Education Package

2SQTP-NB/P2SQT-NB

Version 2 - November 2022

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Women and Gender Equality Canada

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To the project staff, Jacob Barry, Laylia Bennett, and Tif Rogers, thank you for your dedication to ensuring that this project was community-led and handled with care. Your hard work, and attention to detail and the complexity of caring for 2STIGD folks does not go unnoticed or unappreciated.

Furthermore, we are immensely grateful for the resources and tools made available to 2SQTP-NB/P2SQT-NB from the **Community Based Research Centre**, **Trans Care BC**, and **Rainbow Health Ontario**.

Forward

This education package seeks to share lived experiences with accessing care in New Brunswick, was created by Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) individuals in consultation with other 2STIGD community members, with a goal of incorporating as many intersecting identities and voices as possible. Because the project is action oriented, we seek to share our real and lived experiences with the medical system and society at large, and we offer these resources as a way to make a change. Where we repeat ourselves in the education package, it's intentional. Our experiences have been overlooked, erased, and misunderstood repeatedly. We want better care for others and for ourselves.

Land Acknowledgement

Two-Spirit, Queer and Trans Pathways New Brunswick (2SQTP-NB) seeks to positively impact health care for Two-Spirit, trans, Indigiqueer, and gender-diverse individuals (2STIGD) on the unceded and unsurrendered territories of the Wolastokqiyik, Mi'kmaq, and Peskotomuhkati Peoples.

We recognize that the medical system in particular has been weaponized in the past and present against the Indigenous Peoples. For this reason, and in light of the 23rd and 24th TRC Calls to Action, as project members and throughout our Education Package we understand that current health outcomes for Indigenous patients are intrinsically linked to the legacy of residential schools and day schools, and the greater historical context of colonization.

We have a responsibility to use the knowledge we gain to develop and implement healthcare practices that better meet the needs of 2STIGD individuals, to continue to challenge our own biases, and to remember that learning is always ongoing.

Content Warning

This Education Package was created to help practitioners provide safer, and more informed care to Two-Spirit, trans, Indigiqueer, and gender-diverse patients. It discusses historic and contemporary topics such as colonization, residential schools, and the medical mistreatment of Indigenous Peoples, other BIPOC communities, and the 2SLGBTQIAA+ community. This package also discusses lived experiences of individuals with many other intersections and includes various sociocultural and socioeconomic factors that impact patient care. We would urge anyone who is a member of any of these communities to consider whether reading about one's own experience may be emotionally draining or triggering, and how best to navigate that individually. While we have taken care to consider how we are presenting this information, should members of these communities experience any difficulty with this content, the following helplines are available:

The **Hope for Wellness Helpline** is available to all Indigenous Peoples across Canada, is available 24/7, can be reached toll free at 1-855-242-3310 and has an **online chat available**.

Trans Lifeline is available 24/7 and can be reached at 1-877-330-6366 within Canada.

Chimo Helpline is a provincial crisis phone line in New Brunswick available 24/7 at 1-800-667-5005 (toll-free within NB), or by live chat from 5pm-12am daily.

Kids Help Phone Canada is available to youth 24/7 by phone (1-800-668-6868) or text (text CONNECT to 686868).

Contents

Introduction

2SQTP-NB (Two-Spirit, Queer and Trans Pathways New Brunswick) / **P2SQT-NB** (Pistes bispirituelles, queers et trans au Nouveau-Brunswick) is an educational platform and resource bank developed through Imprint Youth Association's 25-month project, funded by Women and Gender Equality Canada ($372,920), ***Building Capacity for Sustainable Trans Health Care in New Brunswick***. This project aims to build and strengthen access to gender-affirming health care in New Brunswick through the development of a training and mentorship program for primary health care providers (i.e., nurse practitioners, physicians, and residents). The training program consists of a self-directed education package and 40 hours of clinical mentorship, and has been developed in consultation with Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) communities, and gender-affirming care providers throughout Wolastokuk, Peskotomuhkatik, and Mi'kma'ki, or what is currently called New Brunswick. By the project's conclusion, 2SQTP-NB/P2SQT-NB aims to train 6 primary health care providers to actively provide gender-affirming, culturally focused care to 2STIGD individuals across the province.

Learning Outcomes

Upon completion of this education package, Trainees are expected to reach the following learning outcomes:

1. A basic understanding of gender-related terminology and inclusive language, including how to work towards cultivating a gender-affirming clinical atmosphere.
2. A working understanding of the experiences, barriers to care, and care needs of Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse People, including an increased understanding of the ongoing impact of colonization on Indigenous health, wellbeing, and gender diversity.
3. A working understanding of the experiences, barriers to care, and care needs of Neurodivergent and Disabled People, IRMU individuals, and People of Colour.
4. An understanding of how the informed consent model is used in gender-affirming health care, particularly in relation to medical and surgical related care.

5. An understanding of the general steps required in conducting a hormone readiness assessment and the array of potential options available to 2STIGD patients.
6. An understanding of baseline considerations and dosages for initiating hormone replacement therapy (GAHT) and how to provide the necessary monitoring related to GAHT.
7. Familiarity with the WPATH criteria for surgical care and the surgical care options available to 2STIGD patients.
8. An understanding of the general steps required in administering a surgical readiness assessment.
9. Familiarity with the referral process for surgery, provision of post-op care and/or liaising with surgeons as needed.
10. Familiarity with the sexual and reproductive health options available to 2STIGD patients, and affirming methods of providing or referring to this care.
11. A basic understanding of the care needs of 2STIGD children, youth, adults, and elderly individuals including developing a baseline for determining what is in a Trainee's scope of practice, and what will require collaboration with another health care professional.

How to Use this Package

The 2SQTP-NB/P2SQT-NB education package consists of 8 core sections intended to provide Trainees with a basic understanding of gender-affirming care prior to the start of their clinical mentorship hours.

Each individual section contains detailed instructions for how to engage with the material as well as any action steps required of Trainees. Although it is not required, it is recommended that Trainees complete each section in chronological order (i.e., beginning with section one and ending with section seven).

Throughout the education package, any words that appear in blue and bolded lettering will contain a hyperlink that will take Trainees directly to the required material or online platform. In addition to being hosted on the project's website, all training materials will be available to Trainees on the project's Google Drive. Here, Trainees will be able to access all forms, templates, and printables in both English and French.

The two external e-learning platforms that Trainees will be required to access are those provided by the **Community Based Research Centre** and **Trans Care BC**. *Follow the instructions provided in the registration process for each individual site.* Trainees will be required to register for three trainings provided by the Community Based Research Centre, including: ***Trans Wellness Initiative Introduction to Affirming Spaces Training*** (to be taken in Part 1), ***Prescribing Gender-Affirming Hormones*** (to be taken in Part 2), and ***Gender-Affirming Care: Surgical Readiness & Aftercare*** (to be taken in Part 3). Trainees will be required to register for one training provided by Trans Care BC: ***Indigenous Gender Diversity: Creating Culturally Relevant and Gender-affirming Services***.

There is no time limit on any of these e-learning platforms for completing course materials, so we suggest that Trainees register for all training sessions as soon as possible.

To register for each training, please click the associated links above.

Should Trainees experience any issues accessing online e-learning platforms or educational material, please contact the project's Clinical Coordinator, Jacob Barry (**Jacob.barry@imprintyouth.ca**) for assistance.

Disclaimer and Limitations

This education package has been developed using the most up to date information and guidelines on providing gender-affirming care to Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) individuals. Such information has been gathered from well-established organizations and health care practitioners, and has been reviewed by 2STIGD community members.

This education package is intended to provide guidance to primary care practitioners on how to better serve 2STIGD patients. This education package is not intended to serve as a standard of care document and does not represent an exhaustive review of the medical literature. 2SQTP-NB/P2SQT-NB assumes no responsibility or liability 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 education package.

Forms, Templates, and Printables

All forms, templates, and patient handouts can be found in the **shared google drive**.

Body Terminology Quick Reference
Consent Form for Estrogen-Based Hormone Therapy
Consent Form for Testosterone-Based Hormone Therapy
Estrogen/Testosterone-Blocker Consent Template
GAHT Quick Reference Guide
GAHT Readiness Assessment Checklist
Gender Confirming Surgery Prior Approval Request Form
Misgendering: What It Is, How It Harms, & How to Respond
Preventive Care Checklist for Estrogen-based GAHT Patients
Preventive Care Checklist for Testosterone-based GAHT Patients
Progesterone consent template
Pronouns 101: What They Are & Why They Matter
Referrals to Mental Health Care
Reference Ranges for Lab Quick Fact Sheet
Sexual health screening quick fact sheet
Surgery Readiness Assessment Checklist and Quick Reference Guide
Surgical Referral Letter Template
Template Letter in Support of an Application For Change of Sex Designation Template
Terminology Quick Reference Guide

Terminology

As with all terminology, language evolves over time and is used in a variety of ways by different people and communities. The purpose of the terms provided, in particular for the definitions of various identities, is not to limit these terms, nor to give primary care providers (PCPs) license to choose labels for their patients. Instead, we are aiming to give PCPs a general idea of what a patient may mean should they identify with a given identity. In all cases, rather than make assumptions, we encourage PCPs to ask patients what they want to communicate about their identity. As such, it should be noted that there will at times be variations between how individuals identify and the definitions provided below, and PCPs are encouraged to always follow their patient in their individual use of terms and definitions.

2SLGBTQIAA+: A collective term that is used to describe people who are Two-Spirit, lesbian, gay, bisexual, transgender, queer, Intersex, asexual, and more. Previously, LGBT had been used as the standard acronym.

Ableism: A form of descrimination against people either with, or perceived to have, disabilities. It is embedded in the way society is structured to accommodate able-bodied people's needs and without Disabled People in mind. See **Disability and Neurodivergence**.

Ageism: A form of discrimination based on negative attitudes and stereotypes about the aging population. It also involves the way that society is structured based on the needs of young people and thereby failing to respond appropriately to the needs of aging individuals.

Agender: Someone who does not identify as having a particular gender or who feels an absence of gender.

Allistic: A term to describe a non-autistic person.

Ally: An ally is someone who supports the autonomy, agency, and livelihood of equity-deserving groups and acts in ways that demonstrate their solidarity to those groups. This is not a self-identified title, and is an ongoing process.

Aromantic / aro: A term describing someone who does not experience romantic attraction and/or doesn't find romantic relationships desirable. Aromantic people may also be asexual, though they are two separate identities.

Asexual / ace: An umbrella term to describe someone who is on a spectrum of experiencing little to no sexual attraction regardless of gender. Asexual people may also be aromantic, however they are two separate identities. Examples of identities which may fall along the asexual specturm are demisexual and gray-asexual.

Assigned female at birth (AFAB): A term used to describe people who were designated female on their birth certificate. This word is often used to describe people who were born with a vagina and/or ovaries.

Assigned male at birth (AMAB): A term used to describe people who were designated male on their birth certificate. This word is often used to describe people who were born with a penis.

Autigender: A term some Autistic folks use to describe their gender identity and how it is interconnected with and inseparable from their autism. See also **Neurogender**.

Binding: The process of tightly wrapping someone's chest or wearing a binder to reduce **Gender Dysphoria** and minimize the appearance of breasts.

BIPOC: An acronym that stands for Black, Indigenous, and people of colour. While this can be a useful acronym in some settings, we urge caution as these are various distinct identities. More often than not, a more specific and accurate identity would be more appropriate, particularly when referring to an individual.

Bisexual / bi: Someone who is attracted to people of their own gender and people of other genders. Bisexual people typically are attracted to more than two genders, despite having a “bi” prefix implying “two.”

Bottom surgery: A word used to describe a range of gender-affirming genital surgeries.

Cisgender / cis: A term to describe a person whose gender identity corresponds to the gender assigned on their original birth certificate (i.e. someone who is not trans or gender-diverse). Cisgender people identify as either male or female / man or woman. Two-Spirit and Indigiqueer individuals may or may not identify as cisgender.

Cisheteronormativity: A patriarchal system that normalizes and privileges those who are cisgender and heterosexual. It also centers the gender binary where there are only two gender options of male and female.

Cis man / cisgender man: Someone who was assigned male at birth and identifies as a man.

Cis privilege: The privilege received when a person’s gender identity or expression matches their sex assigned at birth. For example, they are not denied access to health care, discriminated against in the workplace due to their gender identity, misgendered when addressed or spoken about, questioned about their gender, asked what their "real" name is, or fearful of violence because of their identity.

Cis woman / cisgender woman: Someone who was assigned female at birth and identifies as a woman.

