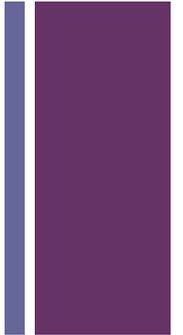




Working with gender diverse clients

Dr Jeannie Oliphant
Sexual Health Physician

+ Trans*



Transman
Transgirl **Fakaleiti** Tangata-ira-tane
Gender-fluid Transwoman
Transmale **Takatapui** Boy Genderqueer
Whakawahine Nonbinary **Fa'afafine**
Transboy Transfemale Man
MTF **FTM** **Woman**
Girl



Original article

The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12)



Terryann C. Clark, Ph.D., M.P.H., N.Z.R.N.^{a,*}, Mathijs F. G. Lucassen, Ph.D., N.Z.R.O.T.^b, Pat Bullen, Ph.D.^c,
Simon J. Denny, Ph.D., F.R.A.C.P.^d, Theresa M. Fleming, Ph.D.^{b,d}, Elizabeth M. Robinson, M.Sc.^e,
and Fiona V. Rossen, Ph.D.^f

“a girl who feels like she should have been a boy, or a
boy who feels he should have been a girl”

4% reported they were transgender or unsure of their
gender (1.2% transgender, 2.5% unsure) in approx 8,000
students.



Supporting gender diversity in primary care

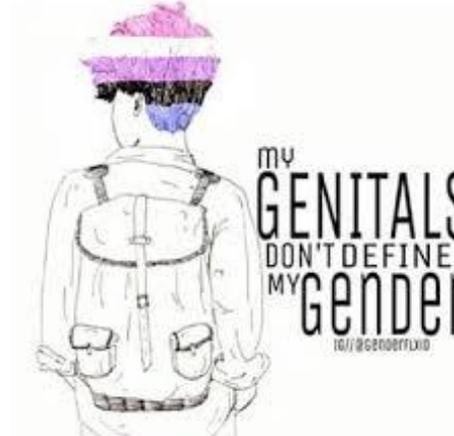


- Gender identity is self-determined – your patient is the expert on their own gender identity!
- Provide an inclusive environment where patients will feel safe talking about their gender.
- Be gender affirming – using chosen names and pronouns when talking to or about your patient.
- Be prepared to discuss gender dysphoria and the range of options available to address this.

Social stigmatisation and discrimination, including within the health care system, is a barrier to accessing health services and contributes to adverse outcomes.

+ Gender dysphoria

- *Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)*
WPATH SOC v7.
- Not everyone experiences gender dysphoria - but a lot of people do.



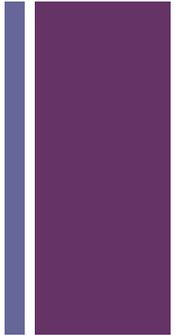
+ Medical reception



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



The Royal New Zealand
College of General Practitioners

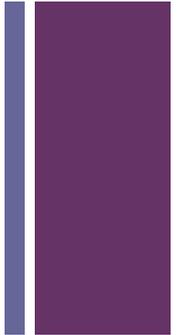


Get your MOPS points here!

GP audit tool

- GP practice audit RNZCGP: Inclusive primary health care for gender diverse patients

+ Asking about gender identity...



Staying open to your patient's unique experience and goals is the best way to provide gender affirming care

- How would you describe your gender identity?
- Do you remember the time when you realised that your gender was different from the one you were given at birth?
- Have you talked to anyone about this? Family, friends...
- Who is supporting you or who do you think might be supportive?
- Have you taken any steps to feel more comfortable in your gender?

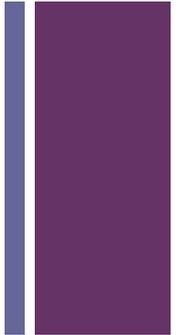
+ Goals and needs

- Discuss current supports and plans for navigating transition in relationships, work or school settings
- Family support
- Review any physical or mental health conditions - ensure that they don't pose barriers to gender affirming interventions
- Hormonal treatments
- Gender affirming surgery
- Psychological support





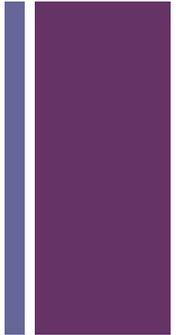
Can I just check how you are feeling?



- Research shows that trans people experience higher rates of anxiety, eating disorders, social phobia, depression and suicidal ideation than their cisgender peers. (Strauss, Transpathways: 2017)
- It is often the cumulative experience of multiple factors that contributes to poor mental health.
- “To me, it’s not the fact that I’m trans that caused problems. It’s that general society doesn’t accept trans people. I’m not anxious in public because I’m trans – I’m anxious in public because people tend to be threatened by people like me.” (Transpathways)
- Dutch cohort study showed post medical transition psychological well being was same or better than aged-matched young adults from general population. (de Vries 2014)



Can I just check how you are feeling?



- Significant depressive symptoms:

41% (transgender) vs 12% (nonTG)

- Suicide attempt in previous 12 months:

20% (transgender) vs 4% (nonTG)

- Unable to access healthcare:

40% (transgender) vs 18% (nonTG)

Clark et al, 2014. JAH 55, 93-99

+ Young people



- Discuss privacy and confidentiality at the beginning.
- Define the limits of confidentiality

Their information will be kept private and confidential within the treating team, unless there are concerns for safety or they consent to sharing information.

