchewan Trans Health Coalition, 2019; Klinic Community Health, 2021; Sante Trans Health, 2020; Government of Newfoundland and Labrador, 2019; Government of New Brunswick, 2021; Government of Nova Scotia, 2020; Government of Prince Edward Island, 2019; Government of Northwest Territories, 2020; Government of Yukon, 2021)

Postoperative Care and Follow-up:
"Follow-up is important to a patient's subsequent physical & mental health. Patients who travel for surgeries often have difficulty accessing post-op follow-up in their home communities, especially if there is no surgical centre there. Patients may be turned away by primary care providers who don't feel they have appropriate training to support trans patients in post-op recovery and end up in an ER that is also not prepared to treat them. Surgeons should include personal follow-up in their care plan and ensure affordable local long-term aftercare in their patients' geographic region. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any post-op adjustment difficulties" (WPATH, 2012)

TABLE 9. COUNSELLING PATIENTS ON WHAT TO EXPECT AFTER SURGERY

Breast augmentation	• Patients' breasts may look or feel different. They may be farther apart, and they may be firmer and rounder. • Patients may lose feeling in their nipples. This may be short-term, but may continue into the long-term.
Mastectomy	• Patients may have scars under their chest (pectoral) muscles. Muscles or chest hair may help cover them. • Patients' nipples may be less sensitive than before. With some techniques, the nipple may be grafted back on and have zero sensation, and grafts may fail and must be removed. Some folks are now opting to have nipples tattooed on instead.
Orchiectomy	• Without the testes, the body will no longer make testosterone. As such, patients may be able to reduce the amount of the estrogen they take. • Patients will be able to urinate sitting down.
Hysterectomy	• Without oophorectomy: patients will no longer have periods or the ability to get pregnant. • With oophorectomy: in addition to the above, the body will no longer make estrogen since the ovaries have been removed. As such, patients may be able to reduce the amount of testosterone they take.
Vaginoplasty	• Patients will need to use a dilator every day to maintain the depth and width of the vagina. • Patients will need to use a lubricant if they have vaginal sex. • Patients are encouraged to let partner(s) know (*if safe/comfortable), as vaginal angle/dimensions may affect intercourse. • Patients will likely be happy with how their vagina looks and works. However, some may have trouble reaching orgasm. • The surgery generally takes several months to heal.
Phalloplasty	• Patients may lose feeling in the places where they used tissue to create the penis. • Patients may see a scar where they took the tissue to create the penis. • High risk of stricture and fistula formation. As a result, some patients require a suprapubic catheter for a period of time. • The surgery generally takes several months to heal.

(Source: Healthwise, 2020)

OTHER PROCEDURES TO BE CONSIDERED

Disclaimer: This section is adapted from Sherbourne's Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients [4th edition] and provides an overview of key considerations and preventative screening for trans and non-binary individuals. Please refer to the comprehensive guidelines for more information, including vaccinations to consider, physical exam considerations, and inclusive preventative care forms

Healthcare providers should discuss preventative care with patients, including barriers to accessing cancer screening, a patient's status regarding gender-related treatments, and timing of treatments. This allows providers to engage in shared decision making and provide patient-centred counselling regarding screening recommendations.

Cervical Cancer Screening & Pap smears

Every person with a cervix, including transmasculine patients, should be regularly screened with a Pap test, in accordance with the provincial screening guidelines.

- If transmasculine patients have had a complete hysterectomy that removed the cervix and have no history of cancerous or precancerous cervical cells, then they may not need regular Pap tests.
- Patients that have had a colpectomy (removal of the vagina) or colpocleisis (closure of the vagina) cannot receive a Pap test.
- Tip: The speculum exam may be painful for transmasculine patients due to atrophic changes. A low-dose lorazepam or vaginal application of topical 2% lidocaine jelly applied 5-10 minutes before the procedure may be helpful in alleviating pain.

Patients that have undergone vaginoplasty (creation of a vagina), should receive an annual speculum exam to detect abnormalities such as granulation tissue, active hair follicles, warts, or malignancy. There is a small risk of developing cancer in these tissues, which depends on the type of surgery, type of tissue used in construction, and personal health history. It is recommended to discuss this with each patient while discussing overall pelvic health after their surgery.

Does testosterone impact Pap test screening?

Being on testosterone does **NOT** affect the risk of getting cervical cancer. However, it can cause cervical cells to mimic cervical dysplasia (Canadian Cancer Society 2021), so it is important to ask patients about this and notify the lab centre if they are taking testosterone.

Chest Cancer Screening & Mammograms

Transmasculine patients between the ages of 50-74 that have not undergone chest reconstruction should receive a mammogram every 2 years (in accordance with provincial screening guidelines). Mammography is not required after chest reconstruction surgery.

Although transfeminine individuals are *not* at higher risk of breast cancer compared to cis women, transfeminine patients on hormone therapy can develop both benign and malignant breast disease. Therefore, it is important to offer counselling around breast self-awareness and screening guidelines.

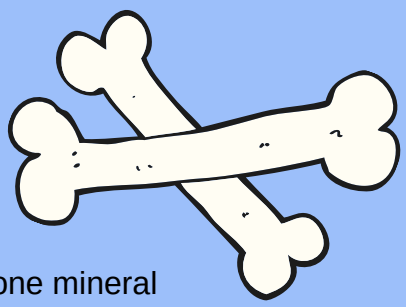
- Transfeminine patients between the ages of 50-74 that have taken estrogen therapy for ≥5 years total (does not need to be consecutive) should receive a mammogram every 2 years. If there are additional risk factors (i.e. family history, estrogen and progestin for >5 years), consider beginning screening earlier.
- For patients aged 30-69 with family history of breast cancer, consider an annual mammography with MRI.

Chest Binding

This is a common concern for patients. However, there is no current evidence that suggests binding increases the risk of developing chest cancer.

Does having breast impact chest cancer screening?

Patients with breast implants require diagnostic mammography as opposed to routine screening mammography. Other imaging modalities, such as MRI or annual ultrasound, may be required by the implant manufacturer or surgeon to detect silent rupture of silicone implants, but rupture of saline implants can typically be detected with clinical exam.