CPATH (Canadian Professional Association for Transgender Health): A group of Canadian health care professionals who seek to discuss and advance trans health care research. For patient referral letters, note that CPATH letters are also accepted by Medicare for approval.

Culturally-focused health care: An approach which integrates the culture and language of all involved, focusing on the patient and emphasizing cultural indicators of respect. This

creates a partnership between the patient and the primary care provider (PCP), increasing trust as the provider is aware of and knowledgeable about their patient's culture, understands the difference between culture and pathology, and integrates those concepts into their care of the patient.

Demisexual / demi: A sexual orientation that describes someone who is only sexually attracted to someone with whom they already have a close emotional connection; sometimes considered to fall under the asexual umbrella.

Dysphoria: See **Gender Dysphoria**.

Female-to-male (FTM): This is an older term that many people still use to self-identify as someone who is transitioning or has transitioned from female-to-male, or in other words, a trans man.

Gaslighting: A form of manipulation to gain power by challenging the validity of someone's personal experience, intending for them to question themself, and their mental soundness In a medical setting, this happens when a patient's concerns are not believed, dismissed or deemed insignificant, or are labeled a psychological rather than biological problem.

Gatekeeping: Intentional or unintentional exclusionary measures that restrict who "is" and who "is not" allowed opportunities. In a health care setting, this is when PCPs create unnecessary and unfair hurdles for those accessing care, for example, requiring Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) patients to "prove" their gender diversity in order to access gender-affirming care. See **Gatekeeping and Bias**.

Gay: A sexual orientation that describes someone who is sexually and/or romantically attracted to people of their own gender. The term can be used regardless of gender identity but is commonly used to describe men who date other men, i.e. gay men.

Gender-affirming health care: An approach which is patient-centered, falling into two distinct branches: delivering transition-related care, as well as addressing all the other primary care needs of 2STIGD patients in a way that is sensitive to the unique needs of these individuals and affirming of their gender identity.

Gender-affirming hormone therapy (GAHT) / Hormone replacement therapy (HRT): Refers to a life-saving and life-affirming treatment process for people seeking to physically change their bodies to fit their gender identities. Estrogen HRT and testosterone HRT are two types of hormone therapy. HRT and GAHT can be interchangeable terms; however, GAHT is more specific to 2STIGD people because HRT can refer to cisgender people. See **Part 4: GAHT (Gender-Affirming Hormone Therapy)**.

Gender-affirming surgery: Refers to a number of life-saving and life-affirming surgeries for people seeking to physically change their bodies to fit their gender identities. Notably, not all 2STIGD people choose gender-affirming surgeries for various reasons. See **Part 5: Gender-Affirming Surgery**.

Gender binary: The ideological concept and belief that there are only two genders, male and female, and that a person must neatly fit into one category or the other.

Gender-diverse: An umbrella term that is used to describe gender identities beyond the binary framework. This includes, but is not limited to, trans, non-binary, agender, and gender fluid folks.

Gender dysphoria: Emotional and physical distress experienced by some 2STIGD people whose genders don't match their sex assigned at birth. Gender dysphoria can cause depression, anxiety, mental unrest, and severe psychological and social distress. It is often made worse by unaddressed transphobia and gendered microaggressions in work, family and public life. Although the diagnosis of gender dysphoria is often required to receive gender-affirming health care, it is not a term or experience with which all 2STIGD people identify. See **Gender Euphoria**.

Gender euphoria: Emotional and physical elation experienced by some 2STIGD people when their gender is acknowledged or apparent. This can be a result of social factors (being acknowledged by others through use of one's name, pronouns, or other gendered or non-gendered indicators), or a result of physical presentation (seeing evidence of one's gender in the mirror, receiving acknowledgement/compliments about appearance in line with one's gender). While healthcare is often approached from a deficit perspective,

emphasizing Gender Dysphoria, we encourage using a strength-based perspective focusing instead on gender euphoria.

Gender expansive: An umbrella term to describe anyone whose gender expression is outside of the gender binary. This can be a more flexible term to describe people who aren't cisgender but don't necessarily identify as trans or non-binary.

Gender expression: How a person chooses to express their gender through behavior, hair, clothing, make-up, etc. Gender expression is not the same as gender identity. The way someone presents themselves to the world around them can be fluid and can change over time, day to day, or situationally. Everyone expresses their gender in some way, whether they are Two-Spirit, trans, Indigiqueer, gender-diverse, or cisgender.

Gender fluid / gender-fluid / genderfluid: Someone whose gender identity is not fixed, and may shift through a binary and/or non-binary framework.

Gender identity: A person's internal sense of their gender or who they know themselves to be (i.e. a man or woman, both, neither, or another gender).

Gender neutral: A term to refer to language and ways of being that are not explicitly gendered. This can mean using gender-neutral language such as "folks" or "all" instead of "guys" or "ladies and gentlemen." It can also mean not prescribing gender to things that are not inherently masculine or feminine, i.e. behaviors, activities, clothing, body parts, etc.

Gender non-conforming: A term to describe a person whose behavior, appearance, or characteristics do not conform to the prevailing gender norms or social expectations of what is appropriate for a masculine or feminine identified person.
Genderqueer: Similiar to gender fluid, this term describes a person whose gender identity is not solely male or female. Genderqueer can describe a person who "queers" gender, meaning their gender can shift and change at any given time.

Gender role: A term describing how people are expected to behave (including dress, approach to sexual relationships, and more) based on their perceived gender. Gender roles

are rooted in gender norms, which is a social code for restricting gender identities into what is considered to be socially acceptable.

Gray-asexuality / graysexual: A sexual orientation that describes someone who rarely experiences sexual attraction, often only under specific circumstances, or who fluctuates between periods of experiencing and not experiencing sexual attraction.

Harm reduction: A set of practical strategies and ideas aimed at reducing negative health, social and legal impacts associated with drug use, sex work, eating disorders, self-harm, etc., without requiring abstinence from the behaviour itself.

Heteronormativity: The assumption that heterosexuality (including heterosexual people) is the default and the standard for defining "normal" sexual, cultural, and social behavior, resulting in heterosexual privilege.

Heterosexism: Prejudice, discrimination, or bias against queer or gay people from heterosexual people based on the belief that heterosexuality is normal, natural, and innate.

Heterosexual / straight: A sexual orientation that describes women who are sexually and romantically attracted to men, and men who are sexually and romantically attracted to women.

Homophobia: An irrational and systematic hatred of or aversion to queer people or people who are perceived as such.

Indigiqueer / Indigequeer: A term coined by Thirza Cuthand to title the Vancouver Queer Film Festival's Indigenous/Two-Spirit program in 2004. They used it as a way to acknowledge that not all LGBTQIAA+ Indigenous People feel that **Two-Spirit** describes their identity. It's sometimes used alongside the Two-Spirit identity, but is used more often by those who do not identify as Two-Spirit as a way to describe the intersection of being queer and Indigenous.

Infantilizing: treating someone like a child or in a way that invalidates, ignores or denies their autonomy, maturity, age and experience. It is a disrespectful and emotionally

damaging experience for many Autistic and Neurodivergent individuals. For more information see **Gaslighting** and **Disability and Neurodivergence**.

Informed consent: In health care, this is when a provider outlines details about risks, benefits, and alternatives of a procedure or intervention and allows the patient to make a decision based on all the information presented.

Intergenerational trauma: Trauma experienced by a person or group of people that gets passed down through subsequent generations, and can occur from a single traumatic event (e.g. an assault), a repetitive traumatic experience (e.g. poverty, domestic violence), or within the context of historical trauma, as it is often used in contexts discussing Indigenous Peoples in relation to their historic and current mistreatment in Canada. See **Intergenerational Trauma**.

Internalized phobias: This includes, but is not limited to, internalized ableism, ageism, classism, homophobia, misogyny, racism, sexism, transphobia, and xenophobia. It should be noted that systems of oppression have caused internalized phobias not just for those outside of individual communities, but for those within communities as well. This can result in **gatekeeping** (for example, biphobia within the queer community, or nonbinary exclusion within the trans community), lateral violence within communities, and negative mental health outcomes impacting one's own self-worth. Particularly within gender-affirming care, it is important to carefully navigate conversations where patients may struggle with this internally, as 2STIGD patients may be navigating internalized transphobia even as they are seeking gender-affirming care.

Intersectionality: a Black feminist theoretical framework with origins as early as the 1850s. Officially coined by Kimberlé Crenshaw in 1989, intersectionality refers to the complex, cumulative way in which an individual's unique identities combine, overlap, or intersect to produce the effects of multiple forms of discrimination (such as racism, sexism, classism, etc.).

Intersex: Intersex is an umbrella term for differences in sex traits or reproductive anatomy. Intersex people may be born with these differences or develop them in childhood. There are many possible differences in genitalia, hormones, internal anatomy, or chromosomes, compared to the more common two ways that human bodies develop. See **Intersex**

Considerations. It should be noted that there are a number of limitations and knowledge gaps with the current WPATH SoC which directly impact the care of Intersex individuals. These are discussed in the section Children and Youth.

Lesbian: A sexual orientation that describes a woman who is romantically and/or sexually attracted to other women, whether the women are 2STIGD or cisgender.

Male-to-female (MTF): This is an older term that many people still use to self-identify as someone who is transitioning or has transitioned from male-to-female, or in other words, a trans woman.

Masking (or camouflaging): A term to describe when a Neurodivergent person develops coping mechanisms to appear neurotypical in social settings.This may be conscious or subconscious. Oftentimes folks do this in social environments to avoid ostracization from peers, colleagues and within other systems of power where they may feel unsafe while being themselves. Masking is extremely exhausting and can lead to burnout.

Microaggressions: An action or statement that is subtle, unintentional, or indirect causing discomfort or harm to whom it is directed. Most often experienced by those belonging to marginalized groups. See Microaggressions.

Misgendering: Refers to someone using gendered language, pronouns, or forms of address that do not correctly reflect the gender that a person is, identifies with, and wishes to be known as. When misgendering occurs, thank the patient if they have corrected you, repeat what you had said with the correct pronoun, and move on. For more information, see the **Misgendering** guide from **Trans Wellness Ontario**. See **Pronouns**.

Monogamous: Refers to a romantic/sexual relationship that takes place exclusively between two partners, or descripes a person who wishes to have an exclusive romantic/sexual relationship with a single partner.

Neurodivergence / neurodivergent: An umbrella term to describe a difference in neurological function from what is considered by society to be "normal" or "typical," and can cover a broad range of mental and neurological diagnoses (e.g. ADHD, autism, dyslexia, etc). See **Disability and Neurodivergence**.

Neurogender: A term some Neurodivergent folks use to describe their gender identity and how it is interconnected with and inseparable from their neurodivergence. See also **Autigender**.

Neurotypical: A term to describe when a person has no presentation of atypical patterns of thought or behavior.

Non-binary / nonbinary / NB / enby: A term to describe people who do not identify as men or women. Some non-binary people also identify as trans while others do not. Non-binary can be thought of as an umbrella term to describe people whose gender(s) fall outside of the gender binary.

Pansexual: A sexual orientation that is not limited in choice by gender identity or sex assigned at birth. Some describe this as being attracted to all genders.

Passing: A term used to describe when someone who is not cisgender is perceived as cisgender. Can also be used to describe a spectrum, that is, the degree to which someone passes (or is perceived as) their gender (rather than as their gender assigned at birth).

Polyamourous: Polyamory is one of the most well-known types of ethical non-monogamy. It involves having romantic and/or sexual relationships with more than one person at the same time. Polyamory can be done in many different ways. For example, several people may all be in a relationship together, or a pair of two individuals may each be committed to additional partners of their own, and these relationships may have varying levels of commitment.

Pronouns: A word that is used to refer to someone instead of a name or noun phrase. Different gendered pronouns include she, him, their, and many more. For a complete list of pronouns, check out **this guide by Egale Canada**. For additional resources on pronoun usage, see the resources compiled by **Trans Wellness Ontario**. When **Misgendering** occurs, thank the patient if they have corrected you, repeat what you had said with the correct pronoun, and move on.

QTPOC: An acronym that stands for queer and trans people of colour.

Queer: A sexual orientation that can be thought of as an umbrella term that means "not straight." This word is often used by people who think of their sexuality as outside of heteronormative societal norms. Some people view the term queer to be more inclusive and political than more traditional categories of sexual orientation, while other people do not use the word to self-identify because of its historical context as a derogatory slur.

Sex assigned at birth: The label a medical professional gives to a baby when it is born. A medical professional may say a baby is male or female depending on an external biological evaluation. Notably, Intersex babies are still assigned male or female at the time of birth despite not falling neatly into either category.

