



FOR PUBLIC AND
PRIVATE HEALTH CARE



TRANS HEALTH TOOL KIT

GENDER-AFFIRMING CARE
FOR TRANSGENDER PATIENTS IN JAMAICA



AUTHORS:
LEE MOY WEAVER
STEVE R. WEAVER





This toolkit is intended as a general guide to assist healthcare providers who are or may be taking on similar work and should not be used as a standard of care. TransWave, Jamaica assumes no responsibility or liability to any party for any harm, damage or other losses, direct or indirect, resulting from reliance on the use or the misuse of any information contained in this toolkit.

For more information, contact
TransWave Jamaica at
hello@transwaveja.org
or (876) 667-6202 or
visit <https://transwaveja.org> or
#8 Sydney Road, Kingston.



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ABOUT

TRANSWAVE JAMAICA

TransWave Jamaica is the country's first non-profit organization solely dedicated to focusing on promoting the health and well-being of the transgender, gender nonconforming and intersex communities. TransWave takes a holistic approach to advocacy, addressing not only the socio-political issues faced by the trans community, but also the mental, emotional, and physical health through our various initiatives.

TransWave envisions a Jamaica where transgender and gender nonconforming persons are included, affirmed and enjoy all universally recognized human rights. Through strategic interventions, TransWave aims to develop measures to strengthen national systems and structures; increase trans acceptance and visibility; increase access to trans specific healthcare; improve access to basic needs such as work education and housing; access to mental health services and improved social support to boost family acceptance.



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TRANS GENDER CONSIDERATIONS

British colonialism in Jamaica had a profound impact on gender diversity and identity. During the seventeenth and eighteenth centuries, the British imposed sociocultural and structural constructs of gender and sexuality as tools to maintain power. These constructs created highly volatile states and left a legacy of trauma for many generations of colonized individuals (Lemonius, 2017).

Jamaica is predominantly Christian, and historically, the Church has firmly supported retaining the buggery law. This legislation, criminalizes consensual same-sex activity between men, labelling it as “the abominable crime of buggery” and punishable by up to 10 years of imprisonment, often with hard labour (UNHCHR, 2019). Many member churches of the Jamaica Council of Churches and the World Council of Churches, representing older denominations, align with this position (Miller, 2017). Their interpretation of biblical teachings and moral principles informs their support for existing legislation. The buggery law remains a contentious issue, reflecting differing perspectives within the Christian community.

Jamaica’s legal and social environment is hostile toward LGBTQ individuals. Transgender people in Jamaica face significant challenges due to a lack of public acceptance, legal protection and recognition (Human Rights First, 2015). The criminalization of consensual same-sex activity between men is rooted in the Offences Against the Person Act, a colonial-era law dating back to 1864, which contributes to widespread stigma and discrimination against the LGBT community. This societal prejudice manifests in various forms, including verbal abuse, physical violence, and social exclusion (UNHCHR, 2019; Human Rights First, 2015). Affirming their gender choice, such as wearing clothing that aligns with their identity, remains a battle, especially for trans men and trans women (Robinson, 2021). Stigma and discrimination also create barriers to accessing health care. Trans individuals often face prejudice from healthcare providers, which can

deter them from seeking necessary medical attention (Global Fund, 2021). Jamaican law does not currently provide explicit protections against discrimination based on gender identity or sexual orientation (Human Rights First, 2015). There is no legal framework in Jamaica that allows trans individuals to change their gender markers on official documents

TransWave Jamaica. (2021). The absence of legal recognition and protection exacerbates barriers to accessing healthcare for trans individuals (Human Rights Watch, 2014). Access to healthcare is particularly concerning, as many community members hesitate to seek healthcare, such as HIV testing and treatment, due to past experiences of discrimination, ridicule, and rejection in healthcare settings (Human Rights First, 2015). Discrimination in healthcare settings and lack of gender-affirming care options contribute to poor health outcomes for the trans community, including mental health.

Research shows that transgender individuals in Jamaica have increased rates of anxiety, depression, substance abuse, and suicide due to the country’s hostile climate (UNDP, 2023; EAFJ, 2023). Trans people experience vulnerabilities related to education, employment, and family safety nets (UNDP, 2023). They also face a high risk of gender-based violence (J-FLAG, 2016) resulting in internal or external migration and many suggest having a strong desire to migrate externally to express their authentic selves without fear of persecution (UNDP, 2023). Despite these challenges, activists continue to advocate for acceptance, safety, and equal rights for trans individuals in Jamaica.

With the use of this guide, it is important to note that historical and ongoing perspectives on gender diversity and identity can affect and interrupt trans people’s identities, and their ability to access care.

PROVIDING CARE

Access to transition-related healthcare is a critical issue for transgender individuals. Research shows that limited access is associated with poor mental health outcomes and reduced quality of life. Discrimination compounds the problem, hindering access to essential services like healthcare, education, and employment opportunities for trans persons (UNDP, 2023). It is the role of all healthcare providers to ensure that the care they deliver is responsive to the needs of their patients. For trans patients, this includes being considerate of the ways that colonization has shaped their relationship with the healthcare system. It's important to take time to understand and reflect on the ways we may need to evolve and adapt our own practice to create a welcoming, inclusive and affirming care experience for transgender patients.



This Trans Health toolkit has been developed not as a standard of care but rather as a general guide to assist healthcare providers who are or may be taking on similar work. Each case is individual and requires assessment by the healthcare providers involved. The protocols reflect our review of the available medical literature, is by no means definitive, and not the result of scientific studies or clinical trials. For these reasons, they should not replace sound clinical judgment by the treating clinician.

DISCLAIMER

DISCLAIMER AS INFORMED CONSENT

The informed consent documents attached to the Toolkit are provided only as examples. No representations are made as to their applicability to or legal sufficiency for your agency. Accordingly, these documents should not be used without professional legal advice. These protocols were designed for trans patients aged 18 and older. They do not account for the specific endocrinological and psychosocial needs of younger patients, nor do they address the legal complexities of obtaining informed consent from minors. Therefore, these protocols should not be used to provide gender-affirming hormone therapy or surgeries to trans patients younger than 18 years old.

Although Jamaica has healthcare providers specializing in medical/chemical and surgical care, we could not identify any who specializes in trans trans-specific healthcare, likely due to the low demand for these services. This posed a limitation in developing the toolkit. However, interviews with healthcare specialists in endocrinology and plastic surgery provide guiding recommendations for creating this toolkit. We also adapted standard protocols and best practices from existing international toolkits to fit the Jamaican context.

LIMITATION

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We extend our gratitude to the following healthcare providers for reviewing this Trans Health

Toolkit and ensuring its validity:

- Dr Brian Kazaara, Psychiatrist
- Dr Tomlin Paul, Family Physician

INTRODUCTION

Primary healthcare providers are uniquely well positioned to address these health disparities and increase access to trans-specific healthcare. A rapid assessment among healthcare providers in Jamaica indicates that while health providers express comfort and willingness to provide trans-specific healthcare, they feel unprepared to deliver trans-specific healthcare. Practicing physicians have been exposed to a traditional medical curriculum with a strong foundation in the biological and medical sciences but which has not adapted or transformed to address many of the emerging health concerns and situations of modern society (Weaver & Weaver, 2024). Issues related to sexual and gender orientation are particularly important to address in physician training as in addition to being part of a rapidly emerging social milieu are also well immersed in societal discrimination. Such discrimination not only takes a toll on the individuals and brings forth pathology and inappropriate health seeking behaviour, but it also negatively impacts the set up and delivery of healthcare by practitioners (Human Rights Watch, 2014).

While curriculum reform efforts are critical and must be addressed by educators, the healthcare system can begin to fill the gap in the provision of quality health for the transgender (trans) community by developing targeted toolkits to support and promote the delivery of relevant and appropriate care (Weaver & Weaver, 2024). Enhancing healthcare providers' skills and providing trans-specific healthcare in their practice can have a profound impact on the health of trans people in their communities (UNDP, 2023). A structured approach to the development of such toolkits is taken to ensure utilization and uptake.

This Trans Health Toolkit includes some basic information about trans-specific healthcare options and tools to assist with initiating and/or maintaining gender-affirming hormone therapy (GAHT), gender-affirming surgeries, navigating legal and ethical considerations, and health maintenance care. It also directs healthcare professions to further reading and provides suggestions for where they can access support from more experienced healthcare providers. This toolkit supports the call to develop specific protocols to guide how services can be offered to the trans community, ensuring that these protocols meet global standards of care for trans people which are set by the World Professional Association for Transgender Health (WPATH) (TransWave Jamaica, 2023).

 **Promote Inclusive Care:** It equips healthcare providers with knowledge and tools to address the unique health needs of transgender people, ensuring respectful and affirming services.

 **Raise Awareness:** By offering information on transgender health, the toolkit helps combat stigma, discrimination, and social exclusion faced by this community.

 **Enhance Access to Care:** It encourages health-care providers to offer evidence-based services, including HIV prevention and treatment, mental health support, and gender affirming care.

 **Empower Transgender Jamaicans:** The toolkit supports their right to pursue all aspects of life - civic, social, economic, emotional, and intellectual - free from discrimination.

 **Align with National Health Strategies:** It harmonizes with Jamaica's broader health vision and strategic plans, ensuring that transgender health is integrated into the overall health agenda.

ESOP

SCOPE

This Trans Health Toolkit is intended to support healthcare providers in the public and private sectors, who are relatively new to providing care to trans people.

TOOLKIT STATEMENT

This Trans Health Toolkit aims to support healthcare facilities working with diversity, by creating an inclusive healthcare culture, free from any form of harassment, bullying or discrimination. It aims to create a welcoming, safe, and caring environment for all patients, regardless of their sex, sexual gender/identity, sexual orientation, or gender expression, inclusive of transgender, gender non-conforming, and transitioning patients.

OBJECTIVE

The objectives of this Trans Health Toolkit for healthcare providers are to enhance understanding and improve care for trans people. This toolkit serves as comprehensive resources, offering evidence-based guidance and practical information. Key objectives of this toolkit are:

01

Understanding Transgender Needs:

The toolkit helps healthcare providers gain insights into the unique needs and challenges faced by transgender (trans) individuals. It educates them about gender diversity, terminology, and cultural competence

04

Navigating Legal and Ethical Considerations:

Healthcare providers need to understand legal protections and rights of trans patients. The toolkit addresses legal aspects,

02

Promoting Inclusive Care:

By providing guidelines, best practices, and protocols, the toolkit encourages healthcare providers to create an inclusive and respectful environment. It emphasizes the importance of affirming language, privacy, and dignity.

05

Health Maintenance Care:

Healthcare providers should aim to enhance mental health and overall wellbeing within the transgender community by addressing discrimination, stigma, and unique stressors associated with gender and intersecting marginalized identities. The toolkit will also emphasize the importance of sexual health care while acknowledging the persistent stressors that impact individuals adversely.

03

Clinical Guidance:

This toolkit offers evidence-based recommendations for trans-specific healthcare. This includes hormone therapy, surgical options, mental health support, and preventive care. Healthcare providers can refer to these resources to provide informed and compassionate care.

06

Collaboration and Networking:

This toolkit also facilitates collaboration between public and private healthcare sectors. They encourage networking, knowledge sharing, and partnerships to improve overall trans-specific healthcare.

This toolkit hopes to empower healthcare providers to provide competent, respectful, and affirming care to trans patients, bridging gaps in knowledge and promoting better health outcomes.

TRANS-SPECIFIC HEALTH

Transgender individuals have unique health requirements that deserve focused attention and tailored care. Understanding and addressing these needs are essential for promoting well-being and ensuring equitable healthcare access. Some key considerations include gender-affirming care, mental health support during gender transition, and preventive care (UCSF, 2016; WPATH, 2012).

Gender-affirming Care:

Gender-affirming care is essential for the well-being of transgender individuals, providing a range of medical and nonmedical services that support a person's gender identity and expression. In Jamaica, where societal attitudes towards transgender people can be challenging, access to such care is crucial. It helps to mitigate the mental health disparities faced by transgender individuals, such as higher rates of depression and suicidal ideation. Access to gender-affirming care has been associated with better mental health outcomes, and it is paramount that such care is available and accessible to those who need it. The strategy acknowledges the importance of creating affirming spaces and services, which are vital for reducing the stressors that contribute to mental health issues within the transgender community. As the global understanding of gender diversity expands, it is imperative that healthcare systems, including Jamaica's, evolve to provide comprehensive and affirming care for all individuals, regardless of their gender identity (UCSF, 2016; WPATH, 2012).

Access to GAHT and gender-affirming surgeries:

■ **Gender-Affirming Hormone Therapy (GAHT)** or hormone replacement therapy involves the use of medications to help transgender and gender-diverse individuals achieve physical changes that align with their gender identity. For trans women (assigned male at birth), feminizing HRT includes oestrogen and anti-androgens. For trans men (assigned female at birth), masculinizing HRT includes testosterone.

■ **Gender-Affirming Surgeries** help align physical characteristics with gender identity. Top surgery (chest reconstruction) and bottom surgery (vaginoplasty or phalloplasty) are common procedures.

Access to GAHT and gender-affirming surgeries is a critical aspect of healthcare for transgender individuals, as these medical interventions are essential for many to align their physical appearance with their gender identity, which can significantly improve their mental health and overall well-being. In Jamaica, the need for such services is particularly pressing due to the challenges faced by the transgender community, including high rates of unemployment, physical and sexual assault, and lack of access to basic healthcare services (UCSF, 2016; WPATH, 2012).

The Trans and Gender Non-Conforming National Health Strategy (2020) emphasizes the importance of allowing transgender individuals to access public health services as their authentic selves, without fear of discrimination or mistreatment. This includes the provision of HRT and gender-affirming surgeries, which are recognized as medically necessary interventions by the World Professional Association for Transgender Health (WPATH). These treatments are not only about physical health; they also play a crucial role in the psychosocial well-being of transgender individuals, as evidenced by research showing improvements in social distress, anxiety, and depression following gender-affirming treatments (UCSF, 2016; WPATH, 2012).

Furthermore, the Standards of Care for Transgender and Gender Diverse People, as outlined by WPATH, highlight the necessity of nonjudgmental care from appropriately trained healthcare providers and the importance of informed consent, assessment of health conditions that may be affected by HRT or surgeries, and discussion of reproductive implications and options. These standards are crucial for ensuring that transgender individuals receive the care they need in a respectful and supportive environment (UCSF, 2016; WPATH, 2012).

In Jamaica, where societal and structural changes are necessary to achieve equitable access to services, the implementation of such standards of care is vital. It is not only about providing medical treatments but also about fostering an inclusive society where transgender individuals can live without fear of violence or discrimination, and where their unique healthcare needs are recognized and met (WPATH, 2012). Efforts of local organizations, international partners, and the Jamaican government in developing and implementing the national health strategy for trans individuals are commendable steps towards this goal (TransWave Jamaica, 2020).

Monitoring hormone levels is a critical aspect of healthcare for transgender individuals undergoing hormone therapy. It ensures that hormone levels are within the desired range for the individual's gender identity, which is essential for the effectiveness of the treatment and the well-being of the patient. For transgender men, this typically involves maintaining testosterone levels within the normal male physiological range, while for transgender women, it involves reducing testosterone levels to the normal female range and managing oestrogen levels. Regular monitoring can help in identifying any adverse effects early, such as metabolic changes, cardiovascular risks, or bone density issues, allowing for timely interventions (UCSF, 2016).

Managing potential side effects is equally important. Hormone therapy can lead to various side effects, such as virilization in transgender men or thrombosis and cardiovascular issues in transgender women. Healthcare providers must be vigilant in managing these risks, possibly by adjusting hormone formulations, doses, or administration methods to balance the benefits of hormone therapy with its risks. Each person responds differently to HRT, therefore individualized care is crucial (UCSF, 2016).

Mental health support during gender transition:

The necessity for robust mental health support during gender transition for transgender individuals in Jamaica is a critical aspect of healthcare that warrants attention. Gender transition is a deeply personal and often challenging journey, involving not only physical changes but also psychological and social adjustments. For transgender people, this period can be marked by experiences of social stigma, discrimination, and lack of understanding from the community, which can exacerbate stress and mental health challenges. In Jamaica, where societal attitudes towards gender diversity can be conservative, the need for mental health support becomes even more pronounced (UCSF, 2016; WPATH, 2012).

Access to gender-affirming care, which includes mental health services, is paramount for the well-being of transgender individuals. Studies have shown that gender-affirming care is associated with significant mental health benefits, including reduced levels of depression and suicidal ideation. This is particularly important in Jamaica, where the availability of such specialized care may be limited. Initiatives like the Psychosocial Support Counselling Pilot Initiative undertaken by UNFPA Caribbean, TransWave Jamaica, and Equality Jamaica are steps in the right direction, providing much-needed support to transgender and gender non-conforming persons (UCSF, 2016; WPATH, 2012).

Access to gender-affirming care, which includes mental health services, is paramount for the well-being of transgender individuals. Studies have shown that gender-affirming care is associated with significant mental health benefits, including reduced levels of depression and suicidal ideation. This is particularly important in Jamaica, where the availability of such specialized care may be limited. Initiatives like the Psychosocial Support Counselling Pilot Initiative undertaken by UNFPA Caribbean, TransWave Jamaica, and Equality Jamaica are steps in the right direction, providing much-needed support to transgender and gender non-conforming persons (UCSF, 2016; WPATH, 2012).

It is essential that such support is not only available but also accessible. Barriers such as cost, location, and societal stigma can prevent transgender individuals from seeking the help they need. Therefore, policies and programs must be designed to overcome these barriers, ensuring that mental health support is inclusive and affirming of all gender identities. The mental health of transgender individuals during their transition is not just a matter of individual well-being but also a public health concern that has far-reaching implications for the broader society. As such, it is incumbent upon healthcare providers, policymakers, and community organizations to advocate for and implement comprehensive support systems that cater to the unique needs of the trans population in Jamaica (UCSF, 2016; WPATH, 2012).

Preventive Care:

Preventative care is a critical aspect of health care, particularly for trans individuals in Jamaica, where societal and systemic barriers often impede access to necessary medical services. Transgender persons need regular check-ups, vaccinations, and screenings similar to cisgender individuals. The high prevalence of HIV among transgender women in Jamaica underscores the urgent need for comp

rehensive healthcare services tailored to this community. Preventative care, in this context, includes regular health screenings, mental health support, and access to hormone therapy and other gender-affirming treatments (TransWave Jamaica, 2020).

Trans-specific health concerns:

Trans individuals in Jamaica encounter a range of health concerns that are intricately linked to their gender identity. These concerns are not only medical but also deeply rooted in societal attitudes and the structure of the healthcare system. The Trans and Gender Non-Conforming National Health Strategy (2020) addresses critical areas such as HIV, which remains a major health concern, with approximately 50% of trans women living with the virus. This is compounded by other challenges, including high unemployment rates, food insecurity, and a lack of access to essential health services. The strategy also highlights the need for psychosocial support as transgender individuals often experience poor mental health such as depression, anxiety, and suicidal ideation, due to societal stigma and discrimination (EFAF, 2023). It also underscores the need for GAHT, and gender-affirming surgeries, which are often inaccessible to transgender individuals in Jamaica. Addressing these concerns requires a holistic approach, including legal reforms, community support, and culturally competent care (TransWave Jamaica, 2020).

Trans-specific health disparities

Trans individuals in Jamaica, as in many parts of the world, encounter a range of health disparities that can adversely affect their overall well-being and hinder their access to necessary medical care. These health challenges are compounded by barriers to accessing care, which include discrimination within the healthcare system, lack of culturally competent care, and economic constraints that make healthcare unaffordable for many. Research indicates that transgender

CHALLENGES ACCESSING HEALTHCARE

individuals may experience higher rates of HIV/AIDS, mental health disorders, and substance abuse, as well as a greater prevalence of violence and physical assault compared to their cisgender counterparts. The situation is exacerbated by legal and social barriers that limit their access to gender-affirming care, which is essential for their mental and physical health (TransWave Jamaica, 2020).

In Jamaica, where societal attitudes towards LGBTQ+ individuals can be particularly challenging, these issues are even more pronounced. The lack of supportive policies and inclusive health services further marginalizes transgender adults, making it difficult for them to receive the care they need.

Access to health insurance is another critical factor influencing the health disparities faced by transgender adults. They are less likely to have health insurance compared to cisgender individuals, which limits their ability to receive preventative care and treatment for chronic conditions. The economic challenges faced by many transgender individuals, including higher rates of unemployment and poverty, further limit their access to healthcare services (TransWave Jamaica, 2020).

It is crucial for healthcare providers to receive training in gender-affirming care and for policies to be enacted that protect the rights and dignity of trans individuals, ensuring they have equal access to health services. Efforts to increase public awareness and understanding of transgender issues are also vital in promoting a more inclusive society where all individuals can thrive without fear of discrimination or violence (TransWave Jamaica, 2020; Weaver et al., 2024)

Transgender individuals in Jamaica face a myriad of challenges when accessing healthcare, rooted in systemic discrimination and a lack of understanding of their unique healthcare needs. The Trans and Gender Non-Conforming National Health Strategy acknowledges that transgender people often encounter healthcare systems that are not equipped to recognize or meet their specific needs, leading to inadequate care and a sense of unwelcomeness. This can result in transgender individuals avoiding seeking medical help or altering their appearance to fit societal norms, which can have detrimental effects on their physical and mental health. Employment discrimination further exacerbates the healthcare challenges faced by transgender persons, as many are unemployed and cannot afford basic healthcare services. The lack of employment opportunities also leads to food insecurity, with one-third of transgender individuals skipping meals, and some resorting to sex work for survival. This precarious economic situation is compounded by the high rates of physical and sexual assault reported by the transgender community, with more than 80% experiencing verbal abuse (TransWave Jamaica, 2020).

The National Trans Health Strategy calls for the government to protect transgender individuals from discrimination by implementing rights-based programs, policies, and legislative frameworks. It also emphasizes the need for the healthcare sector to train providers in delivering safe and competent care to transgender persons, promoting a trans-friendly health system based on informed consent and harm reduction principles (TransWave Jamaica, 2020).

GAPS IN EXISTING HEALTHCARE SERVICES AND POLICIES

In Jamaica, the healthcare system has historically lacked comprehensive services and policies tailored to the needs of transgender individuals. This gap in healthcare provision has significant implications for the well-being and rights of trans persons. Access to healthcare services for trans individuals in Jamaica is impeded by a multifaceted array of barriers. These include, but not limited to structural, educational, cultural and social, and social barriers.

Structurally, the healthcare system may not be equipped with the necessary resources or trained personnel to address the specific needs of transgender patients, leading to a lack of gender-affirming care. There are also delays in accessing gender-affirming treatments due to lengthy waiting lists and limited availability of specialized centres for transgender healthcare. Educationally, there is a significant gap in knowledge and understanding among healthcare providers regarding transgender health issues, which can result in inadequate or inappropriate care. Culturally and socially, pervasive stigma and discrimination against transgender persons often discourage them from seeking healthcare services due to fear of mistreatment or breach of confidentiality. Technical barriers include the absence of standardized protocols for treating transgender patients and a lack of access to specialized healthcare services. There are also challenges related to accurate record-keeping and data management. These challenges are compounded by broader societal issues such as unemployment and homelessness, which disproportionately affect the transgender community and further hinder their ability to access healthcare services (TransWave Jamaica, 2020).

Efforts to address these barriers include initiatives aimed at improving healthcare outcomes for LGBT individuals through research, engagement with healthcare providers, and policymakers, as well as public education campaigns to raise awareness and challenge

societal stigma. Additionally, there is a need for the development of toolkits and guides to educate healthcare providers on the unique healthcare needs of transgender individuals within the Jamaican context. It is also crucial to foster a welcoming environment for transgender patients, emphasizing the importance of non-discriminatory practices and the provision of culturally competent care (TransWave Jamaica, 2020).

To navigate these challenges, transgender individuals in Jamaica require robust support systems and advocacy to ensure their healthcare needs are met. This includes the creation of inclusive policies, the implementation of sensitivity training for healthcare workers, and the establishment of healthcare services that are specifically tailored to the transgender community. Moreover, addressing the root causes of social inequities, such as discrimination in the workplace and the broader societal stigma, is essential for improving the overall health outcomes of transgender persons in Jamaica (TransWave Jamaica, 2020).

LEGAL RIGHTS AND POLICIES

Trans individuals in Jamaica, as in many other parts of the world, encounter significant challenges that stem from discriminatory laws and a general lack of recognition. This marginalization often manifests in various forms of social and legal exclusion, which can lead to a host of adverse outcomes for the transgender community (TransWave Jamaica, 2020). A report by TransWave Jamaica revealed that 87% of trans individuals have been sexually assaulted, verbally harassed, and denied equal treatment (Hutchinson, 2021). These experiences are compounded by the stigma and discrimination that can arise from societal attitudes and institutional biases.

The lack of supportive legal frameworks further exacerbates these issues, as transgender

employment, and education without facing discrimination. There is no legislative framework allowing trans people to formally change their gender on birth certificates or other identification which means that transgender people are unable to have their gender identity legally acknowledged, which impacts their ability to participate fully and equally in society. Transgender persons also have no legal recognition of their preferred gender and therefore face marginalization and unequal treatment under Jamaican law (UN Human Rights Council, 2021).

STANDARDS OF CARE FOR THE HEALTH OF TRANS PEOPLE

The Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC- 8) as outlined by the World Professional Association for Transgender Health (WPATH, 2012), play a crucial role in guiding healthcare providers in Jamaica and worldwide. These standards aim to provide a framework for the highest quality care for transgender and gender diverse individuals, emphasizing the importance of nonjudgmental treatment, informed consent, and a multidisciplinary approach to healthcare. In Jamaica, where societal attitudes towards gender diversity can be complex, the implementation of these standards is vital in ensuring that transgender and gender diverse individuals receive care that is not only competent but also compassionate and respectful of their unique needs.

The guidelines recommend comprehensive healthcare that extends beyond hormonal or surgical treatments to include primary care, reproductive and sexual healthcare, mental healthcare, voice therapy, hair removal, and prosthetics. This holistic approach is essential in a country where access to gender-affirming care might be limited, and where the healthcare system is evolving to become more inclusive of the needs of transgender and gender diverse people. By adhering to these standards, Jamaican healthcare providers can help mitigate the psychological distress often experienced by transgender individuals due to gender dysphoria and social stigma.

Furthermore, the Standards of Care advocate for the education and training of healthcare providers to ensure they are equipped to address the specific health concerns of transgender and gender diverse patients. This is particularly important in Jamaica, where there may be a gap in knowledge and sensitivity towards the transgender community within the medical field. The standards serve as a beacon for the ongoing development of transgender health as a recognized and respected specialty, encouraging evidence-based practices and continuous learning. Key recommendations are:



Primary Care:

- Transgender and gender diverse patients should receive nonjudgmental care from appropriately trained healthcare providers.
- Gender-affirming primary care includes preventive care, mental health and substance use disorder screening, hormone therapy, and education about nonmedical/nonsurgical gender-affirming interventions.



Assessment of Transgender and Gender Diverse Persons:

- For adults seeking gender-affirming medical and/or surgical treatment (GAMST), offer care when there's a marked difference between sex assigned at birth and current gender, informed consent capacity, assessed health conditions, and discussed reproductive implications.



Mental Health:

- Any qualified health professional can assess patients for GAMST.
- Psychotherapy is not required before GAMST, but it may be helpful for some.
- Avoid therapy to change gender identity or expression due to increased suicide risk.



Medication:

- Healthcare providers should assess and initiate hormone therapy for eligible transgender and gender diverse people.

The Standards of Care for the Health of Transgender and Gender Diverse People are a cornerstone for improving the health and well-being of this marginalized community in Jamaica. They provide a clear and comprehensive set of guidelines that, when implemented, can significantly enhance the quality of life for transgender and gender diverse individuals by ensuring they receive the respectful, knowledgeable, and affirming care they deserve. As Jamaica continues to progress in its healthcare policies and practices, the adoption of these standards will be a key factor in promoting equality and dignity for all, regardless of gender identity or expression.

CHARTER OF PATIENTS' RIGHTS

The Charter of Patients' Rights by the Ministry of Health & Wellness in Jamaica (2024) ensures equitable treatment of all patients within the healthcare system, including transgender individuals. It emphasizes the right to access health services that are appropriate to individual needs, which is crucial for transgender patients who may require specific medical interventions and support. The charter also underlines the importance of communication and participation, allowing patients to be involved in decisions about their care, which is particularly significant for transgender individuals as they navigate their unique health journeys.

Confidentiality is another critical aspect of the charter, ensuring that personal health information is kept private, a matter of great importance for transgender patients who may face social stigma. Privacy in treatment and respect for the individual, regardless of circumstances, are also guaranteed, aligning with the principles of dignity and equality. Safety, informed consent, and the right to provide feedback or lodge complaints are further

enshrined in the charter, offering transgender patients a voice in their healthcare experience and recourse should their rights be infringed upon.

However, transgender individuals may avoid seeking healthcare if they feel confidentiality is not assured. Research conducted by TransWave Jamaica highlighted that if transgender individuals feel that confidentiality and privacy are not assured, they may avoid seeking health services or withhold key information from their providers. Fear of providers making private information public jeopardizes both their own health and potentially others' well-being (Hutchinson, 2021). Studies have identified barriers to HIV testing among transgender individuals in Jamaica, including mistreatment by healthcare providers and confidentiality breaches (UNAIDS, 2019). Efforts to challenge HIV-related stigma and improve confidentiality can enhance access to healthcare for transgender communities (UNAIDS, 2019).

JAMAICA CODE OF CONDUCT

The Jamaica Code of Conduct for Primary Healthcare Facilities (2016) is a pivotal document that can significantly promote a trans-inclusive approach within the healthcare system. By explicitly incorporating policies that respect and acknowledge the unique healthcare needs of transgender individuals, the Code of Conduct can foster an environment of inclusivity and sensitivity. Training healthcare staff on the importance of non-discrimination and the provision of stigma-free services, as outlined in the Code, is crucial. This includes understanding the specific health challenges faced by the trans community, such as the need for hormone therapy and mental health support, and ensuring these services are accessible and provided with dignity and respect.