Bone Mineral Density Screening

All transfeminine and transmasculine patients age >65 should receive bone mineral density (BMD) testing in accordance with screening guidelines.

Consider BMD testing even earlier for patients that are at high risk, for example:

- >2 years on anti-androgens or GnRH analogue without exogenous estrogen
- Agonadal or low to no hormones for >2 years

Healthcare providers should follow-up with BMD screening according to the results of the initial scan.

Yearly Bloodwork

Tailor your patient's blood work according to the hormone therapy they are taking, any risk factors they may have and pre-existing conditions. According to the Sherbourne's Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients [4th edition], screening for Diabetes Mellitus Type 2 and dyslipidemia should be done at baseline (prior to hormone therapy initiation) and one year after hormone therapy has been started.

- For patients that are on anti-androgen +/- estrogen hormone regimens use the female reference for lower limit of normal for Hb/Hct values and the male reference for upper limit of normal for Hb/Hct values.
- For patients that are on anti-androgen +/- estrogen hormone regimens use the male reference range for upper limit of normal for Cr values.

Pregnancy Tests

Transmasculine patients on testosterone that have not undergone a hysterectomy can become pregnant even if they are amenorrheic. Since testosterone is a teratogen, it's important to provide counselling if pregnancy is a risk based on sexual activity and review signs and symptoms of pregnancy along with contraception options (Krempasky et al., 2020). Refer to the "Trans-Inclusive Family Planning" section below for more information on pregnancy counselling.

Other Considerations

- After full menstrual cessation is achieved with testosterone, any patient presenting with unexplained vaginal bleeding requires a full work-up for endometrial hyperplasia or malignancy.
- For people with a history of receptive anal sex, healthcare providers can offer an anal Pap test every 2-3 years, or annually if they are living with HIV.

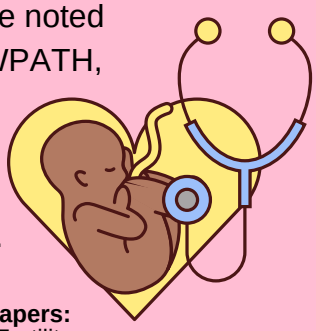
FERTILITY CONVERSATIONS:
TRANS INCLUSIVE FAMILY PLANNING

Many transgender people will want to have children. Since medical and surgical transition may limit fertility (Darney, 2008), it is best to discuss fertility desires and options with patients so they can make informed decisions before starting hormone therapy or undergoing surgery. All guidelines recommend discussion of fertility preservation as well as contraception (Bourns, 2019; Health, 2011; Hembree et al., 2017; Amato, 2016).

AMAB (assigned male at birth) patients should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. Sperm preservation should occur before hormone therapy or after stopping therapy until sperm count rises again. Sperm preservation should be considered even if semen quality is poor. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful (WPATH, 2012).

AFAB (assigned female at birth) patients should be informed about and encouraged to consider oocyte (egg) or embryo freezing. Frozen gametes and embryos could later be used with a surrogate to carry to pregnancy. Studies of cis women with PCOS suggest ovaries may recover in part from high androgen levels (Hunter and Sterrett, 2000). Briefly stopping testosterone may allow ovaries to recover and produce eggs (More, 1998; WPATH, 2012). In terms of contraception, patients should be informed that hormone therapy should not be relied on as contraception.

Patients should be informed that access to these reproductive preservation techniques is variable due to limited availability and significant financial barriers. It should also be noted that trans individuals should not be refused reproductive options for any reason (WPATH, 2012). Special consideration should be made for prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or hormones. These patients should be informed that presently there are no available techniques for preserving gonadal function (WPATH, 2012).



FURTHER READING

More about fertility considerations for trans patients can be found in the following papers:

1. Cheng, P. J., Pastuszak, A. W., Myers, J. B., Goodwin, I. A., & Hotaling, J. M. (2019). Fertility concerns of the transgender patient. Translational andrology and urology, 8(3), 209.
2. Neblett, M. F., & Hipp, H. S. (2019). Fertility considerations in transgender persons. Endocrinology and Metabolism Clinics, 48(2), 391-402.
3. Sterling, J., & Garcia, M. M. (2020). Fertility preservation options for transgender individuals. Translational andrology and urology, 9(Suppl 2), S215.
4. Wang, B., Hengel, R., Ren, R., Tong, S., & Bach, P. V. (2020). Fertility considerations in transgender patients. Current opinion in urology, 30(3), 349-354.

FERTILITY CONVERSATIONS: PREGNANCY CARE

Emerging Reproductive Technologies for Trans People

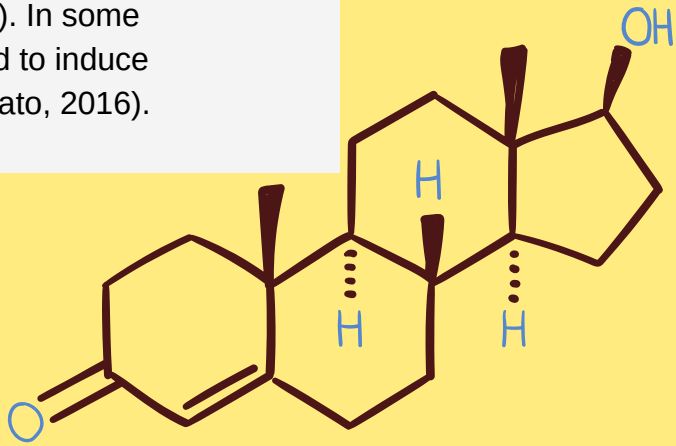
- Some current fertility preservation portions include sperm cryopreservation for trans women and oocyte or embryonic cryopreservation for trans men (Neblett et al., 2019)
- For prepubertal adolescents, some experimental options being trialled include testicular and ovarian tissue cryopreservation (Neblett et al., 2019)
- Uterine transplantation has been done successfully in cis-women and may be a possibility for trans women in the future. More about uterine transplantation for trans women can be found in the study done by Jones et al. (2019).