Sexual orientation: How a person characterizes their emotional, romantic and/or sexual attraction to others.

Sex work: Sex work refers to the consensual exchange of sexual services between adults for money or goods. Peers Victoria, "an organization of sex workers for sex workers," has put together a number of resources for better understanding sex work. Specifically, we would like to draw attention to Who Are Sex Workers, Stigma and Sex Work, and Health and Sex Work. Within the context of the 2STIGD community, see We Belong: Addressing Service Inequity for Trans, Non-Binary, and Two-Spirit Sex Workers.

Stimming: A self regulating behavior (verbal or nonverbal) that can include rocking back and forth, flapping hands, flicking or snapping fingers, bouncing, jumping, twirling, repeating words or phrases, rubbing the skin or scratching, etc. Stimming can be a response to excitement (happy stims), or to stress and anxiety as a self-soothing technique.

Top surgery: A word used to describe a range of gender-affirming chest surgeries.

Transfeminine / transfemme: A word to describe a trans and/or gender-diverse person who identifies as feminine, but may or may not identify as a woman. Two-Spirit and Indigiqueer People may or may not use this terminology to describe themselves in addition to Two-Spirit or Indigiqueer.

Transgender / trans: A term to describe a person whose gender identity and assigned sex at birth do not align. Also may be used as an umbrella term to include other gender identities outside of the gender binary, however not all gender-diverse individuals identify as trans. Two-Spirit and Indigiqueer People may or may not use this terminology to describe themselves in addition to Two-Spirit or Indigiqueer.

Transgender man / trans man: A trans person who identifies as a man. Trans men are men, just like cis men, only they happen to be trans.

Transgender woman / trans woman: A trans person who identifies as a woman. Trans women are women, just like cis women, only they happen to be trans.

Transitioning: For people who are not cisgender, this refers to the process of coming to recognize, accept, and express one's gender identity. Most often, this refers to the period when a person makes social, legal, and/or medical changes, such as changing their clothing,

name, appearance, or sex designation. Notably, not all folks transition or will only choose some aspects of transition (e.g., socially transition, but not medically transition).

Transmasculine / transmasc: A word to describe a trans and/or gender-diverse person who identifies as masculine, but may or may not identify as a man. Two-Spirit and Indigiqueer People may or may not use this terminology to describe themselves in addition to Two-Spirit or Indigiqueer.

Transmisogyny: The intersection of transphobia and misogyny as experienced by trans women and transfeminine people.

Transphobia: The discrimination against or hatred of trans or gender-diverse people, or those who are perceived as such.

Transsexual: A term used in medical literature or by some trans people to describe those who have transitioned through medical interventions. Some find the term to be outdated, while others still self-identify as such. This term should only be used if the individual has already self-identified as transsexual.

Trauma-informed health care: An approach that prevents further and re-traumatization by emphasizing safety, trustworthiness, opportunities for choice, collaboration and connection. Trauma-informed care is implemented in policies, procedures and practices.

Tucking: The process that some people will undergo by hiding one's genitals with tape, tight shorts, or specially designed undergarments to reduce **dysphoria** and the appearance of a bulge.

Two-Spirit / Two Spirited / 2 Spirit / 2S: The term "*Two-Spirit*" originated in Winnipeg, Canada in 1990 during the third annual intertribal Native American/First Nations gay and lesbian conference. It comes from the Ojibwe words *niizh manitoag* (two-spirits), that is reflective of the history and complex understandings of gender roles, spirituality, and sexual and gender diversity in Indigenous cultures. Individual terms and roles for Two-Spirit People are specific to each Nation, and the term Two-Spirit is not meant to replace any culturally specific terminology or concepts already in use within Indigenous communities. Two-Spirit is a term that can encompass Indigenous LGBTQIAA+ People, but is used most often in contexts of gender identity. It is also important to note that not all all Indigenous People who hold diverse sexual and gender identities consider themselves Two-Spirit. An individual may identify as Two-Spirit, **Indigiqueer**, LGBTQIAA+, some/all of those terms, or none. Due to its cultural, spiritual, and historical context, "Two-Spirit" is an identity only to be used by Indigenous Peoples. See **The Gender Binary is a Colonial Construct**.

WPATH (**World Professional Association for Transgender Health**): The current worldwide standard of care for transgender health care. For patient referral letters, note that CPATH letters are also accepted by Medicare for approval. See **Addressing WPATH Knowledge Gaps**.

Addressing WPATH Knowledge Gaps

The World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association (1978–2007), was formed by Dr. Harry Benjamin with the purpose of creating an international group of professionals who specialized in "treating gender nonconformity".[1] The Association published the first Standards of Care (SoC) in 1979, which, alongside the Diagnostic and Statistical Manual of Mental Disorders (DSM), served as the primary pathway to guide medical providers in understanding and caring for Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) people. Since 1979, there have been 7 editions of the SoC, each edition responding to socio-cultural, legal, and medical changes in understanding gender diversity.

The seventh version of the SoC, published in 2012, aimed to address the concerns of community activists who had criticized previous WPATH standards as being overly restrictive and pathological. In addition to loosening the requirements for access to care, that revision established clearer advocacy on trans issues and no longer referred to gender diversity as a disorder. However, despite over a decade worth of calls to decentralize DSM criteria from the SoC, SoC-7 continued to promote assigning a diagnostic category to gender diversity (i.e., currently listed in DSM-V as *Gender Dysphoria*). Although many 2STIGD people do experience **dysphoria**, community activists (such as TPATH) have argued that pathologization should not be the precursor to "promoting optimal health" for gender-diverse people.[2]

Now, a decade after the release of SoC-7, WPATH has released version 8 of the SoC. On December 14th, 2021, WPATH published the draft guidelines for SoC-8, making it available to the public for open comment. Although the SoC-8 draft revealed some progressive elements (i.e., lowering the minimum age of care and introducing a section on

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[1] Barry, J (2022). Transfeminist Care Ethics: Understanding our roots. Western University.
[2] ibid

non-binary folks), there were some additions that have been noted to contain regressive and harmful elements. However, the future remained uncertain for how/if WPATH would amend the sections containing harmful elements. It should be noted that the project team has reviewed the released SOC-8 and are sadly able to confirm that no amendments were made regarding the below concerns.

According to WPATH, the goal of SoC-8 is to provide clinical guidance to health professionals to assist 2STIGD people with safe and effective pathways for maximizing their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (i.e., assessment, counselling, psychotherapy), and hormonal and surgical treatments. While the SoC-8 is primarily a document for health professionals, it may also be used by individuals, their families, and social and legal institutions. Therefore, while the SoC is intended to be a set of flexible guidelines, the SoC have become the 'gold standard' for how to care for 2STIGD folks around the world. Due to the far reaching impact of the SoC guidelines on the health, wellbeing, and care of 2STIGD people, it is important that providers have the ability to think critically about how they are interpreting and following SoC guidelines. To assist providers in doing so, the sections below outline the limitations of SoC-8.

Community consultation / approach to research

In 2020 Eli Coleman, current chair of the SoC-8 committee and former WPATH president, presented an update on the methodology used for the development of SoC-8, noting that the new guidelines sit at the praxis of scientific research and evidence, clinical expertise, and patient factors and clinical circumstances. Working within this paradigm, the SoC-8 revision started by WPATH identifying a multidisciplinary team that would come to decide on chapter topics, aid in systematic literature reviews, and draft clinical recommendations. To determine team membership WPATH used the following eligibility criteria:

1. Longstanding WPATH Full Member in good standing
2. Well recognized advocate for WPATH and the SoC
3. Well known expert in transgender health
4. Extensive experience in leading consensus building projects and guideline development

5. Accomplished clinician, scholar, and/or researcher in trans health with a publication record
6. Able to assess the evidence-based and peer review literature and contribute specific recommendations from an evidence-based perspective.[3]

The eligibility criteria for involvement in the construction of the SoC-8 required contributors to be an 'expert' on trans issues and hold a professional designation (i.e., PhD, MD, MSW, RN, etc.).

While approximately 40 of the 152 contributors to SoC-8 are openly identified as 2STIGD, these individuals were still required to meet WPATH's eligibility criteria of professionalism (i.e., MSW, PhD, MD, etc.). As such, it is important to remain conscious of how the intersection of privilege, and in particular, **classism and colonialism,** limits the dialogue around these topics and actively excludes some of the most marginalized voices. This lack of community consultation has resulted in a top-down process for determining the care needs and desires of 2STIGD people. Remember that the real experts are those who live through these experiences.

As a result of this top-down process, the SoC-8 continue to reflect limiting views on gender identity (i.e., binary-focused) and place a higher emphasis on professional knowledge over that of the lived experience of 2STIGD people. Importantly, while WPATH is an international association, the organization's views on gender identity, expression, and medicine predominantly reflect those of white and Western culture. As such, care providers need to allow patients the space to describe how they experience themselves, rather than assume care needs based on their perception of a patient's gender identity.

Children and Youth

Although the SoC-8 made some progressive adjustments regarding the minimum age of care, a bulk of the documents' regressive elements are located in the chapter on Children and Youth. With the current onslaught of anti-trans legislation directed at 2STIGD youth,

[3] WPATH. (2022). Standards of Care Version 8.

the SoC-8 recommendations for adolescents is particularly troublesome and runs the risk further pathologizing gender diversity in young people.

Perhaps most concerning is the SoC-8's adolescent chapter legitimization of *rapid onset gender dysphoria* (ROGD) and promotion of **gatekeeping** of adolescents from puberty suppression or confirming hormonal care.

ROGD was proposed in 2016 as a phenomenon in youth with **gender dysphoria** that emerges at or after puberty, with the suggested cause being peer influence and social cognition.[4] This theory has now been entirely debunked[5]. Although not directly referenced as ROGD in SoC-8, WPATH describes the "trend" of gender diversity in adolescence as the result of an "increase in visibility of transgender and gender-diverse identities."[6] The same section also references the work of Lisa Littman, who coined ROGD, stating that "another phenomenon is adolescents seeking care who have not apparently experienced and/or expressed gender diversity during their childhood."[7] Failing to reference literature debunking ROGD, SoC-8 merely addresses errors in Littman's (2018) methodology and instead states that "for a select subgroup of young people, in the context of exploration, social influence on gender may be a relevant issue and an important differential."[8] Finally, the section makes reference to prioritizing a caregiver's doubts over the "very recent and/or sudden self-awareness of gender diversity," and encourages providers to give precedence to "several years" of well-documented "gender incongruence or gender diversity"[9] over the adolescent's own identification, bodily autonomy, and right to self-determination. Such a recommendation fails to consider or address the many valid reasons a child or adolescent may not disclose their gender identity or desire to explore their health care options to a parental figure. Additionally, it ignores that children may not experience or recognize dysphoria/gender incongruence until puberty. Puberty kicks off a series of changes to the body that the individual has never experienced and for 2SITGD people this

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[4] Bauer, et al. (2022). Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?. *The Journal of Pediatrics*, *243*, 224-227.

[5] Ashley, F. (2020). A critical commentary on 'rapid-onset gender dysphoria.' *The Sociological Review*, *68*(4), 779–799.

[6] WPATH. (2022). Standards of Care Version 8.

[7] ibid

[8] ibid

[9] ibid

is often the catalyst to realizing that they identify differently than their peers who are experiencing no distress or even excitement over those changes.

Giving priority to caregiver distress is also seen in the SoC-8's chapter on Intersex peoples, where the SoC-8 affirms caregiver distress instead of Intersex patients themselves. Here, caregiver distress is noted as a reason for supporting medical interventions on children with Intersex variations as a means to minimize the "effect Intersexuality may have on parental care". Caregiver distress should not be considered as a reason to perform binary sex assignment surgery. Unsupportive caregiver opinions should never be given precedence over the Intersex child's bodily autonomy and right to self-determination.

Lastly, the Children and Youth chapter describes gender-exploratory therapy (GET) as a "key step" for 2STIGD people, based on an article written by Dr. Edwards-Leeper (chair of the Child and Youth chapter) where she recommends GET over the more commonly recommended gender-affirmative therapy (GAT).[10] Whereas GAT is founded on the position that no gender identity, expression, or experience is any more valid, 'natural' or 'normal' than any other, GET seeks to reduce **gender dysphoria** therapeutically (i.e., through counseling), only offering medical transition as a last resort and often drastically lengthening the period of waiting before transition.[11] It is important to note that GET is a form of conversion therapy that aims to limit or erasure gender diversity within the child. In GET the medical provider dictates the path of care, thus rejecting a collaborative and affirmative therapeutic relationship with the child or youth. Wherever possible, gender-affirmative therapy (GAT) is a more affirming and collaborative option for children and youth.