If safety concerns are raised, others may need to be involved. Promising not to tell can place people in an unsafe situation.

Parents or caregivers do not have access to their health information.

+ Young people



- See all young people on their own for at least part of the consultation to enable full disclosure.
- Families and whānau need information and support.
- Gender diverse young people may not have the support of their parents or guardians but this does not preclude them from receiving support and care.
- Assess for risks around abuse, bullying, drug and alcohol risk taking, sexual health and mental health concerns.
- Provide assistance with family or carer conflict, and family violence.
- Puberty blockers have a positive impact on future well being. Refer promptly.

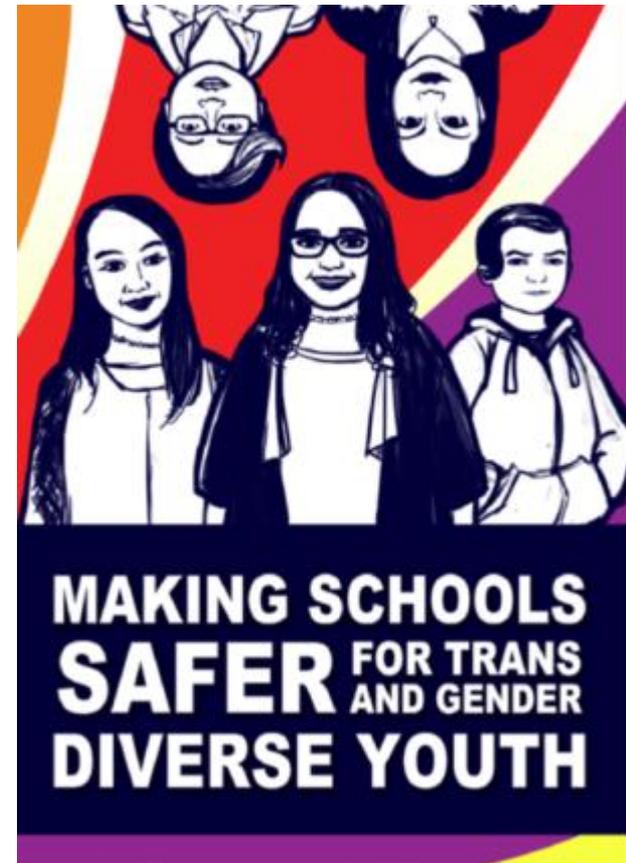
+ Sexual Health



- Sexual orientation is different to gender identity
- **Do not assume anything about a person's sexual orientation or the type of sex that they are having.**
- Do you have a sexual partner? What are the genders of your partners? Are they also trans? Is there a possibility that any of your partners could get you pregnant?
- Ask specifically what sexual contact is occurring in order to provide the appropriate sexual health tests i.e. throat swabs, vaginal swabs, anal swabs, urine samples. Providing a rationale for questions helps.

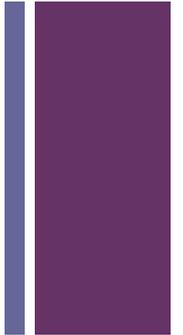
+ Supporting Schools - insideOUT

- Working with school guidance counsellors, health teams, diversity groups
- Advocacy around choice of school uniforms
- Names/gender on school rolls
- School bathrooms
- School sports teams
- Changing gender on NZQA



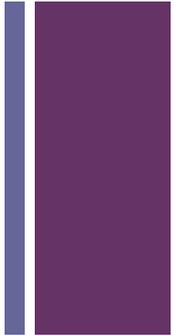


GnRH blockers – puberty blockers

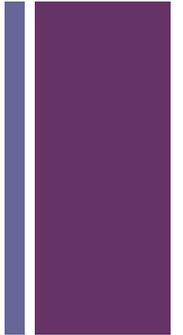


- Field fast evolving in terms of defining best treatment practices – currently recommended to wait for Tanner 2 puberty stage before starting GnRH blockers (Lucrin)
- Beneficial in early and late puberty
- Stops progression of puberty
- Safe, well tolerated and fully reversible
- Can be hugely beneficial in relieving psychological distress
- Can alter life trajectory

+ GnRH blockers



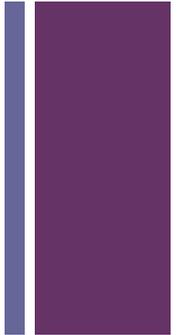
+ PHARMAC



- 1st December 2016 Zoladex (goserelin) implants only subsidised GnRH blocker except –
- Lucrin (leuprorelin) can be used where “the patient is a child or adolescent and is unable to tolerate administration of goserelin and the prescription is endorsed accordingly”



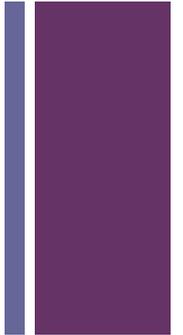
+ Autistic Spectrum



- AS – general pop rates 1% v.s. up to 9.4% in gender diverse (de Vries 2010)
- Clinical complexity – failures of translation
- Concerns about fixations, identifying with being ‘other’
- “They think that we aren’t really transgender – just confused because of autism”
- “It’s tough for us to put our personal sense of gender identity into words – but this doesn’t mean we don’t have one”