Testosterone & Pregnancy

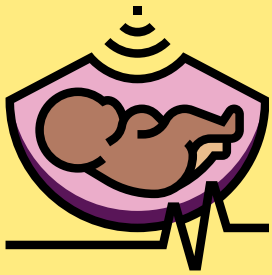
Testosterone is teratogenic and can cause the following effects in a fetus (Krempasky et al., 2020).

- Labial fusion
- Abnormal vaginal development
- Persistence of a urogenital sinus
- Clitoromegaly

There is also an increased risk of pregnancy loss (Bourns, 2019). Amato (2016) recommends that patients are counselled to stop testosterone use prior to attempting to conceive, but currently the literature is variable and uncertain on the duration. Krempasky et al. (2020) have recommended stopping testerone 4 to 6 weeks prior to attempting to conceive. It is safe to conceive a few months after cessation of testosterone because testosterone has a high metabolic rate in vivo (Garcia-Acosta et al., 2019). In some pregnancies, clomiphene citrate can also be used to induce ovulation or hCG injections may be required (Amato, 2016).



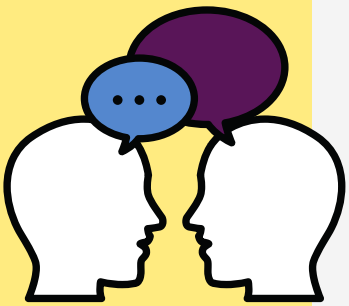
FERTILITY CONVERSATIONS: PREGNANCY



Healthcare Provider Misconceptions that Create Barriers to Pregnancy Care

Misinformation surrounding feasibility of conception, lactation, long-term effects of testosterone, pregnancy, and other aspects of pregnancy care can create bias in healthcare providers that prevents trans patients from receiving care (Garcia-Acosta et al., 2019).

In trans patients who have undergone hysterectomy, metaoidioplasty, or phalloplasty, pregnancy is not possible (Garcia-Acosta et al., 2019), however many other trans patients are able to conceive without any complications. Some trans men who have chest masculinization procedures may have a procedure which differs slightly from conventional mastectomy or breast reduction in which part of their mammary gland is retained and they are able to lactate and chest feed (Garcia-Acosta et al., 2019). Do not assume that all trans men who give birth will want to chest feed their babies (for some, chest feeding may elicit feelings of gender dysphoria).



Inclusive Language in Pregnancy

What is some safe language that can be used for trans people during pregnancy? (Light et al., 2014)

- Dad, parent, carrier, gestational parent
- Chest feeding instead of breastfeeding (but some patients may prefer breastfeeding so make sure to ask!)

Note that both pregnancy and lactation have traditionally been associated with women, however inclusive language can help make your clinic safer for trans, non-binary and gender-diverse patients who are may also be pregnant or lactating. Lactation and pregnancy are not gender-dependent processes.

Special Considerations

- Some trans men may have personal safety concerns to be visibly recognized as a pregnant trans man in public. Given the history of and high risk of violence towards trans communities, it is important to check-in with your patients and assess whether this is a concern for them and if so, work together to create safety plans. Safety concerns are very real and should be validated.
- Some trans men may want to have a C-section instead of vaginal delivery because stretching of the vagina may be a disturbing experience. Have these conversations with your patients ahead of time and explore their attitudes and beliefs. Work together to come up with a labour and delivery approach that is gender-affirming and risk-reducing.

MENTAL HEALTH

The social determinants of health play a key role in the prevalence of mental illness and outcomes among individuals with mental illness.

When it comes to mental health, three important social determinants are particularly significant: social inclusion, freedom from discrimination and violence, and access to economic resources. 2SLGBTQ+ and BIPOC individuals are affected by all three factors and have a higher prevalence of mental health concerns because of intersecting stigmas and discrimination.

Stigma & Discrimination

Many 2SLGBTQ+ people experience stigma and discrimination across their life spans, and are targets of sexual and physical assault, harassment and hate crimes. An Ontario-based study found that 20% of trans people had experienced physical or sexual assault due to their identity, and that 34% were subjected to verbal threats or harassment. Queer Black individuals are also far more likely than any other racial group to be victims of hate crimes, according to statistics from the Canadian Centre for Justice and Community Safety.

Economic Instability

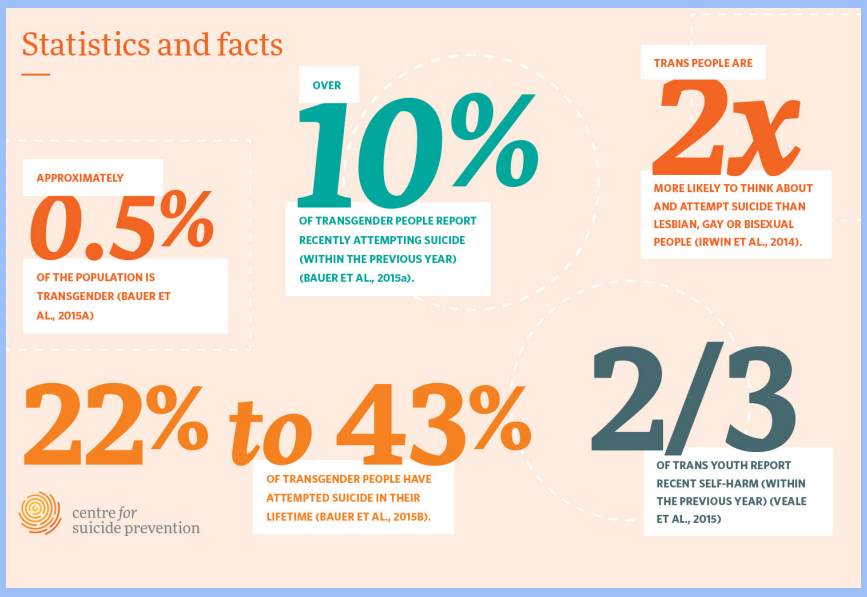
Economic instability also disproportionately affects 2SLGBTQ+ and BIPOC individuals. Trans people are over-represented among low-income Canadians, with half of trans people in Ontario living on less than $15,000 a year. Canadian census data from 2016 shows exceptionally high rates of poverty across the country in Black, First Nations, Métis and Inuit communities. For example, Black Canadians make significantly less money than non-racialized Canadians regardless of how long their families have lived in Canada. Note that these stats are not caused by race, sexuality or gender, but are the result of discriminatory public policy, historical events (ie. colonialism, slavery, etc) and structural racism that is deeply ingrained in our society and impacts every aspect of a marginalized community's ability to participate in society equally.