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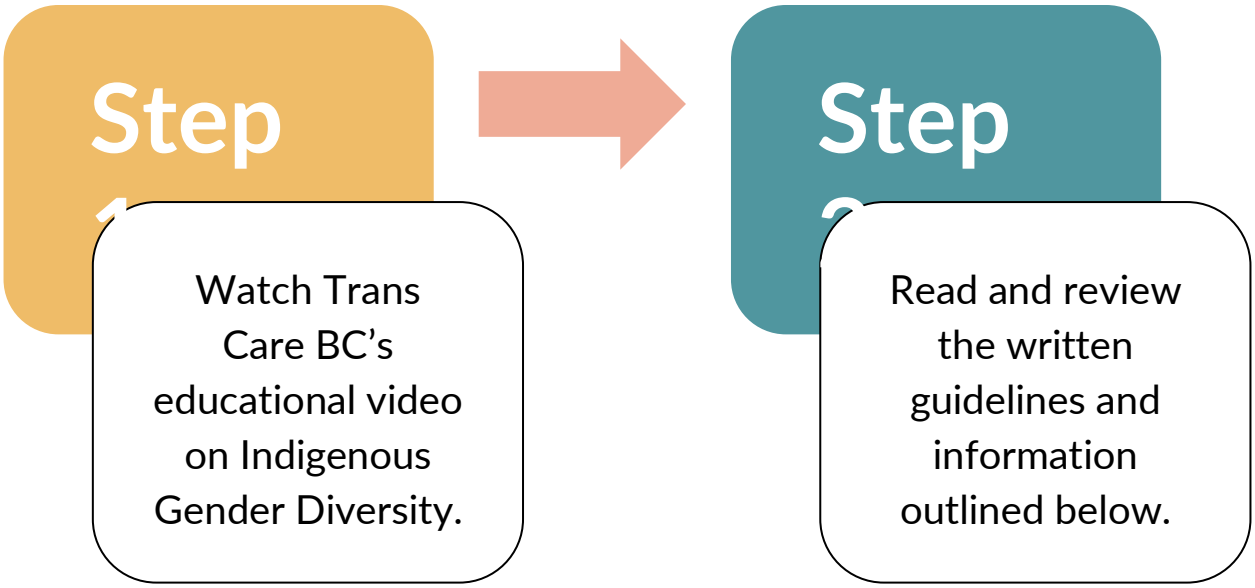
[10] Edwards-Leeper, L., & Anderson, E. (2021, November 26). *Perspective | The Mental Health Establishment is failing Trans Kids*. The Washington Post. Retrieved September 6, 2022, from **www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/**

[11] There is an extensive body of research illustrating that access to affirming medical care without delays results in better mental health outcomes for patients. See Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. CMAJ Open, 9(4), E1213.

Part 1: Indigenous Gender Diversity

The following section outlines the most up to date practices in delivering gender-affirming and culturally-focused healthcare to Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse folks. This section is comprised of both visual and written material, and should be completed in the following order:



Link to e-learning lesson: learninghub.phsa.ca/Courses/26839

We would like to highlight the importance of cultural competency, not just for PCPs, but for all individuals working and volunteering within the health care system. We would encourage you to share these resources with all involved, as all staff and volunteers will be working in some capacity with Indigenous patients.

What Land Am I On?

Acknowledging the land we reside on is a way to honor and respect the Indigenous Peoples who have occupied and cared for the land since time immemorial. It allows us to reflect on a shared history and understand our current roles, responsibilities and relationships both to each other and the land, as settlers[12], or traditional occupants of this land.

"When we talk about land, land is part of who we are. It's a mixture of our blood, our past, our current, and our future. We carry our ancestors in us, and they're around us. As you all do." – Mary Lyons (Leech Lake Band of Oiibwe)

As a part of 2SQTP-NB/P2SQT-NB training we encourage Trainees (if you have not already done so) to start developing this awareness journey by going **here** to find out more about the Indigenous land you occupy and the original and longstanding caretakers of that land.

Wabanaki Territory

The Wabanaki Territory is home to the Waponahkiyik (People of the Dawn) and stretches north into Newfoundland, mid-Maine in the south, and parts of Québec to the west. The Treaties of Peace and Friendship of 1725 and 1726, signed by the Wabanaki and the British Crown, did not deal with the surrender of lands or resources, but recognized Wolastoqiyik, Mi'kmaq and Peskotomuhkati title and established the rules for what was to be an ongoing relationship between nations. We are all Treaty People and have a responsibility to uphold the treaties signed by our ancestors.

Wolastokuk

Wolastokuk is the traditional and ancestral homeland of the Wolastoqiyik, the People of the beautiful and bountiful river, the Wolastoq, which is incorrectly referred to as the Saint

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[12] *When we use the word settler, we are referring to anyone who has settled on the land. This includes immigrants, refugees, and all people of colour.*

John River. There are six Wolastoqey communities: Matawaskiye (Madawaska), Neqotkuk (Tobique), Pilick (Kingsclear), Sitansisk (Saint Mary's), Welamukotuk (Oromocto) and Wotstak (Woodstock). These communities have lived in peace and harmony alongside the Wolastoq since time immemorial.[13]

Peskotomuhkatik

Peskotomuhkat means "those of the place where pollok are plentiful" signifying the importance of this fish in their culture. The Nation's traditional lands are along the coastal regions of the Bay of Fundy, Peskotomuhkati Bay, Gulf of Maine, and the St. Croix River which have been occupied since time immemorial. There are two communities located in Maine, and one in New Brunswick, Qonaskamkuk Peskotomuhkati Nation at Skutik in the South-West of the province, along the American border.[14]

Mi'kma'ki

Mi'kma'ki is the traditional homeland of the L'nu/Mi'kmaq People, whose ancestors have occupied this land since time immemorial. This territory spans what is now known as the Atlantic Region (New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador), and the southern Gaspé Peninsula. There are nine Mi'kmaq communities in so-called New Brunswick: Elsipogtog (Big Cove), Tjipogtotig (Bouctouche), L'nui Menikuk (Indian Island), Ugpi'Ganjig (Eel River Bar), Esgenoopetitj (Burnt Church), Amlamgog (Fort Folly), Naotaganeg (Eel Ground), Oinpegitjoig (Pabineau), and Metepenagiag (Red Bank).[15]

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[13] Government of New Brunswick, C. (2022, August 18). *First Nations communities*. Aboriginal Affairs. Retrieved September 2, 2022, from https://www2.gnb.ca/content/gnb/en/departments/aboriginal_affairs/fnc.html

[14] *Peskotomuhkati Nation*. Peskotomuhkati Nation at Skutik. (2021, February 7). Retrieved September 2, 2022, from qonaskamkuk.com/

[15] Government of New Brunswick, C. (2022, August 18). *First Nations communities*. Aboriginal Affairs. Retrieved September 2, 2022, from https://www2.gnb.ca/content/gnb/en/departments/aboriginal_affairs/fnc.html

The Gender Binary is a Colonial Construct

Colonization distorted and fragmented ideas of gender in Indigenous communities. Traditionally, children were raised in more fluid ways that allowed them to explore their gender identity on their own. The gender binary was enforced through colonial methods like residential schools as an attempt to erase Indigenous gender diversity, gender expression and Two-Spirit roles.[16] As such, Two-Spirit People's health must be understood within the dual contexts of colonial oppression rooted in heteropatriarchy, as well as the resurgence of Two-Spirit People's gender roles and sexuality.[17] This understanding is integral to improving the overall health, wellbeing, and care of Two-Spirit People.[18] During the late 1800s in the area that is now called New Mexico, We'wha was a Lhamana (Zuni Two-Spirit) whose community tended to separate appearance and tasks by gender; however, We'wha dressed and performed tasks associated with both genders. They were accepted and respected in their community as both a weaver and potter, as well as a hunter and spiritual leader, and are known for having been one of the earlier "Two-Spirit heroes who helped light the way."[19]

"Two-Spirit is a cultural identity specific to Indigenous people, with a rich history. While trans is considered a more Western term that some gender-diverse Indigenous peoples use as well."16

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[16] TransCare BC. (2022). Indigenous gender diversity: Creating culturally relevant and gender-affirming services. PHSA's Learning Hub.

[17] Hunt, S. (2016). *An Introduction to the Health of Two-Spirit People*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

[18] ibid

[19] Swan-Perkins, S. W. (2018, November 20). 5 two-spirit heroes who paved the way for today's native LGBTQ+ community. KQED. Retrieved September 2, 2022, from https://www.kqed.org/arts/13845330/5-two-spirit-heroes-who-paved-the-way-for-todays-native-lgbtq-community

Colonization: Impact on Indigenous Health

The effects of colonization are apparent in all aspects of Indigenous peoples' health and well-being, affecting not only their physical health, but also their mental, emotional, and spiritual wellness. It is well established that Indigenous Peoples in so-called Canada experience a disproportionate burden of poor health outcomes compared to non-Indigenous folks.[20] In large part, these health disparities have been a result of government policies that were put in place to eradicate the Indigenous population and assimilate them into Euro-Canadian ways of life, leading to physical and emotional harms to children, loss of culture and language, and the disconnect of family structures and community. Many of the negative health outcomes that are disproportionately experienced by Indigenous peoples have therefore been attributed to the lasting and ongoing effects of colonialism, including the Indian Act, the reserve system, and the residential school system. To promote equity in health care for Indigenous peoples, PCPs must have an understanding of the social determinants of health and health care inequities for Indigenous peoples.

Indian Residential School (IRS) System

In 1884, amendments to the Indian Act, including the creation of Indian residential schools, were adopted. Duncan Campbell Scott, the Deputy Minister of Canada in 1920, was quoted on record for saying "I want to get rid of the Indian problem… Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department."[21] Scott was responsible for the 1920 amendment of the Indian Act that mandated the attendance to residential schools of all children under the age of 15. The schools in Canada were predominantly funded and operated by the Government of Canada and Roman Catholic, Anglican, Methodist, Presbyterian and United churches.

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[20] United Nations. (2019). Indigenous Healthcare and Revitalization. Retrieved November 21, 2022, from https://www.un.org/en/academic-impact/we-are-indigenous-%E2%80%98culture-meets-care%E2%80%99-essential-indigenous-healthcare-and

[21] McDougall, R. L. (2018, January 18). *Duncan Campbell Scott*. The Canadian Encyclopedia. Retrieved September 2, 2022, from www.thecanadianencyclopedia.ca/en/article/duncan-campbell-scott.

An estimated 150,000 First Nation, Metis and Inuit children attended these schools.[22] During their time at the schools, they were physically, sexually, emotionally, and spiritually abused. Thousands of children died at these schools, and many escaped but never made it home. Thousands survived, carrying with them the lasting effects of their experiences. This trauma is carried down through generations in families and communities, and dramatically impacts the overall health and wellbeing of Indigenous Peoples today. In Indian day schools, the same kinds of abuse happened, but in those circumstances, the children were allowed to go home at the end of the day.

This is still within living memory as the last residential school closed in 1997.[23] Thousands of survivors are alive today and are able to tell their stories. It is thanks to their bravery that justice and reparations can be made for the thousands of survivors and their families who are impacted by the irreparable harm caused by the Indian residential school system.

The Truth and Reconciliation Commision of Canada outlines a report on the stories of over 6000 survivors and the impacts of the Indian residential school (IRS) system in Canada. The TRC also reports on links to the child welfare system, referring to it as a continuation of the IRS system in which children are removed from their homes and disconnected from their culture, language, family, and community. There are now three times more Indigenous children in the child welfare system than there had been even at the height of residential schools.[24] It is important to consider the impacts the IRS system has on the current overrepresentation of Indigenous children in the welfare system, and to understand and contextualize the ongoing removal of First Nations, Metis and Inuit children from their homes and communities.

Intergenerational Trauma

Intergenerational trauma is a direct result of colonization, attempted genocide and forced assimilation. Indigenous Peoples now face disproportionate structural disadvantages

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[22] Union of Ontario Indians. (2013). *An overview of the Indian Residential School System - Anishinabek*. Retrieved September 2, 2022, from **https://www.anishinabek.ca/wp-content/uploads/2016/07/An-Overview-of-the-IRS-System-Booklet.pdf**

[23] Miller, J. R. (2012, October 10). *Residential Schools in Canada*. The Canadian Encyclopedia. Retrieved September 2, 2022, from **www.thecanadianencyclopedia.ca/en/article/residential-schools**.