Moreover, the Code of Conduct can encourage the development of educational materials that inform healthcare providers about the nuances of transgender health, thereby reducing the likelihood of inadvertent discrimination. It can also establish clear guidelines for patient privacy and confidentiality, which are of utmost importance to transgender individuals who may face social stigma and discrimination. The inclusion of contact information for clients to report instances of discrimination is a proactive step that can empower patients and hold healthcare providers accountable.

Furthermore, aligning the Code of Conduct with international best practices and the recommendations from local advocacy groups, such as TransWave Jamaica, can ensure that the healthcare system is not only compliant with global standards but also responsive to the local context and needs. The integration of a rights-based approach, as seen in the Trans and Gender Non-Conforming National Health Strategy, can further solidify the commitment to trans-inclusive healthcare.

BENEFITS OF GENDER-AFFIRMING CARE

Gender-affirming care is crucial for improving the health and well-being of trans individuals. It is a comprehensive approach that addresses the medical, psychological, and social needs of trans individuals, leading to a significant improvement in their overall health and well-being. In Jamaica, where trans visibility has increased, organizations like TransWave advocate for holistic, non-discriminatory services. Some benefits of gender-affirming care are as follows:

1. **Improved Mental Health:** Gender-affirming care has been shown to reduce rates of depression and suicidal ideation among transgender individuals. By providing affirming and supportive services, healthcare providers can positively impact mental health outcomes (Columbia University Department of Psychiatry, 2023).
2. **Reduced HIV Risk:** HIV prevalence among Jamaican trans women is high, but many avoid seeking treatment due to stigma and discrimination. Healthcare providers who offer non-judgmental care can encourage more trans individuals to access HIV testing, prevention, and treatment services (UNAIDS, 2019).
3. **Increased Visibility and Understanding:** Gender-affirming care helps educate the public about transgender experiences. By providing inclusive services, healthcare providers contribute to a more informed and accepting society (Poteat et al., 2023).
4. **Validation and Self-Esteem:** Affirming care validates transgender individuals' gender identity, leading to improved self-esteem and overall well-being. Healthcare providers play a crucial role in creating a safe and accepting environment (Columbia University Department of Psychiatry, 2023).
5. **Reduced Health Disparities:** Transgender people face disparities in housing, education, and employment. Healthcare providers can address these gaps by offering gender-affirming services and advocating for transgender rights (Poteat et al., 2023).

Gender-affirming care benefits both patients and healthcare providers by promoting mental health, reducing HIV risk, and fostering understanding and acceptance. This toolkit launched by TransWave provides valuable guidance for healthcare providers in Jamaica.

RECOMMENDATIONS FROM KEY HEALTHCARE PROVIDERS

We interviewed two local healthcare providers – a plastic surgeon and an endocrinologist – to gather their recommendations based on their experience and best practices in working with the trans community. These help to guide the development of this toolkit. Here are highlights from these interviews.

Interview with an endocrinologist

Process for gender-affirming hormone therapy (GAHT) or hormone replacement therapy

First consultation visit:

- Outline psychological, endocrine and surgical services to patient
- Understand patient' long-term goals – full transition to include surgical therapy and voice interventions or partial transition with hormonal therapy only
- Find out at what stage a patient is in their transformation process
- Determine patient' level of commitment to gender transformation:
 - Social transformation – dress, behaviour, identity
 - Legal transformation – change of name
 - Pre-evaluation of psychological readiness for transformation
- Ensure patient has realistic expectations regarding HRT and should be appropriately informed about the pros and cons of treatment.
- Refer patient for full executive panel: chemistry and hormonal evaluation.
 - Cost of lab tests, without health insurance may delay or halt process.
 - Personal resistance to lab tests may also derail process.
- Refer patient for psychological evaluation, if they are not already engaged in psychological support
- Psychological assessment mandatory:
 - Recommends psychological assistance to ensure adequate coping mechanisms and support structures during transitional process.
 - Seek to identify hidden factors that may interfere with the transitional process and provide necessary support
 - Recommendation for psychological assessment usually halts process, especially among trans men.
 - Does not recommend HRT for individuals under 18 years old but, sees a greater need for psychological support, then provide HRT when they reach adult age.

Second consultation visit:

- Review results and make any necessary recommendations.
- Start patient on HRT if lab results are show normal

Process of HRT:

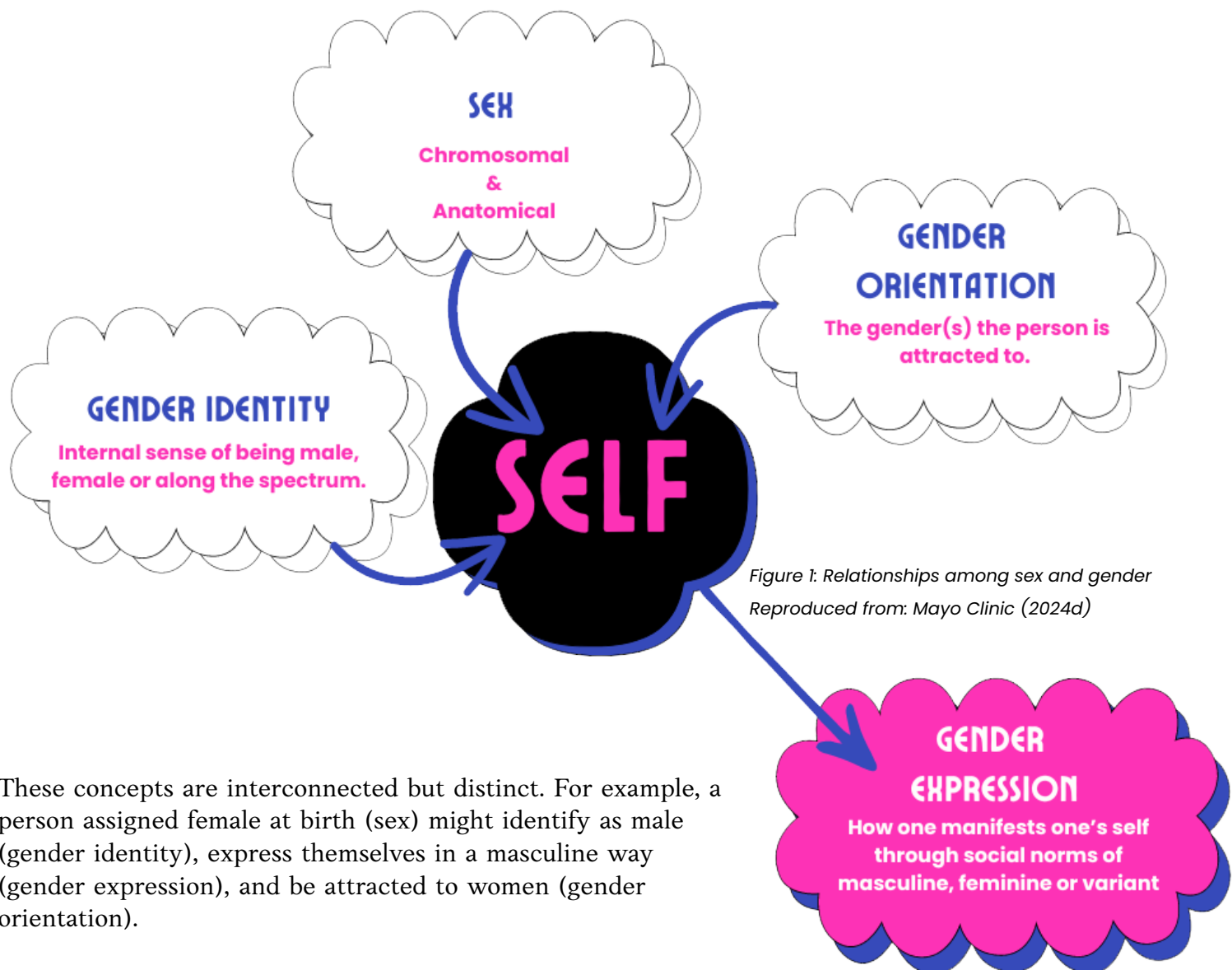
- Prescribe lower dosage of hormone replacement drug to get the pharmacokinetics of the drug into a steady state.
- Three months after first injection, determine the dose level and interval as some persons may only require drug twice a year and not every three months.
- Ensure patients continue with their follow-up visits with the endocrinologist to determine patient's hormonal levels, any side effects of the drug such as diabetes, bone density changes, risk for thrombophilia, etc.
- Recommends a multidisciplinary approach to supporting the trans community

INTERVIEW WITH AN ENDOCRINOLOGIST

- Ensure patient has realistic expectations regarding the intended surgery
- Patient should be appropriately informed about the intended surgery
- Suggests indicating type of gender affirming surgery and associated complications on consent form
- Recommends psychological assessment to determine eligibility for hormone therapy & surgery as precaution
- Does not recommend surgery for individuals under 18 years old
- Cost of surgery may delay process & recommendation for psychological assessment may halt process
- Several consultations with plastic surgeon are recommended pre and post operation
- Interdisciplinary approach is needed to better serve the trans community

KEY DEFINITIONS AND TERMINOLOGY

Transgender is an umbrella term for individuals whose gender identity (their internal sense of being male, female, neither or both) or gender expression (how they communicate their gender identity through behaviour, clothing, hairstyles, voice, or body characteristics) differs from societal norms associated with their assigned sex at birth. This includes people who identify as androgynous, bigendered, or genderqueer, all of whom challenge traditional concepts of gender. Some transgender (trans) individuals may also identify as nonbinary, preferring gender-neutral pronouns like “they” and “them”. A trans or gender-nonconforming person has a gender identity that does not align with the sex (chromosomal or anatomical) assigned at birth. Gender identity is distinct from sexual orientation, which refers to the gender(s) a person is emotionally or physically attracted to, or both (Mayo Clinic, 2024d).



While a comprehensive exploration of terminology related to trans and gender nonconforming individuals across diverse cultures and languages is beyond the scope of these guidelines, below are definitions for commonly encountered terms that will be used throughout this document.

Gender / Gender identity: A person's internal sense of self and how they fit into the world, from the perspective of gender.

Sex: Historically has referred to the sex assigned at birth, based on assessment of external genitalia, as well as chromosomes and gonads. In everyday language is often used interchangeably with gender, however there are differences, which become important in the context of transgender people.

Gender expression: The outward manner in which an individual expresses or displays their gender. This may include choices in clothing and hairstyle, or speech and mannerisms. Gender identity and gender expression may differ; for example, a woman (transgender or non-transgender) may have an androgynous appearance, or a man (transgender or non-transgender) may have a feminine form of self-expression.

Gender nonconforming: A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person. Genderqueer is another term used by some with this range of identities. Nonbinary: transgender or gender nonconforming person who identifies as neither male nor female.

Trans-masculine/trans-feminine: Terms to describe gender non-conforming or nonbinary persons, based on the directionality of their gender identity. A trans-masculine person has a masculine spectrum gender identity, with the sex of female listed on their original birth certificate. A trans-feminine person has a feminine spectrum gender identity, the sex of the male listed on their original birth certificate. In portions of these Guidelines, in the interest of brevity and clarity, transgender men/women are inclusive of gender non-conforming or nonbinary persons on the respective spectre.

They/Them/Their: Neutral pronouns used by some who have a nonbinary or nonconforming gender identity.

Transsexual: A more clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation. Term is less commonly used in present day, however some individuals and communities maintain a strong and affirmative connection to this term.

Cross dresser / drag queen / drag king: These terms generally refer to those who may wear the clothing of a gender that differs from the sex which they were assigned at birth for entertainment, self-expression, or sexual pleasure. Some cross dressers and people who dress in drag may exhibit an overlap with components of a transgender identity. The term **transvestite** is no longer used in the English language and is considered pejorative.

Sexual orientation: Describes sexual attraction only, and is not directly related to gender identity. The sexual orientation of transgender people should be defined by the individual. It is often described based on the lived gender; a transgender woman attracted to other women would be a lesbian, and a transgender man attracted to other men would be a gay man. Reproduced from: UCSF (2016, p. 15-16).

For the purposes of clarity and simplicity, the term “trans” will be used throughout this document to refer to transgender, gender nonconforming, and genderqueer people as a set.

ASKING ABOUT SEXUAL ORIENTATION AND GENDER IDENTITY IN CLINICAL SETTINGS

Fenway Institute (2012) recommends that when meeting a patient for the first time, healthcare providers should inquire about sexual orientation, behaviour, and gender identity during the visit. They can begin with an open-ended question like, “Tell me a bit about yourself.” As the patient discusses their life and family, they may naturally mention aspects related to sexual orientation or gender identity.

Healthcare providers can encourage open conversations about gender identity by creating a welcoming environment.

This can be achieved by displaying symbols such as a rainbow flag, logos of TransWave Jamaica or Equality for All Foundation or social marketing materials with affirming images of trans individuals. Additionally, providers should use inclusive or neutral language, such as asking, “Do you have a partner?” instead of “Are you married?” which often implies a heterosexual relationship. Once healthcare providers build a trusting relationship with patients and they feel at ease discussing their sexuality and/or gender identity, providers should offer care that specifically addresses the unique health issues and disparities faced by trans individuals.

TRANS-SPECIFIC HEALTHCARE OPTIONS

Healthcare tailored for trans individuals should be customized to align with the unique goals of each patient, encompassing a broad spectrum of social, medical, and surgical interventions. The primary aim is to mitigate gender dysphoria, which in turn can yield a multitude of advantages such as enhanced mental and physical well-being, as well as improved social interactions and job performance (Trans Care BC, 2018).

Primary care practitioners play a pivotal role in initiating conversations about gender identity and health objectives with their patients, as well as in delivering or recommending gender-affirming treatments. The strategies detailed in this resource are designed to be inclusive of people with binary gender identities (those who identify as either male or female) as well as non-binary individuals (those who identify with a combination of both genders or with neither), with the understanding that the necessity for these options may vary greatly among individuals, with some requiring all, some, or none of the outlined care approaches (Trans Care BC, 2018).

Social options

Not all trans individuals seek treatment to modify their gender expression to conform to heteronormative binary gender identifiers that mimic the cisgender population. Many choose to socially transition which involves changes in how a person expresses their gender to others. It's a nonmedical, reversible form of gender transition. They may use a new name, adopt different pronouns, change appearance (clothing, hairstyle), altering ways of moving or speaking, or in other way. A social transition affirms a person's gender identity, reduces gender dysphoria, and may increase gender euphoria. There is no pressure to transition publicly if not ready or comfortable. Trans people look to their primary care providers for support with non-medical and non-surgical aspects of gender affirmation. Some examples include education about safer chest-binding or genital tucking, or counselling about common concerns such as coming out to friends and family or coping with transphobia (Trans Care BC, 2018).

Medical/chemical options

Medical or chemical transition involves using cross-gender hormones to align secondary sex characteristics with one's gender identity. Trans men may need masculinizing hormone therapy (MHT) to help develop male secondary sex characteristics and suppress female ones. Medical care may involve the use of testosterone (androgens) which can be administered through injections, gels, or patches, to develop facial hair, voice changes, and muscle mass. They may also need progesterone-releasing IUD or medroxyprogesterone for suppression of monthly bleeding. Trans women may need feminizing hormone therapy which involves taking medicine to block the action of the hormone testosterone. Medical care may involve the use of hormone oestrogen and anti-androgens to promote breast development, softer skin, and fat redistribution, electrolysis for hair removal or hormone therapy. Informed consent is commonly used for hormone therapy (Trans Care BC, 2018).

Surgical options (gender-affirming surgeries)

Surgical procedures are used to modify physical characteristics. These may include top surgery– chest reconstruction (mastectomy or breast augmentation), bottom surgery which is genital reconstruction (vaginoplasty, phalloplasty) and a range of other procedures including facial feminization surgery, tracheal shave. Not all trans individuals pursue surgical transition. Each person's journey is unique, and the combination of chemical and surgical transition varies based on individual needs and preferences (Trans Care BC, 2018).

ROLE OF THE HEALTHCARE PROFESSIONAL

Sherbourne Health (2019) suggests an increasing recognition among healthcare providers that trans and non-binary communities are underserved. Their healthcare needs can effectively be met through primary care. Primary care providers (PCPs) play a crucial role in providing gender-affirming care to trans patients. However, historical barriers, such as the lack of education about trans health in medical training, can make caring for trans patients unfamiliar and intimidating for current providers.

The historical lack of education and available resources - as well as lingering perceptions that transition-related care falls exclusively under the domain of specialists - has limited the number of healthcare providers working with trans patients. As a result, only health care providers who are invested in enhancing their knowledge, skills and cultural competency have integrated gender-affirming care into their practice. The number of providers engaged in this work has grown over the past decade as more health care providers recognize the value, reward and importance of providing gender-affirming primary care to trans patients. While the situation is improving, the historical shortage of healthcare providers available to provide gender affirming primary care has often led to trans patients experiencing protracted searches, long waitlists or distant travel to find providers able to assist with their transition goals.

After undergoing an internal search to make sense of their gender (a process which can vary greatly from person to person), many patients often have to embark on a protracted external search to find a supportive healthcare professional. This critical time, between when a trans person feels they need to start making physiologic changes to their appearance and when they are actually able to find a provider to help with those changes, is when trans patients are most at risk for depression and suicide. Providing timely transition-related care can have a substantial positive effect on mental health, while also decreasing suicidality and suicide attempts.

A FRAMEWORK FOR PROVIDING GENDER-AFFIRMING PRIMARY CARE TO TRANS PATIENTS

Sherbourne Health (2019) states that gender-affirming primary care encompasses two main branches: transition-related interventions and care, as well as addressing the other primary care needs of trans patients in a manner that respects their unique requirements. This section offers a high-level overview of trans primary care, introducing various aspects of care detailed in the guidelines.

Internationally, various protocols and guidelines address transition-related medical interventions. The well-known Standards of Care document by the World Professional Association for Transgender Health (WPATH) is often considered the gold standard. However, it lacks specifics on hormone provision and certain aspects of primary care. Additionally, community and academic centers in Canada and North America have developed publicly available protocols that offer more detailed information on gender-affirming care practices. These protocols are utilized in the development of this Trans Health Toolkit.

- Trans Care BC's **Gender-Affirming Care for Trans, Two-Spirit and Gender-Diverse Patients in BC: A Primary Care Toolkit**
- Sherbourne Health's **Guidelines for Gender-Affirming Primary Care with Trans and Non-Binary Patients**
- Fenway Health's **Medical Care of Transgender Persons**
- Callen-Lorde's **Protocols for the Provision of Hormone Therapy**
- University of California, San Francisco (UCSF)'s **Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People**

When providing primary care to trans patients, it's essential to recognize that their trans identity may necessitate a distinct approach beyond medical transition-related care. While trans patients can experience the same health issues as cis patients, there are specific considerations. For instance, discussions about disease prevention and screening (such as Pap testing for transmasculine patients) or fertility and safer sex require tailored approaches. Unfortunately, gendered assumptions often persist in preventive health, impacting areas like cervical cancer screening. These assumptions should be challenged to ensure inclusive care.

Trans-inclusive practices require considering how elements like office posters, patient handouts, and data collection methods might unintentionally exclude transgender patients, resulting in suboptimal care and negative health outcomes. Reflecting on clinical approaches, such as offering a side-lying position instead of the lithotomy position for Pap tests with trans men, can make the experience more comfortable and less dysphoric.

Although these Guidelines cannot cover every possible adjustment needed, starting to reflect on these issues is a crucial step. When interacting with trans patients, it is essential to ask what

makes them most comfortable, as individual preferences can vary. Considering the diverse spectrum of gender identities and the unique ways each person expresses themselves, there is no one-size-fits-all pathway for a trans individual to present their authentic self. Therefore, it is recommended to take an individualized approach.

INITIATING HORMONE THERAPY

Publicly available protocols mentioned in the previous chapter recommend that, under the informed consent model for initiating hormone therapy, mental health assessments or referrals may not be mandatory unless there are significant mental health concerns. However, during an interview with a local endocrinologist, they recommend making mental health assessments mandatory to rule out any psychological issues and to ensure appropriate support structures for the transitional process. While WPATH SOC7 recognizes both the traditional and informed consent approaches, it is essential to differentiate informed consent from “hormones on demand,” which assumes that anyone requesting hormones will receive a prescription without considering the clinician’s expertise or judgment.

This toolkit takes a collaborative, patient-centered approach to hormone therapy decisions. It focuses on psychosocial preparation and informed consent. Whether led by a primary care provider or a multidisciplinary team, the goal is to inform, educate, and support patients. Healthcare providers should actively assist patients in achieving their transition-related goals while addressing any barriers to safe hormone administration. See Appendix A for sample questions about gender-affirming goal questions that can be used to discuss with patients.

Before starting hormone therapy, new patients should have several visits. During this period, the provider gets to know the patient, provides education about the expected effects and potential risks of hormone therapy, assesses the need for services like fertility preservation, and offers additional support if necessary. The number of visits required depends on factors such as visit duration, provider experience, and clinical considerations.

Appendix B provides a checklist designed for use at the point of care.

EXPLORATION OF GENDER IDENTITY AND EXPRESSION

The understanding of trans identity development is a complex and nuanced field, reflecting the diversity of experiences within the trans community. It is well-acknowledged that not all trans individuals experience gender incongruence or dysphoria, nor do they necessarily display gender non-conformity during childhood. Gender identity can be a fluid and evolving aspect of self that may become apparent at different stages of life for different individuals. The emergence of a trans identity can be influenced by a myriad of factors, including personal introspection, social environments, and cultural contexts. Research have shown that while some trans individuals report a clear sense of their gender identity from a young age, others may not recognize or articulate their gender identity until later in life, which can be due to various reasons such as lack of knowledge, absence of language to describe their feelings, or societal pressures to conform to gender norms (Kuper et al., 2018; Steensma et al., 2013; Devo, 2004).

The process of identity development is inherently personal and can be affected by the interplay of biological, psychological, and social factors. The traditional binary understanding of gender does not encompass the full spectrum of human gender experiences, and thus, the development of a trans identity can be a unique journey for each individual. Models of trans identity development, such as the one proposed by Devor (2004), outlines the complex process of identity development, from initial anxiety about one's assigned gender to eventual pride in one's trans identity.

The model emphasizes the unique and individualized nature of each person's journey through stages such as discovery, acceptance, transition, and integration.

Similar models include *Cass' Model of Homosexuality Identity Formation* (1979), *Bockting and Coleman's Stage Model of Transgender Identity Development* (2007), *D'Augelli's Model of Lesbian, Gay, and Bisexual Development* (1994), *McCarn and Fassinger's Model of Gay and Lesbian Identity Development* (1996), *Troiden's Model for the Formation of a Homosexual Identity Development* (1989), which suggest that identity may not necessarily follow a linear progression. These models provide various perspectives on the complex process of identity development among trans individuals, emphasizing different stages and factors that influence this journey.

It is important for healthcare providers to recognize the diversity of trans experiences and to provide supportive environments where trans individuals can explore and express their gender identity without fear of judgment or discrimination. Healthcare providers often lack training on how to discuss patients' gender history and experiences. However, understanding these aspects is crucial for addressing a patient's needs and creating a personalized care plan. Below are suggested questions to guide conversations about a patient's gender experience

POSSIBLE QUESTIONS TO EXPLORE GENDER IDENTITY AND EXPRESSION

■ How would you describe your gender identity? If prompting is needed: For example, some people identify as a man, a transmasculine individual, genderqueer, etc.

■ Do you remember the time when you realized that your gender was different from the one you were assigned at birth? Or: Do you remember when you first started to see your gender as _____?

■ Can you tell me a bit about what's happened since realizing this? If prompting is needed: Some people find this to be a difficult realization and may not feel comfortable discussing it, while other people are fortunate to have people in their life they feel safe talking with—what was it like for you?

■ Have you taken any steps to express your gender differently/to feel more comfortable in your gender? If prompting is needed: Some people ask others to use a different name and pronoun, or make changes to their hair or clothing styles.

■ If they have taken steps to express their gender differently: What was that like for you? How did that feel?

DIAGNOSIS

Sherbourne Health (2019) indicates that the diagnosis of gender dysphoria, as outlined in the DSM-5, serves a critical role in the provision of hormone therapy for those experiencing a significant incongruence between their experienced gender and the gender assigned at birth. The DSM-5 criteria for gender dysphoria focus on the distress that arises from this incongruence, rather than on the gender non-conformity itself, which is not considered a mental health disorder. This distinction is crucial as it shifts the emphasis from pathologizing trans identities to addressing the distress that can result from societal marginalization and the misalignment of one's psychological identity with their physical form. The diagnosis is a necessary step in accessing GAHT, which has been recognized as a medically necessary treatment for gender dysphoria.

CRITERIA FOR THE DSM-5 DIAGNOSIS OF GENDER DYSPHORIA

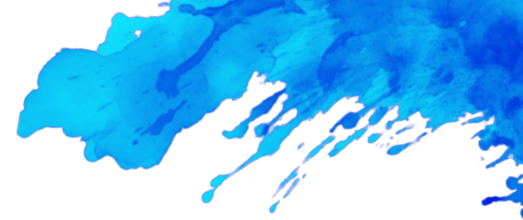
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least two of the following:

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 young adolescents, a desire to prevent the development of the 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).

The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning. Specify if:

A. The condition exists with a disorder of sex development.

B. The condition is post-transitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen - namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).



The process involves a thorough evaluation by healthcare providers, which may include a behavioural health evaluation, to confirm the diagnosis and to discuss the goals, risks, and benefits of hormone therapy. This diagnosis is not only a gateway to hormone therapy but also a means to ensure that individuals receive comprehensive care that includes an assessment of their mental health needs, potential health conditions influenced by hormone therapy, and their capacity for informed consent (Sherbourne Health, 2019).

According to the WPATH Standards of Care (2012), the appropriateness of GAHT is determined through an assessment process that includes:

- 1. Persistent, well-documented gender dysphoria:** The individual must have a consistent and well-documented experience of gender dysphoria.
- 2. Capacity to make a fully informed decision and to consent for treatment:** The individual must be able to understand the risks and benefits of HRT and provide informed consent.
- 3. Age of majority:** The individual must be of legal age to make medical decisions in their country.
- 4. If significant medical or mental health concerns are present, they must be reasonably well controlled:** Any coexisting medical or mental health issues should be managed to ensure the safety and effectiveness of HRT.

GAHT can significantly alleviate the symptoms of gender dysphoria for many individuals, allowing them to live more congruently with their gender identity. It is a critical component of trans healthcare, and the DSM-5 plays an essential role in ensuring that this care is provided in a thoughtful, respectful, and medically appropriate manner. The diagnosis of gender dysphoria thus serves not only as a clinical tool for identifying distress but also as a means to facilitate access to necessary medical treatments that can profoundly improve the quality of life for trans individuals (Sherbourne Health, 2019).

It must be noted that gender diversity should not be pathologized and it is essential to recognise that it does not inherently indicate a clinical diagnosis of gender dysphoria. Not all individuals with diverse gender identities will experience a gender dysphoria that might impair their functioning or compel them to seek gender-specific treatment or interventions (Fenway Health, 2021).

ROLE OF THE PRESCRIBING HEALTHCARE PROVIDER

The role of the prescribing healthcare provider in the context of hormone treatment for trans patients is multifaceted and critically important. It involves not only the medical aspects of prescribing and monitoring hormone therapy but also providing comprehensive support and guidance throughout the treatment process. A key component of this role is to help patients develop realistic expectations about the effects of hormone therapy, the timeline for these changes, and the potential risks and benefits involved. This is essential because it helps patients prepare mentally and emotionally for the changes that will occur and ensures that they have a clear understanding of what the treatment can and cannot achieve (Sherbourne Health, 2019).

Healthcare providers are advised not to view themselves as gatekeepers of hormone therapy but rather as facilitators of informed healthcare decisions. This approach is supported by the informed consent model, which emphasizes the patient's autonomy and understanding of their treatment choices. In this model, healthcare providers provide patients with all the necessary information to make educated decisions about their healthcare, including the likely outcomes of hormone therapy and any associated risks (Sherbourne Health, 2019).

Furthermore, healthcare providers are encouraged to receive specialized training to enhance their competence in managing GAHT. This includes being knowledgeable about the Diagnostic and Statistical Manual of Mental Disorders, 5th ed., and the International Classification of Diseases, as well as having the ability to assess a patient's capacity for consent and address any psychosocial barriers to gender affirmation (Hembree, 2017).

The Endocrine Society also recommends that diagnosing healthcare providers and mental healthcare providers should be knowledgeable about the diagnostic criteria for gender-affirming treatment, have sufficient training in assessing related mental health conditions, and be willing to participate in ongoing care throughout the endocrine transition. It further suggests that healthcare providers who manage hormone therapy for trans patients attend relevant professional meetings. This continuous professional development ensures that healthcare providers remain up-to-date with the latest best practices and research findings, which in turn, allows them to provide the best possible care to their patients (Hembree, 2017).

INFORMED CONSENT



In the context of GAHT, it is crucial for trans patients to have a comprehensive understanding of both the potential risks and benefits associated with this treatment. Hormone therapy is a significant and often life-changing intervention for trans individuals, offering numerous psychological benefits such as alleviating gender dysphoria, reducing anxiety and depression, and improving overall quality of life. Gender-affirming hormones may be administered by healthcare providers once a multidisciplinary team has verified the continued presence of gender dysphoria or gender incongruence, and the individual possesses the mental capacity to provide informed consent for this partially irreversible treatment (Hembree et al., 2017).

For adults experiencing gender dysphoria or incongruence, it is essential that treating healthcare providers (collectively) have expertise in trans-specific diagnostic criteria, mental health, primary care, hormone therapy, and surgical interventions as needed. Maintaining physiologic levels of gender-appropriate hormones is recommended, with vigilant monitoring for known risks and complications. In cases where high doses of sex steroids are necessary to suppress endogenous sex hormones or due to advanced age, healthcare providers may consider surgical removal of natal gonads alongside reducing sex steroid treatment. Healthcare providers should also monitor trans males (female to male) and trans females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, ongoing surveillance of adverse effects related to sex steroids is crucial. When performing gender-affirming surgeries in adults, the treating physician should collaborate with and confirm treatment criteria used by the referring physician. It is essential to avoid causing harm to individuals with conditions other than gender dysphoria or incongruence who may not benefit from the associated physical changes resulting from hormone treatment (Hembree et al., 2017).