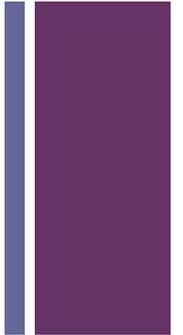
+ Older people

- These patients may have experienced discrimination, non-acceptance, and significant barriers to healthcare for a long time.
- There is no upper age limit to starting hormone therapy. Use an individual risk assessment and discussion on likely benefits to guide an informed consent process.
- Cognitive impairment and chronic disease may require a multidisciplinary approach including primary care, endocrinology, and geriatric medicine, as well as other speciality input.
- Offer to act as an advocate if the patient is
 - receiving support within the aged-care system.
 - resident in an aged care facility.





Auckland services



Centre for Youth Health – Regional service with clinics in Henderson, Ponsonby (Youthline), Papatoetoe (Youthline), Botany, Pukekohe

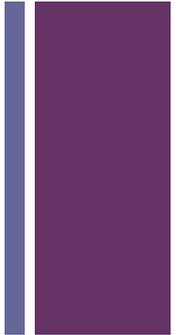
- Multidisciplinary team – doctors, nurses, social workers, youth workers – soon to appoint a psychologist

Auckland Regional Sexual Health Service – Regional service with clinics in Henderson, Glenfield, Greenlane Clinical Centre, Mangere

- Multidisciplinary team – doctors, nurses, psychotherapist, counsellor
- Both services provide Readiness for Hormones assessments and Readiness for Surgery assessments by a mental health professional as part of standard care.



Readiness for hormones – a series of conversations



Informed consent is a process not a piece of paper

- Discuss gender affirming goals
- Discuss hopes and expectations of hormone therapy
- General medical Hx and Fhx
- Baseline blood tests & physical examination
- Review any relative contraindications
- Discuss risk mitigation e.g. smoking cessation
- Ensure capacity to consent

+ Gender diversity

- Do not assume that all transgender people want to conform to binary gender norms. Gender diverse people may identify as binary or non-binary. Each person's gender expression (how they present to the world) is unique.





Precautions to hormonal Rx

Recent or current smoker

Heart failure, cerebrovascular disease, coronary artery disease, AF

Cardiovascular risk factors – BMI > 30, hyperlipidemia, hypertension

History or Fhx of VTE

Migraine

Hx of hormone sensitive cancers e.g. breast, prostate, uterine, testicular

Sleep apnoea

Some intersex disorders of sex development

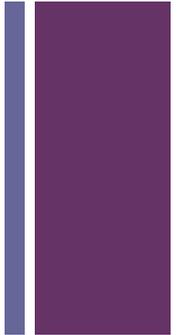
+ Fertility preservation



- There are many ways of creating families...
- For those taking oestrogen – testicular volume is greatly reduced impacting on sperm maturation and motility.
- Consider sperm cryopreservation before starting Rx to preserve fertility. Avoid tucking 5 days prior.
- For those taking testosterone – may regain fertility after stopping T. The likelihood of successful pregnancy is related to the persons age and duration of hormonal treatment.
- Testosterone is contraindicated in pregnancy.

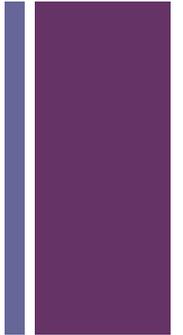
+ Tucking

- Gently pushing testicles up inside the body and pulling the penis back in between the legs.
- Provide patient advice:
 - Use tight-fitting underwear or surgical tape to hold in place. Do not use any other tape as skin could peel off when removed.
 - Cut pubic hair short to help with tape removal.
 - Spend some time each day without tucking to avoid chafing, sores, and lower sperm count. The latter is important to consider if they want to have a child.



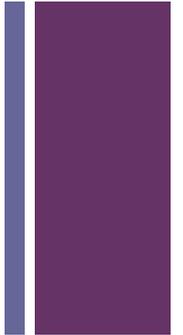


Readiness for hormones – a series of conversations



- Review effects of hormone therapy – including permanent changes
- Discuss potential side effects of hormone therapy
- Review potential risks of hormone therapy
- Discuss and sign written consent

+ Sarah



- Family GP for many years
- Haven't seen Sam for about 6 years, now aged 25 years
- Presents asking for a script for hormones and tells you her name is now Sarah
- Has been seen by a DHB service about 5 years ago and remembers being prescribed some tablets but wasn't the right time for her, struggling with anxiety and low mood at that time, family not accepting of transition and she stopped treatment. Living independently now and starting to socially transition. Works in IT industry. Doesn't want to go back to that DHB service!



Gender diversity and Transgender Health

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Back < >

Gender Diversity and Transgender Health

This pathway provides advice about gender affirming healthcare for people of all ages.

[About gender diversity and transgender health](#)

Assessment

Practice Point

Social stigmatisation and discrimination, including within the health care system, is a barrier to accessing health services and contributes to adverse outcomes.