MENTAL HEALTH

Mental health concerns and suicidality have been reportedly high in QTBIPOC communities and specifically high in trans adolescents (Bourns, 2019). Providing gender-affirming care, using inclusive language and intervening in a timely manner can help drastically decrease suicidality and suicide attempts (Scanlon et al., 2010). Supporting trans individuals to access timely medical transition care has been found to increase personal well-being and reduce suicidality (Bauer et al., 2012). Note that trans people who are planning medical transition but have not yet initiated it are the ones most at risk for attempting suicide—approximately 46% consider suicide in comparison to 23% who have completed their medical transition (Bauer et al., 2012; Bauer et al., 2015).

> **It is critical to the psychiatric well-being of BIPOC and 2SLGBTQ+ folks that physicians understand, screen for and address these social factors in a manner that doesn't impose stereotypes or perpetuate stigma on these communities.**

If you are based in Ontario, Rainbow Health Ontario has a list of trans-positive therapists and service providers which can help your patient navigate their mental health needs (https://www.rainbowhealthontario.ca/lgbt2sq-health/service-provider-directory/).



Source: https://www.suicideinfo.ca/resource/transgender-people-suicide/

Although mental health counseling isn't required before a patient receives gender-affirming hormone therapy, it may help to do an individual assessment of your patient's needs and refer them to a community support group if they think it could be helpful (Bourns, 2019). Trans-positive therapists are also helpful referrals and allow a space for patients to learn about the transition process, receive more psychological support, and discuss concerns without judgement (Bourns, 2019).

MENTAL HEALTH

Considerations for Transitioning

Another important consideration to explore with your patient is how their transition may impact their personal safety, education, workplace environments and interpersonal relationships (Bourns, 2019). Understanding any challenges that may arise post-transition can help you come up with positive coping strategies and safety plans to help your patient deal with the post-transition phase. Additionally, identifying support systems can help your patient have a more positive and safe transition journey.

The Sherbourne Guidelines (Bourns, 2019) have outlined some questions to ask patients about their psychosocial preparation and supports to help facilitate dialogue and build rapport:

Have you thought about how you will manage the changes in your appearance and gender expression at work or school?

Who has supported you along the way? (If they haven't spoken with anyone else yet you can ask them: Who do you think might be supportive if you bring this up with them?)

Have you done anything to prepare yourself for this step? (You can prompt: Have you talked with any peers or asked friends or family for support? Have you done any reading or research?)

Do you anticipate any challenges? (Some people find it helpful to have the support of a counsellor for either decision-making or ongoing support after beginning hormone therapy—would you be interested in a referral to a trans-competent counsellor?)

MENTAL HEALTH

Remember that mental health concerns do not preclude access to hormone therapy but instead should be well-controlled prior to or concurrently with hormone therapy according to WPATH. However, exercise some caution for patients who have bipolar disorder or psychotic disorders that aren't well-managed because there have been some concerns regarding negative psychiatric effects of testosterone in this patient population (ie. increased aggression, occasional psychotic symptoms, hypersexuality) (Bourns, 2019). Consider a transdermal preparation to provide a more steady serum testosterone level in patients with mood or other psychiatric disturbances (Bourns, 2019).

What is minority stress?

Bourns (2019) describes minority stress in trans individuals as "the chronic psychological strain resulting from stigma and expectations of rejection and discrimination; decisions about disclosure of gender identity; and the internalization of transphobia that trans people face in a cis-sexist society".

Gender-Based Interpersonal Violence

Many trans individuals experience gender-based interpersonal violence, including during childhood and adolescent years (Bourns, 2019). Adverse events in childhood and chronic minority stress can exacerbate mental health issues in patients. Ensure that your practice and approach to patients takes an anti-oppressive, trauma-informed lens.

Substance Use

Due to the trauma that many trans patients face as a result of oppression, they may be at higher risk for substance use issues including alcohol, tobacco and other drugs (Bourns, 2019). It is important to explore your patient's substance use using a non-judgmental framework and counsel them on the risks arising from excessive substance use during hormone therapy, particularly the case with smoking (Bourns, 2019). Use a harm-reduction approach where appropriate and when it is not realistic to completely stop smoking prior to initiation of hormone therapy (Bourns, 2019).

Periodic Mental Health Screening

Make sure to periodically screen your patients prior to and during their transition journey (whatever that may look like for them). Include the following elements to screen for (Bourns, 2019):

- Mood: Depressive symptoms, anxiety disorders, other mental health concerns
- Suicidality
- Self-harm: Cutting is the most common method of self-harm in this population
- Changing experiences of gender dysphoria and body image (especially important for those undergoing medical or surgical transition)
- Eating disorders
- Sexual function changes (ie. libido)

MENTAL HEALTH

Differential Diagnoses to Rule Out

Make sure you rule out other possible differentials such as schizophrenia, other psychotic disorders, dissociative disorders, and body dysmorphic disorders (Bourns, 2019). Although these diagnoses are rarely the cause for seeking gender-affirming healthcare, it is good practice to rule them out (Bourns, 2019).

If your patient is intersex, this should also be noted prior to therapy initiation (Bourns, 2019).

*Intersex assessment **does not** have to be done through genital examination as that can be very traumatizing and invasive for many. Instead, inquire through baseline hormone levels and a thorough history if there is any possibility the patient may have (Bourns, 2019):*

- *Ambiguous genitalia*
- *Unexpected pubertal changes that don't align with sex assigned at birth*

Depending on the findings, you may need to consult an endocrinologist prior to initiating therapy (Bourns, 2019).