[24] *First Nations Children's Action Research and Education Service*. The Caring Society. (2021). Retrieved September 2, 2022, from **fncaringsociety.com/fncares**

which lead to barriers in the education system and employment, mental health concerns, reliance on social assistance programs, substance use, survival sex work, etc. It is not a health care provider's place to judge anyone based on the systems of oppression they have lived through; instead, a truly trauma-informed PCP takes into account the history and lived realities of Indigenous patients and proceeds with care, using a non-judgemental approach. It is because of the historic mistreatment and attempted genocide and assimilation of Indigenous Peoples in Canada that culturally-focused care is critical to repairing the harm done and building relationships of trust with **Two-Spirit**, **Indigiqueer**, trans and gender-diverse Indigenous People.

Colonialism and Health Care

The health care system in particular has a long history of violence against Indigenous Peoples. As was the case with various public services (including health, educational, and social services), colonialism systemically limited access on the premise that Indigenous Peoples deserved less, and therefore fewer resources would be allocated to Indigenous Peoples and communities. Furthermore, resource allocation was done with the intention of assimilating, segregating, and eradicating the Indigenous population. As a measure of control, health care provided to Indigenous Peoples has been limited, underfunded, and at times, deliberately harmful.[25]

This systemic racism within the health care system continues today, as Indigenous Peoples, both on an individual level and as a group, "continue to be seen as those who don't really belong; as drains on the system; whose care is never quite as urgent; and, in general, less deserving of the same level of treatment as non-Indigenous patients [...] and are often blamed for their ailments and medical needs."[26] Indigenous patients regularly deal with racism, discrimination, mistreatment, and **microaggressions** when accessing care. Other barriers to health care include but are not limited to; language barriers, transportation, and difficulty navigating funding and support services.

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[25] Gunn, B., & Hall, R. (2017). Ignored to Death: Systemic Racism in the Canadian Healthcare System. Retrieved from: https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf

[26] ibid

When engaging with Indigenous patients, it is important for PCPs to understand the ongoing effects of colonialism and how the attempted assimilation and genocide of Indigenous people continues today (e.g., forced sterilization,[27] lack of access to clean water,[28] and land theft and destruction[29]). Indigenous health care and wellbeing should be approached collaboratively and holistically by addressing the social determinants that impact the overall health and wellbeing of Indigenous Peoples, including but not limited to: poverty, barriers to safe housing, social injustice, and systemic racism.[30]

Indigenous Folks in Rural, Remote, or Reserve Communities

When reserves were created, they were often placed "out of the way" and today many of them remain physically isolated from central community support services This impacts both the services that are readily accessible (the magnitude of infrastructure deficits have been described as "particularly striking"[31]), as well as revenue opportunities for the communities, meaning that individuals need to leave their communities to be able to better access services and/or employment. Similarly, for many rural Indigenous folks living on reserve, there is a lack of services available for gender-affirming care that do not require significant travel.

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[27] Leason, J. (2021). Forced and coerced sterilization of Indigenous women: Strengths to build upon. Canadian Family Physician, 67(7), 525–527. doi.org/10.46747/cfp.6707525

[28] Safe water for First Nations. The Council of Canadians. (2022, July 26). Retrieved September 2, 2022, from canadians.org/fn-water/

[29] Abulu, L. (2021, October 11). Oil pipeline on native lands ramps up as Canada honors its indigenous people. Mongabay Environmental News. Retrieved September 2, 2022, from https://news.mongabay.com/2021/09/oil-pipeline-on-native-lands-ramps-up-as-canada-honors-its-indigenous-people/

[30] Hunt, S. (2016). *An Introduction to the Health of Two-Spirit People*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

[31] Standing Senate Committee on Aboriginal Peoples. (2015). On-Reserve Housing and Infrastructure: Recommendations for Change. Retrieved from: https://sencanada.ca/content/sen/Committee/412/appa/rep/rep12jun15-e.pdf

When booking appointments:

- consider booking them on the same day as other appointments to limit any travel-related concerns
- host appointments virtually if possible
- work with patients to assist with travel (see **NIHB Program** for possible supports)
- Remember that for Indigenous folks who may have moved out of their communities to access gender-affirming care, school or other support services, they may struggle with culture shock

While this is not a "one size fits all" approach, it is important to keep these things in mind when working with **Two-Spirit**, **Indigiqueer**, and Indigenous trans or gender-diverse patients.

Microaggressions

Microaggressions are words or actions that come from implicit biases. It can be described as subtle or unintentional discrimination of a marginalized group, and can impact patients' level of emotional safety. For Indigenous Peoples, this can involve things like: being asked to explain topics about Indigenous history, cultures or political events (unprompted), or receiving inappropriate questions about their identity that are unrelated to their direct care, etc.

Some things to remember:

- Know that you will at times make mistakes with pronunciation and pronouns, and your patient may correct you, or you may realize the mistake yourself. When this happens, thank the patient if they have corrected you, repeat what you had said with the correct pronunciation (to the best of your ability) or pronoun, and move on. For more detail on how to respond to a mispronunciation or misgendering error, please see **Misgendering 101** and **Original Voices**.
- Avoid making assumptions about a patient's identity or lived experience.
- Only ask questions that are relevant to the patient's direct care.

Clinical vs. Relational Approach

Due to the deep rooted systemic racism that has existed historically and continues to exist between health care systems and Indigenous Peoples, it is important to be sensitive

to Indigenous Peoples' potential hesitancy with PCPs, Western medicine, and distrust in the healthcare system as a whole. There can be a lot of vulnerability involved for Indigenous patients to trust non-Indigenous PCPs. Treat the relationship with care and cultivate trust and safety.

Involvement in culture and ceremony may play a huge role for some individuals and for others it may not. Some may need medical care such as GAHT/surgeries, and for others, social and cultural transition *is* the end goal and can look like: the roles someone may play in their community, where they sit in the sweat lodge, or the way they express their gender through clothing, gender-affirming garments, etc.[32]

Gender-affirming care for Two-Spirit, Indigiqueer, and

Some ways to practice a relational approach to working with Indigenous Peoples:

- Act with humility: Be honest about gaps in knowledge and do not make assumptions.
- Use the Informed Consent Model and make your intentions clear. It's important for care providers to be transparent about options and next steps to nurture a relationship of trust and respect with the patient. This is especially important in regards to prescription medication, as patients may be hesitant to trust western medicine, or may prefer other options.
- Encourage follow-ups and referrals and try to avoid delays whenever possible, as this has been and continues to be weaponized against Indigenous folks seeking medical care.
- Use accessible language (avoid overuse of medical jargon).
- Let the patient know that having a support person attending appointments is an option, though this may or may not be necessary for the patient.

[32] TransCare BC. (2022). Indigenous gender diversity: Creating culturally relevant and gender-affirming services. PHSA's Learning Hub.

- Invite them to tell you how they experience themselves and listen to what they need rather than making assumptions or dismissing their concerns. This will help you to avoid **gaslighting**.
- Above all, keep in mind that many of your patients will have had previous negative experiences with the health care system, and it will take time for you to gain trust.

Cultivate relationships by getting involved

- Get to know other service providers who work with **Two-Spirit**, **Indigiqueer**, and Indigenous trans or gender-diverse People.
- Seek partnerships with Indigenous health programs, organizations and communities in your area.
- Encourage your employer, staff, or colleagues to seek further training opportunities on working with Indigneous Peoples, either in-person or online, as well as seeking them out yourself.

If you're making a referral:

- Think beyond the Western idea of service providers (i.e., traditional healers, cultural ceremony, experts in community, etc.). For many Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse People, their gender journey is interconnected with their cultural and spiritual identity. Therefore, some people find cultural and spiritual guidance invaluable during their journey, whether they are transitioning socially, accessing gender-affirming medical care, or preparing for and healing from a surgery.
- When you are unsure if a care provider or service is competent working with Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse People - call ahead. Consider asking them what policies are in place to help Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse People feel safe.

NIHB Program

Some, though not all, of your Indigenous patients will be eligible for financial coverage through the NIHB program. For more information, see **NIHB Program**.

Providing Competent, Culturally-Focused Care is an Ongoing Journey

As is often the case when working with anyone whose experience differs from yours, or even at times when you have a shared experience, mistakes and misunderstandings will

occur, and there will always be room for personal growth. Continuing to challenge your own internal biases, accepting correction, and working to do better in the future will continue to positively impact your relationships with your patients, contribute toward a more trusting environment, and result in favorable health outcomes for 2STIGD patients.

Questions to Ask Yourself and Reflect On

1. What role do I play in reconciliation?
2. Are the services I provide and the spaces that I provide them culturally safe, responsive and accessible to Two-Spirit, Indigiqueer, and Indigenous trans or gender-diverse patients?
3. Am I thinking critically about my positionality and unconscious biases and the ways they impact care delivery?
4. Has my practice or workplace made efforts to learn about the lived experience of the Indigenous Peoples in the area? (i.e., relationship building, training, shared resources, team conversations, etc.)
5. What are three ways I can make my clinical space safer for Indigenous folks in the short term?
6. What are three ways I can make my clinical space safer for Indigenous folks in the long term?

Part 2: Caring for Underserved 2STIGD Folks

The following section outlines the most up to date practices in delivering gender-affirming and culturally-focused health care to Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) folks from underserved communities.

Disability and Neurodivergence

Disability and neurodivergence is a large intersection that can include physical and intellectual disabilities, as well as PTSD, ADHD, **Autism**, and other diagnosable conditions. Disabled and Neurodivergent People have a longstanding history of trauma and mistreatment from the medical care system. Far too often, Disabled and Neurodivergent folks are invalidated or ignored when seeking help from PCPs, which is called medical **gaslighting**. Unfortunately, this means that most Disabled and Neurodivergent patients have likely experienced some level of harm or trauma from the medical care system and it's important to proceed with that awareness and understanding, using a careful, trauma-informed approach.

Disabled People will have different needs based on income, sociocultural factors, access to health care, and gender identity. **Ableism** has one of the biggest impacts on Disabled People's health outcomes, often causing additional intersecting struggles. There are various social determinants to health which impact many Disabled People, including discrimination, inaccessibility, stigma, and barriers to health care. Some barriers include the lack of adequate health insurance coverage, personal and cultural barriers, and a general lack of knowledge among PCPs about disability. These barriers, and others, often lead Disabled People to postpone seeking health care, or avoid the healthcare system altogether. Even though there is a difference between disability and health status, our healthcare system is rooted in systemic issues that increase the likelihood of Disabled People experiencing poor health outcomes compared to their able-bodied peers.

It's also important to note that a patient's age plays an important role in accessing health care services; for older Disabled People, there is a higher rate of unmet health care needs due to ageism and discrimination. When it comes to accessing gender-affirming care, Disabled and Neurodivergent patients who are also Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) can face barriers to accessing services in situations where PCPs negate access based on a belief that the patient does not have the capacity to consent, ignoring their desires to medically and/or socially transition. This is another form of gatekeeping which is rooted in **ableism**. For a more thorough discussion of gatekeeping, please see **Gatekeeping and Bias**.

When working with Disabled and Neurodivergent patients consider the following:

- If a patient has self-identified as Disabled and or Neurodivergent, ask what it means to them and what kinds of needs or challenges they may have, rather than making assumptions about their individual experience.
- Discuss available services/technology that can make appointments accessible for the patient (i.e screen readers, examining table size, accessible pathways with adequate space for mobility aids).
- Let the patient know that having a support person attending appointments is an option, though this may or may not be necessary for the patient.
- Keep in mind that clear and transparent communication is very important, for example; consider offering to send any notes taken during appointments, communicating using visuals, audio recordings of appointments, and sending them home with physical resources or a way to access them online/in store, etc.
- Above all, listen to what the patient needs.

Before making a referral, ensure that they will be safe, affirming, and accommodating, to Disabled and Neurodivergent folks. For example, consider calling ahead to ask what kinds of services or equipment are available to accommodate your patient, as some spaces may contribute to medical trauma and harm. In situations where there are limited options for referrals and you have accessibility concerns, communicate these openly with the patient, inviting the patient to be a part of the process of how best to proceed.

Finally, should a patient highlight that a service is inaccessible, whether within your own practice or outside of it, your attitude is vitally important. Thank them for pointing it out, and carefully consider how you can address this concern for the future when it is in your power to change. If the concern is outside of your control, take time to come up with a plan for how to assist patients in the future, whether referring them to a place that is more accessible for them , or supporting them in some other way.