The necessity of mental health referrals for GAHT has evolved over time. Traditionally, a referral letter from a mental health professional is often required before initiating hormone therapy, ensuring that the patient is mentally prepared for the transition. However, protocols that are utilized in the development of this Trans Health Toolkit recommend an “informed consent” model, which allows patients to start hormone therapy without a prior mental health assessment. Informed consent involves a detailed dialogue between the patient and the healthcare provider, where the patient is fully informed about the advantages, potential risks, and what can realistically be expected from all available treatment options. The informed consent model respects the autonomy of transgender individuals, allowing them to make decisions about their own bodies without unnecessary gatekeeping.

In practice however, healthcare providers in Jamaica, such as the local endocrinologist interviewed for this toolkit, recommend a mental health referral for hormone therapy, while also ensuring that patients understand risks and benefits, which align with the informed consent model. Healthcare providers may refer patients to gender-affirming mental health professionals for a thorough mental health assessment, ensuring that patients are mentally prepared for the changes associated with hormone therapy. Mental health professionals can provide ongoing support, helping patients navigate the emotional and psychological aspects of their transition. This model helps identify any underlying mental health conditions that might need to be addressed before starting hormone therapy, reducing potential risks. For instance, certain pre-existing conditions may increase the likelihood of complications, necessitating the traditional approach (Fenway Health, 2024).

The World Professional Association for Transgender Health (WPATH) recognizes both pathways—mental health referrals and informed consent—as valid approaches. This toolkit advocates for the use of GAHT by integrating both traditional and informed consent models. Combining both models offers flexibility, allowing patients to choose the pathway that best suits their needs and circumstances. This ensures that patients who need additional mental health support can receive it, while those who are ready to proceed can do so without unnecessary delays. This integration promotes a patient-centered approach, recognizing that each individual’s journey is unique and requires personalized care. Appendices C and D are sample consent forms for masculinizing and feminizing hormone Therapy, respectively.



PHYSICAL EXAM AND BASELINE INVESTIGATIONS

The initiation of hormone therapy for trans individuals is a significant step in the gender affirmation process, and it is crucial to approach this transition with thorough medical oversight. Physical examinations and baseline investigations play a pivotal role in ensuring the safety and effectiveness of hormone therapy. A comprehensive physical examination can reveal any underlying health conditions that may affect or contraindicate hormone treatment, such as cardiovascular issues or liver disease. Baseline investigations, including blood tests, are essential to establish a health profile against which the effects of hormone therapy can be monitored. These tests typically assess liver function, lipid profiles, and hormone levels, among other parameters, to identify any potential risks and to tailor the hormone regimen to the individual's specific needs (Sherbourne Health, 2019).

Medical examinations are essential to uncover any underlying health issues, including liver abnormalities, elevated cholesterol levels, or diabetes. It is recommended that these health concerns be addressed before or at the same time as starting hormone therapy. Additionally, these initial test results serve as an important reference point for ongoing observation of hormonal alterations.

Testing hormone concentrations can determine the use of any external hormones. Significant deviations in test results may also suggest the possibility of an intersex variation (Sherbourne Health, 2019).

It is important to note that the physical changes induced by hormone therapy, such as the development of secondary sex characteristics, occur over time and are influenced by factors like the duration of hormone use and the age at which therapy is initiated. Therefore, ongoing monitoring and adjustments to the treatment plan are often necessary to achieve the desired physical outcomes while minimizing potential side effects and health risks (Sherbourne Health, 2019).

Guidelines by Fenway Health (2024) suggests that while it's not mandatory to acquire a patient's gender history, doing so can enhance the understanding of their unique experiences and aspirations, thereby informing a more tailored treatment approach. It's also crucial to document a patient's anatomical profile, noting any organs they possess or have had removed, as this information is vital for the provision of ongoing preventive healthcare. Recording surgeries related to gender affirmation, such as the removal of breast or chest tissue, reproductive organs, and others, is key to offering precise guidance and communication regarding cancer screenings, reproductive choices, contraceptive needs, and other lifelong health considerations.

Gender Narrative

- History of experienced gender awareness and the development, exploration, acceptance/rejection, identification, and persistence of that gender
- Any symptoms of gender dysphoria
- Goals for non-medical affirmation of gender, GAHT, or other gender-affirming medical care

Medical History

- Personal history of coronary artery or cerebrovascular disease, arterial or venous thromboembolism, hypertension, diabetes, hormone-sensitive cancer, polycythaemia, pituitary adenoma, liver disease, HIV infection, and other sexually transmitted infections
- Current specialists for any underlying medical issues
- Use of current or past prescribed and unprescribed hormone use, as well as any history of surgical procedures, including body modifications or injectable silicone use

Behavioural Health History

- History of major depression or bipolar disorder, psychosis, suicidality, impulse control disorder, disordered eating patterns, and substance use and abuse
- Current behavioural health providers and any past or present psychiatric medications
- Psychiatric hospitalizations
- Past or present sexual, physical, or emotional abuse or trauma (it may not be necessary or possible to explore this fully in the initial assessment)
- Current or previous suicidality or self-injurious behaviour

Family History

- Family history of any cancer, cardiovascular disease, diabetes, or blood clotting disorders

Social History

- Family, chosen family, friend support, rejection, acceptance
- Cultural influences that may affect access to care or acceptance by community, religion, ethnicity, age, race, socioeconomic status, etc.
- Supports at work or school
- Community involvement, TGD peer support
- Sexual history, sexual orientation, safety

Reproduced from: Fenway Health (2024)

When addressing sexual health, it's imperative to adopt a trauma-informed method, initially confirming the patient's comfort with the discussion. Transparency about the purpose of these inquiries is necessary, recognizing the significance of sexual health in the broader context of a person's well-being. Healthcare providers should remain adaptable, respecting the patient's preferences on the timing of such discussions and proceeding only when it's deemed appropriate and safe. Additionally, physical examinations involving the chest and genital areas can be challenging for patients experiencing dysphoria or those who do not align with certain body parts. Medical providers must communicate clearly about the examination plan, secure informed consent, and uphold the patient's autonomy throughout the process (Fenway Health, (2024)).



SPECIAL CONSIDERATIONS FOR PHYSICAL EXAM

The University of California - San Francisco's (UCFS, 2016) Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People suggest special considerations for physical exam in transgender persons.

Vaginal exam in trans women: The structure of a neovagina created in a trans woman differs from that of a natal vagina. It forms a blind cuff, lacks a cervix or surrounding fornices, and may have a more posterior orientation. Consequently, using an anoscope could be a more anatomically suitable method for visual examination. The anoscope can be inserted, the trocar removed, and the vaginal walls observed as they collapse around the end of the anoscope as it is withdrawn.

Pelvic examination with trans men: Pelvic exams can be distressing for trans men. These individuals are less likely to stay current with cervical cancer screenings and may have higher rates of inadequate cytologic sampling. When providing a sample for a cervical pap smear, it's crucial to clearly communicate to the laboratory that the sample is for cervical screening (especially if the gender marker is listed as 'male') to prevent it from being mistakenly processed as an anal pap or discarded. Also, the requisition should indicate the use of testosterone or presence of amenorrhea.

If an individual expresses distress or concern about the examination, it may be postponed until a later date, once a trusting relationship has been established. Several approaches can help make a pelvic examination (including bimanual and/or speculum exams) less uncomfortable:

- Discuss procedures with the patient beforehand, including the order in which steps will occur. Allow time for the patient to express any concerns prior to beginning the exam.
- Allow the patient to have a support person in the room, listen to music on headphones, or utilize any other strategies they may have to provide distraction during the exam.
- Explain each step in a clear a direct way throughout, such as saying: “I will touch with my hand now,” “you will experience some pressure next,” “you will hear the clicking noise of the speculum now,” and reminding the patient that the exam can be stopped at any time at their request.
- Avoid using medical terms for body parts, unless discussed beforehand that these are preferred terms the patient would like you to use. Some patients may prefer to refer to their vagina as their “front” or “front-hole.”
- Offer the use of a mirror to allow the patient to directly observe the exam.
- Administration of an oral benzodiazepine 20-60 minutes prior to the exam may be helpful for those with severe anxiety.
- Administration of vaginal oestrogens commonly used in menopausal management for 1-2 weeks prior to the exam may decrease the vaginal atrophy often seen with testosterone therapy.
- Allowing for self-collection of some tests may preclude the need for a speculum exam in certain scenarios, such as a swab for wet prep to analyze abnormal vaginal discharge. Specimen self-collection for HPV testing is currently under investigation.
- In the case of refusal of a speculum exam, consider offering an external and/or bimanual exam as an initial step toward establishing comfort and trust. A positive experience may lead to the patient considering further examinations in the future.

Reproduced from: UCSF Gender Affirming Health Program (2016, p.21-22)

OTHER SPECIAL CONSIDERATIONS

Binding for Trans Men: Chest binding to achieve a masculine appearance can cause skin breakdown and other skin-related complications. Patients may be hesitant to remove the binder during a physical exam. It’s crucial to take a sensitive history and provide education on safe binding practices for all trans male patients.

Tucking for Trans Women: Tucking the testicles and penis can lead to complications such as hernias at the external inguinal ring or skin breakdown in the perineal area. Thorough history- taking and education are recommended for all trans women.

Intersex Conditions: When appropriate, further evaluation should be done for findings suggestive of intersex conditions.

The following guidelines on clinical visits for initiation of hormone therapy are reproduced from Callen-Lorde (2024) *Hormone Therapy Protocols* (p. 5-19). These detailed guidelines align with recommendations given by the local endocrinologist.

Session 1 – Initial Medical Intake

Goals:

- To introduce patients to the facility's health services
- To collect baseline medical information
- To begin hormone therapy assessment
- To engage patients in a comprehensive primary care system

1. Introduce patient to the facility's health services.
2. Discuss hormones, risks and benefits, and elicit patient's expectations
3. Discuss possible diagnostic codes. Some insurance companies may require a medical diagnosis in order to cover transition related services. This should be determined on a case-by- case basis.
4. Complete baseline social and medical assessment.
5. Collect a complete medical history, including medical conditions that can be exacerbated by Hormone Therapy:
 - Coronary Artery Disease
 - Deep Vein Thrombosis/Pulmonary Embolus
 - Embolic stroke
 - Liver disease
 - Pituitary adenoma
 - Uncontrolled Hypertension
 - Uncontrolled Diabetes
 - Breast or uterine cancer
 - Erythrocytosis
6. Assess Health Care Maintenance (HCM) and update as needed, including:
 - Tuberculosis screening
 - Immunization history, including Hepatitis A, Hepatitis B, Measles/Mumps/Rubella (MMR), Tetanus (Td/Tdap), influenza, pneumococcus, Human Papillomavirus (HPV)
 - Breast/chest Self-Exam
 - Testicular Self-Exam
 - Pelvic exam
 - HIV status and risk assessment
 - Assess need for colon cancer screening or baseline EKG
7. Elicit mental health history including history of transgender identity, and screen for potential mental health concerns (see Appendix C):
 - Active psychosis
 - Cognitive impairment
 - Dementia
 - Suicidal/Homicidal ideation/Attempts

8. Elicit social history:

- Alcohol use
- Employment history
- History of or current domestic violence or abuse
- Illicit drug or street hormone use
- Living situation
- Sexual history
- Gender identity history and prior transgender care
- Social supports
- Tobacco use
- Silicone use

9. Elicit family history:

- Cancer (i.e., breast, colon, ovarian, prostate)
- Diabetes
- Heart disease
- Hypertension
- Liver disease

10. Elicit medications:

- Prescribed
- Herbal
- Over the counter
- Street
- Supplements
- Prior hormone use

11. Screen for allergies.

12. Draw labs:

- Complete Blood Count
- Comprehensive Metabolic Panel (electrolytes, liver enzymes, lipids)
- Hepatitis A, B and C panel
- Syphilis screening

13. If HIV status unknown, offer HIV testing.

14. If indicated, ask patient for records of relevant previous or current medical care, including HIV, mental health, and/or substance use/abuse treatment, as applicable.

15. Arrange follow up:

- Supportive counselling and education
- Medical visit

Session 2 – Hormone Counseling & Education Session

Goals:

- To counsel and assess patient ability to provide informed consent to Hormone Therapy
- To assess and initiate management of mental health complaints that might be adversely affected by Hormone Therapy
- To assess additional biopsychosocial needs of patient and offer related referrals/resources as indicated and/or requested

1. Introduce purpose of Hormone Counseling & Education Session:
 - Counsel about the known risks and benefits of exogenous hormone therapy and confirm patient can provide informed consent to Hormone Therapy
 - Assess acute, active mental health complaints that may be adversely affected by Hormone Therapy
 - Assess and provide psychosocial supports and referrals as indicated.
 - Communicate assessment and findings to the medical provider who will be prescribing Hormone Therapy.
2. Obtain informed consent to Hormone Therapy:
 - Assess that the patient's goals and understanding of Hormone Therapy match the general nature and purpose of Hormone Therapy
 - Assess patient's understanding of the physical, mental health, and social benefits and risks of Hormone Therapy
 - When applicable discuss alternatives to Hormone Therapy.
3. Assess patient's day-to-day mood/mental health:
 - Counsel patient on the psychoactive effects of hormones:
 - *Some mood/mental health problems such as depression and anxiety may be addressed by hormones, some symptoms are not.*
 - *Some mood/mental health problems, including depression, anxiety and psychosis, may be exacerbated by hormones.*
 - Gather information about patient's mood/mental health for the purpose of forecasting symptoms that may be intensified by Hormone Therapy:
 - *If patient has untreated, non-acute symptoms, offer and refer patient to supportive mental health services (such as psychotherapy or psychiatry)*
 - *If patient has acute, untreated mood problems, discuss ways Hormone Therapy and mood problems can be managed safely. Guide patient to discuss these symptoms with the medical provider who will be prescribing Hormone Therapy.*

4. Explore patient's social transition needs such as peer support, psychotherapy, identifying documentation changes, care coordination, and legal advocacy

■ As indicated, refer patient to internal and external resources, including Transgender Care Coordinator.

Note: Engagement in mental health care is a recommended requirement for hormone initiation.

5. Elicit any additional questions the patient may have about Callen-Lorde's services, and/or physical or social transition.

■ If patient intends to pursue gender confirming surgery, discuss ways to access surgical referrals as well as documentation required for surgery.

6. Arrange an additional Hormone Counselling & Education Session visit if:

■ Patient is unable to establish informed consent in the first session

■ Patient is interested in accessing additional support and/or counselling around Hormone Therapy

7. Document visit in electronic health record: including overall assessment of patient's ability to provide informed consent and any relative or absolute contraindications elicited during evaluation. Communicate directly with the prescribing provider about any serious concerns.

Session 3 - Medical Visit

Goals:

- To complete medical/psychosocial assessment
- To initiate hormone therapy

Note: Depending on how much was covered in Visit 1/2, Visit 3 may cover more ground than is feasible in one appointment. If necessary to cover all the following elements, Visit 3 may be split into two appointments. Importantly, hormone treatment should not be initiated in a hormone-naïve patient until all the elements in Visits 1-3 are completed.

1. Continue medical/psychosocial work-up
2. Review records from prior Primary Care Provider, if obtained.
3. Perform a complete physical exam.

Note: The patient may postpone or refuse breast/chest or genital exam. If the patient refuses, renegotiate the time at which the exam will be done

4. Review lab results and discuss implications of abnormal findings.
5. Continue Healthcare Maintenance assessment from Visit 1.
6. If indicated, perform tuberculosis screening.
7. Give vaccines (Hepatitis A/B, HPV, etc) if indicated and desired.
8. Discuss smoking cessation if appropriate.
9. Arrange follow up medical visit within 4 weeks.
10. Discuss treatment plan.
11. Review the hormone therapy consent forms (see Appendices C, D).
12. Document formal assessment of capacity to give consent in chart:
 - Ability to communicate choice
 - Comprehension of clinical situation
 - Understanding of alternatives (hormones, surgery, no treatment), benefits, and risks.

13. If patient has capacity, have patient sign the informed consent for hormone therapy.
14. If patient signs informed consent, document that patient can begin hormone therapy.
15. Review available medications, potential side effects, and timeline of expected physical changes.
16. Discuss with the patient the preferred route of hormones and prescribe one month of the appropriate regimen:
 - For Transgender men (FTM): The usual regimen is testosterone.
 - For Transgender women: The usual regimen is an oestrogen + anti-androgen.
17. Give appropriate vaccinations
18. Order lab work for next medical visit (schedule 4 weeks after starting hormones)
 - Liver enzymes
 - Electrolytes, if taking spironolactone
 - Complete blood count, if taking flutamide
19. Arrange follow up
 - If patient is taking injectable hormones and is not returning on the same day for the injection, first available nursing visit after filling prescription.
 - Nursing visit 2 weeks after first injection (if using injectable)
 - Nursing visit 4 weeks after first injection (if using injectable)
 - Medical visit in 5 weeks (all clients)

Session 4 - Nursing Visit

Goal:

■ To provide patient with first injection of hormone therapy

1. Ask patient preferred method of injection: self-injection, injection by a significant other, friend, family or ally (SOFFA) or by nurse at your healthcare facility.
2. If the patient chooses self-injection or by a SOFFA and is unfamiliar with self-injection, initiate teaching of safe injection technique
3. If the patient or a SOFFA is familiar with self-injection, observe the injection being administered by the designated person and provide feedback. If the technique is sound, document approval for self-injection in the chart. If technique needs improvement, offer instruction.
4. Arrange follow up Nursing Visit every 2 weeks to continue teaching of safe injection technique to patient or SOFFA.
5. Arrange for laboratory testing 4 weeks after initiation of hormones:
 - Liver enzymes
 - Electrolytes, if taking spironolactone
 - Complete blood count, if taking flutamide

Visit 5 - Medical Visit

(4 weeks after starting half-dose hormones)

Goals:

- To perform initial assessment after the initiation of hormone therapy
- To continue hormone therapy
- To continue the provision of primary care

Nursing Provider:

1. Check the patient's vital signs, including blood pressure.
2. Proceed with hormone injection after Medical Provider has reviewed the laboratory results and authorized continuation of the treatment.

3. If patient has chosen injectable hormones and is due for an injection:

- Ask if the patient is receiving injections from self or a SOFFA. If so, observe the injection technique. If the technique is sound, document approval for self-injection in the chart.
- If the technique needs improvement:
 - *Offer instruction and support.*
 - *Schedule bi-weekly nursing appointments for further teaching and injections until the nursing provider assesses that the patient or SOFFA has learned the proper technique and can safely inject without supervision.*
- If the patient prefers nursing staff to inject, administer appropriate hormone and dose.

Medical Provider:

4. Take history with focus on

- Patient's tolerance of hormones and anti-androgens
- Any side effects patient may be experiencing
- MTF client: Cessation of erections
- FTM client: Cessation of menses

5. Perform physical exam, including blood pressure.

6. Review lab results and discuss implications of abnormal findings. Increase the dosage of hormones as prescribed.

7. Order lab work for next medical visit in 4-5 weeks:

- Liver enzymes
- Lipids
- Prolactin level, if MTF on oestrogen
- Electrolytes, if taking spironolactone
- Complete blood count, if taking flutamide

8. Arrange follow up:

- *Nursing visit every 2 weeks, if requesting injections by nurse*
 - *If the patient chose self-injection or injection by SOFFA, observe the injection being administered by the designated person and provide feedback.*
 - If the technique is sound, document approval for self-injection in the chart. If technique needs improvement, offer instruction.*
- Medical visit in 4-5 weeks

Session 6 - Medical Visit (4 weeks after starting full-dose hormones)

Goals

- To perform assessment after a change of hormone therapy
- To continue hormone therapy
- To continue the provision of primary care

Nursing Provider:

1. Same as visit 5 above.

Medical Provider:

2. Take brief history with focus on:
 - Patient's tolerance of hormones and anti-androgens
 - Any side effects patient may be experiencing
 - MTF client: Cessation of erections
 - FTM client: Cessation of menses
3. Review lab results and discuss implications of abnormal findings (see Appendix D).
4. Discuss smoking cessation if appropriate.
5. Prescribe three months of ONE of the hormones and anti-androgens as outlined in Visit 5.
6. If the patient chose injection by herself or SOFFA and nursing approved the injection technique, prescribe syringes and needles as outlined in Visit 5.
7. If the patient is receiving injections from self or SOFFA and the technique needs improvement, refer to nursing provider for further teaching and injections until the nursing provider assesses that the patient or SOFFA has learned the proper technique and can safely inject without supervision.
8. Order lab work for next visit:
 - Liver enzymes
 - Lipids
 - Prolactin level
 - Electrolytes, if taking spironolactone
 - Complete blood count, if taking flutamide
9. Arrange follow up:
 - Medical visit in 3 months
 - Lab visit one week prior to medical visit
 - Supportive counselling and education session in 1 month, if the need is identified
 - Nursing visits for injection teaching as needed

Session 7 - Medical Visit (9 weeks after starting full-dose hormones)

Goals

- To continue health assessment after the initiation of hormone therapy
- To continue hormone therapy
- To continue the provision of primary care

1. Take brief history with focus on:
 - Patient's tolerance of hormones and anti-androgens
 - Any side effects patient may be experiencing
 - How transition is going
 - Cessation of erections/cessation of menses
2. Perform brief physical exam.
3. Review lab results and discuss implications of abnormal findings.
4. Give vaccines as needed.
5. Discuss smoking cessation if appropriate.
6. Prescribe hormones, anti-androgens, syringes and needles for 6 months.
7. Order lab work for next visit:
 - Complete blood count
 - Comprehensive metabolic panel (liver enzymes, electrolytes, lipid panel)
 - Prolactin (for MTF on oestrogen)
8. Arrange follow up:
 - Medical visits every 6 months with lab visits one week prior and appointments for refills as needed.
 - Supportive counselling and education sessions and psychiatric consultations offered whenever the need is identified.
 - Continue routine, age-appropriate healthcare maintenance, including screening for sexually transmitted diseases if appropriate.

OVERVIEW OF TESTOSTERONE-BASED (MASCULINIZING) HORMONE THERAPY

Masculinizing hormone therapy aims to develop male secondary sex characteristics while minimizing female secondary traits. General effects include facial hair growth, deepening of the voice, fat redistribution, increased muscle mass, body hair growth, and changes in sweat and odour patterns. Sexual and gonadal effects include increased libido, clitoral growth, vaginal dryness, and cessation of menstruation. An ovulatory state is common but not guaranteed, and long-term fertility may be impacted. Some transgender men can discontinue testosterone and achieve successful pregnancies. Masculinizing hormone therapy can also affect emotional and social functioning, although individual experiences vary, and it's essential to avoid stereotypes. The general approach involves using one of several forms of parenteral testosterone (UCSF, 2016).

Testosterone

The most common form of testosterone are injectables, due to their low cost and ability to increase testosterone quickly and efficiently. Testosterone can be injected subcutaneously (SC) or intramuscularly (IM). Administering testosterone through the skin on a daily basis may result in more consistent blood testosterone levels, which mimic the body's natural testosterone variations (Fenway Health, 2024).

Topical applications are recommended, particularly for individuals concerned about

substantial hormone level fluctuations. Unlike injectable options, transdermal testosterone avoids extreme surges in blood levels, leading to a more subtle and progressive onset of physical changes. Moreover, the convenience of daily application facilitates swift alterations in dosage, cessation of treatment if necessary, and greater control over the therapy's management. This method is particularly suitable for those seeking a more measured approach to hormone therapy or wishing to manage their treatment closely (Fenway Health, 2024). Appendix E is a sample of a consent form for starting masculinizing hormone therapy.

Progesterone Therapy

Some patients may seek or be advised to take extra medication to alleviate dysphoria symptoms, like halting menstruation if the effects of testosterone are unwanted. For such situations, hormone-based drugs, particularly contraceptives, are effective in diminishing or ceasing menstrual flow. Moreover, these drugs can serve the dual purpose of contraception for patients capable of conceiving, since testosterone alone is not a dependable contraceptive method (Fenway Health, 2024).

Progesterone plays a role in reducing testosterone levels, which may justify its use as an alternative anti-androgen. This is particularly relevant when treatments like oestrogen or the combination of oestrogen and spironolactone fail to sufficiently lower testosterone levels. While there's no concrete evidence indicating harm from using progesterone in GAHT, data on its safety in this context is scarce. Concerns about prescribing progesterone alongside oestrogen stem from the Women's Health Initiative studies (WHI), which indicated a slight increase in

cardiovascular issues and breast cancer risk with hormone use. However, these findings, based on older post-menopausal cisgender women taking specific hormone combinations, may not be directly applicable to gender-affirming care. In such care, patients are generally younger, and the recommended hormones are micronized progesterone and 17-beta estradiol, which are considered to have a lower risk for thromboembolic events compared to other hormone therapies. In the context of gender affirming treatment, the advantages are likely to surpass any potential risks that are perceived (Fenway Health, 2024).

Previous use of oral methyltestosterone and other synthetic androgens, often encountered in bodybuilding communities, has led to unfounded concerns about negative liver effects from testosterone use in transgender men. Testosterone is available in various injected and topical forms, originally designed for non-trans men with low androgen levels. However, since label dosing is based on treating men with low, but not absent, testosterone, trans men may require higher doses compared to non-trans men (UCSF, 2016).

Given that progesterone is a natural component of a cisgender woman's hormonal profile, individuals may opt for its inclusion in GAHT. The decision to initiate or continue progesterone therapy should be carefully considered, balancing its advantages against possible long-term risks (Fenway Health, 2024). Appendix F is a sample of a consent form for starting progesterone.

Titration and Monitoring Masculinizing Hormone Therapy

Healthcare providers ought to consider patient goals, clinical response, and safety when adjusting testosterone doses. They should monitor hormone levels (including haemoglobin and haematocrit). Clinical response can be assessed by the presence of amenorrhea within 6 months. Once testosterone is within the normal male range, higher doses don't necessarily increase virilization. If levels are low, gradually increase the dose while monitoring for side effects. Beyond the midpoint of the reference range, further dose increases may not significantly impact progress or mood symptoms (UCSF, 2016).

When healthcare providers omit hormone level monitoring and only focus on clinical progress or changes, there's a risk of inadequate virilization if testosterone levels haven't reached the desired target range. Regular monitoring is essential to ensure safety and optimal outcomes for trans individuals undergoing hormone therapy. Hormone imbalances can occur due to metabolic changes, such as diabetes or thyroid disorders. Substantial weight changes can impact hormone levels. Evidence of regression (reversal) of masculinizing effects may prompt adjustments, monitoring helps maintain desired virilization. Hormone imbalances can cause symptoms like hot flashes, bleeding, or migraines. Some patients with complex psychosocial situations require more frequent office visits due to coexisting conditions (UCSF, 2016).



Interpreting Laboratory Results in Trans Care

Trans healthcare involves a multifaceted approach, and interpreting laboratory results plays a crucial role in providing safe and effective care. As trans individuals seek GAHT to align their physical characteristics with their gender identity, healthcare providers must navigate several complexities related to lab testing. Guidelines by UCSF (2016) indicates that numerous sources provide target ranges for hormone levels (such as serum estradiol, total oestrogens, free and total testosterone, and sex hormone-binding globulin) and these ranges can vary significantly between different laboratories and testing techniques. Healthcare providers must be aware of these variations and consider them when interpreting results. Also, a critical consideration is the patient's affirmed gender identity. Trans individuals often undergo GAHT to align their physical characteristics with their gender identity. Lab reference ranges supplied with result reports may not align with the intended hormonal sex. For instance, a trans man (assigned female at birth) using virilizing hormone therapy should not be assessed based on female reference ranges. Providers are encouraged to consult local labs to obtain reference ranges for both "male" and "female" norms. Applying the correct range based on the current hormonal sex ensures accurate interpretation.

Table 1: Testosterone-based (masculinizing) hormone therapy preparations and dosing

Medication	Dosage
Testosterone	
Testosterone cypionate 100mg/mL (injectable, suspended in cottonseed oil)	Starting dose: 25 mg IM or SC q weekly Usual maintenance dose: 50-100 mg weekly If local skin reaction occurs, switch oils Weekly dosing is preferred to minimize peak/trough variation Biweekly injection (of 2x the weekly dose) may be tolerated in some individuals
Testosterone enanthate 200mg/mL (injectable, suspended in sesame oil)	Fenway Health (2021, p.14): ■ Dose recommendations are the same whether using IM or SC injections. SC injections use smaller needles (both in length and gauge) than IM, and tend to be less painful. IM injections may be preferred or necessary for larger volumes. ■ Biweekly dosing reduces the number of injections, but leads to wider fluctuations in testosterone levels which can be uncomfortable for some patients. Weekly dosing may be a better choice for those concerned about the impact of fluctuating hormone levels on mood or other medical conditions. ■ Testosterone cypionate comes compounded in cottonseed oil, where testosterone enanthate is most commonly compounded in sesame oil. Dermatitis at the injection site as a result of a mild allergy to the compounding oil can occur and may dictate a need to change from one formulation to another. However, pre-dosing with Benadryl is sometimes enough to counter any mild reaction.

Medication	Dosage
Androgel® 1% (gel) 12.5 mg/pump or 25mg/2.5g or 50 mg/5g packet	Starting dose: 2 pumps or 1 x 2.5 g packet (25 mg daily) Usual maintenance dose: 4-8 pumps or 1-2 x 5 g packet (50- 100 mg daily) Fenway Health (2021, p.15): ■ Patients must use caution in avoiding skin to skin contact at application area(s) with partners, children, or pets until the medication is completely absorbed. Hands should be washed immediately after application. If skin to skin contact is anticipated, the area should be washed with soap and water or covered. It is advised to wait at least 2 hours after application before bathing or showering. ■ Recommended application site is at upper arms and shoulders.
Testopel implantable pellets	Implanted every 3 to 4 months. ■ Requires a minor surgical procedure to implant pellets in the subdermal space at the upper, outer area of the buttock. ■ It is recommended that individuals have been on another form of testosterone prior to initiating Testopel to ensure testosterone is tolerated and affirming
Testosterone undecanoate capsules (Jatenzo)	Twice daily dosing ■ Jatenzo has a black box warning for risk of elevated blood pressure while taking this medication. It is recommended to monitor blood pressure closely in the first several months of use ■ There does not appear to be any specific or significant risk of hepatotoxicity or transaminitis with this oral formulation, as opposed to risks seen with oral methylated testosterone ■ Based on the recent approval of this medication, no generic alternative, and little information of effectiveness in TGD populations, this medication may be expensive and difficult to obtain through prior authorization
Progestins: May be used for contraception or to assist with suppression of monthly bleeding (menses)	
Medroxyprogesterone IM (Depo-Provera®)	150 mg IM q 12 weeks or by mouth once daily
Progesterone releasing IUD Higher dose progesterone preferred for suppression of monthly bleeding (menses)	Inserted by MD or NP. Devices effective for 3-5 years
Progestin implant (Nexplanon®)	Inserted sub-dermally by trained MD, NP or RN(C), effective up to 3 years

It is important to discuss risks, benefits, and potential side effects with patients before starting treatment. Healthcare providers may vary in their approaches to hormone initiation, maintenance dosing, and lab work orders, with much of the decision-making tailored to the specific clinical situation.