TRANS & NON-BINARY YOUTH

Care Team

- Unless you have expertise working with transgender youth, refer to specialized center or seek an expert's guidance.
- Refer to experienced mental health professional for support and a safe space for identity exploration and processing the transition, regardless of emotional state.
    - NB: Puberty may be very distressing for trans and non-binary youth, making them at risk for suicide ideation and attempts; however, many transgender adolescents don't have serious mental health concerns.

(Bourns, 2019; Olson et al., 2011; Thoma et al., 2019)

Family Dynamics

- Involve family when possible and if preferred by patient.
- Many cultures may not be accepting of gender diversity
    - Look outside White & Eurocentric narratives of gender diversity when working with racialized & Indigenous patients.
    - Understand how culture can impact family dynamics
    - Never make assumptions about family relationships/dynamics or culture.

(Trans Care BC, 2020)

TRANS & NON-BINARY YOUTH

Before initiating care consider whether:

a) the youth is capable of consenting to care;

b) the youth understands implications of care including foreseeable consequences, benefits and risks, and;

c) care is in the youth's best interest.

If these criteria aren't filled, seek alternative consent.

(Trans Care BC, 2020)

Difference between youth and adult transgender care:

- GnRH analogues for puberty suppression (see Table 3 for mechanism of action and side effects), i.e. Leuprorelin (Lupron(R)).
- Leuprorelin blocks developmental changes of puberty:
  - allows time to assess the persistence of affirmed gender as the child matures, but before undergoing physical changes of puberty.
  - Puberty blockers are indicated between Tanner stage 2 and 4.
  - Side effect: reduced fertility (Table 3), which should be discussed with patient and family, if applicable. Hormone therapy post-GnRH analogue use will likely result in the gonads not maturing, which will not allow sperm or ova banking.

(Bourns, 2019; Olson et al., 2011)

Available Therapies:

Hormone therapy:

If in Tanner stage 5 or post-pubescence.

Surgery:

Generally only top surgery is available from 16 - 18 years (Table 6a);

- in rare cases (e.g. transition began at young age) gonadectomy and genital surgeries may be done earlier.

(WPATH 2012; Trans Care BC, 2020)

TRANS & NON-BINARY YOUTH

SPECIAL POPULATIONS

Access to Care for Canadian Youths:

In preliminary data from Trans Youth CAN! study, trans and gender diverse youth report:

- being referred to multiple providers lacking competence in gender affirming care
- difficulty accessing clinicians who are inclusive and respectful
- lack of appropriate reproductive counselling and STI screening
- difficulty accessing non-gender related mental health counselling
- spending 13.5 months on average seeking hormone treatment, and waiting an average of 269 days from referral to first appointment at a gender clinic to discuss hormone treatment.

In light of these barriers to care, primary care providers play an integral role in:

- easing the distress of gender dysphoria
- providing initial medical care with referral to gender clinics
- providing resources to community supports, e.g. mental health care, support groups, access to binders and packers, and school support including name and pronoun navigation.

(Mokashi et al., 2021)

TRANS & NON-BINARY YOUTH

Trans and nonbinary older adults expect discrimination in long-term care facilities, including:

- deliberate misuse of names and pronouns
- discrimination from other residents, especially since older adults are more likely than other age demographics to hold transphobic views.

Transphobia is connected to negative health outcomes and reluctance to access needed care.

(Miller et al., 2020)

Trans older adults are more likely to consider and attempt suicide than cisgender peers, and may choose suicide or death at home to avoid discrimination and disrespect in long-term care.

Some trans individuals reported hope long-term care facilities would become safer and more inclusive by the time they require this care, though this is anticipated to require long-term care facilities to implement **anti-oppressive training, policy, and practice changes**.

(Knochel and Flunker, 2021)

FREQUENTLY ASKED QUESTIONS:
PROVIDING CULTURALLY SAFE CARE

DO'S AND DON'TS

DO Always use correct names and pronouns (ask the patient when in doubt)

DON'T Assume the patient's gender identity, sexual orientation, or sexual behaviours.

DO Frame your questions in a way that does not assume the patient's gender identity, sexual orientation, or sexual behaviours.

DO Use inclusive language, and appropriate terms for the patient's gender identity during patient encounters, be it for talking about care needs, discussing about prevention, taking a history or doing a physical examination.

DO Be mindful of your use of gendered language with every patient, not only the ones who disclose trans or gender diverse identities.

DO **Trans Sensitive Examination**

- Trans people can have a varying degree of comfort with physical examination as it can be gender affirming or difficult due to gender dysphoria. Take into account past medical negative experiences when assessing the patent's comfort level.
- Take time to explain why the patient needs the examination or test.
- Invite the patient to bring in a support person if they wish.
- Be mindful of gendered language especially when examining sensitive body parts. Try to use gender neutral language where possible (ex. instead of "vagina", say "genitals" depending on what the patient is comfortable with)
- Examine only the body parts relevant to the situation!

DON'T See the patient's trans identity as a central cause of health issues, or as a barrier to health.

DO See the patient as a whole person with unique health needs, just like every other patient.

- *"From other trans folx I know, if say they are both diabetic and require care for hormone therapy, often endocrinologists will deny the hormone therapy and focus only on their diabetes. It's very frustrating. Many endocrinologists refuse to do hormone therapy for trans folks (there's always exceptions of course)."*

DO Refer to trans health specialists if you don't feel able to offer the best care for your patient.

DO Consider trans sensitivity when making referral to other non-trans specialists: is there a specialist known for trans sensitivity? You can also inquire about their experience working with trans people.

(Greatheart, 2021; Razack and Martens, 2019; Tellier, 2019)

General Tips

- Be educated on cultural competency and the intersectionality of queer, racial, ethnic, and Indigenous identities.
- Create a physical environment (posters, intake forms, etc.) that is welcoming for 2SLGBTQ+ BIPOC patients.
- Be aware of financial support and resources in the community to refer your patients.
- Be ready to talk about sexual identities and how it affects health outcomes.
- **You have the responsibility, especially as a healthcare provider, to intervene if you witness inappropriate or harmful behaviors towards the 2SLGBTQ+ individuals**

How to ask difficult or uncomfortable questions for you/the patient?