Debunking Myths About Autism

Much of our current medical research prioritizes the needs of white cisgender males of European descent, and the diagnostic criteria for Autism is no different. Limited research of traits and symptoms of Autism has resulted in many AFAB folks and trans and non-binary AMAB folks being severely underdiagnosed and misdiagnosed as their symptoms are often missed in childhood.[33] Additionally, the way these individuals tend to be socialized is heavily influenced and impacted by heteronormativity and cisnormativity, which in turn increases their likelihood to be diagnosed incorrectly as their symptoms may present differently.[34] With increased research in diverse populations, we are beginning to understand the many different ways neurodivergence can present, and what supports are needed for Autistic adults

Autism or ASD is best understood on a spectrum of needs, abilities and experiences. In the past, folks began referring to autistic people as being either low or high functioning based on a research study in the 1980s. The study differentiated between those with or without an intellectual disability as determined by an IQ test. Functioning labels have since been identified as problematic, as they are not only extremely harmful and damaging but they also do not accurately represent the autistic experience.[35] Autism is a developmental disability and it is not mutually exclusive to intellectual disabilities. Similarly in the past, 'levels' were used to describe the 'severity' of someone's autism including terms such as Aspergers syndrome. There is no such thing as mild or severe autism. That language is

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[33] Mandavilli, A. (2015, October 19). The lost girls: Misdiagnosed, misunderstood or missed altogether, many women with autism struggle to get the help they need. Retrieved November 16, 2022 from **https://doi.org/10.53053/WJAF1376**

[34] Dattaro, L. (2022, May 9). Null and Noteworthy: Sex bias and gender blend. Retrieved November 16, 2022 from **https://doi.org/10.53053/IDRH9667**

[35] Lee, J. (2021, April 28). Why functioning labels for autism are actually harmful. Retrieved November 16, 2022 from **https://graymattersmd.com/functioning-labels-autism/**

outdated and no longer accepted. Rather than focusing on an ableist view of 'how well someone is functioning,' it is more respectful and accurate to view the person as a whole, autonomous individual with accessibility needs that will vary from person to person. Everyone's experience with autism is different and can also vary based on other intersecting identities (socioeconomic status, gender, culture, mental health, etc.) in addition to the environment in which they were socialized.

Autism is not curable and does not need to be 'fixed.' ABA - a type of behavior therapy aimed at minimizing symptoms and traits in Autistic kids has been identified as more harmful than helpful. Anne Borden, cofounder of Autistics for Autistics, says "ABA is fundamentally flawed and problematic" and many folks in the Autistic community have even referred to ABA as abusive.[36] Borden calls ABA "compliance training" and explains that this type of treatment teaches children to ignore their intuition and damages their understanding of boundaries and consent which can impact their future judgement and relationships. Borden also suggests that they may suffer lasting trauma as a result of ABA. The journal Advances in Autism validates this claim through a study published in 2018. They found that "nearly half of children and adults exposed to ABA had **post-traumatic stress disorder** (PTSD)."[37] Additionally, ABA tends to reduce only the outward appearance of autism. For the individual experiencing this therapy, it deeply damages their self-esteem and sense of self as they're trained to act neurotypical and hide who they are. This internalization can lead to symptoms of severe anxiety along with many other long-lasting negative health outcomes.

When looking for further information, seek out Autistic individuals who choose to share their experiences rather than an organization that may or may not be operated by Autistic people themselves. There is a lot of misinformation about autism so it's important to be very conscious of where and who the information is coming from. Autism Speaks for

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[36]Delisle, R. (2018, May 31). Is the most common therapy for autism harmful or helpful? Retrieved November 16, 2022 from **https://www.todaysparent.com/family/special-needs/is-the-most-common-therapy-for-autism-harmful-or-helpful/**

[37] ibid

example is an organization that perpetuates harmful information about Autistic people and is widely discredited by the community.[38]

Autism and Gender Diversity

There is a strong correlation between autism and gender diversity, as 2STIGD individuals are three to six times more likely to be Autistic than cisgender individuals.[39] Additionally, gender-diverse individuals are more likely to suspect they have undiagnosed autism or have autistic traits.[40] The reason for this strong intersection between autism (and neurodivergence more broadly) and gender diversity is still unclear due to a lack of research. However, many feel that it is connected to the way that autistic individuals interact with social norms and social communication. As much of our current understanding of gender is socially constructed, it can be understood that Autistic individuals would not naturally conform to these ideas of cisnormativity.

In addition to being gender-diverse, it was found that "nearly 70 percent of Autistic gender-diverse adolescents say they need medical gender-related care [...] and 32 percent say their gender identity has been questioned because of their autism diagnosis."[41] As Autistic individuals have also been noted to have an increased risk of depression[42] and other psychiatric conditions,[43] PCPs should be conscious of the health impacts that can result from multiple layers of marginalization and to work with the patient to determine how best to support their mental health as necessary. That said, it is very important to keep in mind that these comorbidities do not mean that one should be denied care, or that an individual's gender identity is invalid.

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[38] Autistic Self Advocacy Network, et al. (2014, January 6). 2014 Joint Letter to the Sponsors of Autism Speaks. Retrieved November 20, 2022 from **https://autisticadvocacy.org/2014/01/2013-joint-letter-to-the-sponsors-of-autism-speaks/**

[39] McCarty, N. (2022, May 16). Autistic LGBTQ+ people report frequent mental health problems. Retrieved November 16, 2022 from **https://doi.org/10.53053/XMKX9346**

[40] Furfaro, H. (2019, January 28). Study strengthens autism's curious link to gender variance. Retrieved November 16, 2022 from **https://www.spectrumnews.org/news/study-strengthens-autisms-curious-link-gender-variance/**

[41] Dattaro, L. (2020, September 14). Largest study to date confirms overlap between autism and gender diversity. Retrieved November 16, 2022 from **https://doi.org/10.53053/WNHC6713**

[42] Weinstock, C. (2019, July 31). The deep emotional ties between depression and autism. Retrieved November 16, 2022 from **https://doi.org/10.53053/WRSX5772**

[43] Choi, C. (2022, September 19). Autism diagnosis in adulthood tied to increased burden of psychiatric conditions. Retrieved November 16, 2022 from **https://doi.org/10.53053/GCOY5940**

Just as neurotypical 2STIGD patients are at an increased risk of depression or anxiety due to the weight of today's cisnormative society, there are also negative mental health outcomes for Autistic 2STIGD patients. For Autistic folks, navigating a world that is inaccessible, and **masking** as a means to survive can be incredibly exhausting and can take a toll on a patient's overall health and sense of self.[44] Especially in the case of 2STIGD Autistic patients, those experiences are compounded by the negative health outcomes that 2STIGD patients face more broadly. It is important for PCPs to be aware of the relationship between autism, gender, sociocultural factors, and mental health when working with 2STIGD individuals. See also **informed consent** and **Mental Health** for further discussion.

Person-First or Identity-First Language?

Is it more respectful to say "Disabled person" or "person with a disability?" The short answer is both, and as such PCPs should always adjust their language based on how the patient speaks about their disability. For autism in particular, there have been efforts within the community to move away from person-first language as the standard practice and instead use identity-first language, as "many self-advocates prefer terminology such as 'Autistic,' 'Autistic person,' or 'Autistic individual' because we understand autism as an inherent part of an individual's identity."[45] In all cases however, deference should always be given to the individual.

2STIGD People of Colour

Studies have shown that there are greater health disparities among 2STIGD who are also POC (People of Colour), compared to their white counterparts. Using the theory of intersectionality, it can be understood that 2STIGD People of Colour can face systemic oppression in a compounded way due to their "double minority status." They are confronted not only with the discrimination and violence imposed by cisheteronormativity, but also with racism. 2STIGD People of Colour also often deal with the intersecting burden of economic oppression and financial barriers to health care. They also may be less likely to be insured and therefore are less likely to receive appropriate

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[44] Russo, F. (2018, February 21). The costs of camouflaging autism. Retrieved November 16, 2022 from https://doi.org/10.53053/ZNSG1811

[45] Brown, L. (2011, August 4). Identity-First Language. Retrieved November 16, 2022 from https://autisticadvocacy.org/about-asan/identity-first-language/

care when needed. 2STIGD folks accessing care are often put into positions where they need to educate their provider on the care they need.[46] Additionally, People of Colour manage the added burden of educating their provider on care that is culturally safe and responsive to their needs. The links between these identities must be understood in order to understand the social determinants that lead to poor health outcomes among this population.

Resources

BIPOC Women's Health Network

- How to Make Your Practice Inclusive for 2SLGBTQ+ BIPOC Folx
- Anti-Asian Racism & The Healthcare System

Immigrants, Refugees, Migrant Workers and Undocumented Individuals

Immigrants, Refugees, Migrant Workers and Undocumented (IRMU) individuals often have overlapping barriers to care as POC. Although not all IRMU folks are People of Colour, they may face similar and additional compounded difficulty when accessing health care and facing discrimination related to their status in Canada. IRMU individuals may also commonly deal with economic oppression and other barriers to accessing support services such as a lack of language translation. Undocumented individuals in particular are one of the most underserved populations as a lack of immigration status leads to a fear of accessing services, as this poses a risk of being reported to immigration authorities and even deportation. Undocumented folks are a vulnerable population as they have limited access to health care, social services, and employment protections. This may increse their likelyhood of working in informal sectors which have less systemic support and protections, including childcare, housekeeping, agriculture, construction and sex work.[47] IRMU individuals who are also 2STIGD face additional layers to their already marginalized identity, impacting not only their access to safe and culturally-sensitive gender-affirming

[46] Kannout, L. (2022). Examining Associations between Discrimination, Social Cohesion, and Health among White and POC LGBT Chicagoans. ProQuest Dissertations Publishing.

[47] Immigration, R. and C. C. (2022, June 15). Government of Canada. Canada.ca. Retrieved September 2, 2022, from https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/committees/cimm-mar-03-2022/undocumented-populations.html

care, but also to their ability to have immigration documents which accurately reflect their gender identity.

Refugee claims may be made for many reasons, including those on the basis of facing violence due to the individuals' sexual orientation, gender identity and expression, sex characteristics, HIV+ status, and more. This happens in instances where their home country cannot or will not protect them, or for other reasons.[48] They may often deal with additional mental health challenges related to the trauma/violence of transphobia and homophobia and the discrimination and stigmatization they faced in the country they are seeking assylum from.[49] It is important for PCPs to be aware that this is a reality for many and these relationships must be handled with care to achieve positive health outcomes.

It is critically important for translation services to be available when needed. Some recent data shows poorer health outcomes and higher mortality rates when translation services are omitted or when practitioners rely on family members to translate.[50] Call your nearest hospital for more information on translation services for patients' health care visits. If translation services are not regularly offered in your practice, consider contacting your local Multi-Cultural Association and create a plan for translation to ensure informed consent is accessible to IRMU patients.

Application for Canadian Citizenship: Adults - Subsection 5(1) CIT 0002 - Appendix C outlines the process of changing your gender marker for those born outside of Canada. Many countries may require the gender marker to be changed on the original birth certificate first before any Canadian citizenship documents can be changed. Alternatively, patients may only need to access the original copy of their birth certificate in order to proceed. This adds a complex layer of difficulty as not everyone will have access to their original birth certificate for a number of reasons including a country being in conflict, and there may be barriers to changing original documentation based on a country's beliefs on

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[48] Capital Rainbow Refuge. (2021). Queer Refugee Hearings Program Toolkit.. Retrieved September 2, 2022, from **capitalrainbow.ca/qrhp?l=&lang=en_us**

[49] Rainbow Health Ontario. (2016). Mental Health Challenges for LGBT Asylum Seekers in Canada. Rainbow Health Ontario. Retrieved September 2, 2022, from **www.rainbowhealthontario.ca/**

[50] Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health services research, 42(2), 727–754.

2STIGD individuals and their rights. It's important for PCP's to be aware of how name changes and gender markers involve many additional barriers for folks born outside of Canada.

Specific considerations for accessing health care must be made due to their citizenship/imigration status as access will vary extensively. For refugees and patients seeking asylum in Canada, they are eligible for health coverage under the Interim Federal Health Program (IFHP) even before their case is decided. The coverage is equivalent to New Brunswick Medicare and includes all health needs, including prescription drugs. For more information on this program, visit the **Interim Federal Health Program**. For folks who may not have access to health coverage (considering undocumented individuals and migrant workers) cost may be one of the biggest barriers. Community health centers and hospitals will see patients who are undocumented or otherwise do not have access to New Brunswick health care. However, patients get billed directly for those health care costs and can vary depending on the service (bloodwork, prescriptions, etc).