- Ask the patient about:
 - their preferred [pronoun](#), name, title, and [gender identity description](#). Enter the patient's self-identified name and gender into the clinical records.
 - [history](#).
 - [suicidal ideation and intent](#) and screen for self-harming behaviours. Gender diverse people are at higher risk of developing anxiety and depression. In a mental health emergency with immediate risk, request [emergency department assessment](#) or call 111 if immediate assistance is required.
- Discuss the patient's [goals and needs](#).
- If hormones may be part of the patient's treatment plan:
 - Discuss [treatment effects](#) and manage expectations of hormonal therapy to enable informed treatment decisions.
 - Assess for [precautions to hormonal treatment](#).
 - Arrange investigations:
 - [Baseline tests before feminising therapy](#)
 - [Baseline tests before masculinising therapy](#)

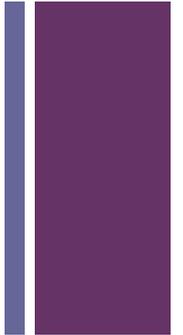
Management

Timely and appropriate management reduces the risk of self-harm and suicidal intent, and is associated with better health outcomes.

- Provide patient information and support. Provide specific support to:
 - [young people](#).
 - [older adults](#).



What information is relevant in a medical history?

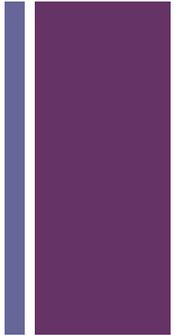


- [history](#).

History

- Ask the patient about:
 - how they would describe their gender to others and duration of awareness.
 - what supports they would like to access.
 - who is supporting them with their gender identity.
 - how comfortable they are with currently living in the gender they identify with.
 - prescribed and non-prescribed medications including self-medicating with hormones.
 - past medical history.
 - drug and alcohol history.
 - [sexual health](#) and [risk activity for STI](#) or blood borne virus (BBV).
 - mental health conditions e.g., depression, anxiety.
 - Include [Headssss](#) psychosocial assessment for all young people to identify risks and resiliencies.
- [suicidal ideation and intent](#) and screen for self-harming behaviours. Gender diverse people are at higher risk of developing anxiety and depression. In a mental health emergency with immediate risk, request [emergency department assessment](#) or call 111 if immediate assistance is required.

+ Baseline investigations



- Arrange investigations:
 - [Baseline tests before feminising therapy](#)

Baseline tests before feminising therapy

- Blood test – FBC, LFT, renal function, HbA1c, non-fasting lipids, prolactin, LH and FSH, testosterone.
- If clinically indicated, karyotype.
- Blood pressure, height, weight, and BMI.

Oestrogen/anti-androgen effects	Expected onset	Maximum effect
*Breast growth	3-6 months	2-3 years
*Smaller testes	3-6 months	2-3 years
Decreased fertility	Variable	Variable
Fat redistribution	3-6 months	2-5 years
Decreased muscle mass	3-6 months	1-2 years
Mood changes	Variable	Variable
Decreased erections	1-3 months	3-6 months
Changes to sex drive	Variable	Variable
Softer skin	1-6 months	3 years
Decreased body/facial hair	6-12 months	3 years
Decreased balding	No regrowth, loss stops 1-3 months	1-2 years

+ Prescribing Rx

10. Refer adults to Northern Region Transgender Health Services for support around medical transition if needed.

- [Feminising therapy](#)

Feminising therapy

- Consider whether a GnRH blocker is needed. This is recommended to prevent full pubertal changes.
- Note that the Zoladex implant (goserelin) is currently the sole subsidised supply brand but that Lucrin (leuprorelin) is fully subsidised for adolescents with specialist endorsement.
- If not commencing a GnRH blocker, start with an anti-androgen agent e.g. cyproterone 25 mg or spironolactone. If starting on spironolactone, check electrolytes, urea, and creatinine after 1 to 6 weeks.
- Add oestradiol valerate e.g.:
 - Progynova 1 mg daily.
 - Estradot 50 microgram every 24 hours (change patch twice a week), measure oestradiol 48 hours after application and before applying the new patch.
 - These are suggested starting doses, which may need to be increased according to the patient context and biochemical levels achieved with therapy.
- Progesterone therapy is not recommended as it is associated with cardiovascular disease, breast cancer, weight gain, and depression. There is no evidence that it enhances breast development.
- Biochemical targets:
 - Testosterone < 2 nmol/L
 - Oestradiol – Titrate dose gradually to achieve feminisation. Avoid supraphysiological levels.
- [Consent form for feminising hormone therapy](#)

+ Prescribing Rx



Cyproterone: scored tablet usual dose is $\frac{1}{2}$ tablet (25mg)

- Side effects – fatigue, depression, wt. gain. In higher doses can cause abnormal LFT, hepatitis, jaundice.
- Not required post orchidectomy/GRS.

Progynova (oestradiol valerate): usual starting dose 1 mg.

- Gradual increase (6 monthly) recommended for best breast growth.
- Start 1 mg and increase to 2-4 mg (rarely need higher doses).
- Estradot patches 25/50/75 or 100 mcg twice weekly (fully subsidised).
- Lower doses oestrogen needed post orchidectomy/GRS 1-2 mg daily.



Discuss risks

The full medical effects and safety of taking hormones are not fully known.