Trans Care BC (2018 p. 7) recommends the following risk considerations, dose titration and goal of therapy.

Risk considerations: Some contraindications for testosterone therapy include unstable cardiovascular disease, pregnancy or breastfeeding, unstable psychosis or mania, active hormone-sensitive cancer, and allergies. Despite these contraindications or increased risks, many patients opt to start or continue hormone therapy. In such situations, healthcare providers should conduct a thorough informed consent process, considering the patient's decision-making capacity and the potential harm from withholding treatment.

Dose Titration: Gradually adjust the dosage q 4-6 weeks until reaching the maintenance dose. For example, start with 25 mg for 4-6 weeks, then increase to 50 mg for the same duration, followed by 75 mg, and so on. Some patients may prefer a slower titration rate, which can also be determined based on clinical considerations.

Goal of therapy: To maintain mid-injection cycle levels in the mid to high end of the male range, minimize side effects, and maintain expected rates of physical change, consider adjusting the dosage. The degree of change can be influenced in part by patient preference.

Guidelines are reproduced from Trans Care BC (2018 p. 7-8) for lab monitoring, follow up visits, managing side effects of testosterone, screening and health promotion as follows:

Lab monitoring:

Request the lab to report male reference ranges

Baseline and annually thereafter	■ Testosterone, CBC, ALT, fasting glucose, lipids
Following dose changes and 4-6 weeks after gonadectomy	■ Mid-injection cycle testosterone, CBC, ALT ■ Trough testosterone if amenorrhea is delayed >6 months

Areas for review in follow up visits:

Subjective	Objective
■ Effects of hormones: physical, emotional ■ Current dose/desire for dose change ■ Side effects/concerns ■ Mental health: mood, body image, libido ■ Social: significant others, support, acceptance, safety, housing, finances ■ Lifestyle: exercise, nutrition, smoking, substance use	■ Blood pressure ■ Weight (baseline and q 6 months prn) ■ Mental status (brief assessment) ■ Cardiovascular and abdominal exam (baseline and yearly) ■ Labs ■ Other investigations as indicated

Managing side effects of testosterone, screening & health promotion

Managing side effects of testosterone & other common concerns	
Acne	Typically most problematic in the first year of hormone therapy Treat as per usual, consider lower dose or switching testosterone type if persistent
Scalp hair loss	Minoxidil – will not impact facial hair growth Finasteride – will inhibit facial hair growth
Polycythemia	Usually a misinterpretation due to lab using “female” ranges. Ensure the haemoglobin and haematocrit are being interpreted based on male laboratory ranges. If haemoglobin > 175 g/L or haematocrit > 0.52 or if symptomatic (headaches, facial flushing) increase frequency of dosing to weekly, reduce dose, or switch to a patch or gel to minimize peak/trough variation
Elevated transaminases	Usually transient unless another cause of hepatic dysfunction is identified
Unexpected (menstrual/cyclical) bleeding	Bleeding is typically suppressed within 6 months of starting testosterone. Evaluate for missed, inconsistent or excessive testosterone dosing (missed or inconsistent doses can cause spotting, excess testosterone can convert to oestrogen with theoretical risk of endometrial proliferation) Check trough testosterone levels, estradiol, LH, FSH. Consider more frequent dosing (weekly at half the q 2 week dose) or dose adjustment. Persistent, unexplained bleeding should be evaluated with pelvic ultrasound +/- endometrial biopsy
Internal genital (vaginal) dryness	Internal genital atrophy is fairly common for those on long-term testosterone. It can be treated with over-the-counter internal genital moisturizers or topical oestrogen: estradiol cream 0.5-1 g daily for 2 weeks then twice weekly or estradiol tablet 10 mcg daily for 2 weeks then twice weekly. It can be helpful to advise patients that product names may not be affirming.

Screening

Cardiovascular risk	Testosterone use does not appear to significantly increase cardiovascular risk. If using a risk calculator, use male scores if hormones were started early in life, female scores if hormones were started later (or both to estimate range)
Chest/Breast cancer	If the client has not had chest surgery, screen as per BC Cancer guidelines. The risk of cancer related to residual tissue after chest construction (double mastectomy) is unknown. If high risk or patient concern, consider physical exam and diagnostic ultrasound or other modality when appropriate.
Cervical cancer	Screen as per BC Cancer Cervical Screening guidelines On the requisition, use “T” for the gender marker, in the notes section indicate testosterone use, including dose and duration. See Appendix G - Sexual Health Screening
Sexual health	Some trans people may be at higher risk for sexually transmitted infections (STIs) including HIV and syphilis. Screen for STIs and consider HIV pre-exposure prophylaxis based on patient-specific risk factors. See Appendix G - Sexual Health Screening
Osteoporosis	Screen as per national guidelines (ages 65 and up) or earlier if higher risk (for example, long term low levels of testosterone post- oophorectomy). Encourage vitamin D and calcium intake and weight bearing exercise. Maintain hormone therapy post-gonadectomy.
Colon cancer	Screen as per BC Cancer Colon Screening guidelines

FERTILITY

Masculinizing hormone therapy can impact fertility. It is therefore advisable to make fertility decisions before starting treatment, as long-term hormone use increases the risk of permanent infertility. Even after discontinuing therapy, the ovaries and uterus may not fully recover, potentially affecting natural pregnancy. For patients seeking biological children, options include egg freezing (mature oocyte cryopreservation), embryo freezing (fertilized egg preservation), and ovarian tissue cryopreservation. Each method involves different steps and considerations. While testosterone may impact fertility, trans men can still become pregnant if they retain their uterus and ovaries and engage in sexual activity with a person who produces sperm (Mayo Clinic, 2024).

What to expect from masculinizing hormone therapy

Trans Care BC (2018) identifies some physical changes over time after beginning masculinizing hormone therapy.

Testosterone-related changes may include:	Expected onset	Expected maximum effect
*Deeper voice	3-12 months	Years
*Growth of body and facial hair	3-6 months	3-5 years
*Growth of the external genitals (clitoris)	3-6 months	1-2 years
*Scalp hair loss	>12 months	Variable
Decreased fertility	Variable	Variable
Fat redistribution and possible weight gain or loss	3-6 months	2-5 years
Increased muscle	6-12 months	2-5 years
Mood changes	Variable	Variable
Changes to sex drive, sexual interests or sexual function	Variable	Variable
Skin changes including increased oil and acne	1-6 months	1-2 years
Dryness of internal genitals (vagina)	3-6 months	1-2 years
Stopping of monthly bleeding (period)	2-6 months	n/a

**Change is permanent and will remain even if hormone therapy is stopped*
Reproduced from: Trans Care BC (2018, p.21)

OVERVIEW OF OESTROGEN-BASED (FEMININIZING) HORMONE THERAPY

Oestrogen therapy may lead to a softer skin texture, reduction in muscle bulk, development of breasts, deceleration of hair loss typically influenced by androgens, and a shift in fat storage towards the hip and buttock areas. While oestrogen has the capability to inhibit testosterone and its associated effects, for some, oestrogen by itself might not adequately reduce testosterone levels. To enhance the suppression of testosterone's influence, androgen blockers, also known as anti-androgen therapy, can be employed. These medications are designed to further decrease the production of testosterone or the body's sensitivity to it, thereby amplifying the physical changes induced by oestrogen (UCSF, 2016). Appendix H is a sample of a consent form for starting feminizing hormone therapy.

The following provides an overview of oestrogens, antiandrogens, and progestogens as guided by UCSF (2016).

Oestrogens

Oestrogen Choice: The primary oestrogen used for feminizing therapy is 17-beta estradiol. It's considered "bioidentical" because it's chemically identical to the oestrogen produced by human ovaries.

Delivery Methods: Trans women typically receive 17-beta estradiol through:

- Transdermal Patch: Applied to the skin.
- Oral or Sublingual Tablet: Taken by mouth.
- Injection: Administered as a conjugated ester (estradiol valerate).

Other Routes: Some trans women may use transdermal gel or spray, but achieving physiologic female blood levels can vary.

Compounded Options: Specialty pharmacies offer compounded topical creams and gels. Consult with a compounding pharmacist for dosing details.

Injection Alternatives: Compounded estradiol valerate injections can be an option during shortages or for cost-effectiveness.

Research: The recommend starting doses 2 to 10 mg weekly or 5 to 30 mg every 2 weeks of estradiol valerate are too high and likely lead to patients having supraphysiologic levels across much of their injection cycle. Recommendations to start injectable estradiol valerate via subcutaneous or intramuscular injections at a dose ≤ 5 mg weekly and then titrate accordingly to keep levels within guideline-recommended range (Rothman et al., 2024).

Conjugated equine oestrogens (Premarin®) have been used in the past but are not recommended due to its inability to accurately measure blood levels and some suggestion of increased thrombogenicity (blood clot formation) and cardiovascular risk. In the context of contraception, ethinyl estradiol is preferred because it offers more consistent and reliable cycle control, balancing out the potentially increased risk of venous thromboembolism (VTE). However, in the setting of gender affirmation, where cycle or bleeding regulation is not necessary, the use of ethinyl estradiol and its inherent risks may not be warranted (UCSF, 2016).



Concern is emerging that prolonged use of high-dose cyproterone (a medication used for gender affirmation) may be associated with the development of meningiomas. Meningiomas are rare, most-often benign, tumours of the meninges (membranes covering the brain and spinal cord). Observations suggest that these tumours are hormone-sensitive, as they have increased incidence in cis women compared to cis men, and histologically show progesterone and oestrogen receptors (Sherbourne Health, 2020-2011).

Antiandrogens – common approaches

Antiandrogens:

The suppression of testosterone production and the blocking of its effects lead to a reduction in male secondary sexual characteristics.

Unfortunately, many of these characteristics become permanent after natural puberty and are irreversible. Androgen blockers enable lower estradiol dosages, which contrasts with the supraphysiological oestrogen levels (and associated risks) previously used to suppress pituitary gonadotropins.

Antiandrogen Choice:

Spironolactone is a commonly used androgen blocker in the U.S. It serves as both a potassium-sparing diuretic and an anti-androgen:

■ **Antiandrogenic Properties:** Spironolactone blocks androgen receptors, which helps counteract the effects of male sex hormones (such as testosterone) on the skin. It mainly acts at two sites:

■ **Hair Follicle and Sebaceous Gland:** It blocks androgens at the hair follicle and sebaceous gland.

■ **Adrenal Gland:** It reduces the secretion of androgens from the adrenal gland.

■ **Suppression of Testosterone Synthesis:** In higher doses, spironolactone directly suppresses testosterone synthesis, contributing to its anti-androgen effect.

Safety and Side Effects:

■ Doses of up to 200 mg daily have been considered safe for non-trans women being treated for hair loss. Some reports mention doses of up to 400 mg/day without negative effects.

■ The most serious risk is hyperkalemia (high potassium levels), but this is rare when precautions are taken (e.g., avoiding use in individuals with renal insufficiency) and with careful monitoring.

■ Patients may experience self-limited polyuria (increased urination), polydipsia (increased thirst), or orthostasis (dizziness upon standing) due to its diuretic effect

Antiandrogen Choice: 5-alpha reductase inhibitors include finasteride and dutasteride.

Finasteride:

■ **Mechanism of Action:** Finasteride specifically inhibits Type II 5-alpha reductase, an enzyme found in the prostate, seminal vesicles, and skin. This enzyme normally converts testosterone into a more potent androgen called dihydrotestosterone (DHT). By blocking this conversion, finasteride reduces the levels of DHT in the body.

■ Clinical Uses:

□ Benign Prostatic Hyperplasia (BPH): Finasteride is FDA-approved for treating symptomatic BPH in men with an enlarged prostate. It helps improve symptoms, reduces the risk of acute urinary retention, and lowers the need for surgical procedures like transurethral resection of the prostate (TURP) or prostatectomy.

□ Male Pattern Hair Loss (Androgenic Alopecia): Finasteride is also approved for treating male pattern hair loss. It can help slow down hair loss and, in some cases, promote hair regrowth.

Dutasteride Comparison:

■ **Mechanism of Action:** Dutasteride, another 5-alpha reductase inhibitor, more effectively blocks both Type I and Type II isozymes. While finasteride mainly targets Type II, dutasteride has a broader effect. Dutasteride may have more pronounced feminizing effects due to its impact on the pilosebaceous unit (hair follicles and sebaceous glands).

■ **Antiandrogenic Effect:** Although finasteride doesn't fully block testosterone production or action, it does reduce DHT levels. This antiandrogenic effect is less potent than complete androgen blockade but can be useful for individuals who cannot tolerate spironolactone or have contraindications to its use.

■ **Partial Feminization:** For patients seeking partial feminization or those with persistent virilized features or hair loss after other treatments (such as orchiectomy or full androgen blockade), 5-alpha reductase inhibitors like finasteride may be considered.

Antiandrogen Choice: Progestagens.

Although there are no well-designed studies on the role of progestagens in feminizing hormone regimens, anecdotal reports from trans women and providers suggest potential benefits. These include improved breast and/or areolar development, mood, or libido. While there's no evidence of harm, individual responses to progestagens can vary. Progestagens have some anti-androgen effects but also carry a theoretical risk of direct androgenization. Commonly used progestins include micronized bioidentical progesterone (Prometrium) and oral medroxyprogesterone acetate (Provera).

While the Women's Health Initiative (WHI) raised concerns about cardiovascular disease and breast cancer risks associated with medroxyprogesterone use, these concerns may not apply in trans care for several reasons:

■ **Lower Breast Cancer Risk:** Trans women may have a lower risk of breast cancer compared to non-trans women.

■ **Study Context:** The WHI study involved conjugated equine oestrogens combined with medroxyprogesterone in menopausal women, some of whom were post-menopausal for up to 10 years.

■ **Subtle Findings:** Although statistically significant, the clinical impact of WHI findings was minimal. The combined group had slightly increased risks of cardiac events, strokes, pulmonary emboli, and invasive breast cancers, but overall mortality remained unchanged. Therefore, combined menopausal hormone therapy isn't recommended for chronic disease prevention.

In context of gender-affirming care, several differences exist compared to the WHI study. These include a younger population, absence of equine oestrogens, and a focus on gender-affirming interventions rather than prevention. Given the minimal increase in overall risk, lack of mortality difference, and recent reassuring data on other forms of oestrogen, the risks of using progestagens in trans women are likely minimal or absent. Injected depo-medroxyprogesterone acetate (Depo-Provera®) is less commonly used, and other synthetic progestins may be necessary due to formulary limitations; some evidence suggests that norethandrone-derived progestins (norethindrone, norgestrel) may carry an increased risk of venous thromboembolism.

Guidelines for hormone preparations and dosing for feminizing hormone therapy are adapted from Trans Care BC (2018 p. 9) and presented in Table 2.

Table 2: Oestrogen-based (feminizing) hormone therapy preparations and dosing

Medication	Dosage
Oestrogen	
17-beta estradiol (Estrace®) (oral/sublingual) Lowest risk of all oestrogens and first choice	Starting dose 1-2 mg po daily Usual maintenance dose 4-8 mg daily Can be divided bid
Estradiol patch (Estradot®/Estraderm®) (transdermal) Eligible for Special Authority for clients >40 years old with additional risk factors	Starting dose 50 mcg patch twice per week. Usual maintenance dose: 100-400 mcg twice per week
Estradiol valerate (injectable) Only available compounded	Starting dose a 5 mg IM/SC weekly Usual maintenance dose 10-20 mg IM/SC weekly Weekly dosing is preferred to minimize peak/trough variation Biweekly injection (of 2x the weekly dose) may be tolerated in some individuals *Recommended to start dose ≤5 mg weekly and then titrate accordingly to keep levels within guideline-recommended range.
Progesterone Not routinely recommended but may be included based on patient preference No clear evidence of benefit and possible increased risk. Potential role in breast/nipple development (unproven)	
Micronized progesterone (Prometrium®) First choice but more expensive	Starting dose 100 mg po daily Usual maintenance dose 100 – 400 mg daily
Medroxyprogesterone (Provera®)	Starting dose 5 mg po bid Usual maintenance dose 10-15 mg bid

Table 2: Oestrogen-based (feminizing) hormone therapy preparations and dosing

Medication	Dosage
Androgen Blockers	
Spironolactone First-line due to lower cost, effectiveness and tolerability May not significantly lower T levels alone	Starting dose: 50 mg po daily Usual maintenance dose: 200-300 mg daily Can be divided bid
Finasteride An anti-androgen with primarily peripheral action Eligible for Special Authority if needed to augment effect of primary anti-androgen	2.5 mg po every other day
Alternative: not using a blocker A higher dose of estradiol may effectively suppress testosterone production	Maintain oestrogen levels in sufficiently high range

It is important to review risks, benefits and potential side effects with patients prior to initiating treatment. There is variation in practice among healthcare providers regarding dosing for hormone initiation, hormone maintenance and ordering lab work, and much of the decision-making depends on the clinical situation.

Trans Care BC (2018 p. 10) recommends the following risk considerations, dose titration and goal of therapy.

■ **Risk considerations:** Contraindications to oestrogen therapy may include unstable cardiovascular disease, active hormone-sensitive cancer, end-stage liver disease and allergy. Many patients choose to begin or continue hormone therapy in spite of higher risks. In such cases, care providers should do a careful informed consent process that takes into consideration the capacity of the patient to make an informed decision and the significant harm that can come from withholding treatment.

■ **Dose Titration:** Titrate dose of oestrogen and androgen-blocker q 4-6 weeks until maintenance dose is achieved (e.g. 2 mg estrace + 50 mg spiro x 4-6 weeks, then 3 mg estrace + 100 mg spironolactone x 4-6 weeks, then 4 mg estrace + 150 mg spironolactone x 4-6 weeks, etc.) A slower titration rate may be preferred by some patients or may be chosen based on clinical indication.

■ **Goal of therapy:** To maintain testosterone levels in the female range, oestrogen levels in the 300-800 pmol/L range, minimize side effects and maintain expected rates of physical changes (degree of change influenced in part by patient preference).

Recommendations are adapted from Trans Care BC (2018 p. 10-11) for lab monitoring, follow up visits, managing side effects of oestrogen/testosterone-blocker, screening and health promotion as follows:

Lab monitoring:

Request the lab to report female reference ranges

Baseline and annually thereafter	■ Total testosterone, CBC, ALT, fasting glucose, lipids, prolactin and if on spironolactone: CR and electrolytes
Following dose changes and 4-6 weeks after gonadectomy	■ Total testosterone, estradiol, ALT, and if on spironolactone: CR and electrolytes

Areas for review in follow up visits:

Subjective	Objective
■ Effects of hormones: physical, emotional ■ Current dose/desire for dose change ■ Side effects/concerns ■ Mental health: mood, body image, libido ■ Social: significant others, support, acceptance, safety, housing, finances ■ Lifestyle: exercise, nutrition, smoking, substance use	■ Blood pressure ■ Weight (baseline and q 6 months prn) ■ Mental status (brief assessment) ■ Cardiovascular and abdominal exam (baseline and yearly) ■ Labs ■ Other investigations as indicated

Managing side effects of oestrogen, screening & health promotion

Managing side effects of Oestrogen/Testosterone blockers and other common	
Persistent dizziness/postural hypotension	Caused by spironolactone, usually temporary and mild If severe or persistent switch to cyproterone. See Medication table for Special Authority eligibility
Low libido	Consider maintaining testosterone at higher level Trial of progesterone
Difficulty having/maintaining physical arousal (erections)	Consider maintaining testosterone at a higher level Trials of phosphodiesterase Type 5 inhibitor (Cialis®, Viagra®)
Elevated prolactin	Common and typically benign with oestrogen therapy. Some guidelines recommend routine measurement of prolactin while others do not Consider pituitary imaging if level is >80 mcg/L or if symptomatic (headaches, visual changes, excessive galactorrhoea)
Elevated transaminases	Usually transient unless another cause of hepatic dysfunction identified
Increase in and/or malodorous vaginal dischargepost-vaginoplasty	The lining of the vagina is created from inverted penile/scrotal skin (squamous epithelium) and oral antibiotics are therefore usually ineffective at treating bacterial overgrowth. Use intravaginal metronidazole gel bid and plain water douching until symptoms resolve See Appendix G - Sexual health screening for direction on how to assess vaginal symptoms post vaginoplasty

Screening

Cardiovascular risk	Oestrogen may increase cardiovascular risk. If using a risk calculator, use female scores if hormones were started early in life, male scores if hormones were started later (or both to estimate range)
Breast cancer	Average risk, oestrogen use >5 years & ages 50-74: as per BC Cancer Breast Screening guidelines Higher risk (e.g. positive family history, BMI > 35, progestin use) - consider early or more frequent screening, refer to BC Cancer Breast Screening guidelines for higher than average risk
Osteoporosis	Screen as per national guidelines (ages 65 and up) or earlier if higher risk. For example: ■ long-term low levels of oestrogen post gonadectomy, or ■ long-term use of androgen blocker without oestrogen Encourage vitamin D and calcium intake and exercise. Maintain hormone therapy post-gonadectomy.
Colon cancer	Screen as per BC Cancer Colon Screening guidelines
Prostate cancer	Long term androgen suppression likely lowers the risk of prostate cancer but as per BC Cancer, providers should discuss the benefits and limitations of the PSA test with patients between the ages of 50-70. PSA may be less reliable/falsely low in low androgen settings. The prostate is not removed during vaginoplasty/vulvoplasty - if indicated, assess the prostate with a digital vaginal exam via lower aspect of anterior vaginal wall. Screen as per BC Cancer Colon Screening guidelines
Sexual health	Some trans people may be at higher risk for sexually transmitted infections (STIs) including HIV and syphilis. Screen for STIs and consider HIV pre-exposure prophylaxis based on patient-specific risk factors. See Appendix G - Sexual health screening

FERTILITY

Feminizing hormone therapy can impact fertility, and it's advisable to address fertility decisions before starting treatment. Long-term hormone use increases the risk of permanent infertility. Even

after discontinuing therapy, the

testicles may not fully recover, potentially affecting natural conception. For those desiring biological children, sperm cryopreservation (freezing sperm before therapy) is recommended

What to expect from feminizing hormone therapy

Trans Care BC (2018) identifies some physical changes over time after beginning feminizing hormone therapy.

Testosterone-related changes may include:	Expected onset	Expected maximum effect
* Breast growth	3-6 months	2-3 years
* Smaller genitals (testes)	3-6 months	2-3 years
Decreased fertility	Variable	Variable
Fat redistribution and potentially weight gain or loss	3-6 months	2-5 years
Decreased muscle mass	3-6 months	1-2 years
Mood changes	Variable	Variable
Decreased spontaneous genital arousal (erections)	1-3 months	3-6 months
Changes to sex drive, sexual interests or sexual function	Variable	Variable
Skin changes including softening & decreased oiliness	1-6 months	Unknown
Decreased growth of body & facial hair	6-12 months	3 years
Decreased scalp hair loss (balding)	No regrowth, loss stops 1-3 months	1-2 years

**Change is permanent and will remain even if hormone therapy is stopped*

Reproduced from: Trans Care BC (2018, p.24-25)

PATIENTS ON PREEXISTING GAHT WHEN ENTERING CARE

GAHT plays a crucial role in the well-being and gender affirmation of transgender individuals. When patients with preexisting GAHT seek healthcare services, healthcare providers must navigate specific considerations. Guidelines by Fenway Health (2024) put forward some considerations.

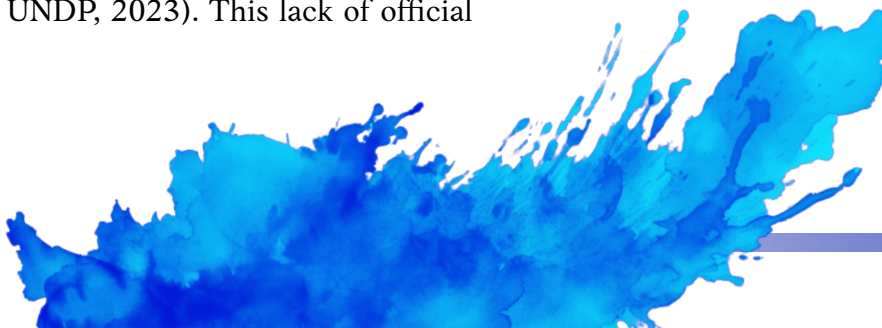
Patients who are transitioning their hormone therapy from a former healthcare provider or facility to a new one should experience no interruption in their treatment. Healthcare providers must strive to maintain the continuity of established care, ensuring it is both responsible and medically appropriate. Those moving their care are encouraged to present records of their past treatments or authorize the new provider to obtain these records, guaranteeing optimal ongoing care.

Continuation of hormone therapy is crucial, barring any significant medical or psychological reasons for cessation. During the initial medical assessment, healthcare providers will confirm the suitability and safety of the hormone therapy dosages and types for each patient. Additionally, they will determine the necessity for regular monitoring through physical exams and lab tests to ensure the patient's well-being.

In Jamaica, transgender individuals face significant challenges when it comes to accessing GAHT and gender-affirming surgeries. The Jamaican healthcare system does not currently provide state-funded access to HRT or gender-affirming surgeries for transgender individuals (J-FLAG, 2016; UNDP, 2023). This lack of official

support leaves many trans persons without a formal pathway to medically supervised care. Due to the absence of accessible and affordable options, some transgender individuals resort to self-medication. Self-medication involves obtaining hormones from non-official sources (such as online platforms or acquaintances) without proper medical guidance. This practice puts trans individuals at risk of both underdosing (not receiving adequate hormone levels) and overdosing (excessive hormone intake). Underdosing can lead to inadequate gender affirmation and persistent dysphoria, while overdosing can cause health complications. Overdosing may lead to adverse effects such as blood clots, cardiovascular issues, and liver damage. Without proper monitoring, patients may miss out on necessary adjustments to their hormone regimen (Fenway Health, 2024).

In such instances, Fenway Health (2024) recommends that the healthcare provider evaluate whether the medications being taken are safe and suitable. To minimize risks, the healthcare provider might opt to maintain the individual's current regimen of gender-affirming hormones without any gaps ("bridging therapy"), while also overseeing lab tests as needed, and gradually take on the role of prescribing GAHT. Patients transitioning care should undergo a thorough evaluation similar to new patients, including a detailed medical history, physical exam, and any necessary lab tests, along with receiving comprehensive information to give informed consent.



GAHT FOR NONBINARY/ GENDERQUEER INDIVIDUALS

Individuals who identify as nonbinary or genderqueer may seek hormone levels that are intermediate between typical male and female physiological levels, or they may opt for a temporary use of gender-affirming hormones. Fenway Health (2024) indicates that the process of prescribing GAHT and determining the appropriate dosage is a collaborative one, involving thorough conversations with the patient. It's crucial to establish clear objectives and manage expectations realistically, considering the distinct and often unpredictable effects of hormone therapy on each person. The practice of microdosing, which involves administering low or limited quantities of testosterone or oestrogen, is sometimes adopted to support one's gender identity. While commonly associated with nonbinary or genderqueer individuals, microdosing can be beneficial for anyone seeking to align their hormonal profile with their intricate gender identity.

Microdosing is not a one-size-fits-all method; it represents a personalized strategy in hormone therapy prescription. Typically, the initial doses are kept minimal and are meticulously supervised by both the patient and healthcare provider to confirm the medication's alignment with the patient's identity and to prevent any unwanted changes. It is crucial to have a pre-prescription discussion to convey the unpredictability of the outcomes and the rate at which they may manifest on hormone therapy for each person. Discussing the potential permanence of certain changes is essential, as well as the fact that it may not be feasible to customize hormone plans to select specific changes while avoiding others. The choice to discontinue hormone therapy should always be available to patients if they determine that the medication no longer supports or aligns with their identity (Fenway Health, 2024).

For some, initiating treatment with doses lower than the standard and gradually increasing them may be preferable. This gradual approach can offer comfort, reduce anxiety, and grant patients more control over their treatment journey. A secure yet adaptable dosing strategy ought to be communicated to all patients as part of the informed consent process when starting hormone therapy (Fenway Health, 2024).



SPECIAL CONSIDERATIONS DURING GAHT

Callen-Lorde (2024, p.20) put forward the following special considerations for patients undergoing gender-affirmation hormone therapy.

1. Hormone-Experienced Patients

- To minimize interruption in hormonal transition, patients who have been on hormones for more than 50% of the last two years can be prescribed hormones at the end of the first intake visit, after completing the informed consent forms and having baseline laboratory tests drawn.
- Ongoing engagement in preventive health services should be strongly encouraged.

2. Patients who have undergone gonadectomy (removal of the testes or ovaries)

- Transwomen/MTF: Lower doses of oestrogens are recommended, usually half of the dose used before surgery, e.g. 1-2 mg estradiol daily. Anti-androgens (spironolactone) can be stopped, although clients may wish to continue dihydrotestosterone blockers if androgenic hair loss continues.
- Transmen/FTM: Testosterone doses can be maintained at usual levels.
- All clients: Monitor bone density, especially in clients with risk factors or who have stopped hormone therapy.

3. Clients over 45 years/smokers

- Oral oestrogens confer an increased risk of thromboembolic disease. Transdermal or parenteral routes are preferred over oral oestrogen. Conjugated oestrogen (e.g., Premarin®) is not recommended.
- Consider addition of aspirin.