- Create a safe space: talk about confidentiality and respect. Let the patients know they can choose what they feel comfortable disclosing and stop at any point.
- Be aware that if the question is uncomfortable for you, it is also for the patient. Acknowledge that some of the questions asked can be considered very private and explain why you need to ask them.
- Recognize your own biases and prejudices.
- Be aware of barriers that can affect both you and the patient when talking about gender identity, sexual orientation, and sexual behaviors: age, gender, culture, religion, belief system, etc.
- Be mindful of the patient's body language, and your own as well; small things such as blushing, stammering, avoiding eye contact and positioning can sometimes make patients feel judged, despite intentions

When is someone's gender identity medically pertinent, and when is it not?

Gender identity, sexual orientation, and sexual behaviors *may be relevant* when:

- Investigating for conditions such as infections, genital pain, etc.
- Assessing risk for conditions that are influenced by the patient's gender assigned at birth or anatomy, or medical treatments (hormone therapy, surgery) that trans patients may have

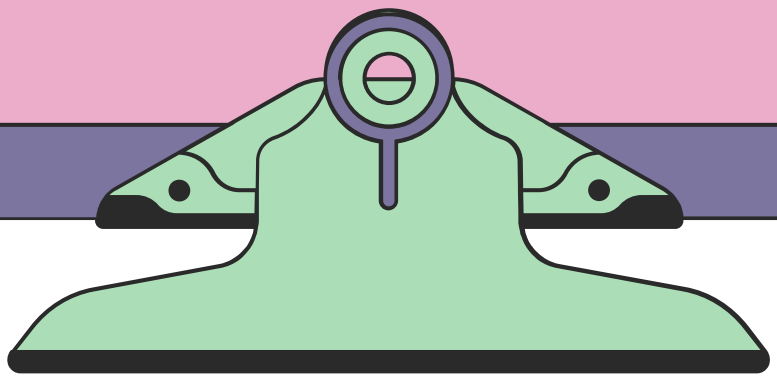
Gender identity, sexual orientation, and sexual behaviours *are not relevant* when:

- There is no causal relationship between the medical issue at hand and their gender or sexual identity.
- There is no effect of gender affirming care on the medical issue at hand, nor is there an effect of the medical issue on gender affirming treatments.
- There are no risk factors associated with their gender identity that are also related to the medical issue at hand.

When making referral to other specialists, consider if disclosing a patient's trans identity is actually relevant or not.

(Greatheart, 2021; Razack and Martens, 2019; Tellier, 2019)

What an Inclusive Intake Form Can Look Like



BIPOC WOMEN'S HEALTH NETWORK

Date: _____

Legal Name (last name, first name): _____

Preferred Name: _____ Birthdate: _____

Best Phone Number: _____ Alternate Phone: _____

Can we leave a voicemail at the number(s) provided? _____

Address: _____ Email Address: _____

Can you receive mail/email at the above addresses? _____

If we cannot phone or write, how can we reach you?_____

Legal Sex: _____

Gender Identity (please circle):

Female
Intersex
Male
Trans-Female to Male
Trans-Male to Female
Two-Spirit
Other, please specify if you prefer: _____
Do not know
Prefer not to answer

Sexual Orientation (please circle):

Lesbia, gay, or homosexual
Bisexual
Do not know
Straight or heterosexual
Other, please specify if you prefer: _____
Prefer not to answer

Relationship status: _____ Language: _____

Race: _____ Ethnicity: _____

Adapted from Women's Health in Women's Hands and the Michigan Cancer Consortium

APPENDIX

This section contains extra resources for learners to go through as well as resources, checklists & patient resources that can be provided in your clinics.

Resources of Clinics/Centres

- Complete database on BIPOC WHN website
- Unity Health Google Drive of resources for marginalized populations (with mental health resources)
- Women's College Hospital Transition-Related Surgeries Clinic
- Trans Women HIV Research Initiative (TWRI)

Extend Your Learning

- Legal process of name change
- Self-determination of gender
- Legal problems facing trans people in Ontario
- Human rights and legal protection for trans people
- Hormonal therapy and HIV viral load suppression (with table on drug-drug interactions between hormones and anti-viral drugs)
- Violence experienced by trans communities
- Dddressing transphobia in Canada's healthcare system

Online Courses to Expand Your Learning

- Transgender medicine for general medical providers by Icahn School of Medicine at Mount Sinai
- Health across the gender spectrum by Stanford
- TransLink Network (providing gender-affirming care for trans sexual assault and intimate partner violence survivors)
- UMich ob/gyn transgender healthcare curriculum
- Video Series: Caring for transgender/gender non-conforming patients and visitors
- Rainbow Health Ontario courses
- Trans PAP 101 video series
- Trans Wellness Initiative introduction to affirming spaces—community-based research centre

APPENDIX

Workshops & Other Documents to Build Competency

- Workshop: Working with and supporting trans people of colour (TPOC) around sexual health. Training provided by Yasmeen Persad for service providers on how to support and work with TPOC around sexual health inclusion. To book contact ypersad@the519.org
- Reflections of trans women of colour on their experiences of health
- Pap smears for trans men
- Complete Sherbourne Guidelines to provide gender-affirming primary care for trans and non-binary patients (with quick reference guide)
- What you need to know about masculinizing hormone therapy
- What you need to know about feminizing hormone therapy
- Gender-affirming care for trans, Two-Spirit, and gender diverse patients in BC: A primary care toolkit
- Trans men's sexual health and HIV risk
- Transition-related surgery post-surgical care

Deeper Dive Issues

- Eating disorders in 2SLGBTQ+ adults & adolescents
- Health equity impact assessment: 2SLGBTQ+ populations supplement
- Two-Spirit and LGBTQ+ Indigenous health
- Experiences of racism in trans people living in Ontario
- A pracitionter's resource guide: helping families to support their LGBT+ children
- Implementing trauma-focused cognitive behavioural therapy for LGBTQ youth and their caregivers

2SLGBTQ+ Older Adult Care

- LGBTQ+ older adult virtual social groups
- 2SLGBTQ+ Seniors
- Prov idling services for 2SLGBTQ+ seniors
- LGBTQ+ Older adult quality of life