■ Likely increased risk:

- Thromboembolic disease
- Cholesterol changes
- Gallstones

■ Possible increased risk if extra risk factors:

- Heart disease
- Diabetes

■ Possible increased risk:

- Increased BP
- Liver abnormalities
- Increased prolactin and possibility of benign pituitary tumors

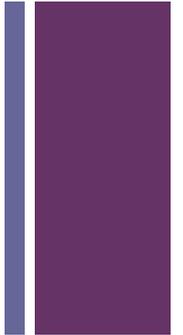
■ No increased risk/unknown risk:

- Breast cancer





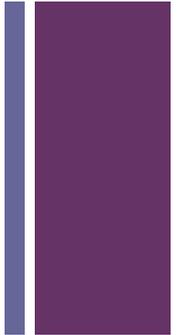
Thrombotic risk



- Meta-analyses suggest transdermal oestrogens have minimal thrombotic risk for cis-women taking HRT.
- No prospective trials for transwomen taking oestrogen.
- Retrospective studies for transwomen show increased risk of venous thromboembolism – lowest with transdermal oestrogen and oestradiol valerate. (Shatzel et al. 2016)
- Thrombosis most likely in the first year after starting Rx.
- Consider transdermal oestrogen if > 40 years, BMI > 30, smoker.
- Consider stopping oestrogen 2/52 prior to any planned surgery.



Monitoring maintenance therapy



- [Surveillance for maintenance hormonal therapy.](#)

Surveillance for maintenance hormonal therapy

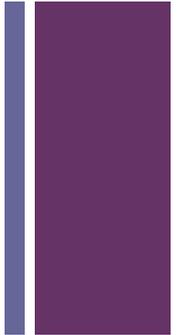
The prescribing and monitoring of maintenance hormonal therapy is best done in primary care as part of the patient's overall care.

- [Surveillance for maintenance feminising therapy](#)

Surveillance for maintenance feminising therapy

- Check mental health issues – anxiety, depression.
- Check blood pressure (BP) and BMI every 6 months.
- Monitor for cardiovascular risks e.g., smoking.
- Ongoing investigations:
 - Every 3 to 6 months for first year then at least annually:
 - Blood tests – FBC, renal function, LFT, HbA1C, lipids, oestradiol (avoid supraphysiological levels), testosterone (aim for < 2 nmol/L).
 - Monitor K+ if on spironolactone – 1 to 6 weeks after starting or changing dose.
 - Every 2 years – prolactin (recommended although abnormality unlikely).
 - If [major risk factors](#) for [osteoporotic](#) fracture are present consider [bone density scan \(DEXA\)](#) testing.
- Potential complications:
 - Venous thromboembolism (VTE):
 - particularly if aged > 40 years.
 - most common in first 2 years of treatment.
 - reduced risk on transdermal oestrogen.
 - if aged > 40 years or other DVT risks, consider switching to transdermal oestrogen.
 - Cardiovascular disease – adverse lipid profile, hypertension
 - Insulin resistance
 - Liver dysfunction
 - Gallstones
 - Alterations in mood and libido
 - Small risk of osteoporosis, breast cancer, and (rarely) hyperprolactinaemia.

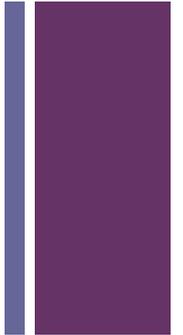
+ Ezra



- New patient registered with your practice. Ezra is a transgender male aged 22 years and moved to Auckland 5 years ago. Family supportive. Works for St. Johns ambulance service. Stealth at work. Has been under the care of the DHB transgender health service and now is being discharged to primary care.
- Stable on maintenance Reandron (testosterone). Had chest reconstructive surgery last year and pleased with outcome.
- Discharge letter from DHB service outlining current treatment but little information provided regarding ongoing care!

Testosterone effects	Expected onset	Maximum effect
*Deeper voice	3-12 months	Years
*Body and facial hair	3-6 months	3-5 years
*Growth of external genitals (clitoris)	3-6 months	1-2 years
*Scalp hair loss	> 12 months	Variable
Decreased fertility	Variable	Variable
Fat redistribution	3-6 months	2-5 years
Increased muscle	6-12 months	2-5 years
Mood	Variable	Variable
Changes to sex drive	Variable	Variable
Skin changes - acne	1-6 months	1-2 years
Vaginal dryness	3-6 months	1-2 years
Bleeding cessation	2-6 months	n/a

+ Prescribing testosterone



- Specialist only medication. Comes in various forms:
- Shorter acting - Depot T, Sustanon IM every 3 weeks
- Longer acting Reandron (testosterone undecanoate) 1000mg/4 mls given every 12 weeks (10 – 14).
- Provides more steady state levels, check testosterone level before next injection.
- Risk – (rare) pulmonary oil microembolism.
- Needs to be given by a health professional.
- Testosterone is contra-indicated in pregnancy.



Discuss risks

The full medical effects and safety of taking hormones are not fully known.