4. HIV infection

- HIV disease is not a contraindication to hormone therapy.
- Most antiretrovirals can be used safely although unboosted amprenavir (Agenerase®) or fosamprenavir (Lexiva®) are not recommended for coadministration with oestrogens due to a decrease in amprenavir serum concentrations.
- Screen for osteoporosis in accordance with current prevention guidelines for HIV-infected individuals. Monitor vitamin D levels and replace if low.
- Consider monitoring estradiol levels when initiating or changing anti-retroviral therapy.
- Consider addition of aspirin.

5. Screening Guidelines

Patients may avoid regular physical examinations and screening procedures due to fear of discrimination, encountering providers who are inadequately trained in transgender health, or personal discomfort with their physical bodies. There are no national screening guidelines transgender-specific for clients receiving hormones.

Standard screening guidelines should be followed for the natal sex, with the following additions:

- Patients who have undergone vaginoplasty (either penile inversion or colo-vaginoplasty) do not have a cervix, therefore a Papanicolaou test is not required. An annual examination should be done with the goal to detect problems such as granulation tissue, ulcers and other skin lesions.
- Transmen/FTM who have undergone bilateral mastectomy may still have breast tissue remaining. Conduct an annual clinical chest exam. The decision for mammography according to natal guidelines should be discussed with the client.
- Transwomen/MTF on oestrogen, who have no known increased risk of breast cancer, should follow breast screening guidelines recommended for natal females.
- The rates of osteoporosis may be increased in transwomen. Follow screening guidelines for natal females.

CARE PLANNING FOR MEDICAL OR SURGICAL INTERVENTIONS

Primary care providers play a crucial role in supporting patients with care planning for gender-affirming interventions, such as hormone therapy or surgery. In addition to confirming a diagnosis of gender incongruence, several preparatory steps are necessary to ensure safe and appropriate treatment. While assessment by a psychologist or psychiatrist is not universally required, primary care providers should evaluate both mental and physical health during care planning. Referrals to specialists may be necessary based on individual needs. Care planning typically occurs over multiple visits, considering factors like available time per visit, the clinical context, and the clinician's experience (Trans Care BC, 2018).

The checklist below outlines essential considerations and steps involved in care planning for medical or surgical interventions.

Care planning for medical or surgical interventions:

- Review gender identity and experience of gender incongruence (see pages 22, 23)
- ☐ Discuss overall gender-affirmation goals (immediate, long-term, etc.) (Appendix A)
- ☐ Discuss hopes & expectations of proposed treatment(s)
- ☐ Confirm diagnosis of gender incongruence and exclude rare differential diagnoses (e.g. delusional disorder, body dysmorphic disorder)
- ☐ General medical intake (complete medical history, family history etc.)
- ☐ Review of relevant health records
- ☐ Discuss contraindications & risk mitigation
- ☐ Discuss treatment in detail, including permanence, potential benefits, risks & complications
- ☐ Discuss the following where applicable: potential impacts on chest feeding, fertility, need for contraception & other sexual considerations
- ☐ Confirm patient has the capacity to consent to the proposed treatment(s)
- ☐ Review relevant patient handouts & resources
- ☐ Review recommendations for monitoring and health screening
- ☐ Discuss support system(s), planning related to work or school & housing
- ☐ Refer for psychological assessment, counselling or peer support (based on initial evaluation or if assessment is beyond scope of healthcare provider)
- ☐ Discuss potential costs

Hormone Therapy	Surgery
□ Baseline blood work □ Review potential side effects □ Review and sign consent form(s) (see Appendices E, F, H)	□ Review potential need for revisions □ Complete the relevant Surgical Recommendation form or refer for surgical care planning □ Complete the surgical referral (see Appendix I)

Adapted from: *Trans Care BC* (2018, p.4-5)

SURGICAL CARE PLANNING

Some trans individuals benefit from gender-affirming surgery. Gender-affirming surgeries encompass both masculinization and feminization procedures, which can be further categorized into genital and non-genital surgeries (such as facial and chest surgeries). Genital surgery is often considered the final and most significant step in the treatment process for gender dysphoria. While some patients find relief without undergoing surgery, for many others, surgery is essential and medically necessary to alleviate their gender dysphoria (Andromedic Academy, 2023).

To access surgery, a “surgical recommendation” is required in addition to the surgical referral. This recommendation confirms that the patient meets the World Professional Association for Transgender Health (WPATH) criteria and is psychologically prepared, adequately supported, and has a plan for successful recovery after surgery (Trans Care BC, 2018). The UCSF (2016) provides a template for surgical referral (see Appendix I). For upper surgeries and gonadectomy, care planning can be provided within a primary care setting. Once the surgical recommendation is complete, healthcare providers can proceed with referring the patient for surgery.

Criteria for surgery

To qualify for gender-affirming surgery, individuals typically need to meet specific criteria that are guided by the World Professional Association for Transgender Health (WPATH) Standards of Care. These standards ensure evidence-based care and informed decision-making. These criteria for surgery are as follows:

Criteria for surgery:

- Gender incongruence is marked and sustained
- Meets diagnostic criteria for gender incongruence and other possible causes of apparent gender incongruence have been identified and excluded
- Demonstrates capacity to consent for the specific gender-affirming surgical intervention
- Understands the effect of gender-affirming surgical intervention on reproduction and reproductive options have been discussed
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, risks and benefits have been discussed
- Stable on gender-affirming hormonal therapy (minimum 6 months for genital surgery & minimum 18 months for breast construction surgery, unless not desired or is medically contraindicated)

***Note that these are only guidelines and healthcare providers should continue to apply clinical judgment. While these criteria are specific to adult care, surgery may sometimes be appropriate for older adolescents. Please see the section on working with trans youth for further discussion**

Adapted from: Trans Care BC (2018, p.12)

For certain surgeries, additional criteria may include undergoing feminizing or masculinizing hormone therapy and living continuously for one year in a gender role that aligns with the patient's gender identity. If patients with gender dysphoria also have severe psychiatric disorders, efforts should be made to improve these conditions with psychotropic medications and/or psychotherapy before planning surgery. A re-evaluation by a mental health professional should be conducted after treatment and before surgery. Surgeries should not be performed on patients who are actively psychotic (Andromedic Academy, 2023). During an interview with a local surgeon, they recommend that a psychological assessment is needed to determine patients' eligibility for surgery given the irreversible nature of these surgeries. Surgeons need to understand each patient's history and maintain close communication with other healthcare professionals involved in the patient's care. Once the surgeon confirms that the criteria for a specific surgery are met, they should

consider surgical treatment and conduct a preoperative consultation. During this consultation, the surgeon should thoroughly discuss the procedure and postoperative course with the patient. This includes explaining the different surgical techniques available, their advantages and disadvantages, the limitations of achieving ideal results, and the inherent risks and possible complications of each technique (Andromedic Academy, 2023).

These discussions form the foundation of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. It is crucial to ensure that patients have realistic expectations of the outcomes to effectively alleviate their gender dysphoria. All relevant information should be provided to patients in writing, well in advance, allowing them ample time to review and understand it thoroughly. Given the irreversible nature of these surgeries, it is essential to ensure that patients have sufficient time to fully comprehend the information before giving their informed consent (Andromedic Academy, 2023).

OVERVIEW OF GENDER-AFFIRMING SURGERIES

Gender affirmation surgery refers to procedures that help people transition to their preferred gender. These surgeries aim to align the body with an individual's gender identity, addressing gender dysphoria.

Masculinizing surgery	
Type of care	Description
Mastectomy	Removal of breast tissue and creation of a flatter and/ or more sculpted chest.
Hysterectomy +/- Salpingo-oophorectomy	Removal of uterus, ovaries, and fallopian tubes. May eliminate the need for pap tests. Eliminates risk of ovarian, uterine, and cervical cancer. Prevents monthly bleeding.
Erectile tissue release	Creation of a penis by surgically releasing the erectile (clitoral) ligaments from the pubis.
Metoidioplasty	Creation of a penis using erectile release +/- the following: urethral lengthening, vaginectomy, scrotoplasty & testicular implants.
Phalloplasty	Creation of a penis +/- the following: urethral lengthening, vaginectomy, scrotoplasty & testicular and/or penile implants.
Facial surgery	May include alterations to the facial bones, cheeks, forehead, nose, hairline and areas surrounding the eyes, ears, or lips.
Voice surgery	Alteration of vocal fold mass and/or tension to elevate pitch.
Liposuction or lipofilling	Removal or transfer of body fat to achieve desired body contour.
Pectoral augmentation	Implants placed beneath pectoral muscles to increase size and projection of muscles.

Adapted from: Trans Care BC (2018, p.13-14)

GENITAL SURGERY

Total hysterectomy, salpingo-oophorectomy and vaginectomy

A total hysterectomy with salpingo-oophorectomy involves the removal of the uterus, cervix, ovaries, and fallopian tubes. This procedure can be performed using various techniques, including laparoscopic, abdominal, and vaginal methods, all typically carried out by gynaecologists. A vaginectomy involves the removal of all or part of the vagina. This procedure is performed through colpocleisis, which includes the ablation of the vaginal epithelium with electrocautery, followed by the closure of the vaginal lumen and the placement of a drain. Undergoing a hysterectomy with salpingo-oophorectomy results in irreversible reproductive sterilization. This procedure can be done separately or in conjunction with metoidioplasty or phalloplasty (Andromedic Academy, 2023).

Metoidioplasty

Metoidioplasty is a procedure to create a phallus by increasing the length of the clitoris using a genital tissue. Metoidioplasty takes advantage of enlarging effect of testosterone on the clitoris and results in a small phallus. The length of phallus is dependent on how much clitoral growth testosterone has caused. Because of the small size of phallus best result can be achieved if patients are close to their ideal weight before surgery. Before procedure a vaginectomy need to be performed to create an anatomically male perineum. The testosterone enlarged clitoris is freed from labia minora and a suspensory ligament.

Urethra needs to be extended through released clitoris using a buccal mucosa graft (typically taken from the lining of patient's mouth) and genital flaps. Genital tissue is wrapped around the released clitoris to transform it into a phallus. Scrotoplasty and insertion of testicular implants is done during the operation. All these steps of metoidioplasty procedure can be performed in one stage (clitoral release, urethral lengthening, scrotoplasty, insertion of testicular implants, vaginectomy with perineoplasty)

After metoidioplasty, a tube placed in urethra and suprapubic bladder catheter to

collect urine are necessary. Recovery might take up to two-three weeks.

This procedure will make standing voiding possible. A penis created by this procedure has length of between 3 and 8 cm, but full sensation and orgasmic function are retained. Metoidioplasty does not produce obvious surgery scars. Penetration probably will not be possible because of small phallus. If a patient wants penetrative intercourse, the total phalloplasty with penile implants, as staged procedures, needs to be performed.

Many patients will benefit from a plastic surgery procedure called pubic lift or mons resection. In this procedure fat from the pubic mound is removed and the phallus is pulled into a higher, more natural-looking position.

Complications of procedure include migration and/or extrusion of testicular implants, urethral fistula or stricture, infection.

Recovery time and resuming of normal activities

After surgery patient could experience some discomfort, swelling and bruising, which can be minimized with rest and pain medications. Daily medical check-ups are necessary. After four to six weeks most patients are ready to return to all activities.

Reproduced from: Andromedic Academy (2023)

Phalloplasty (Total Phalloplasty)

Phalloplasty is a procedure to create a neopenis using an extragenital tissue. The final goal of phalloplasty is male appearance of genitals with full sexual and voiding function. Typically, penetrative sexual intercourse and voiding in standing position could be achieved in three stages. First stage is creating of the neophallus (with or without vaginectomy and hysterectomy), second stage is urethral joinup, scrotoplasty with testicular implant and glansplasty; and finally, third stage is insertion of penile prosthesis. Some steps in these stages may differ.

Surgical procedures used for creating a neophallus are divided into pedicle flaps and free flaps. Pedicle flaps are used from the thigh, groin or lower abdomen and free flaps involve transfer of tissue from a remote location, such as forearm or patients back (latissimus dorsi), and microsurgical anastomosis with vessels and nerves at the recipient site.

Grafted tissue and skin from other parts of the body will be rolled into the shape of a penis and anchored into proper position. Also, urethral lengthening trough neopenis, grafting of nerves and blood vessels to provide sensation in neopenis are needed. Glansplasty (creating the penile glans), scrotoplasty and insertion of testicular implants are done during same or the following operation. Before procedure a vaginectomy (and hysterectomy, if not done previously) need to be performed to create an anatomically male perineum. These procedures cause significant scarring (contrary to metoidioplasty), particularly at the donor site of the flap.

Radial forearm free flap phalloplasty

The radial forearm free flap is the most often used technique for phalloplasty. Forearm skin with subcutaneous tissue (including radial artery, venae comitantes, cephalic vein, lateral and medial antebrachial cutaneous nerves) is used to create the phallus and urethra. Constructing a neourethral tube over catheter and multiple layer closure of neourethral tube is completed on forearm by “tube within a tube” technique. Also, neoglans could be created simultaneously by folding back wings over a de-epithelialized portion of shaft of the phallus, while phallus is steel attached to forearm blood vessels. After de-attaching of the created phallus with neourethra from forearm donor site microsurgical skills are necessary to create anastomosis between blood vessels and nerves of thigh recipient site. The dorsal clitoral nerves and the femoral artery and veins needs to be identified for micro-anastomosis. Procedure is the single stage and allows a sensate phallus and glans penis. The disadvantage of procedure is the visibility of the donor site on the forearm, limited volume of the neophallus and high rate of urethral complications (urethral stenosis and fistulas). Urethral join-up and insertion of penile implants are performed in following stages.

Forearm Flap Phalloplasty Stage 1: Phallus Creation

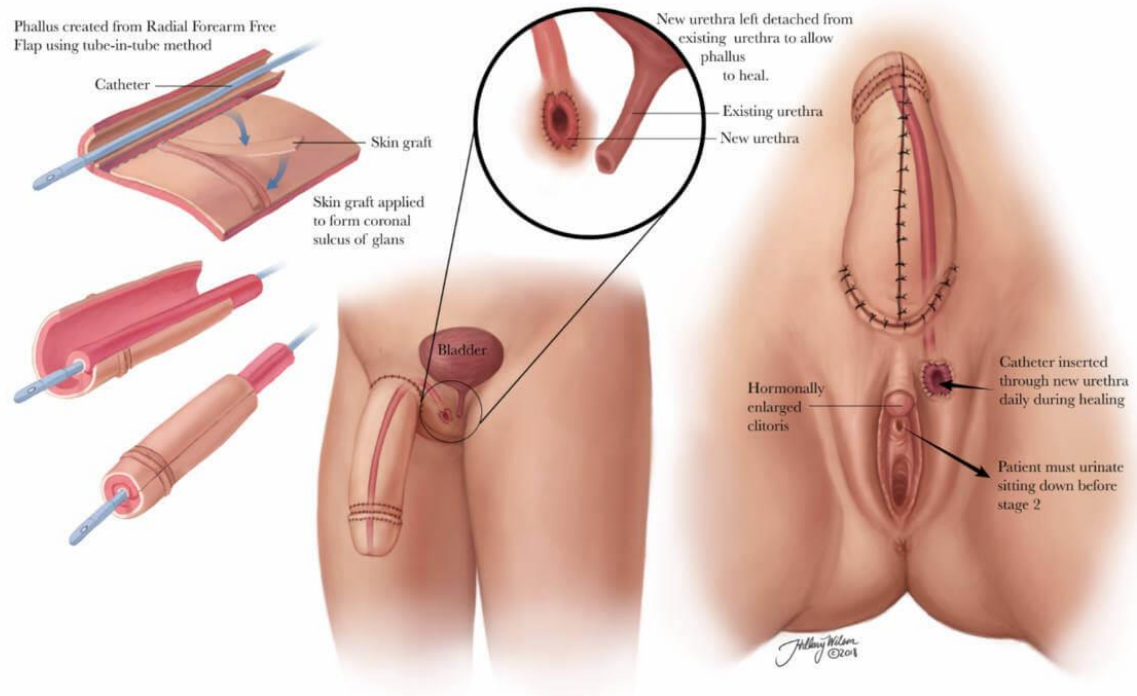


Figure 2: Forearm Flap Phalloplasty – Stage 1: Phallus creation Reproduced from: John Hopkins Medical Center (2024)

Forearm Flap Phalloplasty Stage 1: Urethral lengthening and scrotoplasty

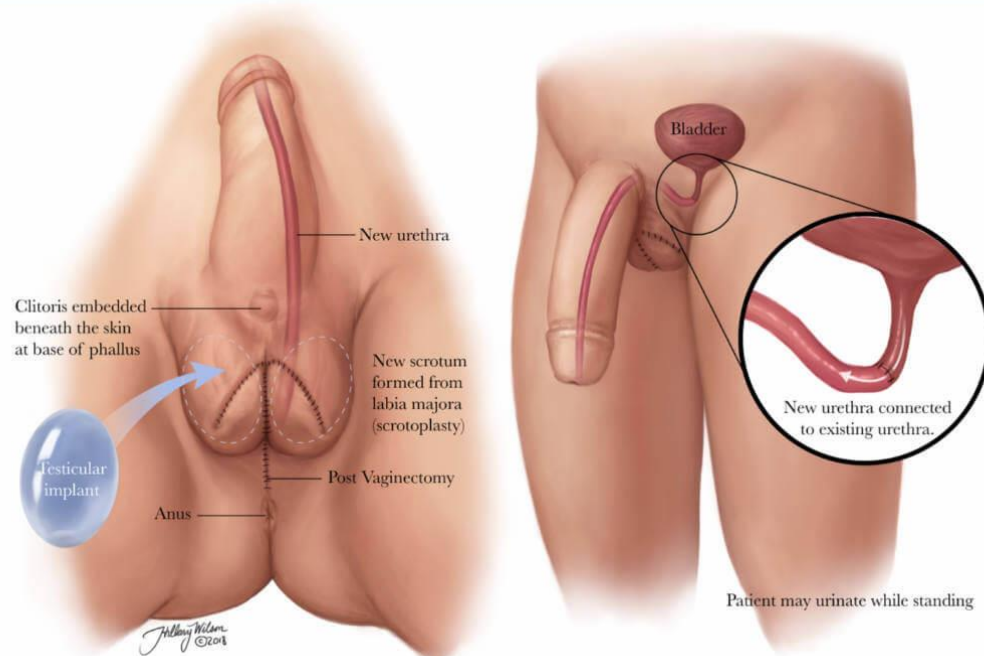


Figure 3: Forearm Flap Phalloplasty – Stage 2: Urethral lengthening and scrotoplasty Reproduced from: John Hopkins Medical Center (2024)

Forearm Flap Phalloplasty Stage 1: Penile Prosthesis

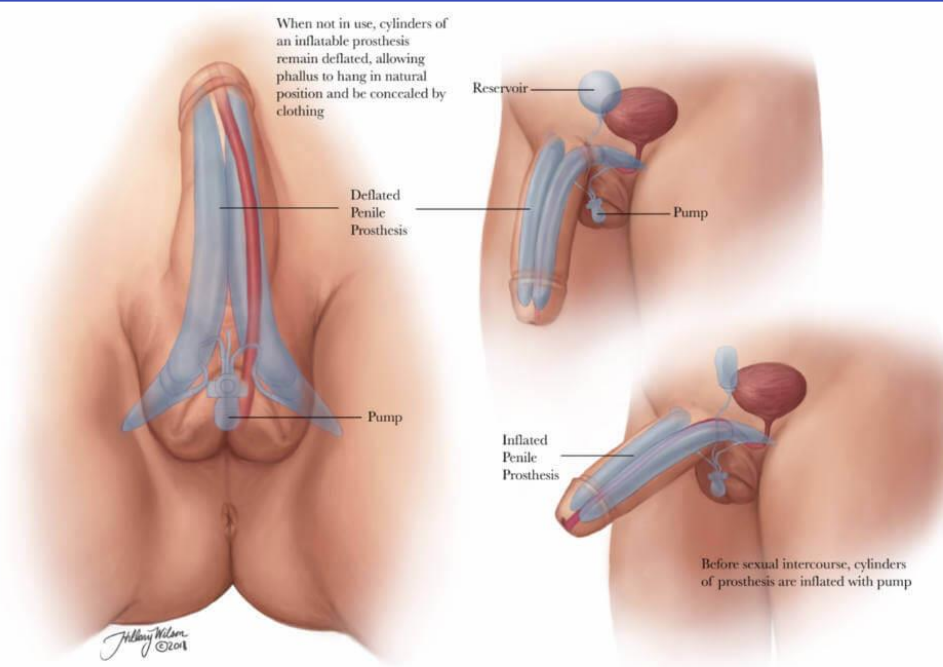


Figure 4: Forearm Flap Phalloplasty – Stage 3: Penile Prosthesis Reproduced from: John Hopkins Medical Center (2024)

Latissimus dorsi musculocutaneous flap phalloplasty

Latissimus dorsi musculocutaneous flap phalloplasty with urethral lengthening consists of creating a neophallus using part of skin from patients back with part of muscle latissimus dorsi. The flap is harvested from non-dominant side and tubularized. Microvascular anastomosis is created between thoraco-dorsal vessels and femoral artery and saphenous vein. After neophallus is positioned adequately the creation of neourethra is performed by combining genital flaps. The clitoris is fixed to the ventral base of the neophallus.

The advantages of procedure are acceptable cosmetic outcome (the donor site scar is less visible and more easily concealed), good volume of neophallus, and voiding while standing. The main disadvantage is less sensitive phallus and thick skin on the neophallus. There is high rate of urethral complications (urethral stenosis and fistulas), as in all phalloplasty procedures. Creating of glans and insertion of penile implants are performed in following stages.

Abdominal phalloplasty

Abdominal phalloplasty is a one-stage procedure which results in an adult-sized phallus. Procedure uses a pedicled abdominal flap that is tubed to create the phallus. The lower abdominal arteries, veins and nerves are preserved in the flap,

providing good blood supply, tactile and temperature sensation. There is a scar after procedure across the pelvis. The advantage of the procedure is less demanding surgery since there is no need for microvascular anastomosis, but the neophallus is sometimes smaller and cannot fit the penile implant.

After phalloplasty

After phalloplasty, a tube placed in urethra and suprapubic bladder catheter to collect urine are necessary, for two and three weeks respectively. After surgery patient could experience some discomfort, swelling and bruising, which can be minimized with rest and pain medications. Daily medical check-ups are necessary. After six to 12 weeks most patients are ready to return to all activities.

A penile implant will be needed in following stage to enable penetrative sexual intercourse, because neopenis is not erectile.

Many patients will benefit from a plastic surgery procedure called pubic lift or mons resection. In this procedure fat from the pubic mound is removed and the phallus is pulled into a higher, more natural-looking position.

Phalloplasty carries a high rate of complications and might require many follow-up surgical procedures. Complications can include tissue necrosis, migration and/or extrusion of testicular implants; infection.

Reproduced from: Andromedic Academy (2023)

Feminizing surgery

Type of care	Description
Breast construction	Implantation of prosthesis to enhance size and shape of breasts
Orchiectomy	Removal of testes. Eliminates need for testosterone blocker
Vaginoplasty	Creation of vagina and vulva (including mons, labia, clitoris, and urethral opening) and removal of penis, scrotum, and testes.
Vulvoplasty	Creation of vulva (including mons, labia, clitoris, and urethral opening) and removal of penis, scrotum, and testes.
Facial surgery	May include alterations to the facial bones, cheeks, forehead, nose, hairline and areas surrounding the eyes, ears, or lips.
Tracheal shave	Reduction and reshaping of thyroid cartilage.
Liposuction or lipofilling	Removal or transfer of body fat to achieve desired body contour.

Adapted from: Trans Care BC (2018, p.13-14)

GENITAL SURGERY

Orchiectomy

Orchiectomy is a surgical procedure that involves removing both testicles. This can be done through an incision in the scrotum or the groin. After an orchiectomy, testosterone blockers are not needed, and the amount of oestrogen is reduced. This procedure is usually performed as part of the surgery for vaginoplasty. Post-surgery, patients may experience pain, swelling, and bruising. Recovery time varies, but most patients can resume normal activities within a few weeks (Andromedic Academy, 2023).

Vaginoplasty

Vaginoplasty is a surgical procedure to create a neovagina that is functional, aesthetically feminine, and capable of normal voiding and satisfactory sexual function, with minimal scarring. Ideally, the neovagina should be moist, flexible, hairless, and at least 10 cm in depth and 3-4 cm in diameter. Two common techniques of creating neovagina are the penile inversion and recto-sigmoid procedure (Andromedic Academy, 2023).

Penile inversion vaginoplasty

The penile inversion vaginoplasty procedure involves creating a neovagina using the skin and tissue from the penis and scrotum. During the penile inversion procedure, a cut is made in the area between the rectum and the urethra and

prostate. Skin from the penile shaft is inverted to form the vaginal canal, while skin from the scrotum is utilized for labiaplasty (creating the labia). For clitoroplasty (creating a clitoris), a part of the glans of the penis and the neurovascular bundle that supplies it are used to create a clitoris, ensuring sensitivity. The penile corpora cavernosa is removed during the procedure. If there is insufficient penile skin, scrotal skin flaps can also be used to create the vagina. If there's not enough penile or scrotal skin, skin from another area of the body may be used for the neovagina as well (see Image 4). In most cases, an orchiectomy is performed during vaginoplasty (Andromedic Academy, 2023).

Penile inversion vaginoplasty is considered the gold standard of male-to-female gender reassignment surgery, resulting in an authentic appearance with excellent depth, function, and sensation. Postoperative use of vaginal dilators for at least six months is required (Andromedic Academy, 2023).

Sigmoid vaginoplasty

Sigmoid vaginoplasty, also known as colovaginoplasty, is a surgical technique used to create a neovagina using a section of the sigmoid colon. This procedure is often chosen when other methods, such as penile inversion vaginoplasty, are not feasible such as insufficient penile or scrotal skin for the penile inversion method. Sigmoid vaginoplasty can also serve as a salvage procedure following a failed penile inversion vaginoplasty. In most cases, an orchiectomy is performed during the vaginoplasty (Andromedic Academy, 2023).

The procedure typically involves small incisions. A section of the sigmoid colon, usually 18- 20 cm long, is detached and rotated down to form the new vaginal canal. A tunnel is created from the perineum to the peritoneum, where the neovagina will be located. The remaining sections

of the colon are reconnected to maintain normal bowel function (see Image 5). The sigmoid colon naturally produces mucus, which helps keep the neovagina moist and self-lubricating.

The colon tissue is stretchy and can provide a neovagina with good depth and flexibility. The procedure aims to create a neovagina that is both aesthetically pleasing and functional. However, it is a more invasive surgery that requires a longer recovery time and carries a higher risk of serious complications, such as rectal fistula. Other potential complications include colitis, vaginal atrophy, and constipation (Andromedic Academy, 2023).

After vaginoplasty

After vaginoplasty, a catheter is placed in the urethra to collect urine. To maintain, lengthen, and stretch the neovagina, regular vaginal dilations with dilators of increasing sizes or penetrative intercourse are necessary. Recovery can take up to two months, and monitoring is needed as to when to begin sexual activity. Since the prostate gland is not removed during surgery, regular prostate cancer screenings are still necessary (Andromedic Academy, 2023).

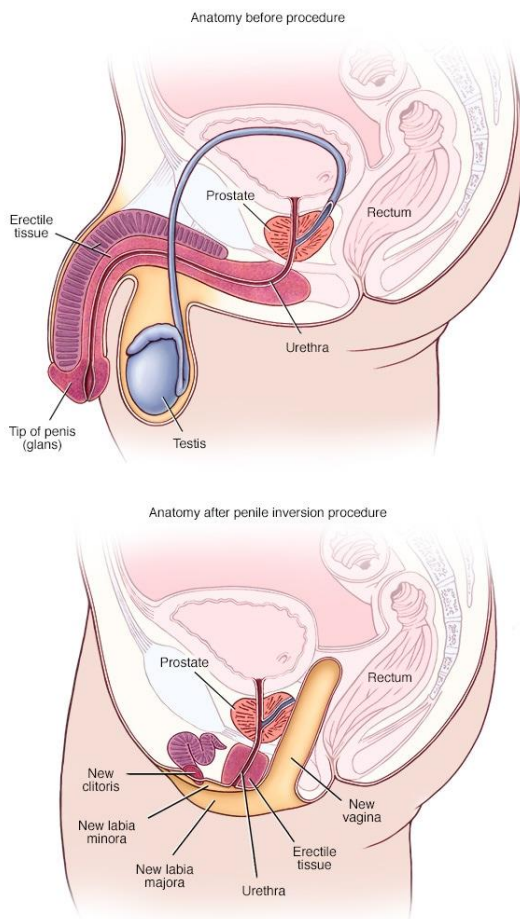


Figure 5: Anatomy before and after penile inversion

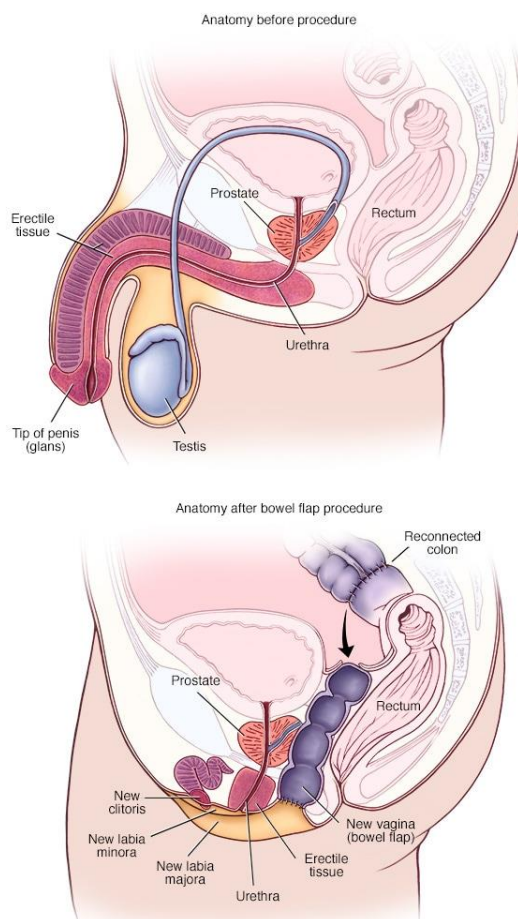


Figure 6: Anatomy before and after bowel flap procedure

Reproduced from: Mayo Clinic (2024a)

TRACHEAL SHAVE

Tracheal shave surgery, commonly known as Adam's apple reduction, is often performed as part of facial feminization surgery for trans women and non-binary individuals to achieve a more feminine appearance. This procedure is also referred to as chondrolaryngoplasty or thyroid cartilage reduction. A small, horizontal incision is made in a skin crease on the throat, in the shadow of the neck or in a skin fold to minimize the visibility of the scar. The thyroid cartilage and laryngeal prominence are then shaved down and removed (Tran Plastic Surgery, 2021).