APPENDIX

Checklists for Healthcare Providers

- Preventative care checklist for transfeminine patients
- Hormone planning period checklist
- Checklist for patient review: Feminizing hormone therapy
- Checklist for patient review: Masculinizing hormone therapy
- Checklist for patient review: Initiation of progestin therapy

Resources to Give Your Patients

- Transition-related surgery patient education materials
- Rainbow Health Ontario surgical summary documents
- Trans health FAQs for those considering transitioning
- Transition-related surgery FAQs
- Trans Men: Trans health matters
- Trans Women: Trans health matters
- Primed: A sex guide for trans men into men
- 10 things trans people can discuss with their healthcare providers
- Lower surgery for trans women: A patient guide
- Assisted human reproduction in Canada: A guide for LGBTQ+ communities
- Trans Care BC: Hormone readiness assessment information

Resources to Provide Parents of Trans Youth

- Gender variance for parents
- A guide to support trans students from kindergarten to Grade 12
- Families in transition support group
- Gender creative kids for parents
- Impact of strong parental support for trans youth (by TransPulse Canada)
- Families in transition: A resource guide for families of transgender youth
- Gender Spectrum: Affirming versus non-affirming parenting
- PFlag: Our trans loved ones
- Greater Toronto Area-Specirfic resources for trans youth & parents

REFERENCES

Alberta Health Services. (n.d.) Indigenous Myths & Misconceptions. https://www.albertahealthservices.ca/assets/info/ihp/if-ihp-indigenous-peoples-and-health-care-in-canada-.pdf

Amato, P. (2016) Fertility options for transgender persons. UCSF Transgender Care and Treatment Guidelines. https://transcare.ucsf.edu/guidelines/fertility

Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. JAMA Psychiatry, 77(1), 68. https://doi.org/10.1001/jamapsychiatry.2019.2285

Bauer, G., K, A., Pyne, J., Scanlon, K., & Travers, R. (2012). Improving the health of trans communities: Findings from the Trans Pulse Project. Conference presentation presented at the Rainbow Health Ontario Conference, Ottawa, ON.

Bauer GR, Scheim AI, for the Trans PULSE Project Team (2015). Transgender People in Ontario, Canada: Statistics to Inform Human Rights Policy.

Bourns, A. (2019). Guidelines for gender-affirming primary care with trans and non-binary patients [4th edition]. https://www.rainbowhealthontario.ca/product/4th-edition-sherbournes-guidelines-for-gender-affirming-primary-care-with-trans-and-non-binary-patients/

Canadian Cancer Society. (2021). Screening in LGBTQ patients. https://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/?region=on

Chih, C., Wilson-Yang, J. Q., Dhaliwal, K., Khatoon, M., Redman, N., Malone, R., Islam, S., & Persad, Y. on behalf of the Trans PULSE Canada Team. (2020). Health and well-being among racialized trans and non-binary people in Canada. Available from: https://transpulsecanada.ca/research-type/reports

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review, 43(6), 1241-1299.

Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), Williams textbook of endocrinology (11th ed., pp. 615- 644). Philadelphia: Saunders.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth edition. American Psychiatric Association. 2013

Fenway Health. Transgender Health: Injection Guide. Available from: http://www.phsa.ca/transcarebc/hormones/how-to-inject

García-Acosta, J. M., Juan-Valdivia, S., María, R., Fernández-Martínez, A. D., Lorenzo-Rocha, N. D., & Castro-Peraza, M. E. (2020). Trans* pregnancy and lactation: A literature review from a nursing perspective. International journal of environmental research and public health, 17(1), 44.

GlobalPost Reports: The Terror Of Forced Sterilization For Transgender People. (n.d.). HuffPost. https://www.huffpost.com/entry/transgender-forced-sterilization_n_1071328

Government of Newfoundland and Labrador. (2019). Transition-Related Surgeries. https://www.gov.nl.ca/hcs/files/mcp-pdf-trs-policy.pdf

Government of New Brunswick. (2021). Gender Confirming Surgery. Accessed 24 April 2021. https://www2.gnb.ca/content/gnb/en/departments/health/patientinformation/content/GenderConfirmingSurgery.html#:~:text=New%20Brunswick%20Medicare%20now%20covers,recognized%20treatment%20for%20gender%20dysphoria

Government of Northwest Territories. (2020). Health Care for Transgender, Non-Binary, and Gender Non-Conforming People: Guidelines for the Northwest Territories ('NWT'). https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/health-care-transgender-non-binary-gender-nonconforming-people-guidelines-nwt.pdf

REFERENCES

Government of Nova Scotia. (2020). Gender Affirming Surgery. Accessed 24 April 2021. https://novascotia.ca/dhw/gender-affirming-surgery/

Government of Prince Edward Island. (2019). Transgender Health Services. Accessed 24 April 2021. https://www.princeedwardisland.ca/en/information/health-pei/transgender-health-services

Government of Yukon. (2021). New health care policy supports transgender community. Accessed 24 April 2021. https://yukon.ca/en/news/new-health-care-policy-supports-transgender-community

Greatheart, Marcus. (2021). Reducing Barriers to Healthcare for our Transgender Patients. Jan 5 2021. CFMS LATS.

Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. Plastic and Reconstructive Surgery, 105(3), 1222- 1227.

Healthwise. (2020). Learning About Gender-Affirming Surgeries for Transgender Women. MyHealth Alberta. Reviewed by Heather Quinn, JoLynn Montgomery, and Thomas M. Bailey. https://myhealth.alberta.ca/health/AfterCareInformation/pages/conditions.aspx?hwid=ack1544#ack1537

Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. American Family Physician, 62(5), 1079-1095.

Jones, B. P., Williams, N. J., Saso, S., Thum, M. Y., Quiroga, I., Yazbek, J., ... & Smith, J. R. (2019). Uterine transplantation in transgender women. Bjog, 126(2), 152.