Substance Use Disorder (SUD)

Anyone experiencing mental health challenges, regardless of their age or identity, is at an increased risk of self-medicating in the form of substance use and addiction. As 2STIGD individuals often experience stigmatization and discrimination, they are at an increased risk of mental health challenges, which in turn increases the risk of substance use and addiction. In fact, according to a 2019 national survey of mental health among 2SLGBTQIAA+ youth, "approximately 60-75% of adolescents with mental illness have a co-occurring substance use disorder." Recent data shows that youth who identify as a sexual minority are about twice as likely to use substances compared to heterosexual youth. Additionally, those who identify as a gender minority face exceptionally high levels of stigmatization and discrimination, which correlates to higher rates of mental health challenges and suicidality; one research study identified that the risk of substance use among these youth is 2.5 to 4 times higher, relative to their cisgender peers. It is important to remember that being a part of the 2STIGD community is not inherently a risk factor for

substance use, but rather, "the heightened risk comes from the stigma and discrimination they face as a result of their sexual orientation and/or gender identity."[51]

In treatment centers for Opioid Use Disorder (OUD) and other substance use disorders, some have "no-needle" policies or rules about self-administration of medications, however it is vital that 2STIGD patients continue GAHT during this time,[52] as suddenly stopping the medication can cause negative side effects such as depression and suicidal thoughts.[53] When a referral is being made for a patient undergoing GAHT, be sure to call ahead and ask treatment programs how they address this. For referrals within New Brunswick, see **New Brunswick Addiction Centers**.

"Opioid agonists, including treatments such as methadone and buprenorphine, have known interactions with certain ART (Antiretroviral) medications, particularly efavirenz, and with hormone-modulating medications, such as spironolactone." Known or perceived medication interactions may deter some patients from potentially life-saving treatment for OUD. "Co-prescription of these medications is safe and feasible with appropriate monitoring and follow up."[54] Ensure however, that patients are always given fully informed consent on these medication interactions.

Intersex Considerations

Disclosure: *The following information was obtained from The Fenway Institute's* ***National LGBTQIA+ Health Education Center*** *and incorporated into this education package with their permission. Seeing as the Fenway Institute is an American organization, all information has been fact checked for accuracy within the Canadian context.*

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[51] *Why LGBTQ+ youth are at increased risk for Substance Use & How You Can Help*. Partnership to End Addiction. (2022, June 23). Retrieved September 7, 2022, from **https://drugfree.org/article/reducing-substance-use-risk-among-lgbtq-youth/**

[52] Fenway Institute. (2018). Addressing Opioid Use Disorder among LGBTQ Population. Retrieved from: **https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/06/OpioidUseAmongLGBTQPopulations.pdf**

[53] *Considerations for medication to treat opioid disorder within the LGBTQ+ community*. Partnership to End Addiction. (2021, June 2). Retrieved September 7, 2022, from **https://drugfree.org/article/considerations-for-using-medication-to-treat-opioid-disorder-within-the-lgbtq-community/**

[54] Fenway Institute. (2018). Addressing Opioid Use Disorder among LGBTQ Population. Retrieved from: **https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/06/OpioidUseAmongLGBTQPopulations.pdf**

Intersex is an umbrella term that refers to those with a wide range of natural variation in sex characteristics and development that falls outside traditional conceptions of female or male. Although biological sex has traditionally been seen as binary (female or male) in many cultures, the reality is more complex. Variations may occur in the chromosomes, external genitalia, gonads (testes or ovaries), hormone production, hormone responsiveness, internal reproductive organs, or any combination of these, among others.[55] People are born with these variations or develop them at a young age. The word Intersex also invokes a community. Intersex people are diverse, coming from all socioeconomic backgrounds, races, ethnicities, genders, sexual orientations, faiths, and political ideologies.

Language related to Intersex health is complex. Currently, the medical field uses the terms "differences of sex development" (DSD) as well as Intersex.[56] The term "diverse sex development" has also been cited in the literature.[57] The DSD acronym originally referred to disorders of sex development, however Intersex community members have made it clear that the term disorders is pathologizing and demeaning.[58] The outdated terms hermaphrodite, pseudohermaphrodite, and ambiguous genitalia are experienced as stigmatizing and hurtful; these terms should be avoided unless an Intersex person asks you to use them. PCPs should also avoid terms that describe a person's anatomy as defective or abnormal.

While some people in the community use the terms Intersex or difference of sex development, other people in the community prefer to use the specific name of their diagnosis.[59] For PCPs, the best practice is always to mirror the term(s) patients use, or ask patients what they prefer.

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[55] InterACT Advocates, Lambda Legal. (2018). Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies. Retrieved from: https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_20180731_hospital-policies-intersex.pdf

[56] Johnson EK, Rosoklija I, Finlayson C, et al. (2017). Attitudes towards "disorders of sex development" nomenclature among affected individuals.

[57] Roen, K. (2019). Intersex or diverse sex development: critical review of psychosocial health care research and indications for practice. Journal of sex research, 56(4-5), 511–528.

[58] InterACT Advocates, Lambda Legal. (2018). Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies. Retrieved from: https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_20180731_hospital-policies-intersex.pdf

[59] InterACT Advocates, Lambda Legal. (2018). Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies. Retrieved from:

Caring for Intersex Patients

Like Two-Spirit, trans, Indigiqueer, and gender-diverse people (2STIGD), Intersex people may have a gender identity that does not correspond with their sex assigned at birth or gender of raising. In addition, because Intersex people have sex characteristics that transcend typical notions of female and male bodies, they may experience barriers similar to 2STIGD people in accessing affirming health care that respects their bodies, gender identities, and physical needs.

While some intersex variations are noted prenatally or at birth, many intersex traits do not become apparent until puberty or later in life. Below are common points at which an intersex variation may be identified:

- During a prenatal ultrasound
- At the time of child's birth, if genital variation is identified
- During care related to an inguinal mass/hernia that leads to the discovery of internal testes
- At time of puberty, if pubertal changes do not occur, or if there are unexpected physical changes (e.g., virilization of an individual assigned female sex at birth)
- Incidentally during a laparoscopy for another medical concern
- During evaluation of an adult for infertility

While PCPs are not expected to be intersex specialists, they still require education in the basics of intersex care. PCPs can provide affirming and compassionate care for intersex patients and their families. To practice affirming care in interactions with intersex patients, it is important for PCPs to listen with sensitivity to their patients and acknowledge that:

- Sex development, like gender identity, exists on a continuum
- Human fetal development is complex - variations in sex characteristics are an expected and natural outcome of sex development
- An individual born with variations in their sex characteristics may or may not identify as Intersex or as part of the 2SLGBTQIAA+ community

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https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_20180731_hospital-policies-intersex.pdf

Medically unnecessary cosmetic surgeries

Starting in the 1950s, the prevailing medical approach to treating Intersex infants and children emerged as an attempt to "correct" the appearance and function of atypical genitalia. Surgeries also aimed to prevent the possibility of a child growing up to have "non-heterosexual relationships".[60] Unfortunately, the practice of surgical "correction" continues today. Often, families feel pressured to consent to surgeries on their child without being given sufficient mental health counselling, peer support, or information on alternatives to surgery.[61] The majority of these surgeries are not medically necessary and can be delayed until the individual can decide for themself. There is no evidence demonstrating the benefits of cosmetic genital surgery to a child's long-term mental or physical health, nor is there evidence of any risk to delaying the procedures until the individual can decide if they wish to have the surgery.[62]

In actuality, many Intersex people experience multiple adverse side effects from genital surgeries, including scarring, chronic pain, loss of sensation, urinary and sexual dysfunction, and other complications that require repeated follow-up surgeries. Intersex people also report symptoms of post-traumatic stress disorder, depression, feelings of loneliness, and fear of intimacy due to surgeries performed on them before they were old enough to participate in the decision themselves.[63] Furthermore, surgery performed at an early age can assign a genital appearance that does not align with the individual's gender identity that emerges later.[64]

In recent years, Intersex-led community organizations have made great advances in raising awareness and promoting a patient- and family-centered long-term management strategy that safely delays surgery. Multiple human rights and medical professional societies (e.g., CPATH) have also issued policies opposing medically unnecessary surgeries on Intersex

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[60] Roen, K. (2019). Intersex or diverse sex development: critical review of psychosocial health care research and indications for practice. Journal of sex research, 56(4-5), 511–528.
[61] ibid
[62] Fenway Institute. (2020). Affirming Primary Care for Intersex People. National LGBTQIA+ Health Education Center. Retrieved from: https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/08/Affirming-Primary-Care-for-Intersex-People-2020.pdf
[63] Fenway Institute. (2020). Affirming Primary Care for Intersex People. National LGBTQIA+ Health Education Center. Retrieved from: https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/08/Affirming-Primary-Care-for-Intersex-People-2020.pdf
[64] ibid

infants. It should be noted that there are a number of limitations and knowledge gaps with the current WPATH SoC which directly impact the care of Intersex individuals. These are discussed in the section **Children and Youth**.

Unnecessary and Objectifying Medical Examinations

Intersex people are often made to feel like medical curiosities. Adults report long-term emotional consequences from repeatedly undergoing intrusive, objectifying, and medically unnecessary genital examinations and photography as children.[65] Even today, some children still undergo repetitive genital examinations which are not necessary for their medical care.[66]

Providers should keep in mind that even a medically necessary genital examination can re-traumatize an Intersex patient. Prior to performing an exam, it is vital to first establish a warm and respectful relationship with the patient, engage them in shared decision making about their health, and use a trauma-informed approach (see **Tips for Sexual Health Screening**).

Non-Disclosure

Another common practice that has harmed Intersex people and their families is the concealment of information from patients about their bodies.[67] Concealing information from Intersex people (including youth) delays the process of self-acceptance and increases shame and stigma. Sharing information in an age-appropriate manner enables people to process the information and access peer support.[68]

Patients and their families need full disclosure of medical information and options so they can make informed decisions that are appropriate to the child's developmental stage. Behavioral health providers and Intersex-affirming peer support organizations (such as

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[65] Roen, K. (2019). Intersex or diverse sex development: critical review of psychosocial health care research and indications for practice. Journal of sex research, 56(4-5), 511–528.
[66] ibid
[67] Roen, K. (2019). Intersex or diverse sex development: critical review of psychosocial health care research and indications for practice. Journal of sex research, 56(4-5), 511–528.
[68] Fenway Institute. (2020). Affirming Primary Care for Intersex People. National LGBTQIA+ Health Education Center. Retrieved from: https://www.lgbtqiahealtheducation.org/wp-content/uploads/2020/08/Affirming-Primary-Care-for-Intersex-People-2020.pdf

Egale and Intersex London Canada) can help families learn to disclose information to their child in age-appropriate ways, and to share information with extended family, babysitters, and others who would benefit from learning about the child's variations. For adult Intersex persons who only recently learned of their diagnoses, PCPs can help them access medical records, understand their medical history, and engage with mental health professionals and peer support as needed to adjust to their new reality.

Specific medical needs

While many Intersex people do not need any specialized medical care, some require care at specific developmental junctures, and others have lifelong needs related to their individual variation. PCPs should help individuals and families find trusted referrals and navigate specialized care.

Some common medical specialty care needs include:

- Steroid replacement for individuals with combined adrenal gland/gonadal variations
- Gynecologic, urologic, and sexual health care, particularly to address any complication created by prior surgical procedures
- Hormone therapy to:
    - induce secondary sex characteristics, as desired by the individual
    - affirm gender identity if sex assigned at birth does not correspond with gender identity
    - replace sex hormones after surgical removal of gonads
- Prevention and treatment of osteoporosis
- Cancer surveillance of internal gonads; some individuals/families may elect to surgically remove the internal gonads or gonadal streaks if there is elevated risk of malignant transformation relative to the general population; however, cancer risk may not be present; make sure to check updated recommendations.

Gender-Affirming Care for Aging 2SLGBTQIAA+ Folks

Disclosure: *The following information was adapted from The City of Toronto's* ***Leading & Learning WITH PRIDE: A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*** *and incorporated into this education package with their permission.*

2SLGBTQIAA+ elders, seniors, and older persons in Canada face systemic discrimination and oppression based on their sexual orientation, gender identity, and gender expression. As a result, many continue to face unique challenges as they age and often experience barriers to access across healthcare, long-term care, retirement, homecare, and social service environments. 2SLGBTQIAA+ elders, seniors, and older adults experience stigma and discrimination at all points of the healthcare continuum, negatively affecting physical and psychological health and wellbeing.[69] Gaining an understanding of the issues and experiences of 2SLGBTQIAA+ elders, seniors, and older adults is critical to informing government, service providers and community organizations on how to provide appropriate policies, programs and services, and positive, caring environments for aging 2SLGBTQIAA+ people.[70]

Respectful, inclusive, and affirming care acknowledges the diverse experiences of 2SLGBTQIAA+ elders, seniors, and older adults and addresses their physical, psychological, emotional, social, and spiritual needs. Keep in mind that 2SLGBTQIAA+ elders, seniors, and older adults are an incredibly diverse group. As such, the common experiences, needs, and challenges examined in this section may not apply to everyone you work with. Additionally, while research on 2SLGBTQIAA+ elders, seniors, and older adults is gradually increasing, it is still limited, particularly for those identifying as 2STIGD.[71] These gaps in evidence reflect that our knowledge and understanding of 2SLGBTQIAA+ elders, seniors, and older adults and their needs are incomplete and still developing.