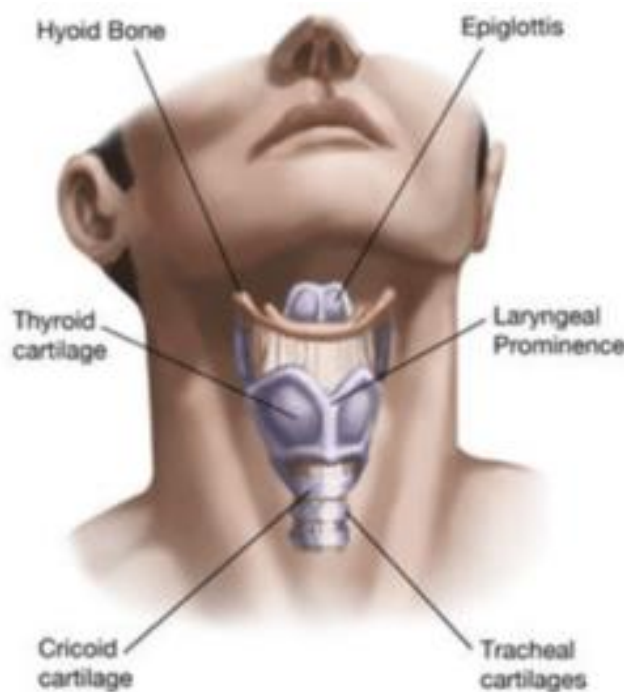


Fig. 2. Anatomy of the thyroid cartilage

Figure 7: Tracheal Shave

Reproduced from: Tran Plastic Surgery (2021)

After tracheal shave

Some pain and discomfort are expected for several days following the surgery. Post-operative side effects may include, slight pain, swelling, bruising, sore throat, weak voice, difficulty swallowing. Icing and taking prescribed medications will help minimize these side effects (Tran Plastic Surgery, 2021).





PRE, PERI, AND POST-OPERATIVE CARE

Fenway Health (2024) states that it is essential for healthcare providers to be informed about the range of surgical interventions, the intricacies of insurance policies, and the overall approval framework, along with support mechanisms before and after surgery. Although it may not always be practical for these providers to possess in-depth knowledge of every surgical procedure, a broad understanding of the different types of gender-affirming surgeries and the local surgeons who perform them is important. Establishing connections with referring entities and their staff can enhance the management and communication of patient care. Participation in professional gatherings or utilizing resources like professional provider websites, such as WPATH, can be instrumental in locating surgeons nationwide and the procedures they offer. Both medical and behavioural health practitioners should be adept at providing basic education and managing patient expectations concerning prevalent surgical procedures. Following a patient's referral for surgery, it is crucial for the referring provider to maintain open lines of communication with the operating surgeon to ensure seamless care coordination and to address any complications that may arise during recovery. Optimal surgical outcomes may be achieved through comprehensive pre-operative preparation, which encompasses the management of existing health conditions, mental well-being, and socio-economic factors. This preparation could involve improving glycaemic control, regulating blood pressure, curtailing substance consumption, and ensuring stability in mental health, housing, financial status, and

employment. Additionally, engaging in pre-operative physical therapy, especially before chest or genital surgeries, can enhance overall function and alleviate discomfort before significant surgical procedures.

Equally crucial is the post-operative care within primary healthcare settings. Healthcare providers should be adept at navigating post-surgical anatomy to evaluate and manage expected post-surgical signs, minor issues treatable on-site, or severe complications necessitating specialist intervention or surgeon consultation. Fostering connections with local experts skilled in gender-affirming procedures can greatly aid patients facing post-surgical challenges who need such referrals. Given that many patients may undergo surgery abroad or in different states, the support from local primary care and specialists becomes vital for managing complications ranging from minor to critical. Primary care teams ought to be proficient in liaising with surgeons to grasp specific post-surgical care protocols and advice. Post-surgical physical therapy also holds significant value in restoring muscle strength, enhancing flexibility, diminishing scar impact, boosting mobility, and bolstering confidence in one's abilities post-surgery. Genital reconstruction and related urological surgeries, including urethral extension, are complex procedures that necessitate extensive and often long-term postoperative care, which can span several years based on the chosen surgical techniques and any arising complications. These operations can be demanding on an emotional, psychological, and physical level, even for individuals in prime health. The post-surgery care can be quite burdensome, involving frequent dressing changes, incision monitoring, routine dilation for neovaginal procedures, and managing surgical drains, among other tasks. It's crucial for healthcare providers to set clear postoperative expectations with patients and evaluate their capacity to adhere to the care regimen after the surgery.

Before undergoing surgery, it's essential for the primary care provider or mental health professional to work closely with the patient to create a comprehensive care plan for after the procedure, which includes emotional and psychological preparation. This preparation should cover setting realistic expectations about the surgery and the necessary postoperative care, as well as making plans to address any possible complications. It's also important to discuss specific stress factors, such as financial concerns related to insurance, travel costs, and loss of income during recovery. Ensuring that the patient has a support system and a secure, clean space for recuperation is critical for safety and successful recovery. In some cases, patients may require a referral to specialized postoperative care facilities to support their healing, especially if their living conditions do not provide a safe and sanitary environment.

In primary care, various routine interventions are available to aid and control lesser complications. These can encompass evaluating and dressing wounds, replacing suprapubic Foley catheters, applying silver nitrate for granulation tissue, and addressing minor to moderate infections such as urinary tract infections, cellulitis, and abscesses. Possessing the skills to identify issues like infections, granulation tissue, urethral constrictions, wound separation, congested tissue, insufficient dilation of the neovagina, and fistulas is crucial. Such competencies facilitate the prompt recognition and immediate treatment of these conditions, which is instrumental in preventing the escalation into more severe complications.



Specific considerations: breast augmentation, orchiectomy, and vaginoplasty surgeries

Fenway Health (2024) puts forward the following surgical considerations for breast augmentation, orchiectomy, and vaginoplasty surgeries. Individuals starting estradiol therapy are often advised to delay breast augmentation surgery for at least one year, if not two, to allow for the fullest potential breast development and accurate sizing. Undergoing the procedure too soon may result in suboptimal size or shape outcomes over time. Since surgical and insurance guidelines vary, it's essential to consult with specific surgeons and insurance providers to understand their unique requirements before moving forward with surgical evaluations and referrals.

Following an orchiectomy, patients will no longer need medications to block androgens and may be able to reduce their oestrogen dosage, as it will not have to counteract natural testosterone. However, it's generally advised to maintain oestrogen therapy to support bone health until reaching the average age of menopause.

Patients who didn't achieve complete testosterone suppression with GAHT before orchiectomy might experience symptoms associated with a significant and abrupt drop in testosterone, such as fatigue or reduced libido. Typically, testosterone levels become undetectable after gonadectomy. To alleviate these symptoms, some individuals may benefit from minimal testosterone supplementation for a brief period. This can be administered through a transdermal testosterone gel, which offers controlled dosing, the ease of discontinuation, and the flexibility for patients to manage their dosage. Healthcare providers should weigh the

pros and cons of this supplemental therapy with patients, emphasizing the option to discontinue use at any point.

The reconstructed vagina, typically fashioned from penile skin, is lined with squamous epithelium instead of mucosa. Consequently, the pH balance and microbial environment of the reconstructed vagina are significantly different from a mucosal vagina, lacking lactobacilli and seldom experiencing yeast infections. Bacterial vaginosis can present with a more diverse range of bacteria, and when necessary, clindamycin is the suggested treatment.

Post-vaginoplasty, it's common to have a yellowish or brownish discharge for the first month. If this discharge or any bleeding persists, it's often due to granulation tissue at the surgical site. Healthcare providers might use instruments to check for any remaining granulation tissue, which can be treated with silver nitrate application. In rare cases where the granulation tissue is excessive and silver nitrate is insufficient, further medical consultation may be required. To preserve the depth and openness of the new vagina, consistent self-dilation is essential. Starting a few weeks after surgery, the frequency of dilation is initially high and then decreases over time. Even with regular sexual activity, ongoing dilation is advised to maintain vaginal function. Surgeons should provide and primary care providers should confirm that patients have and follow proper dilation instructions, ensuring they have the necessary support.

Infections of the wound or fistulas, leading to the leakage of urine or faeces into the newly formed vagina from the bladder or bowels, can arise at any point, even as late-stage surgical complications. Those experiencing such issues ought to consult their surgical team or seek out local experts skilled in trans healthcare when necessary. It's also not unusual for the wound to partially reopen, a condition which typically resolves on its own, healing internally to yield cosmetically satisfactory outcomes.



Specific considerations: chest reconstruction, metoidioplasty and phalloplasty

Fenway Health (2024) puts forward the following surgical considerations for chest reconstruction, metoidioplasty and phalloplasty. For most insurance providers, undergoing hormone therapy for a specific duration is not a prerequisite for chest reconstruction surgery. Primary care physicians can endorse patients for this surgery without the need for concurrent testosterone therapy by noting that hormone therapy does not align with the patient's gender identity, and that the presence of breasts is the primary source of gender dysphoria, making hormone therapy medically unnecessary. Typically, the procedure performed is a double incision mastectomy, involving two horizontal cuts across the pectoral area and the removal and resizing of the nipple-areola complex before it is reattached in a position that resembles the typical male chest. This reattachment process disconnects the nerves, leading to a loss of erotic sensation in the nipples. While some individuals may regain a degree of protective sensation, others may experience persistent numbness in the nipples or the broader chest area. Less common alternatives for masculinizing the chest, usually

suitable for those with minimal breast tissue, include the peri-areolar or “keyhole” technique, which involves liposuction and often retains nipple sensation and results in less scarring.

After chest reconstruction operations, it's fairly common for patients to experience seromas and hematomas. To mitigate fluid accumulation and swelling, surgeons may opt for post-surgery compression garments or place drains near the incision sites. Typically, these drains are removed after two weeks, but some cases may necessitate a longer period before removal by a primary care

physician, which is a straightforward process. It's beneficial for primary care providers to be familiar with the surgeon's methods and post-surgery protocol to ensure effective postoperative care coordination. Additionally, patients undergoing a double incision surgery might need further surgery to remove excess skin, known as “dog ears,” at the incision's lateral ends.

For procedures like phalloplasty or metoidioplasty, complications are reported in over 80% of cases, primarily due to urethral extension, especially where the original and new urethra connect. These complications can include infections, narrowing of the urethra, or fistulas. While some strictures may be treated with dilation or surgery, fistulas might heal independently after urinary diversion through a catheter, though surgical intervention is sometimes necessary. Addressing these issues can range from simple office visits to multiple surgeries over several years. In certain instances, patients with a stricture or fistula may choose to redirect the urethra from the neophallus to the perineum, simplifying the healing process by eliminating the need for urethral extension.

A primary care provider can support the patient by directing the types of questions they should consider asking their surgeon and by establishing achievable expectations for recovery and outcomes following surgery. In situations where the operating surgeon is not readily available, it may be advisable to consult with a reconstructive urologist who is more accessible before proceeding with genital surgical procedures.

Navigating legal and ethical considerations

In Jamaica, the legal and ethical framework for the protection of trans individuals' rights, particularly in healthcare, is an evolving landscape. Legal reforms are necessary to protect trans individuals from discrimination and stigmatization. The implementation of anti-discrimination laws in healthcare, training for healthcare providers on trans health issues, and public awareness campaigns to reduce stigma could significantly improve overall health outcomes for trans individuals in Jamaica (TransWave Jamaica, 2020).

Charter of Fundamental Rights and Freedoms

The Charter of Fundamental Rights and Freedoms Act (2011) while ensuring several legal rights for all Jamaicans, does not explicitly protect against discrimination based on gender identity or sexual orientation, which can leave trans patients vulnerable to discrimination and stigmatization. However, healthcare providers can play a crucial role in safeguarding the legal rights of trans patients. The Charter can inform healthcare providers actions.

1. Universal respect for human rights:

- The Charter emphasizes the obligation to promote universal respect for human rights.
- Healthcare providers should ensure that transgender patients receive respectful and non-discriminatory care.

2. Entitlement to fundamental rights:

- All persons in Jamaica, including trans individuals, are entitled to preserve fundamental rights.
- Providers must uphold these rights regardless of gender identity or sexual orientation.

3. Right to life, liberty, and security:

- Section 3 of the Charter addresses the right to life, liberty, and security of the person.
- Healthcare providers should protect transgender patients' safety and well-being.

4. Freedom from discrimination:

- While the Charter does not explicitly mention gender identity, it prohibits discrimination based on various grounds.
- Advocacy for explicit inclusion of gender identity protections is essential.

5. Equitable and humane treatment:

- The Charter guarantees the right to equitable and humane treatment by any public authority in the exercise of any function.
- The duty to provide equitable and humane treatment extends to all functions performed by public authorities, including those in public health spaces.

6. Trans rights as human rights:

- Healthcare providers must emphasize that trans rights are human rights.
- Advocacy efforts should focus on strengthening legal protections for transgender individuals.

Data Protection Act

The Data Protection Act (2020) aims to protect the privacy of certain data. It establishes principles for handling personal data and ensures transparent oversight across all sectors. Key provisions include the right of access to personal data, consent requirements, and standards for data controllers. Healthcare providers must comply with discreet data collection methods, keep data accurate, and address breaches. The Act can play a crucial role in safeguarding the privacy and rights of trans patients.

1. Confidentiality and Privacy:

- The Act ensures that healthcare providers handle patients' personal data confidentially.
- Trans patients' medical history, gender identity, and other sensitive information should be protected.

2. Informed Consent and transparency:

- Personal data, including health data, must be collected and processed only with explicit consent from individuals.
- For trans patients, this includes consent for medical procedures, hormone therapy, and disclosure of gender identity.
- Healthcare providers must inform patients about data usage, access, and purposes, ensuring transparency in handling sensitive information.

3. Anti-Discrimination Measures:

- The Act prohibits discrimination based on personal characteristics, including gender identity.
- Healthcare providers must treat trans patients fairly and equally.

4. Access to Personal Data:

- The Act emphasizes implementing technical measures to protect data against unauthorized access or alteration.
- Ensuring secure electronic health records and encrypted data transmission is crucial for safeguarding patient privacy.

5. Data Security Standards:

- The Act emphasizes implementing technical measures to protect data against unauthorized access or alteration.
- Ensuring secure electronic health records and encrypted data transmission is crucial for safeguarding patient privacy.

6. Data Breach Notification:

- The Act mandates reporting data breaches to the information commissioner and affected individuals.
- Transparency and prompt action mitigate potential harm, maintaining patient trust in the healthcare system.

7. Data Minimization and Purpose Limitation:

- Data collected should be limited to what's necessary for diagnosis, treatment, and care.
- For trans patients, this means collecting relevant health data without unnecessary intrusion.

Changing medical records

Sometimes doctors are asked by trans patients to change their name and/or gender on the medical record. Currently, patients have the right to change their name on medical records if they have the legal documentation to make changes, such as a deed poll, or national identification (JIS, 2024). However, patients currently do not have the legal right to change their gender on medical records (UNHCHR, 2019).

While the inability to change gender markers on medical records poses challenges, healthcare providers can still take proactive steps to foster a trans-inclusive environment.

1. **Gender identity:** To accurately capture a trans patient's gender identity, it's best to ask two separate questions: one about their current gender identity and another about their sex assigned at birth. By asking both questions, healthcare providers can gain a clearer picture of the patient's identity and medical history (see recommended questions below). This is particularly important for transgender individuals who might not select "Transgender Man" or "Transgender Woman" on forms, instead choosing "Man" or "Woman" based on their current identity. Knowing both the current gender identity and the sex assigned at birth helps in making informed clinical decisions. For example, a transgender man (assigned female at birth) might still need certain screenings like cervical cancer screening. Including options for non-binary and other gender identities ensures that all patients feel recognized and respected (UCSF, 2016).

2. **Respect preferred pronouns:** Always ask patients for their preferred pronouns. Use them consistently in interactions and documentation. This might involve using general terms for body parts or inquiring if patients have a preferred terminology (UCSF, 2016).

3. **Educate staff:** Training staff in culturally sensitive terminology and transgender topics can facilitate improved patient interactions and create welcoming clinical environments (TransWave, 2020; PAHO, 2014). Health professionals often lack training in trans health, which can contribute to barriers in providing good-quality care to trans people. Most healthcare providers have had little or no formal training in addressing the needs of transgender patients, which can lead to stigmatization, avoidance, discrimination, and prejudice (Weaver et al., 2024).

4. **Advocate for policy changes:** Collaborate with institutions to update policies. Advocate for updating gender markers on medical records (PAHO, 2014).

5. **Adjust intake forms:** Healthcare facilities can incorporate gender identity two-step questions into their intake forms or processes, accompanied by a brief description or disclaimer (see recommended questions below). This helps prevent confusion for patients to whom these questions may not be relevant. Educate healthcare staff on the importance of these questions and how to ask them sensitively (Fenway Institute, 2012).

Gender identity (two-step):

1. What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender man / Transman
- ☐ Transgender woman / Transwoman
- ☐ Genderqueer / Gender nonconforming
- ☐ Additional identity (fill in) _____
- ☐ Decline to state

2. What sex were you assigned at birth?

- ☐ Male
- ☐ Female
- ☐ Decline to state

Reproduced from: UCSF (2016, p. 18).

Disclosure of information and medical records

Respecting a person's privacy, their gender history should not be disclosed without their consent. When communicating, especially in referrals, it's essential to retain relevant information for the patient's ongoing care. However, details that reveal gender history and are unrelated to the current medical situation should not be shared. Gender history can be inferred without explicitly stating someone's trans or non-binary status. For instance, listing past surgeries incongruent with their current gender—such as gender-confirming or sex-specific procedures—may make their history evident to the reader. Caution is necessary when handling documentation, especially in automated systems that populate form sections with such data (British Medical Association, 2024).

When healthcare providers refrain from disclosing sensitive information, such as a patient's gender identity or history, it respects their privacy. This discretion can create a safer environment for trans individuals who may fear discrimination or stigmatization. By not sharing a patient's trans status without their consent, healthcare providers avoid acting as gatekeepers. Trans patients often face barriers to accessing care due to gatekeeping practices. Non-disclosure helps break down these barriers. Focusing on the patient's immediate health needs rather than their gender identity promotes patient-centered care. When healthcare providers prioritize treating the individual, regardless of their gender, it fosters inclusivity. Non-disclosure allows healthcare providers to interact with trans patients without preconceived notions. This neutrality can lead to more affirming conversations and better health outcomes (British Medical Association, 2024).



HEALTH MAINTENANCE CARE

The trans community often face greater challenges in mental health and overall wellbeing when compared to the broader population. Trans people also encounter significant challenges in receiving social and family support based on their gender identity. These are largely attributed to the discrimination, stigma, and the unique stressors associated with gender and intersecting marginalized identities. Even with the availability of some gender-affirming care and services, the persistent and overwhelming stress can have adverse effects on their social development (Fenway, 2024).

Sexual health and safety are crucial considerations for transgender individuals. Because of gender minority stress, trans people may face higher risks of emotional and psychological abuse, physical and sexual violence, sexually transmitted infections, substance misuse, and mental health challenges such as depression and anxiety (EFAF, 2023; Mayo Clinic, 2024c).

Medical considerations for binding and tucking among trans feminine patients need to be taken into account. These practices impact physical health, body comfort, and overall well-being, making thoughtful consideration crucial for safe and affirming experiences. Research show that patients avoid seeking medical care despite experiencing side effects due to fear of discrimination or lack of knowledgeable healthcare providers (Kidd et al., 2024; Jarrett et al., 2018).

Mental health care

Mental health is crucial for achieving positive physical health outcomes and should be a priority in primary care for transgender patients. However, due to pathologization by mental health professionals, trans individuals are hesitant to seek mental health care, especially among trans women (Local Endocrinologist). Primary care settings can provide a safer and more accessible environment for transgender individuals to discuss mental health concerns compared to specialized mental health services. Therefore, every intake for care should include a comprehensive mental health history and an assessment of current mental health concerns. This screening should cover primary mental health issues, environmental and social stressors, and gender-related needs. Additionally, it is essential to provide appropriate referrals to transgender- affirming mental health services when necessary (UCSF, 2016).

Organizations like TransWave Jamaica and Equality for All Jamaica have been working to provide psychosocial support and counselling specifically tailored to trans and gender non-conforming persons. These initiatives are crucial because they address the specific needs of the trans community, which often go unmet in general mental health services (UNFPA Caribbean, 2022a). Training for mental health service providers on how to address the needs of the trans community is also needed (CMHN, 2022). This training would help ensure that mental health professionals can offer culturally competent and affirming care to transgender individuals. The Caribbean Mental Health Network (CMHN) emphasizes the importance of such training to better serve diverse populations, including the transgender community.

Mental health concerns expressed by a patient should not be automatically assumed to be related to their gender identity. Trans people may seek mental health care for various reasons, including issues unrelated to their gender identity. They experience the same rates of mood disorders and other psychiatric conditions as the general population. Some individuals may seek specific assistance for gender-related issues, whereas others may require support for depression, anxiety, or other clinical concerns (UCSF, 2016). While mental health issues are a concern for the general population of Jamaica, with 80% of mental health visits to public health clinics in 2016 being due to psychosis, and depression and anxiety accounting for 3% and 4% of visits respectively, the trans community encounters additional layers of difficulty. The stigma and discrimination experienced by trans individuals can exacerbate mental health conditions, leading to higher rates of depression, anxiety, and other stress-related disorders (EFAF, 2023). Research finds that all trans men in a study indicate that they have contemplated suicide at some point, and trans men report the highest suicide attempts in comparison to other gender identities (UNDP, 2023). This is further compounded by the limited access to mental health resources, with few dedicated mental health clinics and a scarcity of psychological therapies and psychiatric medication available to the general population (EFAF, 2023).

The UCSF (2016) recommends that primary care should adopt a trauma-informed approach, recognizing that many patients have complex trauma histories involving interpersonal, social, and medical system-related experiences.

Providing trauma-informed care and training for all staff and providers can improve patient engagement and health outcomes. Machtinger and colleagues (2015) propose a theoretical framework for providing trauma-informed primary care. This framework is designed to address the needs of patients with a history of trauma, recognizing that trauma can significantly impact health outcomes.

Trauma-informed Primary Care

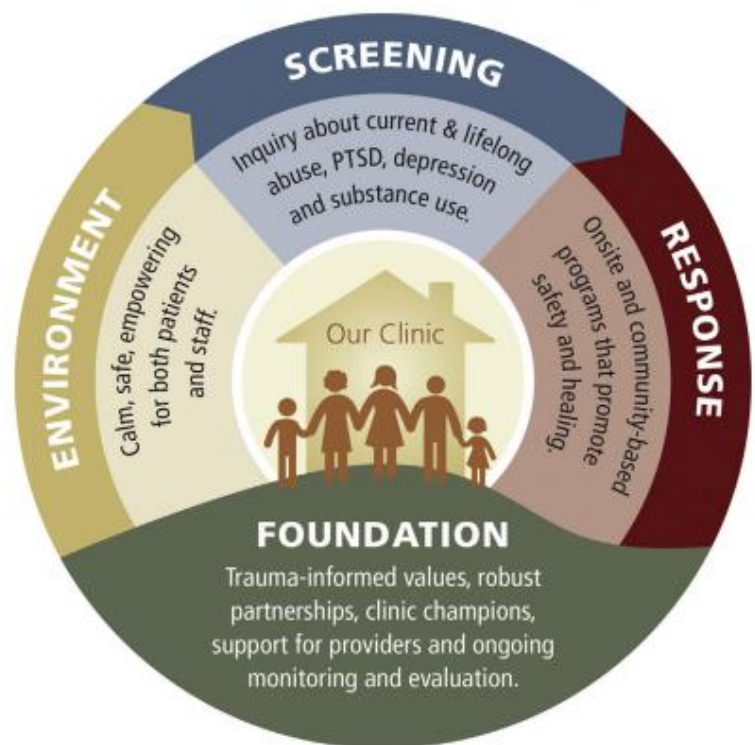


Figure 8. A framework for trauma-informed primary care

Reproduced from: Machtinger et al., (2015, p.195)



The trauma -informed primary care model proposes the need to address the following core components:

1. **Environment:** Creating a physical space that ensures privacy, confidentiality, and a sense of safety for patients.
 2. **Screening:** Routinely screening patients for trauma and being prepared to respond supportively when trauma is disclosed.
 3. **Response:** Providing a supportive response that includes safety assessments and referrals to community resources.
 4. **Organizational Foundation:** Establishing a strong organizational foundation that respects patient choices, supports staff, and fosters local partnerships.
- This approach aims to improve patient engagement and health outcomes by addressing the underlying trauma that can perpetuate health issues.

Machtinger and colleagues (2015) also emphasize the importance of creating private and confidential spaces for conducting thorough screenings in trauma-informed primary care. They recommend providing soundproofed areas for discussions, consultations, or examinations to ensure patient privacy and confidentiality. This approach helps reduce potential anxiety and confusion for patients, fostering a safer and more supportive environment.

SOCIAL AND FAMILY SUPPORT

Social support, which is vital for mental well-being, also differs significantly between the trans community and the general population. While the general population may rely on established social networks, trans individuals in Jamaica often face rejection from their families and communities, leading to isolation and a lack of familial support. This rejection can have profound implications for their mental health and overall well-being (UNFPA, 2022b). Familial support is also a critical aspect of the social support system, and it is an area where the trans community in Jamaica often finds itself at a disadvantage. The lack of understanding and acceptance from family members can lead to trans individuals being ostracized or subjected to conversion therapy attempts, further contributing to mental health struggles (Human Rights Watch, 2014). This highlights the critical issue of familial support and its impact on the mental health of transgender individuals in Jamaica. Research shows that family rejection can also lead to higher rates of attempted suicide, depression, drug use, and unprotected sexual intercourse among trans individuals (Ryan et al., 2009). On the other hand, family support during trans disclosure can foster positive outcomes, including improved self-esteem, social support, and mental health, as well as reduced depression, substance abuse, and suicidal thoughts (Padilla et al., 2014).

Initiatives that provide education and advocacy for the rights and well-being of the trans community are essential in fostering a more inclusive and supportive environment which can make a substantial difference in their overall health and resilience. Coswosck and colleagues (2023) examines the quality of life of trans individuals through the lens of social determinants of health.

The study highlights how inclusive policies and advocacy efforts can significantly improve the quality of life for trans people by addressing key areas such as healthcare access, social support, and legal protections. Access to gender-affirming treatments, including hormone therapy and surgeries, greatly improves the quality of life for transgender individuals by aligning their physical appearance with their gender identity. Having supportive family, friends, and community members is linked to lower levels of depression and anxiety, as well as higher life satisfaction. Trans individuals residing in areas with comprehensive legal protections experience better mental health outcomes and a heightened sense of safety. The study emphasizes that inclusive environments help reduce stigma and discrimination, leading to better mental and physical health outcomes for trans individuals.

Sexual health and safety

It is essential for healthcare providers to engage in discussions about sexual health with patients, ensuring such dialogue is initiated when it is suitable and received positively by the patient. Employing a trauma-informed approach grants patients control over the depth and pace of these discussions. Healthcare providers should maintain transparency regarding the rationale behind each question to foster a tailored and assumption-free environment. When the patient is receptive, the use of open-ended inquiries is recommended to embrace a broad spectrum of responses, followed

by more focused questions as needed. It's crucial to acknowledge and affirm all expressions of sexual behaviour, evaluating them beyond the scope of risk to include aspects of enjoyment (Fenway Health, 2024).

Centring these discussions on the patient's and their partners' anatomical features, rather than their gender identity, ensures that the dialogue remains pertinent and devoid of presuppositions, tailored to the individual's circumstances. Conducting a thorough anatomical review is a fundamental component of compiling a comprehensive sexual history. This involves inquiring about any surgeries that affirm gender identity, alter body shape, or involve the removal of organs. Such details are vital for discussions pertaining to genitalia, sexual activities, pleasure, locations for STD testing, and standard preventive care guidelines (Fenway Health, 2024).

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Examples of possible questions may include:

- Have you had any gender-affirming surgeries?
- When referring to your genitals, are there specific terms that you use or that you would feel more comfortable with me using?
- Who are you sexually active with?
- What kinds of sex do you engage in? What body parts of yours touch body parts of your partner(s)?
- Are you using toys or prosthesis for sex? Are you sharing these?
- Are you or your partner(s) using any form of protection from STDs (or pregnancy if appropriate)? Do you feel empowered to ask your partner(s) to use these protections?
- Are you engaging in sex for pleasure or do you feel forced in any way?
- Are you engaging in sex for money, housing, drugs, or any other services?

Reproduced from: *Fenway Health* (2024 p. 34)

COMMON MISCONCEPTIONS ABOUT SEXUAL HEALTH

There are several common misconceptions about health among trans individuals that can lead to significant misunderstandings and barriers to appropriate care. One prevalent myth is that being trans is a mental illness, which has been debunked by medical experts and is not supported by contemporary medical understanding (WHO, 2024). Additionally, there's a false belief that all trans people undergo medical transition, whereas many may not pursue surgery or hormone therapy and still identify as trans. It's also mistakenly thought that gender-affirming treatments for trans individuals are experimental or non-essential, when in fact they are evidence-based and recognized as standard medical practice (APA, 2024). Misunderstandings about the difference between sex and gender contribute to these misconceptions, where sex refers to biological attributes and gender is a deeply felt sense of self that may or may not align with the sex assigned at birth. Dispelling these myths is crucial for the advancement of trans health and well-being, as well as for fostering a more inclusive and informed society (Fenway Health, 2024).