Klinic Community Health. (2021). Health Care Providers – Trans Health Klinic. Accessed 24 April 2021. https://klinic.mb.ca/health-care/transgender-health-klinic/health-care-providers/

Knochel KA, Flunker D. Long-Term Care Expectations and Plans of Transgender and Nonbinary Older Adults. Journal of Applied Gerontology. February 2021. doi:10.1177/0733464821992919

Krempasky, C., Harris, M., Abern, L., & Grimstad, F. (2020). Contraception across the transmasculine spectrum. American Journal of Obstetrics and Gynecology, 222(2), 134-143.

Light, A. D., J. Obedin-Maliver, J. M. Sevelius & J. L. Kerns (2014) Transgender men who experienced pregnancy after female-to-male gender transitioning. Obstetrics and gynecology, 124, 1120.

Logie, C.H., James, L., Tharao, W., & Loutfy, M. R. (2011). HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. PLoS Medicine, 8(11), e1001124.

Lora DiCarlo (2020). Honouring the Black, Trans History of Pride. https://www.loradicarlo.com/blog/honoring-the-black-trans-history-of-pride

Merasty, C., Gareau, F., Jackson, R., Masching, R., Dopler, S., on behalf of the Trans PULSE Canada Team. (2021). Health and well-being among Indigenous trans, two-spirit and non-binary people. Available from: https://transpulsecanada.ca/research-type/reports

Michigan Cancer Consortium. Health Equity: Inclusive Intake Forms for the LGBT+ Community. https://www.michigancancer.org/bcccp/PDFs/AnnualMtg/Handouts/CatherinesFormChanges.pdf

Miller, P. R., Flores, A. R., Haider-Markel, D. P., Lewis, D. C., Tadlock, B., & Taylor, J. K. (2020). The politics of being "Cait": Caitlyn Jenner, transphobia, and parasocial contact effects on transgender-related political attitudes. American Politics Research, 48(5), 622–634. https://doi.org/10.1177/1532673X20906460

Mokashi, A. Temple Newhook, J., Gotovac, S., Singh, G., Johnson, N., Stein, R., Lawson, M.L., & Bauer, G. R., for the Trans Youth CAN! Research Team. Gender-affirming care for trans and non-binary youth: Lessons for Canadian medical education from Trans Youth CAN! Oral presentation presented at Canadian Conference on Medical Education Virtual conference; April 20, 2021.

More, S. D. (1998). The pregnant man-an oxymoron? Journal of Gender Studies, 7(3), 319-328. doi:10.1080/09589236.1998.9960 725

REFERENCES

Narayan, S. K., Hontscharuk, R., Danker, S., Guerriero, J., Carter, A., Blasdel, G., Bluebond-Langner, R., Ettner, R., Radix, A., Schechter, L., & Berli, J. U. (2021). Guiding the conversation-types of regret after gender-affirming surgery and their associated etiologies. Annals of translational medicine, 9(7), 605. https://doi-org.proxy1.lib.uwo.ca/10.21037/atm-20-6204

Neblett, M. F., & Hipp, H. S. (2019). Fertility considerations in transgender persons. Endocrinology and Metabolism Clinics, 48(2), 391-402.

Olson J, Forbes C, Belzer M. Management of the Transgender Adolescent. Arch Pediatr Adolesc Med. 2011;165(2):171–176. doi:10.1001/archpediatrics.2010.275

Rasmussen, P. (2019). Colonizing Racialized Bodies: Examining the Forced Sterilization of Indigenous Women and the Shameful History of Eugenics in Canada. Cover Image, 36(3), 18.

Razack, S. and Martens, D. (2019). LGBTQA* Health: Creating Safe Spaces for Sexual and Gender Minority Patients and Colleagues. Department of Pediatrics, Faculty of Medicine, McGill University. Sept 2019

Sante Trans Health. (2020). Trans-specific Surgeries: Access to Sex Reassignment Surgery in Quebec. Accessed 24 April 2021. http://santetranshealth.org/jemengage/en/guide-contents/trans-specific-surgeries/

Saskatchewan Trans Health Coalition. (2019). Saskatchewan Medical Transition Guide. https://www.transsask.ca/wp-content/uploads/2019/02/Saskatchewan-Medical-Transition-Guide-Final-Draft-1.pdf

Scanlon K, Travers R, Coleman T, Bauer G, Boyce M: Ontario's trans communities and suicide: transphobia is bad for our health. Trans PULSE e-Bulletin. 2010, 1 (2): 1-2.

Sherbourne Health Centre. (2020). As a newcomer or refugee, what care do I have access to? Accessed 24 April 2021. https://www.rainbowhealthontario.ca/trans-health-knowledge-base/as-a-newcomer-or-refugee-what-health-care-do-i-have-access-to/

Sherbourne Health Centre. (2016). Surgical Summary Sheets. https://klinic.mb.ca/wp-content/uploads/2019/10/All-surgical-summary-sheets.pdf

Snorton, C. R. (2017). Black on both sides: A racial history of trans identity. U of Minnesota Press.

Tellier, Pierre-Paul. (2019). Sexual History, Take Two. CLSC Côtes des neiges Mtl QC. Sept 2019.

Thoma BC, Salk RH, Choukas-Bradley S, Goldstein TR, Levine MD, Marshall MP. (2019). Suicidality Disparities Between Transgender and Cisgender Adolescents. Pediatrics, 144 (5); DOI: 10.1542/peds.2019-1183.

Trans Care BC. (2020). Gender-affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Care Toolkit. Available from: http://www.phsa.ca/transcarebc/Documents/HealthProf/Primary-Care-Toolkit.pdf

Trans PULSE Canada Team. Health and health care access for trans and non-binary people in Canada. 2020-03-10. Available from: https://transpulsecanada.ca/research-type/reports

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020).

White Hughto JM, Reisner SL, Pachankis JE. Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Inter- ventions. Soc Sci Med. 2015;147:222-231. Available from: https://doi.org/10.1016/ j.socscimed.2015.11.010.

Wills, M. (2020, October 1). A History of Transphobia in the Medical Establishment. JSTOR Daily. https://daily.jstor.org/a-history-of-transphobia-in-the-medical-establishment/

World Professional Association for Transgender Health. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People [7th Version]. https://www.wpath.org/publications/soc

https://cyndigilbert.ca/wp-content/uploads/2020/05/Neutralizing-Clinical-Language.pdf