■ Likely increased risk:

- Increased RBC (polycythemia)
- Sleep apnoea

■ Possible increased risk if extra risk factors:

- Diabetes
- Increased BP

■ Possible increased risk:

- Cholesterol changes
- Liver abnormalities

■ No increased risk/unknown risk:

- Breast cancer
- Cervical, ovarian, uterine cancer
- Blood clots (DVT)



Monitoring maintenance therapy

Surveillance for maintenance hormonal therapy

The prescribing and monitoring of maintenance hormonal therapy is best done in primary care as part of the patient's overall care.

- [+ Surveillance for maintenance feminising therapy](#)
- [- Surveillance for maintenance masculinising therapy](#)

Surveillance for maintenance masculinising therapy

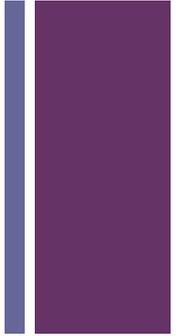
- Check mental health issues – anxiety, depression.
- Check blood pressure (BP) and BMI every 6 months.
- Ongoing investigations – Every 3 to 6 months for first year then at least annually:
 - Blood tests – FBC (polycythemia risk), renal function, LFT, HbA1C, lipids, oestradiol, testosterone. Aim for normal male ranges for all hormone levels.
 - If [+ major risk factors](#) for [osteoporotic](#) fracture are present, consider [bone density scan \(DEXA\)](#) testing.
 - Arrange ultrasound to assess endometrial thickness if vaginal bleeding restarts.
- Potential complications:
 - Polycythemia – If severe could lead to stroke
 - Adverse lipid profile
 - Mood and libido changes
 - Obstructive sleep apnoea
 - Small risk of liver dysfunction, insulin resistance, cardiovascular disease, endometrial hyperplasia, and osteoporosis

+ Binding 101

- Bind for less than 8 hours a day to avoid skin irritation, tissue breakdown, back pain, and breathing problems.
- Always take the binder off before sleep and exercise.
- Never use duct tape or Ace bandages to bind as they can restrict breathing and movement.
- Stop binding if experiencing pain.
- Purchase a binder made specifically for the task



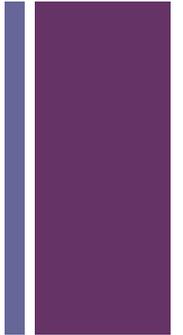
+ Gender affirming surgery



Transfemales – variable access to

- Breast augmentation
- Orchiectomy
- Facial feminising surgery
- Tracheal shave
- Vocal cord surgery
- Genital gender affirming surgery (lower surgery)

+ Gender affirming surgery



Transmales – variable access to

- Chest reconstruction
- Hysterectomy
- Oophorectomy
- Genital gender affirming surgery – metoidioplasty
- Genital gender affirming surgery - phalloplasty



GRS



The New Zealand Herald



A possible 50 – year wait for transgender surgery:

“It’s absurd, at this rate I wouldn’t get the surgery until I was 73” (Jennifer Shields, August 2016)

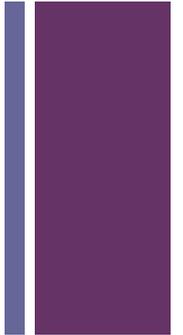
- High Cost Treatment Pool funds overseas surgery for 3 MtF and 1 FtM every 2 years.
- Currently approx. 86 people on the waiting list.
- NZAPS – position statement on GRS (August 2016).
- Preferred NZAPS option is to develop centralised GRS for MtF in NZ.

+ Other gender affirming interventions

- Voice therapy
- Facial hair removal – laser/electrolysis



+ Ongoing care



- Patients who are trans or gender diverse experience the same health problems as other patients and have very few differing needs.

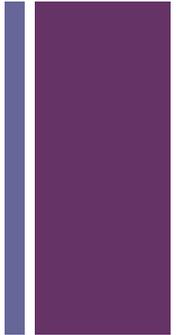
6. Ensure appropriate **-** [cancer screening](#) according to National Guidelines.

Cancer screening

- Gender diverse people who have not undergone the surgical removal of breasts, cervix, uterus, ovaries, prostate, or testicles remain at risk of cancer in these organs.
- Manage this carefully, as many gender diverse people find cancer screening physically and emotionally challenging.



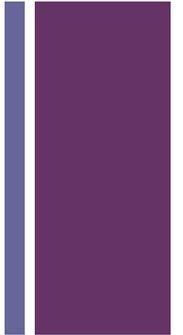
Cervical Smear tests for trans men



- Acknowledge that this may be a difficult experience and ask – what do you think may make this a better experience for you?
- Ask whether or not they have/have had penetrative sex. This may help you gauge a person's comfort during the exam.
- Show them the speculum before the examination. It is important to be attentive to the ways that the speculum may add an extra layer of discomfort for trans men



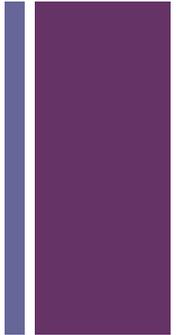
Cervical Smear tests for trans men



- Using the right words: During the interview portion, ask your clients what words they use for their body parts.
- The terms vagina and labia may be very disconcerting for some, while others will say “it is what it is” and want you to use those commonly understood terms regardless of their comfort with them. Using vague terms such as ‘external genitals’ or ‘internal part of the exam’, instead of labia and cervix, may also be preferred.
- Testosterone can cause vaginal dryness. Using lube and warm water can be very helpful for speculum insertion.