The Human Rights Campaign (2023) helps to dispel some of these myths. A common misconception about HIV among trans people is that it is solely a “gay” or “LGBTQ+” disease, which is medically inaccurate and perpetuates harmful stereotypes. While rates of HIV are disproportionately higher among members of the LGBTQ+ community, HIV is not confined to LGBTQ+ individuals and can affect anyone, regardless of sexual

orientation or gender identity. Another myth is that one can tell if someone is HIV-positive just by looking at them, which is untrue as the virus can remain asymptomatic for years. Additionally, there's a belief that HIV cannot be transmitted through oral sex, but while the risk is lower, transmission is still possible, especially if there are cuts or ulcers in the mouth. It's also mistakenly thought that being in a monogamous relationship eliminates the risk of HIV, ignoring the fact that trust does not equate to safety and testing is still crucial. Furthermore, the idea that older individuals do not need to worry about HIV is false; transmission is about behaviour, not age, and older adults are often diagnosed at later stages of the disease. These misconceptions highlight the need for comprehensive education and awareness to combat stigma and promote health equity.

HIV prevention and treatment

Estimates for Jamaica in 2018 indicate 51% HIV prevalence among transgender people (The Global Fund, 2021). A 2016 report suggests that trans women are disproportionately affected by HIV, exhibiting higher infection rates (of more than 40%) than the general population, sex workers, gay men and other men who have sex with men (PANCAP, 2024). In another study, Logie and colleagues (2017) find a significant proportion of trans women are involved in sex work. This involvement is often driven by economic necessity and lack of alternative employment opportunities. They face high levels of discrimination and stigma, which contribute to their marginalization and push them towards sex work as a means of survival. Transgender

women involved in sex work are at an elevated risk of HIV infection. This is due to factors such as engaging in condomless sex, having multiple sexual partners, and limited access to healthcare services. The study adds that mental health issues, including depression and anxiety, are prevalent

among transgender women engaged in sex work. These issues are often exacerbated by the discrimination and violence they face.

Preventing HIV among trans individuals involves a multifaceted approach that includes both behavioural and medical strategies. Common prevention methods include abstinence, consistent and correct use of condoms, use HIV prevention medicines such as PrEP or PEP, which significantly reduce the risk of HIV transmission (CDC, 2024). Condom negotiation is also key among trans people as a study finds a strong link between lower condom negotiation, self-efficacy and higher HIV risk. Trans women who struggle with condom negotiation are less likely to use condoms consistently, increasing their vulnerability to HIV (Mfecane, 2013).

It is crucial for those at elevated risk for HIV to be informed about and given easy access to Pre-exposure prophylaxis (PrEP), as well as regular HIV and STD screenings, Post-exposure prophylaxis (PEP), comprehensive sexual health education, and consistent healthcare services (CDC, 2024). Conversations around the safety of PrEP and its non-interference with GAHT are vital in lowering obstacles and promoting the adoption of these medications (Sherbourne Health, 2019; CDC, 2024).

Pre-exposure prophylaxis (PrEP) is a medication taken by HIV-negative individuals to prevent infection and is highly effective when taken as prescribed. It involves taking a daily pill containing two antiretroviral drugs: tenofovir disoproxil fumarate and tenofovir alafenamide (CDC,

2024). The CDC (2024) indicates that medications in PrEP do not change serum testosterone or oestrogen levels. Hormone therapy is primarily metabolized by the liver and the drugs in PrEP do not specifically act on any of the metabolic pathways, which make interactions between the drugs less likely. (Trans Care BC, 2018). As for PrEP successes, Jamaica AIDS Support for Life (JASL) initiated a PrEP program in June 2020. To date, approximately 100 participants, including men who have sex with men (MSM) and trans individuals, have benefited from JASL's PrEP program. None of the participants continuously on PrEP have contracted HIV (Jamaica AIDS Support for Life, 2021).

Post-exposure prophylaxis (PEP) is another preventive measure that can be taken after potential exposure to HIV, but it must be started within 72 hours after the exposure, which contains tenofovir disoproxil fumarate and emtricitabine (CDC, 2024). The CDC (2024) indicates that PEP is to be taken during sex (for example, if the condom broke), through sharing needles, syringes, or other equipment to inject drugs, if an individual has been sexually assaulted. There is limited research specifically examining the interaction between PEP and HRT. However, PEP is most effective when initiated as soon as possible after exposure to HIV (ideally within 24 hours and no later than 72 hours). It involves a four-week course of medication that may block HIV infection after exposure. PEP is effective in preventing HIV transmission, only when taken correctly. As for successes, observational studies indicate that PEP is highly effective. Among those who took PEP, the majority remained HIV negative. Some cases of HIV transmission occurred due to ongoing risk behaviour after completing PEP (NIH, n.d.). It is not a substitute for regular use of other HIV prevention methods such as PrEP (CDC, 2024).

Regular HIV testing is crucial for early detection and treatment, which can improve health outcomes and reduce the risk of transmission. Encouraging regular HIV testing and providing confidential, non-stigmatizing testing services can help with early detection and treatment. This is crucial for managing HIV and preventing its spread (CDC, 2024).

Comprehensive Sexual Health Education: Providing comprehensive sexual health education that includes information on safe sex practices, HIV prevention, and the importance of regular testing is essential. This education should be inclusive of trans experiences and needs (CDC, 2024).

Navigating sexual health after gender-affirming procedures

GAHT may influence sexual drive, whereas surgical alterations in the genital area may affect how a person attains and perceives pleasure. It's also fairly common for individuals to discover new sexual interests, behaviours, and partners following gender-affirming procedures. It's important to monitor any shifts in sexual drive, preferences, activities, partners, and potential risks after starting GAHT. For those with a uterus and ovaries who are exposed to sperm, conversations about birth control preferences and future plans for having children are recommended. Routine testing for HIV and

sexually transmitted diseases (STDs) should be considered, just as it would for any patient. The individual's sexual history and current anatomy should inform the locations of testing, including both genital and extragenital sites. All trans individuals, especially those at increased risk, should be educated about the availability and safety of PrEP and PEP. Lastly, immunizations for human papillomavirus (HPV), Hepatitis A, and Hepatitis B should be proposed if they haven't been administered previously (Fenway Health, 2024).



MEDICAL CONSIDERATIONS

Binding

Binding is a method used by trans individuals to achieve a more masculine chest appearance without undergoing surgery. Recommendations by Callen-Lorde Community Health Center (2021) for safe binding are as follows.

Safe Practices

1. Safety Considerations:

- **Safest option:** The safest option is a specialized binder—a shirt designed specifically for chest flattening.
- **Avoid Improvised Methods:** Some people use bandages or other materials, but these can be risky. Binders are the preferred choice.
- **Size Matters:** Getting the right size is crucial. Smaller isn't always better; proper fit ensures safety and effectiveness.
- **Custom Options:** For unusual sizes, consider custom-made binders available online.

2. Choosing the Right Binder:

- **Material:** Most binders are a combination of nylon and spandex.
- **Straps Over Shoulders:** Opt for binders with shoulder straps (similar to undershirts or tank tops) rather than those that only wrap around the chest using velcro or buckles.

3. Limitations:

- Even with binding, some individuals may not achieve a completely flat chest without surgery.

Warning signs of harmful binding

1. **Persistent Shortness of Breath:** If shortness of breath doesn't improve after removing the binder.
2. **Bruising or Redness on Ribs:** Any signs of injury or discomfort in the rib area.
3. **Skin Cuts or Openings:** Be cautious if you notice cuts or wounds on your skin.

Safety and Tips

1. Complications from Improper Binding:

Wrapping non-binding materials (like ace bandages) tightly around your chest can lead to:

- Difficulty breathing
- Rib injuries
- Lung infections
- Insufficient airflow

Even with a proper binder, excessive tightness can cause back and muscle pain.

2. Safe Binding Practices:

- **Duration:** Aim for 8-12 hours maximum per day; avoid sleeping in a binder.
- **Stretch and Breathe:** During breaks, stretch your arms and chest. Take slow, deep breaths to maximize lung capacity.
- **Movement:** Engage in gentle arm motions (windmills, swimming) to reduce stress on muscles.
- **Doorway Stretch:** Place hands on an open doorway and lean gently to stretch your pecs.
- **Foam Roller:** Lie on the ground with a foam roller under your spine to relax your chest.

3. Skin Reactions and Hygiene:

- Sweating under the binder can cause skin issues. Maintain good hygiene and wash binders.
- “Trans tape” or KT tape can be harsh on the skin; follow instructions carefully.
- Seek medical evaluation for rashes or discomfort.

4. Taking Breaks:

If needed, layer shirts and overshirts to achieve a flatter shape.

Packing

Packing is wearing padding or a prosthetic penis (or packer) in the front of the pants or underwear to give the appearance of having a penis or bulge. Packing is commonly practiced by trans masculine individuals. The safest option is medical grade silicone without additional ingredients. Silicone is nontoxic, less likely to harbour germs that can cause UTIs. The Stand-to-Pee (STP) collect urine as it exits the urethra and guide it forward (Callen-Lorde Community Health Center, 2021).

There are various packing methods, and the choice will depend on one's preferences and the desired functionality. Trans Care BC (2024) puts forward the following recommendations for packing.

Choosing the right packer

1. **Packer:** There are options in many sex stores or online that closely resembles a penis which varies in size, skin tones, foreskin and testicles. Some can be strap-on or tight-fitting underwear that can be used for penetration or stand to urinate.
2. **Non-flesh (prosthetic) penis:** These are designed to closely resemble the look and feel of real skin. They can be attached to the body with medical adhesive or suction. They can also be used for penetration or stand to urinate.

Safe Practices

1. Skin irritation from non-flesh materials may occur. In such cases, wearing two pairs of underwear with the penis placed between them can prevent irritation. Using a non-lubricated condom can also help prevent direct rubbing against the leg.
2. Reactions to the medical adhesive used for attaching a prosthetic penis may also occur. To ensure safety, test a small amount of the adhesive on the skin before full application.
3. Using a condom with any packer or prosthetic penis during sex can reduce the risk of transmitting HIV and other sexually transmitted infections (STIs).

Tucking

Tucking involves positioning the penis and testes to keep them concealed. Trans persons may choose tucking to feel more at ease with their body, being more comfortable in their clothing, and helping others to correctly perceive their gender. There are various ways to tuck. The penis is positioned between the legs, while the testes and scrotum can be placed between the legs or inside the body. Trans Care BC (2024) puts forward the following recommendations for tucking.

Option 1: Testes between the legs

To secure the penis, it should be wrapped in tissue or a piece of soft, thin cotton. The testes and penis can then be tucked between the legs and, if possible, the buttocks. For added security, a long strip of medical or sports tape can be used, running down the item and up the buttocks or lower back, with additional tape as needed. Finally, the arrangement should be held in place with tight panties made from materials like spandex, Lycra, or microfiber.

Option 2: Testes inside the body

Some people prefer the smoothest-looking option, which involves tucking their testes inside themselves. The goal is to gently push testes into the inguinal canals (the tube at the top of each testicle). First, the penis should be wrapped in tissue or a piece of soft, thin cotton. There is an opening to the inguinal canal at the base of each testicle, with a diameter similar to a finger, though it can stretch. Using two or three fingers, each testicle is gently lifted up into scrotum and through the corresponding inguinal ring. Once the testes are tucked, a hand should be kept firmly over the base to prevent anything from slipping back out. Some people also tuck the scrotum, while others wrap it around the penis and secure it with tape. Medical tape is safer than duct tape because it breathes better and is easier to remove. Next, the penis is pulled back

between the legs and held in place with tight panties, tape, or a gaff. If tape is used, shaving the pubic hair first will make removing the tape more comfortable. If there is difficulty removing the tape, soaking the area in warm water can help.

Tucking tips

It's important to go slow and trust the body during this process, as it can take time. One can choose to tuck one testicle at a time or both simultaneously. Some people find it helpful to get into a tub of cold water before tucking. The process should not feel overly uncomfortable, and taking breaks between tucking attempts is advisable. If feelings of faintness, nausea, or pain occur, it is best to take a break and try again later.

Safe tucking

For those new to tucking, it's advisable to start with shorter periods and allow ample time for practice, as learning a new skill can be challenging when rushed or stressed. Experimenting with different tucking methods can help in finding what works best. With practice or after being on hormones for a while, tucking may become easier. Using medical adhesive removers can assist with tape buildup and residue. After untucking, it's important to check for any skin irritation, sores, or rashes, and to allow the skin to heal before applying products again. Staying hydrated is crucial, as avoiding drinking and urination can lead to health issues. To prevent skin chafing and infection, body powder can be used in warm creases like the thighs, buttocks, and genital area. It's also important to be aware that regular tucking can affect fertility, so some people consider banking sperm or limiting how often they tuck gonads inside the body.

Signs of unsafe tucking:

- **Aching, tingling, or numbness:** These sensations that continue even when not tucking could indicate a problem.
- **Blood in urine or orgasmic fluid:** This is a serious symptom that requires immediate medical attention.
- **Inflammation or infection:** Any feeling of inflammation or infection inside the genitals needs medical attention.
- **Skin rash or sores:** These are signs that medical advice is needed.
- **Pain with urination:** Experiencing pain while urinating is a red flag.
- **Bladder or lower back pain:** Persistent pain in these areas should not be ignored.

Padding

Padding is a great way to create the appearance of larger breasts, hips, or buttocks without the need for surgery. Many people choose padding because it helps them feel more comfortable in their bodies and clothing, and it can also help others read their gender correctly. Compared to surgical options, padding is affordable and painless, and it's much safer than using non-medical silicone injections, which can cause severe complications. There are various padding products available, like padded panties for wider hips and fuller buttocks, padded bras for enhancing breast size, and breast forms made of soft silicone gel that can be placed in a bra or adhered to the body. Some breast forms even come with nipples. Additionally, bras with pockets, often called mastectomy bras, are designed to accommodate breast forms (Trans Care BC, 2024).

Collaboration and networking between public and private healthcare sectors in Jamaica are crucial for the advancement of trans healthcare. Such partnerships can lead to the sharing of resources, expertise, and information, which is essential for addressing the unique healthcare needs of the trans community (Osbourne, 2022). The Ministry of Health & Wellness demonstrates a commitment to public-private partnerships (PPPs) to enhance healthcare delivery, as seen in their initiatives for non-communicable diseases (MOHW, 2024). These PPPs have been instrumental in providing more efficient and accessible care, and similar models could be adapted for trans healthcare.

By leveraging the strengths of both sectors, Jamaica can develop a more inclusive healthcare system that caters to the needs of trans individuals. This could involve training for healthcare providers in both sectors on trans health issues, creating guidelines for respectful and competent care, and establishing referral networks to ensure that trans individuals can access the full spectrum of healthcare services. Additionally, these collaborations could facilitate research and data collection to inform policy and practice, ensuring that the healthcare system evolves to meet the changing needs of the population (TransWave, 2020).

Integration of services between public and private entities can help to reduce stigma and discrimination, which are significant barriers to healthcare for trans people. A collaborate effort from both sectors sends a powerful message of acceptance and support, which can encourage trans individuals to seek the care they need. It is also important for these partnerships to engage with trans communities directly, to ensure that their

voices are heard, and their specific healthcare needs are met. Such efforts can lead to improved access, quality, and equity in healthcare services for trans individuals, ultimately contributing to a healthier and more inclusive society (TransWave, 2020).

Trans Healthcare Collaboratives can bring together researchers, healthcare providers, and community organizations that can promote trans health through research, clinical services, and education.

1. Public-Private Partnerships:

■ **Public Sector:** The government can develop and implement right-based programs, policies, and legislative frameworks to protect trans people from discrimination. This includes ensuring legal recognition, anti-discrimination laws, and inclusive healthcare policies (TransWave, 2020).

■ **Private Sector:** Private healthcare institutions can complement public efforts by participating in awareness campaigns, training their staff, and adopting inclusive practices. This collaboration ensures that healthcare providers are well-equipped to offer respectful and competent care to trans individuals (TransWave, 2020).

■ **Public-Private Partnerships:** These partnerships can be adapted to ensure that trans individuals have access to a comprehensive range of healthcare services, from primary care to specialized treatments like hormone therapy and gender-affirming surgeries. By working together, public and private entities can create a seamless referral network, ensuring continuity of care for trans patients. Collaborations between public and private sectors can also advocate for legal and policy changes that benefit the trans community (TransWave, 2020).

2. Healthcare Provider Training:

■ **Private Sector:** Private providers can develop standardized training materials and guidelines that emphasize cultural competence, helping providers understand the social and cultural contexts that affect trans health. Private sector can also invest in training programs to ensure their staff is knowledgeable about unique health needs of trans people (WPATH, 2012).

■ **Public Sector:** Public healthcare providers can support these efforts by receive specialized training to offer safe and affirming care to trans individuals. This includes understanding gender diversity, informed consent, and harm reduction principles (WPATH, 2012).

■ **Public-Private Partnerships:** Public-private partnerships can create and disseminate guidelines and protocols for trans-inclusive care. These guidelines help standardize practices across different healthcare settings, ensuring that all providers follow best practices in trans health. Engaging with the trans community is essential for effective training. Collaboratives can involve transgender individuals in the development and delivery of training programs, ensuring that the content is relevant and addresses real-world needs. Collaboratives can offer workshops, webinars, and certification courses on cultural competence and best practices. Regular evaluation and feedback mechanisms help assess the effectiveness of training programs. Collaboratives can use this feedback to continuously improve and adapt their training initiatives. Ongoing education and professional development opportunities are crucial. Collaboratives can offer workshops, seminars, and online courses to keep healthcare providers updated on the latest research and best practices in trans health (WPATH, 2012).

3. Research:

■ **Identifying Health Needs:** Research helps to identify the specific health needs and disparities faced by trans individuals. This includes understanding the prevalence of mental health issues, chronic conditions, and the impact of social determinants of health such as discrimination and access to care (Deutsch et al., 2016).

■ **Evidence-Based Practices:** By conducting rigorous studies, collaboratives can develop and promote evidence-based practices. This ensures that the care provided to transgender individuals is based on the best available scientific evidence, leading to better health outcomes. Medical associations can promote research on transgender health outcomes. Encourage evidence-based practices by disseminating research findings. Support studies that address disparities and inform clinical guidelines (Deutsch et al., 2016).

■ **Policy Development:** Research findings can inform the creation of policies that protect and support transgender individuals. This includes advocating for legal recognition, anti-discrimination laws, and inclusive healthcare policies that ensure equal access to services (Deutsch et al., 2016).

■ **Clinical Guidelines:** Research can lead to the development of clinical guidelines for healthcare providers. These guidelines help ensure that providers offer respectful, competent, and affirming care to transgender patients. This includes protocols for hormone therapy, surgical procedures, and mental health support (Deutsch et al., 2016).

■ **Community-Based Participatory Research (CBPR):** Engaging the trans community in the research process is crucial. CBPR involves trans individuals in designing and conducting research, ensuring that the studies are relevant and beneficial to the community. This approach helps build trust and ensures that the research addresses the real-world needs of transgender people (Deutsch et al., 2016).

■ **Data Collection and Analysis:** Collecting and analysing data on trans health is essential for tracking progress and identifying areas for improvement. This data can be used to monitor health outcomes, evaluate the effectiveness of interventions, and guide future research and policy efforts (Deutsch et al., 2016).

■ **Research Consortia:** Public and private institutions can form consortia or partnerships focused on transgender health. These consortia facilitate collaboration, resource sharing, and joint research efforts. Researchers from diverse backgrounds can work together on studies, clinical trials, and data collection (TransWave, 2020).

■ **Funding and Grants:**

Public and private collaborations can pool resources to fund research projects. Seek grants from government agencies, private foundations, and industry partners. Funding should prioritize transgender health research and address disparities (Deutsch et al., 2016).

4. Professional Medical Associations:

■ **Active Involvement:** Both public and private sectors should actively engage medical associations, including those representing physicians, nurses, and other healthcare providers. This involvement ensures that the medical community is aligned with the goals of improving trans healthcare (Prenestini et al., 2023).

■ **Guidelines and Training Programs:** Medical associations can play a pivotal role in developing and disseminating guidelines and training programs specific to transgender health. These guidelines help standardize care practices and ensure that healthcare providers are equipped with the knowledge and skills needed to offer competent and respectful care to transgender individuals (WPATH, 2012).

■ **Collaboration with Community Organizations:** Fostering collaboration between medical providers and community organizations is essential.

Community organizations often have direct insights into the needs and challenges faced by transgender individuals.

By working together, medical associations and community organizations can create more effective and relevant training programs and guidelines (TransWave, 2020).

■ **Professional Development:** Encouraging continuous professional development is key. Medical associations can offer workshops, seminars, and certification courses on transgender health, ensuring that healthcare providers stay updated on the latest research and best practices (WPATH, 2012).

■ **Advocacy and Policy Development:** Medical associations can also advocate for policy changes that support transgender health. This includes lobbying for anti-discrimination laws, inclusive healthcare policies, and funding for transgender health research and services (APA, 2024).

5. Shared Care Agreements:

Shared healthcare agreements between public and private healthcare providers are essential for ensuring coordinated and effective care for trans patients. These agreements typically include responsibilities that clearly defined roles for each provider involved in the patient's care, referrals involving streamlined processes for referring patients to specialists or other necessary services, and mechanisms for sharing patient information and coordinating care plans to avoid duplication and ensure continuity of care. Examples of shared care agreements between public and private health providers in Jamaica are the Primary Healthcare Reform for Jamaica 2021- 2030 which outlines strategies for integrating and coordinating healthcare services across both sectors, and the

Health Connect Jamaica which highlight the importance of public-private partnerships in enhancing healthcare delivery, particularly in areas like HIV prevention and treatment. Both initiatives can be leveraged to enhance healthcare outcomes for transgender patients.

The Primary Healthcare Reform for Jamaica 2021-2030 is a comprehensive plan aimed at transforming the healthcare system to provide more integrated and patient-centered care (MOHW, 2022).

■ **Integration of Services:**

Holistic Care: By integrating services across public and private sectors, transgender patients can receive comprehensive care that addresses both their physical and mental health needs.

Continuity of Care: Ensuring that transgender patients have continuous access to healthcare services, reducing gaps in care that can lead to adverse health outcomes.

■ **Strengthening Primary Care:**

Preventive Care: Emphasizing preventive care and early intervention to address health issues before they become severe, which is particularly important for transgender individuals who may face barriers to accessing care.

■ **Capacity Building:**

Training and Education: Providing specialized training for healthcare providers on transgender health issues to improve service delivery and patient outcomes.

■ **Community Involvement:**

Engagement: Involving transgender communities in the planning and implementation of healthcare services to ensure they are relevant and effective.

Support Networks: Building strong support networks within communities to provide emotional and social support for transgender individuals.

Health Connect Jamaica is an initiative that builds a network of clinicians to provide comprehensive care, particularly targeting HIV/AIDS patients (Health Connect Jamaica, 2022).

■ **Private Sector Involvement:**

Expanded Access: Encouraging private healthcare providers to offer transgender-specific services, increasing the availability of care options for transgender patients.

■ **Confidential Services:**

Confidential Health Services:

Ensuring that transgender patients can access confidential and non-judgmental healthcare services, which is crucial for building trust and encouraging regular healthcare visits. This includes HIV testing, treatment, and counselling, through accredited private doctors.

■ **Accessibility:**

Online Booking: Making it easier for transgender patients to book appointments and access healthcare services online, reducing barriers to care.

Inclusive Services: Ensuring that online platforms and healthcare services are inclusive and respectful of transgender identities.

■ **Support and Education:**

Health Education: Providing targeted health education for transgender individuals, covering topics such as hormone therapy, mental health, and preventive care.

Peer Support: Facilitating peer support groups and counselling services to help transgender individuals navigate their healthcare journeys.

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Appendix A – Sample questions about gender-affirming goals

Sample Questions

- 1.How would you describe your gender? If prompting is needed: For example, some people identify as a man, a trans man, genderqueer, etc.
- 2.When did you start thinking about taking hormone therapy (or having surgery)?
- 3.What do you anticipate to be the main benefits of hormone therapy (or surgery) for you?
- 4.What changes from hormones are you most looking forward to?
- 5.Are there any potential changes that you are not sure of?
- 6.Have you done anything to prepare yourself for this step? If prompting is needed: Have you talked with any peers, or asked friends or family for support? Done any reading or research?
- 7.Do you anticipate any challenges?
- 8.Who is there to support you with any challenges that do occur?
- 9.Are you aware of some of the risks of hormone therapy (or surgery)?
- 10.Do you know about any potential impacts of this intervention on your fertility? Would you like me to refer you to a fertility clinic to learn more about fertility preservation options?
11. 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 like a referral to a trans competent counsellor?
12. Do you have any questions for me?

Adapted from: *Trans Care BC* (2018, p. 19)

Appendix B – Hormone Planning Period Checklist

Hormone Planning Period Checklist

The following is a tool to assist in undertaking planning visits with new (or newly transitioning) trans patients in primary care settings who wish to initiate hormone therapy. This checklist is for patients who have completed puberty.

NOTE: A “No” response does not necessarily preclude a patient from being a candidate for hormone therapy however it does indicate an area that may need ongoing attention.

ITEM	YES / DONE	NO	COMMENTS
PATIENT HISTORY			
Discussion of rationale for planning period			
General medical intake & medical history			
Obtain/Review records from previous providers			
Exploration of gender identity and expression			
BASELINE DATA			
Vitals (incl BP, Ht, Wt)			
Focused physical exam (+/- Breast inspection/ measurement in transfeminine patients)			
Bloodwork (liver enzymes, lipids, fasting glu or a1c, complete blood count, hormone levels, +/- renal function – See Tables 6 & 10)			
Health screening commensurate to age/risk			

ITEM	YES / DONE	NO	COMMENTS
PATIENT EDUCATION, PREPARATION & SUPPORTS			
Articulation of transition goals, (including interest in transition-related surgeries)			
Reasonable expectations expressed			
Risks + side effects, and potential benefits (expected changes both reversible & irreversible) associated with treatment discussed and patient understanding demonstrated (See Appendices K-M for checklists)			
Effects on fertility and options for preservation discussed, early referral for preservation if desired			
Pregnancy risk/options for contraception discussed & implemented if needed			
Possesses capacity to consent			
Potential costs (e.g. medication, hair removal, fertility preservation) reviewed and considered			
Psychosocial preparation and supports discussed			
Medication options/routes reviewed			
EAP form submission (patients on ODB wishing to start testosterone)			
RISK MANAGEMENT			
Absence of contraindications			
Precautions optimally managed or management plan in place			
If present, mental health conditions reasonably well-managed or management plan in place			

ITEM	YES / DONE	NO	COMMENTS
If smoker, smoking cessation counselling done			
DIFFERENTIAL DIAGNOSIS			
Other possible diagnoses ruled out			
Meets criteria for Gender Dysphoria/Gender Incongruence			
Intersex condition ruled out or taken into consideration			
FINAL / NEXT STEPS			
Choose initial hormone regimen			
Discuss/arrange follow up			

Appendix C – Managing Co-Morbidities

Reproduced from: *Callen-Lorde (2024, p. 29-30)*

1. Active Psychosis

Active psychosis is defined here as loss of contact with reality and a decline in general functioning.

If a patient presents with active psychosis that is not centered on their gender identity, the patient should be stabilized by psychotropic medications and/or psychotherapy before beginning hormone therapy. A mental health professional with experience in transgender care must confirm the patient's ability to consent to treatment at the time hormone therapy is initiated. The treatment plan can be determined by the patient's medical and mental health providers and the patient. When setting the plan of transgender care including for hormone therapy, medical and mental health providers should also consider the impact of the psychological distress associated with a delay of hormone treatment.

2. Cigarette Smoking

While patients who smoke can begin hormone therapy, it should be made clear that for both

women and men of transgender experience, smoking while taking hormones may increase the risk of adverse events. For patients on feminizing hormones, cigarette smoking may increase the likelihood of thrombotic events. For patients on masculinizing hormones, it may increase the potential for coronary artery disease. At every visit, the provider should actively engage the patient in negotiation around smoking cessation. Aspirin therapy may be considered.

3. Coronary Artery Disease

Hormone therapy is not contraindicated in the presence of stable coronary artery disease. The provider should intervene to decrease all other risk factors for coronary artery disease. Transdermal oestrogen therapy may be preferred over alternate routes of administration.

4. Dementia

Dementia is not an absolute contraindication to hormone therapy. Hormone therapy can be provided to patients who are able to give informed consent. For patients who cannot give consent, provision of hormone therapy should be decided on a case-by-case basis, e.g., involvement of guardian. Education of all caretakers is an important component of the treatment plan.

5. History of Deep Venous Thrombosis, Pulmonary Embolism or Embolic Stroke

Some forms of oestrogen may increase future risk of venous thromboembolism (VTE). In one study only ethinyl estradiol was linked to VTE among transgender women. Use of transdermal oestrogens may be preferred. Patients should be aware of the potential increased risk of complications as part of the informed consent process.

6. Homicidal/Suicidal Ideation/Attempts

Patients presenting with active suicidal or homicidal ideation or attempts should be engaged in mental health care. A mental health professional with experience in transgender care should be involved in the treatment plan. When setting the plan of transgender care including a time frame for hormone therapy. Medical and mental health providers should also consider the impact of the psychological distress associated with a delay of hormone treatment.

7. Liver Disease

If the patient has a self-limited hepatic infection, such as acute Hepatitis A or B, initiation of hormone therapy should be delayed until the patient is in the convalescent stage and transaminases have returned to normal. If the patient has chronic hepatitis for which treatment is available, such as Hepatitis C, treatment should be pursued. Patients with chronic hepatitis should be closely monitored during initiation of hormones or hormone dosage change. If transaminases (ALT) increases 2 times above baseline then consultation with hepatologist is advised. Transdermal/parenteral hormones are preferred to oral administration. For all patients with chronic liver disease, the primary care provider should minimize the risk of further liver injury with appropriate immunizations and behavioural interventions.

8. Pituitary Adenoma

If the patient has a history of pituitary adenoma, oestrogen therapy should be delayed until the patient has had a full evaluation and clearance from an endocrinologist.