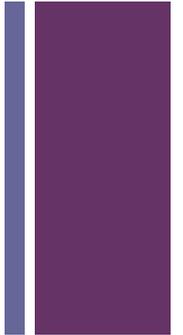
Cervical Smear tests for trans men



- Testosterone also makes trans male genitals look different. It can cause the clitoris to grow and the cervix may look atrophic. This is not the time to start a discussion about those changes (except for things directly relevant to the pap).
- Do not make a trans person feel like they need to provide an education session.
- Writing that this is a trans man's sample on the lab form can avoid confusion if the NHI states M.



Ensure correct name/gender on medical records/NHI



Continuing support and care

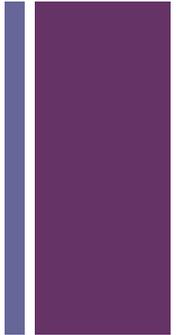
- Ensure [changes in name and gender markers](#) are made in the practice system. Contact the [Ministry of Health](#) to update the NHI.

Changes in name and gender markers

- Electronic and paper medical records must clearly indicate the patient's self-identified name and title.
- Ministry of Health advice is for the NHI to reflect the name and gender of choice. There is no requirement for individuals to provide proof of their gender to support the information recorded in the NHI gender field. A preferred name can be recorded against the NHI also. Contact the Ministry of Health, phone **0800-855-151**, to make these changes.
- Updating the NHI is important for the self-identified name and gender to be reflected in other health services. Do this only if the patient agrees.



Supporting social and legal transition



- Advocating in schools and work places
- Supporting with documentation
- Name change with Department of Internal Affairs
- Passport – changing gender
- Birth certificates
- IRD



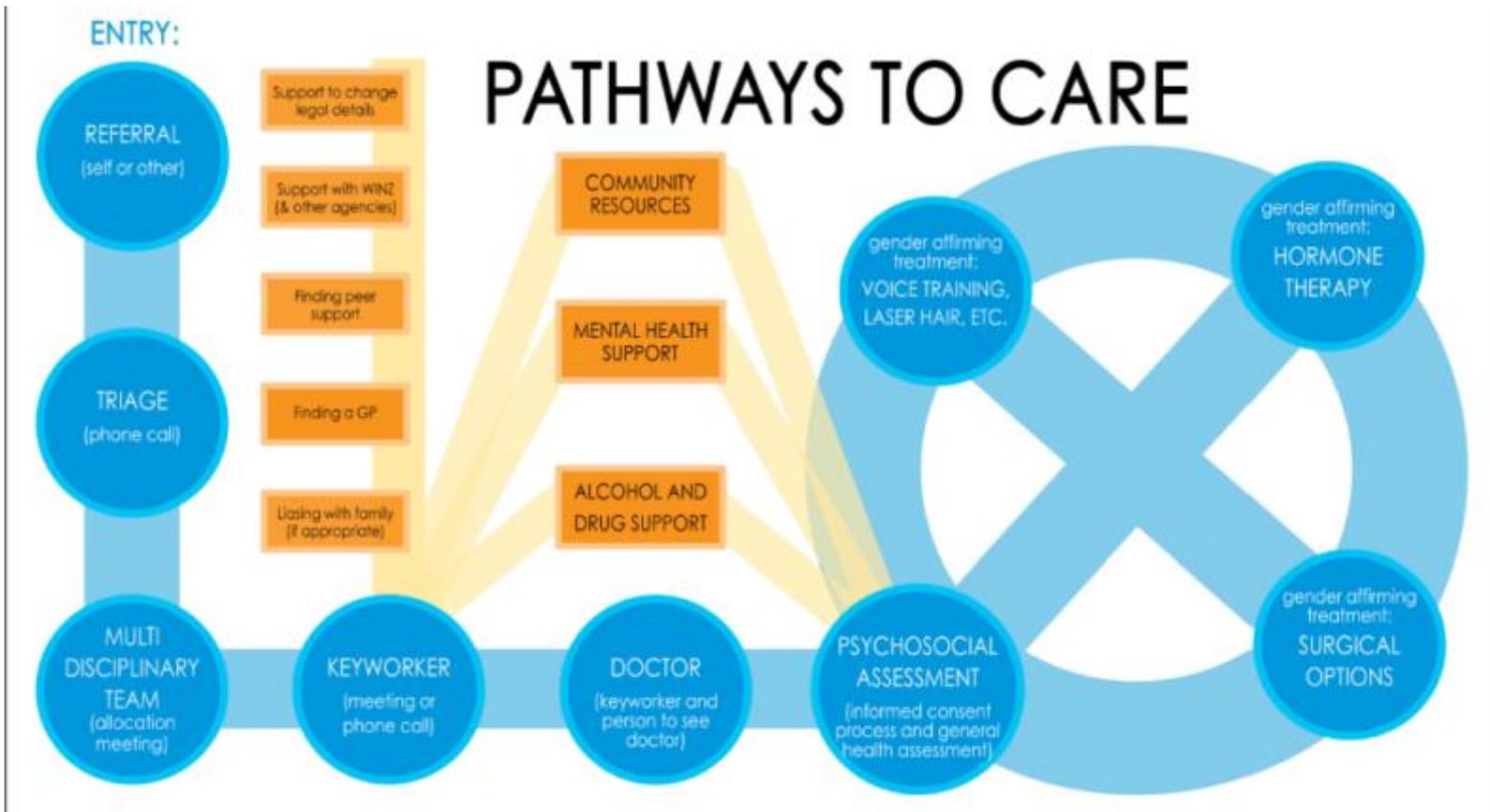
+ Petition 2011/107



- Response to Petitioner:
- Stocktake of gender reassignment services by DHB
- 11 of the 20 DHBs provide services to some degree
- The Ministry of Health's view is that transgender health services are best organised, developed and provided on a regional basis by DHBs.
- Services such as counselling, endocrinology and surgical services are already available in the public health system



Auckland Regional Pathways to Care Model

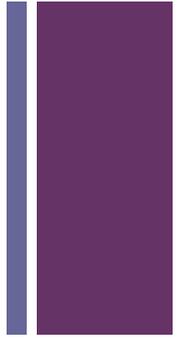


+ Resources

- Websites – Gender minorities NZ



+ Resources – Inside Out



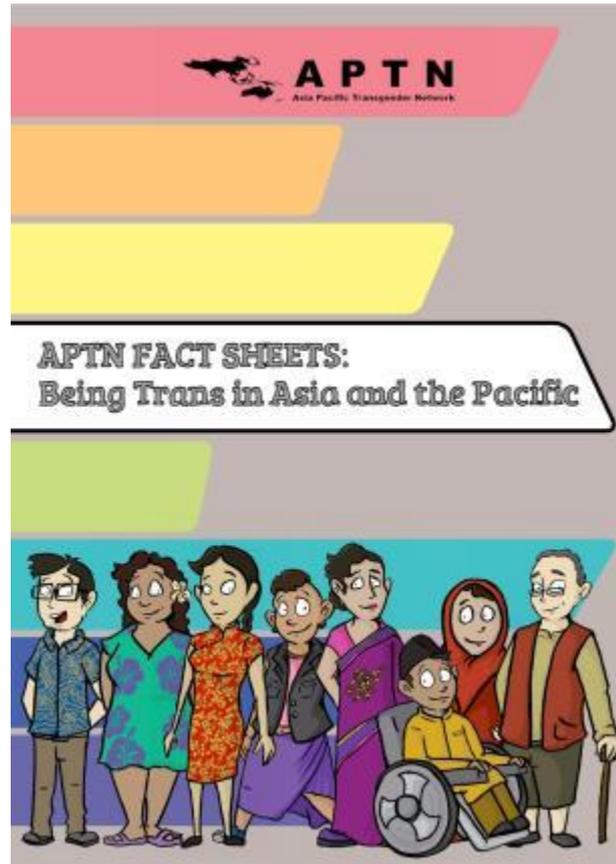
A friendly and accessible learning resource to help increase understanding and support of sex, gender and sexuality diversity, so we can all belong

[VIEW THE TRAILER](#)

[WANT TO KNOW MORE?](#)

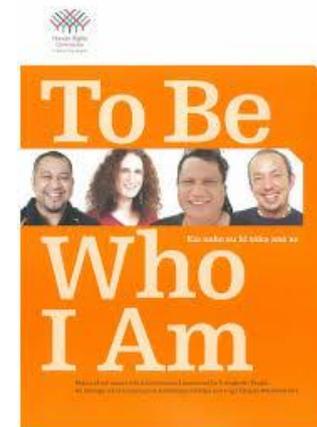
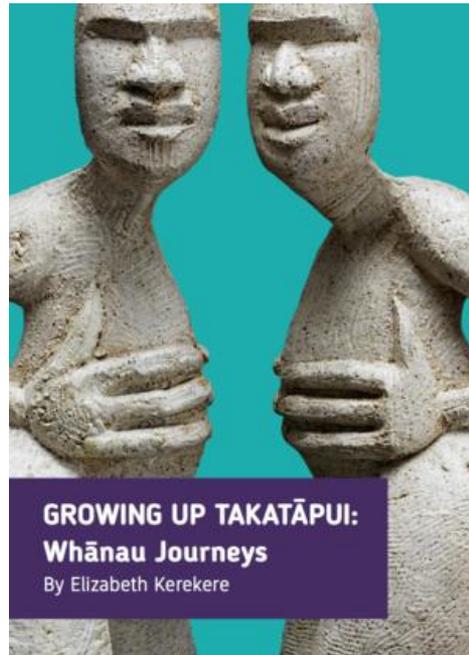
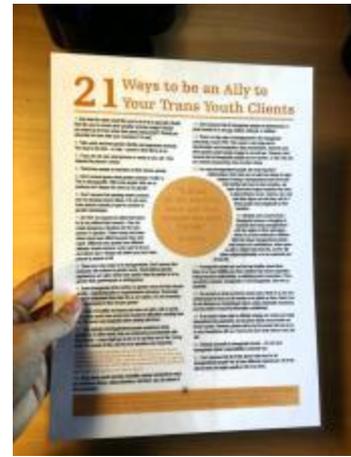


+ Asia Pacific Transgender Network



+ Resources

- Human Rights Commission: To be who I am/Trans ally
- Growing up takatāpui



+ Pride Parade