9. Uncontrolled Diabetes

There is no clear evidence on the relationship between hormone therapy and glycaemic control in diabetics. Diabetes should be managed independent of hormone therapy.

10. Uncontrolled Hypertension

Hypertension should be managed independently of hormone therapy. Spironolactone is the preferred anti-androgen.

11. Substance Use

Substance use is not a contraindication to hormone therapy. In some cases, hormone therapy may increase the likelihood of patients engaging in treatment for substance use. When making referrals it is important to ensure that the program will affirm the patient's gender identity.

12. HIV Infection

HIV disease is not a contraindication to hormone therapy. In fact, hormone therapy may improve engagement and retention in care.

There are no specific data on interactions between the doses of oestrogens commonly used in feminizing regimens and antiretroviral regimens. Most of the available data is based on studies with oral contraceptives (ethinyl estradiol). Metabolism of oestrogens occurs via the cytochrome P450 enzyme system, thus potential drug-drug interactions may exist between oestrogens and Non-nucleoside reverse transcriptase inhibitors (NNRTIs) and the Protease inhibitors (PIs). Most boosted PIs decrease ethinyl estradiol levels. The effects of Non-nucleosides vary, e.g. nevirapine decreases oestrogen levels, etravirine and rilpivirine increase ethinyl estradiol levels, whereas efavirenz appears to have no effect affect levels. There are no known drug-drug interactions between ethinyl estradiol and NRTIs / NtRTIs / integrase inhibitors / CCR5 antagonists/fusion inhibitors. DHHS recommends that oral contraceptives and amprenavir (or fosamprenavir) not be co-administered due to decrease in amprenavir serum concentrations; therefore, we recommend avoiding the use of amprenavir (Agenerase) and fosamprenavir (Lexiva) with oestrogens. Consider monitoring estradiol levels when initiating or changing anti-retroviral therapy.

Appendix D – Managing Laboratory Abnormalities

Reproduced from: *Callen-Lorde (2024, p. 31)*

1. Anaemia

If a patient develops haemoglobin less than 11gm/dL and the patient is taking flutamide, the flutamide should be discontinued and the haemoglobin should be rechecked one month later. If it remains abnormal, a full anaemia work-up should be initiated.

2. Erythrocytosis

Testosterone may result in an elevated haematocrit due to increased erythropoiesis. It is important to rule out other causes of erythrocytosis such as polycythaemia vera. Haematocrit should be maintained at less than 45%. If the haematocrit increases above 52%, measures include initiation of phlebotomy, decreasing the dose of intramuscular testosterone, or switching to transdermal testosterone gel.

3. Elevated Prolactin Level

If a patient has a prolactin level between 20 and 100 ng/mL, the patient should be followed with history (focusing on visual field deficits, headaches) and physical exam (blood pressure, fundoscopic exam and gross visual field assessment). For prolactin levels 40-100 ng/mL, reduce oestrogen levels by half and recheck in 6-8 weeks. Continue hormones at the lower dose if prolactin levels remain under 40ng/mL. If a patient has a prolactin level over 100ng/mL, hormones should be discontinued, and the level should be rechecked. If it remains over 100ng/mL, an MRI of the pituitary should be obtained to rule out pituitary adenoma. If the MRI is normal, hormones can be restarted at a lower dose, and prolactin level should be followed. If it continues to rise, or if the MRI is abnormal, the patient should be referred to an endocrinologist.

Guidelines for Elevated Prolactin Level

LEVEL (ng/mL)	ACTION
< 25	Continue to monitor per protocol.
25-40 per protocol.	Ask patient about outside sources of oestrogen and continue to monitor
41-100	Decrease oestrogen does by half and recheck in 6-8 weeks
>100	Stop oestrogen and recheck in 6-8 weeks. If level remains high, MRI pituitary. If level decreases, restart oestrogen at lower dose.

4. Elevated Transaminases (LFTs)

Elevated Transaminases should be defined as AST/ALT greater than three times the upper limit of normal or twice baseline if the patient has chronically elevated liver enzymes. If transaminases are elevated, hormone therapy should be discontinued while a workup is initiated. The initial evaluation should include a careful history of the patient's symptoms and use of alcohol, hormones that were not prescribed by the provider, other prescription, over the counter and herbal medications, and other potential hepatotoxic agents* as well as evaluation for acute and chronic hepatitis. If acute viral hepatitis is diagnosed, hormone therapy should be withheld until the patient is in the convalescent stage and transaminases have returned to normal. If no identifiable cause is revealed, transaminases should be rechecked two months after stopping hormone therapy. If they

have returned to normal, the provider can conclude that the hormones were causing the liver inflammation, and they can be restarted and maintained at a lower dose, or a different medication can be tried. If transaminases remain abnormal, the patient should be referred for evaluation by a gastroenterologist.

* Medications to consider include acetaminophen, phenytoin, valproic acid, sulfonamides, nitrofurantoin, isoniazid, rifampin, niacin and alpha-methyldopa.

Appendix E – Sample Informed Consent for Masculinizing Hormone Therapy

Reproduced from: *Fenway Health* (2023)

Informed Consent for Masculinizing Hormone Therapy

The use of hormone therapy for gender transition/affirmation is based on many years of experience treating trans persons. Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood. This informed consent asks you to consider the expected benefits of hormone therapy and the possible side effects of hormone therapy, so that you can decide, with your medical provider, if hormone therapy is right for you. By signing this form, you are stating that you have discussed the risks and benefits with your medical provider or a member of the medical team and that you understand and accept how these apply to you personally. Testosterone is used to masculinize the body, to reduce the female features and increase the masculine features. Your medical provider will determine the form of testosterone (shots, gels or creams, patches, implanted pellets) and the dose that is best for you based on your personal needs and wishes, as well as any medical or mental health conditions you might have. Each individual person responds to testosterone differently, and it is difficult to predict how each person will respond. You agree to take the testosterone only as prescribed and to discuss your treatment with your doctor before making any changes.

The Expected Effects of Testosterone Therapy

The masculine changes in your body may take several months to become noticeable and usually take 3 to 5 years to be complete.

Changes that will be PERMANENT; they will not go away, even if you decide to stop testosterone treatment:

- The pitch of your voice becomes deeper
- Increased growth, thickening and darkening of hair on the body
- Growth of facial hair
- Possible hair loss at the temples and crown of the head (male pattern baldness) with possible complete baldness
- Increase in the size of the clitoris/phallus

Changes that are NOT PERMANENT and will likely reverse if testosterone treatment is stopped:

- Menstrual periods will stop, usually within a few months of starting testosterone
- Possible weight gain. If you gain weight, this fat will tend to go to the abdomen and mid- section, rather than the buttocks, hips and thighs, making the body look more masculine.
- Increased muscle mass and upper body strength
- Possible feeling of more physical energy
- Skin changes, including acne that may be severe
- Increased sex drive
- Changes in mood or thinking may occur; you may find that you have a decreased emotional reaction to things and possible increased feelings of anger or aggression. Some persons find that their mental health improves after starting hormone therapy. The effects of hormones on the brain are not fully understood.

_____ I have questions about the possible effects of testosterone.

_____ My medical provider or member of the medical team has answered my questions about the effects of testosterone.

The Risks and Possible Side Effects of Testosterone Therapy

- Possible loss of fertility; you may not be able to get pregnant after being on testosterone therapy for some time; how long this might take to be a permanent effect is unknown. Some persons choose to harvest and bank eggs before starting on testosterone therapy.
- Testosterone is not reliable birth control, however. Even if your periods stop, you could get pregnant; if you are having penetrative sex with a natal male partner, you should discuss using some form of birth control with your medical provider.
- If you do get pregnant while taking testosterone, the high levels of testosterone in your system may cause harm and even death to the developing fetus
- Other effects of testosterone on the ovaries and on developing eggs are not fully known
- Some trans men, after being on testosterone for a number of months, may develop pelvic pain; often this will go away after some time, but it may persist; the cause of this is not known
- The lining of the cervix and walls of the vagina may become more dry and fragile; this may cause irritation and discomfort; it also may make you more susceptible to sexually transmitted infections and HIV if you have unprotected penetrative sex
- The effects on the risk of breast, uterine and ovarian cancer is not known
- Possible changes in cholesterol, higher blood pressure and other changes to the body that might lead to an increased risk of cardiovascular disease (heart attacks, strokes and blockages in the arteries)
- Possible changes in the body that might increase the risk of developing diabetes
- Increased appetite and increased weight gain from both muscle and fat
- Increased risk of sleep apnea (breathing problems while you are sleeping)
- Possible abnormalities in blood tests for the liver; possible worsening of damage to the liver from other causes
- An increase in the hemoglobin and hematocrit (the number of red blood cells); if this increases to levels higher than is normal in males, it may cause problems with circulation, such as blood clots, strokes and heart attacks
- Increased sweating
- Weakening of tendons and increased risk of injury
- Possible worsening or triggering of headaches and migraines
- Possible increase in frustration, irritability or anger; possible increased aggression and worsened impulse control
- Possible worsening of bipolar disorder, schizophrenia and psychotic disorders or other unstable moods

_____ I have questions about the risk of testosterone treatment

_____ My medical provider or a member of the medical team answered my questions about the

risks of testosterone

_____ I would like to discuss ways to help me quit smoking

You understand

- Smoking cigarettes may increase some of the risks of taking testosterone therapy
- Taking testosterone in doses that are higher than recommended will increase the risks of testosterone treatment; higher doses will not necessarily work better to masculinize the body; in fact, abnormally high amounts of testosterone can be converted to estrogen that may interfere with masculinization
- Testosterone treatment is expected to be lifelong; suddenly stopping testosterone after a long time on the medication may have negative health effects
- You may choose to stop hormone therapy at any time and for any reason. You are encouraged to discuss this decision with your medical provider.
- Your provider may decrease the dose of testosterone or stop prescribing testosterone because of medical reasons and/or safety concerns; you can expect that the medical provider will discuss the reasons for all treatment decisions with you.
- Hormone therapy is not the only way that a person may appear more masculine and live as a male; your medical provider and/or a mental health provider can help you think about these other options

You agree to

- Take testosterone only at the dosage and in the form that your medical provider prescribes.
- Inform your medical provider if you are taking or start taking any other prescription drugs, dietary supplements, herbal or homeopathic drugs, or street/recreational drugs or alcohol so that you can discuss possible interactions with and effects on your hormone treatment
- Inform your medical provider of any new physical symptoms or any medical conditions that may develop before or while you are taking testosterone and discuss the evaluation of these conditions; inform your provider if you think you are having bad side effects from the testosterone
- Keep regular follow up appointments; this may include appointments for Pap smears, pelvic exams and mammograms
- Have regular monitoring blood testing done; your provider will discuss with you what tests are necessary in order to monitor for potential harmful effects and to ensure that your testosterone treatment is safe and effective

_____ I have questions about my rights and responsibilities with taking hormone therapy.

_____ My medical provider has discussed my questions and concerns with me.

By signing this form you acknowledge that you have adequate information and knowledge to be able to make a decision about hormone therapy and that you understand the information your medical provider has given you. Based on this information:

_____ I choose to begin testosterone therapy
_____ I do not want to begin testosterone therapy

Patient 's name on health insurance

Patient's preferred name, if different

Patient signature

Date

Provider name

Provider signature

Date

Appendix F – Sample Informed Consent for Progesterone

Reproduced from: *Trans Care BC* (2018, p. 28-29)

Progesterone Consent

Progesterone is not included in standard hormone regimens but may be desired by some trans people. Requests for progesterone are usually related to a desire to enhance breast development. While there is no clear evidence of benefit from progesterone, some trans people and clinicians believe that it may have a role in breast and areola/nipple development and/or may be beneficial for enhancing sex drive, sleep and mood.

Research suggests that taking a combination of both oestrogen and progesterone carries higher risk for cardiovascular disease and breast cancer compared to taking oestrogen on its own. This research came from a study of older cisgender (non-trans) women going through menopause who were using a type of oestrogen that is no longer recommended. Because there is evidence showing increased risk associated with progesterone use and a lack of clear evidence showing benefits, progesterone is not generally recommended in published gender-affirming care guidelines. However, some experts believe that this evidence does not apply to trans people taking hormone therapy.

This means that some care providers may decide to include progesterone, at least for a trial period, after a careful discussion of risks and benefits. They may request that patients sign an additional consent form if progesterone is prescribed.

Additional risks from progesterone may include:	
Heart and circulation problems (cardiovascular disease)	Diabetes
Breast cancer	Testosterone-like effects such as increased body hair, acne
Mood changes including depression	Weight gain
Increased blood pressure and cholesterol	

Risks for some of these conditions may be affected by:

- Pre-existing physical or mental health conditions
- Family history of physical or mental health conditions
- Cigarette smoking or other substance use
- Nutrition, exercise, stress

_____ (name of care provider) has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the possibility that hormone

therapy may not accomplish the changes I want; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options

1. I have read and understand the above information regarding hormone therapy, and accept the risks involved
2. I have had enough opportunity to discuss my health, goals and treatment options with my care provider, and all of my questions have been answered to my satisfaction
3. I believe I have adequate knowledge on which to base informed consent to receive hormone therapy
4. I authorize and give my informed consent to receive hormone therapy

Patient signature _____ Provider signature _____

Date _____

Appendix G – Sexual Health Screening

Adapted from Trans Care BC (2018, p. 30-35)

Sexual health screening

This guideline provides screening recommendations that are based on anatomy and is inclusive of gender-affirming surgeries and hormone therapy.

All patients should be screened according to the types of sexual activities they participate in. This may include screening throats, rectums, genitals and genital lesions as indicated. Serology should be included during routine STI screening for all patients, including TP EIA, HIV, and Hepatitis A, B & C as indicated. Assess need for immunizations (HPV, HAV, HBV) and HIV PrEP on an individual basis. Self-swabbing, blind swabs and urine CT/GC NATs are appropriate for symptomatic patients who do not desire a physical exam.

Note: Symptomatic patients should have microbiological analysis (which includes yeast and BV prn) in addition to STI screening.

Site	Asymptomatic	Symptomatic	Notes
Penile urethra (with or without phalloplasty or metoidioplasty with urethral lengthening) *If urethral symptoms occur after gender-affirming surgery, consult with an experienced clinician, as swabs may be	CT/GC NAT urine	STI Screen: - CT/GC NAT (urine) - Trich NAT	All swabs may be self or practitioner collected <u>Requisition tips:</u> - Specify site as “Urethra” prn - If ‘female’ or ‘X’ gender marker, indicate “Trans patient” to reduce likelihood of sample rejection
		Microbiological analysis: - GC culture - Yeast - C&S superficial wound - Urine dipstick and/or urinalysis prn	Use liquid Amies culture red-top swab

Site	Asymptomatic	Symptomatic	Notes
Vagina after vaginoplasty If pain, discharge or bleeding occur in the early post-operative period, consult with an experienced clinician.	• CT/GC NAT urine Some patients may find pelvic exams affirming. If patient preference is for pelvic exam: CT/GC NAT vaginal (clinician-collected) Note: This test has not been validated for use in vaginoplasty • There is no evidence to support the need for Pap tests of vaginal vault	STI Screen: • CT/GC NAT (urine or vaginal) • Trich NAT	All swabs may be self or practitioner collected <u>Requisition tips:</u> • Specify site as “Vaginoplasty” prn • If ‘male’ or ‘X’ gender marker, indicate “Trans patient” to reduce likelihood of sample rejection
		Microbiological analysis: • GC culture • Yeast • C&S superficial wound • Urine dipstick and/or urinalysis prn	Use liquid Amies culture red-top swab
		Prostate exam prn Note: the prostate is not removed during vaginoplasty	Assessment can be done by digital exam via lower aspect of anterior vaginal wall

Site	Asymptomatic	Symptomatic	Notes
Vagina after total hysterectomy See BCCDC's Pelvic Exam Decision Support Tool (March 2017)	CT/GC NAT urine (preferred) or vaginal	STI Screen: - CT/GC NAT (urine or vaginal) - Trich NAT	All swabs may be self or practitioner collected Requisition tips: If 'male' or 'X' gender marker, indicate "Trans patient" to reduce likelihood of sample rejection
	See "BCCA Screening for Cancer of the Cervix" to determine screening recommendations for patients with removal of cervix	Microbiological analysis: - Urine dipstick and/or urinalysis prn - GC culture - Yeast <u>If on testosterone*:</u> - C&S superficial wound <u>If not on testosterone:</u> - Vaginitis Chronic	Use liquid Amies culture red-top swab

*Testosterone can induce a hypoestrogenic state in the internal genitals. This decreases epithelial cells, tissue resilience, skin barrier function and lactobacilli, and leads to increased susceptibility to traumatic irritation (during ADLs, sexual activity, etc), increased genital pH and susceptibility to BV symptoms. LifeLabs has advised that the low (or non-existent) levels of lactobacilli make screening for BV inapplicable, since this would yield results (BV intermediate or BV positive) that may not accurately reflect the underlying cause of symptoms.

The "C&S superficial wound" panel will provide more information about the types of organisms present and would better assist in clinical decision-making.

For information on treating internal genital dryness (atrophy), see "Managing side effects of testosterone & other common concerns".

Site	Asymptomatic	Symptomatic	Notes
Vagina with cervix See BCCDC's Pelvic Exam Decision Support Tool (March 2017)	CT/GC NAT (urine <u>or</u> vaginal)	STI Screen: - CT/GC NAT (urine or vaginal) - Trich NAT	All swabs may be self or practitioner collected Requisition tips: If 'male' or 'X' gender marker, indicate "Trans patient" to reduce likelihood of sample rejection
		Microbiological analysis: - Urine dipstick and/or urinalysis prn - GC culture - Yeast <u>If on testosterone*</u> : • C&S superficial wound <u>If not on testosterone:</u> - Vaginitis Chronic	Use liquid Amies culture red-top swab
		Bi-manual exam. If patient declines or is not able to tolerate bi-manual, assess for fundal tenderness only	Note: patients on testosterone may have cervical motion tenderness (CMT) due to genital tissue atrophy (presence of CMT not necessarily indicative of Pelvic Inflammatory Disease)
	Cervical screening prn	If due for cervical screening, advise patient that inflammatory exudate may obscure endo-cervical cells, and recommend booking a separate appointment for cervical screening	

Site	Asymptomatic	Symptomatic	Notes
Throat	CT/GC NAT	- GC C&S - CT/GC NAT	Listed in order of collection All swabs may be self or practitioner collected
Rectum	CT/GC NAT	- GC C&S - CT/GC NAT - HSV PCR	Listed in order of collection All swabs may be self or practitioner collected
Lesions (genital and oral) *For lesions suspected of LGV or Syphilis, consult with an experienced clinician.		HSV PCR	
		LGV* Use CT/GC NAT swab	Sample must be sent to BCCDC PHL Use 'Bacteriology' requisition and write "If positive for CT, send to NML for testing"
		Syphilis* <u>Syphilis buffer:</u> Submit swab in Syphilis PCR buffer <u>No Syphilis buffer available:</u> Use CT/GC NAT swab (orange Gen-Probe Aptima)	<u>Syphilis PCR buffer:</u> Sample must be sent to BCCDC PHL. Use 'Bacteriology' requisition and write "For <i>T.pallidum</i> PCR" <u>No Syphilis PCR buffer available:</u> Sample must be sent to BCCDC PHL. Use 'Bacteriology' requisition and write "Attn Dr Morshed, for <i>T.pallidum</i> PCR"

*Testosterone can induce a hypoestrogenic state in the internal genitals. This decreases epithelial cells, tissue resilience, skin barrier function and lactobacilli, and leads to increased susceptibility to traumatic irritation (during ADLs, sexual activity, etc), increased genital pH and susceptibility to BV symptoms. LifeLabs has advised that the low (or non-existent) levels of lactobacilli make screening for BV inapplicable, since this would yield results (BV intermediate or BV positive) that may not accurately reflect the underlying cause of symptoms.

The “C&S superficial wound” panel will provide more information about the types of organisms present and would better assist in clinical decision-making.

For information on treating internal genital dryness (atrophy), see “Managing side effects of testosterone & other common concerns”.

Appendix H – Sample of Informed Consent for Feminizing Hormone Therapy

Reproduced from: *Fenway Health* (2023)

Informed Consent for Feminizing Hormone Therapy

The use of hormone therapy for gender transition/affirmation is based on many years of experience treating trans persons. Research on hormone therapy is providing us with more and more information on the safety and efficacy of hormone therapy, but all of the long-term consequences and effects of hormone therapy may not be fully understood. This informed consent asks you to consider the expected benefits of hormone therapy and the possible side effects of hormone therapy, so that you can decide, with your medical provider, if hormone therapy is right for you. By signing this form, you are stating that you have discussed the risks and benefits with your medical provider or a member of the medical team and that you understand how these benefits and risks apply to you personally.

Androgen (testosterone) blockers are used to decrease the amount and/or block the effect of testosterone on and reduce the male features of the body. Oestrogen (usually estradiol) is used to feminize the body; oestrogens can also decrease the amount and effect of testosterone. Your medical provider will determine the form of oestrogen (pills, patches, gels or shots) and the dose that is best for you based on your personal needs and wishes, as well as considering any medical or mental health conditions you might have.

Each individual person responds to hormone therapy differently, and it is difficult to predict how each person will respond. You agree to take the androgen blockers and/or the estrogen only as prescribed and to discuss your treatment with your medical provider before making any changes.

The Expected Effects of Feminizing Hormone Therapy

The feminine changes in the body may take several months to become noticeable and usually take up to 3 to 5 years to be complete.

Changes that will be PERMANENT; they will not go away, even if you decide to stop hormone therapy:

- Breast growth and development. Breast size varies in all women; breasts can also look smaller if you have a broader chest.
- The testicles will get smaller and softer
- The testicles will produce less sperm, and you will become infertile (unable to get someone pregnant); how long this takes to happen and become permanent varies greatly from person to person

Changes that are NOT PERMANENT and will likely reverse if hormone therapy is stopped:

- Loss of muscle mass and decreased strength, particularly in the upper body

- Weight gain. If you gain weight, this fat will tend to go to the buttocks, hips and thighs, rather than the abdomen and mid-section, making the body look more feminine
- Skin will become softer and acne may decrease
- Facial and body hair will get softer and lighter and grow more slowly; usually, this effect is not sufficient, and most women will choose to have other treatments (electrolysis or laser therapy) to remove unwanted hair
- Male pattern baldness of the scalp may slow down or stop, but hair will generally not regrow
- Reduced sex drive
- Decreased strength of erections or inability to get an erection. The ejaculate will become thinner and watery and there will be less of it.
- Changes in mood or thinking may occur; you may find that you have increased emotional reactions to things. Some persons find that their mental health improves after starting hormone therapy. The effects of hormones on the brain are not fully understood.

Hormone therapy will not change the bone structure of the face or body; your Adam's apple will not shrink; the pitch of your voice will not automatically change. If necessary, other treatments are available to help with these things

_____ I have questions about the possible effects of hormone therapy.

_____ My medical provider or a member of the medical team has answered my questions about the effects of hormone therapy.

The Risks and Possible Side Effects of Oestrogen Therapy

- Loss of fertility (unable to get someone pregnant). Even after stopping hormone therapy, the ability to make healthy sperm may not come back. How long this takes to become permanent is difficult to predict. Some persons choose to bank some of their sperm before starting hormone therapy.
- Because the effect on sperm production is hard to predict, if you have penetrative sex with a natal female partner, you or your partner should still use birth control (e.g. condoms)
- Increased risk of developing blood clots; blood clots in the legs or arms (DVT) can cause pain and swelling; blood clots to the lungs (pulmonary embolus) can interfere with breathing and getting oxygen to the body; blood clots in the arteries of the heart can cause heart attacks; blood clots in the arteries of the brain can cause a stroke. Blood clots to the lungs, heart or brain could result in death.
- Possible increased risk of having cardiovascular disease, a heart attack or stroke. This risk may be higher if you smoke cigarettes, are over 45, or if you have high blood pressure, high cholesterol, diabetes, or a family history of cardiovascular disease.
- Possible increase in blood pressure; this might require medication for treatment.
- Possible increased risk of developing diabetes
- Nausea and vomiting (like morning sickness in a pregnant woman), especially when starting oestrogen therapy
- Increased risk of gallbladder disease and gallstones
- Changes in blood tests for the liver; oestrogen may possibly contribute to damage of the liver from other causes
- May cause or worsen headaches and migraines

- May cause elevated levels of prolactin (a hormone made by the pituitary gland); a few persons on oestrogen for hormone therapy have developed prolactinomas, a benign tumor of the pituitary gland that can cause headaches and problems with vision and cause other hormone problems
- May worsen depression or cause mood swings
- May increase the risk of breast cancer. The risk is probably higher than in natal men but lower than in natal women; the risk probably is related to how long you take oestrogen therapy.

The Risks and Possible Side Effects of Androgen Blockers (Spironolactone)

- Increased urine production and needing to urinate more frequently; possible changes in kidney function
- A drop in blood pressure and feeling lightheaded
- Increased thirst
- Increase in the potassium in the blood and in your body; this can lead to muscle weakness, nerve problems and dangerous heart arrhythmias (irregular heart rhythm)

- _____ I have questions about the risks of hormone therapy.
- _____ My medical provider or a member of the medical team has answered my questions about the risks of hormone therapy.
- _____ I would like to discuss ways to help me quit smoking.

You understand that

- Smoking may greatly increase the risks of taking hormone therapy, especially the risk of blood clots and cardiovascular disease. If you smoke, you should try to cut back or quit. If you have other risks for blood clots or cardiovascular disease, your provider may ask you to quit smoking before you start on hormone therapy.
- Taking oestrogen in doses that are higher than recommended by your doctor will increase your risk of side effects and may not produce better feminizing effects.
- You will need to stop taking hormones for a few weeks before and after any surgery.
- Treatment with oestrogen is expected to be lifelong; suddenly stopping oestrogen treatment after you have been on it for a long time may have negative health effects
- You may choose to stop taking hormone therapy at any time or for any reason. You are encouraged to discuss this decision with your medical provider.
- Your provider may decrease the dose of oestrogen or androgen blockers or stop prescribing hormone therapy because of medical reasons and/or safety concerns; you can expect that the medical provider will discuss the reasons for all treatment decisions with you.
- Hormone therapy is not the only way that a person may appear more feminine and live as a female; your medical provider and/or a mental health provider can help you think about these other options.

You agree to

- Take androgen blockers and/or oestrogens only at the dosage and in the form that your medical provider prescribes.
- Inform your medical provider if you are taking or start taking any other prescription drugs, dietary supplement, herbal or homeopathic drugs, or street drugs or alcohol so that you can discuss possible interactions with and effects on your hormone treatment
- Inform your medical provider of any new physical symptoms or any medical conditions that may develop before or while you are taking hormone therapy and discuss the evaluation of these conditions; inform your provider if you think you are having bad side effects from the medications.
- Keep regular follow up appointments; this may include appointments for mammograms and prostate exams
- Have regular monitoring blood testing done; your provider will discuss with you what tests are necessary in order to monitor for potential harmful effects and to ensure that your hormone therapy is safe and effective

_____ I have questions about my rights and responsibilities with taking hormone therapy

_____ My medical provider has discussed my questions and concerns with me

By signing this form you acknowledge that you have adequate information and knowledge to be able to make a decision about hormone therapy and that you understand the information your medical provider has given you. Based on this information:

_____ I choose to begin oestrogen

_____ I choose to begin taking androgen blockers only

_____ I do not want to begin hormone therapy

Patient 's name on health insurance

Patient's preferred name, if different

Patient signature

Date

Provider name

Provider signature

Date

Appendix I – Sample of Surgical Referral Template

Date

Patient Name

Legal name, if different Date of birth

To Whom It May Concern,

Regarding the above named patient:

I am a _____ practicing at _____

I have worked with this patient since _____ and have seen them [FREQUENCY OF VISITS]. I am appropriately qualified to perform preoperative evaluations in accordance with the criteria described in the World Professional Association for Transgender Health (WPATH) Standards of Care 8th Version (SOC8). In the course of our patient-provider relationship, I have assessed them for readiness, appropriateness, and eligibility for _____ surgery.

I have evaluated the above named patient and diagnosed them with Gender Incongruence and Dysphoria (F64.0) in line with DSM-5 criteria. They have received gender affirming hormone therapy since _____. *[Or indicate that the patient is unable to, or unwilling to take hormone therapy. If unable/unwilling to take hormone therapy and seeking gonad removal, please explain, including that the patient understands hormone therapy may be required after surgery]* Despite this treatment, they continue to experience severe gender dysphoria and emotional distress due to their body not fully aligning with their gender identity.

As a result of my assessment, I recommend _____ surgery as the next appropriate step to allow them to continue living in their true identified gender. Rectifying body incongruence is expected to provide marked relief of the anxiety and distress that they experience.

From a clinical standpoint, they have demonstrated an understanding of the impact of this surgical procedure(s). NAME is fully capable of making an informed decision about surgery and is expected to follow and adhere to pre- and post-surgical treatment recommendations responsibly.

NAME is emotionally and practically ready for this gender affirmation surgery, provided they are recommended for surgery by the surgeon after consultation. The patient has the following social supports in place: _____ and their recovery plan is _____. The patient has reasonable expectations with regards to surgical outcomes, and is prepared for the potential of complications or less-than-satisfactory results.

NAME has further diagnosed psychiatric or mental health history.

NAME has a history of [list mental health/psychiatric history]. These conditions are managed via _____ and are currently reasonably well controlled. I believe that the patient has adequate resilience and capacity to undergo this procedure, and cope with any potential

complications. The patient IS/IS NOT linked to mental health care currently, and WILL/WILL NOT remain linked throughout the surgical process. Contact info for the patient's mental health provider(s):

It is my clinical opinion that NAME meets the criteria for gender dysphoria (F64.0) and the requirements for the WPATH Standards of Care, version 8, and it is at this time medically necessary for this patient to undergo _____surgery.

Sincerely,

NAME
Credentials
Practice Name
Contact info



For more information, contact
TransWave Jamaica at
hello@transwaveja.org
or (876) 667-6202 or
visit **<https://transwaveja.org>** or
#8 Sydney Road, Kingston.



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