Terminology

The language we use to describe ourselves and others matters, because terms related to our social identities can help us feel seen and understood, especially when pieces of our identity might not be readily visible to others or made invisible by stigma, discrimination, and oppression. In this section you will notice that instead of using the acronym 2STIGD, that we have opted to use the larger umbrella term 2SLGBTQIAA+. The reason for this is to more accurately reflect the evolution of terminology.

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[69] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.
[70] ibid
[71] ibid

Although the language and terminology related to 2SLGBTQIAA+ communities is understood to be fluid, the way in which language evolves over time is particularly important to note when it comes to 2SLGBTQIAA+ elders, seniors, and older persons. Some words that may have been appropriate in the past can become dated and offensive. Other words that were once derogatory can be reclaimed and used by 2SLGBTQIAA+ people in an empowering way. For example, some older people may refer to themselves using terms such as transsexual, crossdresser, or homosexual.

For 2SLGBTQIAA+ elders, seniors, and older persons, providing respectful, inclusive and affirming care often starts with the use of appropriate language and terms. As with all 2SLGBTQIAA+ people, PCPs should use the language and terminology that each individual patient prefers.

Context

The last 50 years have seen immense progress for 2SLGBTQIAA+ liberation movements worldwide. However, many elders, seniors, and older adults grew up in places and times where stigma, discrimination, and oppression against 2SLGBTQIAA+ communities were rampant and normalized.

Many 2SLGBTQIAA+ elders, seniors, and older adults grew up during periods where gender and sexual diversity was criminalized and pathologized. In fact, homosexuality was only partially decriminalized in **Canada in 1969** and up until 1973, was included in the **Diagnostic and Statistical Manual of Mental Disorders**. As a result, many 2SLGBTQIAA+ elders, seniors, and older adults have been subjected to police brutality and incredibly harmful, scientifically discredited **conversion therapies**[72] focused on changing their sexual orientation, gender identity, and/or gender expression. Many of these so-called 'treatments' have **continued into the present day**.[73] 2SLGBTQIAA+ elders, seniors, and older adults may have come of age during the **1969 Stonewall Riots** or the **1981 Toronto Bathhouse Raids**. Many have lost partners, friends, chosen family, and entire communities during the **AIDS crisis**. Some may have lost their jobs during the '**LGBT Purge**,' a process

[72] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.
[73] ibid

through which the Canadian government systematically surveilled, interrogated, abused, and fired 2SLGBTQIAA+ people serving in the Canadian Armed Forces and the Royal Canadian Mounted Police between the 1950s and mid-1990s.

Resource

Fruit Machine, a documentary by Sarah Fodey recounting the personal stories of survivors of the LGBT Purge.

However, it is important to avoid thinking of 2SLGBTQIAA+ elders, seniors, and older adults only through the narrow lens of victimhood. Despite the challenges they may have faced, 2SLGBTQIAA+ elders, seniors, and older adults belong to diverse, vibrant, and resilient communities with rich histories full of activism, advocacy, and joy. Understanding significant 2SLGBTQIAA+ historical events can help contextualize the current needs of 2SLGBTQIAA+ elders, seniors, and older adults, and contribute to your knowledge and skills in inclusive and affirming care.

Social Isolation and Mental Health

Social isolation, meaning infrequent or poor quality contact with others, can be a significant concern for 2SLGBTQIAA+ elders, seniors, and older persons. The factors contributing to social isolation among 2SLGBTQIAA+ elders, seniors, and older persons are numerous, but may include any of the following:[74]

- More likely to live alone
- Less likely to have spouses, life partners, or children
- Less likely to have other familial supports, sometimes due to rejection from their family of origin
- Limited opportunities for community connection, as programs and services geared towards 2SLGBTQIAA+ elders, seniors, and older persons are generally limited
- Hesitancy to form new connections due to past and/or anticipated experiences of stigma and discrimination

[74] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.

- May have lost partners, friends, chosen family, or entire communities to AIDS or due to homophobic, biphobic, and transphobic violence.

It is important to note that social isolation among 2SLGBTQIAA+ elders, seniors, and older persons is not inevitable and not all 2SLGBTQIAA+ elders, seniors, and older persons are socially isolated. Protective factors like connection to community and social support networks can shield against isolation and promote resilience.[75] Without access to these critical supports, social isolation can result in a number of physical and mental health challenges.[76] These may include:

- Loneliness
- Chronic Pain
- Low Physical Activity
- Falls and Hospitalization
- Anxiety and Depressive Disorders
- **Substance Use**
- Suicidality

In addition to these isolation-related challenges, 2SLGBTQIAA+ elders, seniors, and older persons may experience increased mental health issues.[77] These may include:

- Poor Self-Rated Mental Health
- Self-Harm
- Suicidal Ideation and Attempts
- Anxiety Disorders
- Depressive Disorders
- Other Mood Disorders
- **Substance Use**

For more information on mental health supports and the role of a PCP in supporting the mental health and wellbeing of 2SLGBTQIAA+ patients please see **Part 7: Mental Health**.

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[75] ibid

[76] ibid

[77] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.

As always, it is important to recognize the oppressive social contexts in which 2SLGBTQIAA+ elders, seniors, and older persons grew up and acknowledge how repeated exposure to stigma and discrimination can impact mental health over the life course. Of note, Two-Spirit, Indigiqueer, and Indigineous LGBTQIAA+ Elders, seniors, and older persons may experience heightened mental health challenges as a result of the violence and abuse in Canadian Residential Schools and during the 60s Scoop. For more information on the impacts of colonization see **Part 1: Indigenous Gender Diversity**.

Memory Loss and Cognitive Disability

Like other seniors, 2SLGBTQIAA+ seniors may struggle with various forms of memory loss and cognitive changes or disability, including dementia. There is some evidence that 2SLGBTQIAA+ seniors may be impacted by higher rates of memory loss and cognitive disability due to increased exposure to contributing factors like depression, smoking, and social isolation.[78] A recent Canadian report further identifies parallels in the experience of 2SLGBTQIAA+ seniors 'coming into' living with dementia and their experiences 'coming out' about their gender identity or sexual orientation, as both periods can be marked by significant change or uncertainty with respect to one's relationships and sense of self.[79] Additionally, seniors living with HIV may be impacted by HIV-Associated Neurocognitive Disorders, a group of conditions that are often overlooked in care settings and characterized by declining brain function and movement, as well as shifts in behaviour and mood.[80] The experiences of 2SLGBTQIAA+ seniors living with memory loss and cognitive disability are not well characterized. Some 2SLGBTQIAA+ seniors with dementia may experience changes in the way they feel about or express their sexual orientation and/or gender identity, which can result in anxiety about managing the disclosure of their 2SLGBTQIAA+ identity, discrimination from service providers, or ending significant relationships.[81] This can be the case particularly for trans seniors living with dementia, who may experience shifts in memory around transition and associated changes to pronouns, clothing, and care decisions.[82]

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[78] ibid

[79] Eagle. (2022). Coming Out And Coming In To Living With Dementia. National Institute on Aging.

[80] Eagle. (2022). Coming Out And Coming In To Living With Dementia. National Institute on Aging.

[81] ibid

[82] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.

Resource

Coming Out and Coming In to Living with Dementia: Enhancing Support for 2SLGBTQI People Living with Dementia and their Primary Unpaid Carers by Dr. Ashley Flanagan (National institute on Ageing) and Dr. Celeste Pang (Egale Canada). This is to date the most thorough investigation on the unique needs and experiences of 2SLGBTQIAA+ Canadians living with dementia and their unpaid carers. This report also includes four high-impact recommendations to improve programming, policy, advocacy, and research.

End-of-Life

2SLGBTQIAA+ elders, seniors, and older persons may experience anxiety about isolation near the end-of-life. They may fear being placed in long-term care homes, hospices, or other facilities where their independence is undermined and their identity may be invalidated. Some 2SLGBTQIAA+ elders, seniors, and older persons may be contacted by their family of origin near the end-of-life, regardless of whether they are on good terms or estranged. Reconnecting with family of origin at this time may or may not be beneficial for 2SLGBTQIAA+ elders, seniors, and older persons. It is important that PCPs do not assume that a patient's family of origin is best suited to care for the individual. As always, what is important is attending to the needs of the individual using a person-centered, individualized approach to help understand a person's wishes and advocating with them to ensure that dignity and autonomy are maintained during this time.

Resource

Egale's Crossing the Rainbow Bridge, a helpful resource to explore end-of-life care planning with 2SLGBTQIAA+ Seniors, whenever they are ready. Although a section of this resource is specific to Ontario, a great deal of the report is application across Canada and/or easily translatable to a NB context.

Barriers to Care

Despite the unique needs and challenges experienced by 2SLGBTQIAA+ elders, seniors, and older persons, many do not receive adequate care and support. Across healthcare,

long-term care, retirement, homecare, and social service environments, 2SLGBTQIAA+ elders, seniors, and older persons report barriers to access.[83]

Many of these barriers are rooted in past experiences of discrimination or fears of stigmatization in care and support settings. However, many also stem from actual or perceived knowledge gaps in the competence of service providers to address the needs of 2SLGBTQIAA+ elders, seniors, and older persons. In fact, a report from Trans Pulse Canada indicates that despite a common desire for more education, 90% of homecare providers in Canada do not receive any training related to inclusive and affirming care for 2SLGBTQIAA+ communities.[84] This finding suggests that a lack of education among providers can also be due to low commitment from an organization's leadership to offer training on 2SLGBTQIAA+ elders, seniors, and older persons' needs. A lack of access to education for care providers, knowledge gaps, and discriminatory practices create care environments where 2SLGBTQIAA+ elders, seniors, and older persons are not able to be themselves or express their needs. This can deter or delay them from accessing important services.

In long-term care or retirement settings, 2SLGBTQIAA+ elders, seniors, and older persons are often faced with the difficult decision to hide their 2SLGBTQIAA+ identities and 'go back into the closet' for fear of being stigmatized or discriminated against by staff and other residents. In a 2017 community consultation hosted by Egale, 52% of 2SLGBTQIAA+ elders, seniors, and older persons reported fears about being "forced back into the closet" in long-term care or retirement settings.[85] When helping a patient plan for long-term care, end of life, or home-care, it is important that their autonomy, safety, and integrity be at the center of decision making. Whenever possible PCPs should work collaboratively with patients to determine what options are available to them in order to assist them in making an informed decision.

Resource

[83] City of Toronto. (2022). *Leading & Learning WITH PRIDE A Revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. City of Toronto.

[84] Scheim, A. I., Coleman, T., Lachowsky, N., & Bauer, G. R. (2021). Health care access among transgender and nonbinary people in Canada, 2019: A cross-sectional survey. CMAJ Open, 9(4), E1213.

[85] Plante, Filipenko, & Bontje. (2017). "Community Engagement Consult for LGBTQI2S Seniors." Eagle Canada.

To hear more from 2SLGBTQIAA+ Seniors about their care concerns, check out this video: Canada's LGBT seniors fear discrimination in elder care.

Gender-Affirming Medical and Surgical Care

Gender-affirming medical and surgical care for elders, seniors, and older persons is similar to that of all other 2STIGD folks who are above the age of 18. Oftentimes hormone initiation and surgical care are associated with a younger (<30) demographic; however, it is important for PCPs to note that transition (i.e., social, medical, surgical, and legal) is a process that takes place over time. There are numerous reasons as to why someone may transition later in life (e.g., money, access to care, timing for recovery, priorities, discrimination and stigmatization, etc). Importantly, PCPs should not assume that 2STIGD elders, seniors, and older persons experiences of gender diversity are new or sudden. In the last decade advancements in gender-affirming medical care and human rights protections have resulted in the increased access to knowledge about care options and equitable health care services. As such, many 2STIGD elders, seniors, and older persons are just now able to explore their gender identity in a way that they may not have been able to before.

For more detailed information on the special considerations that should be given to aging 2STIGD folks seeking Gender-Affirming Hormone Therapy, please see the following subsections: Special Considerations for Aging Patients (Estrogen-Based GAHT) and Special Considerations For Aging Patients (Testosterone-Based GAHT).

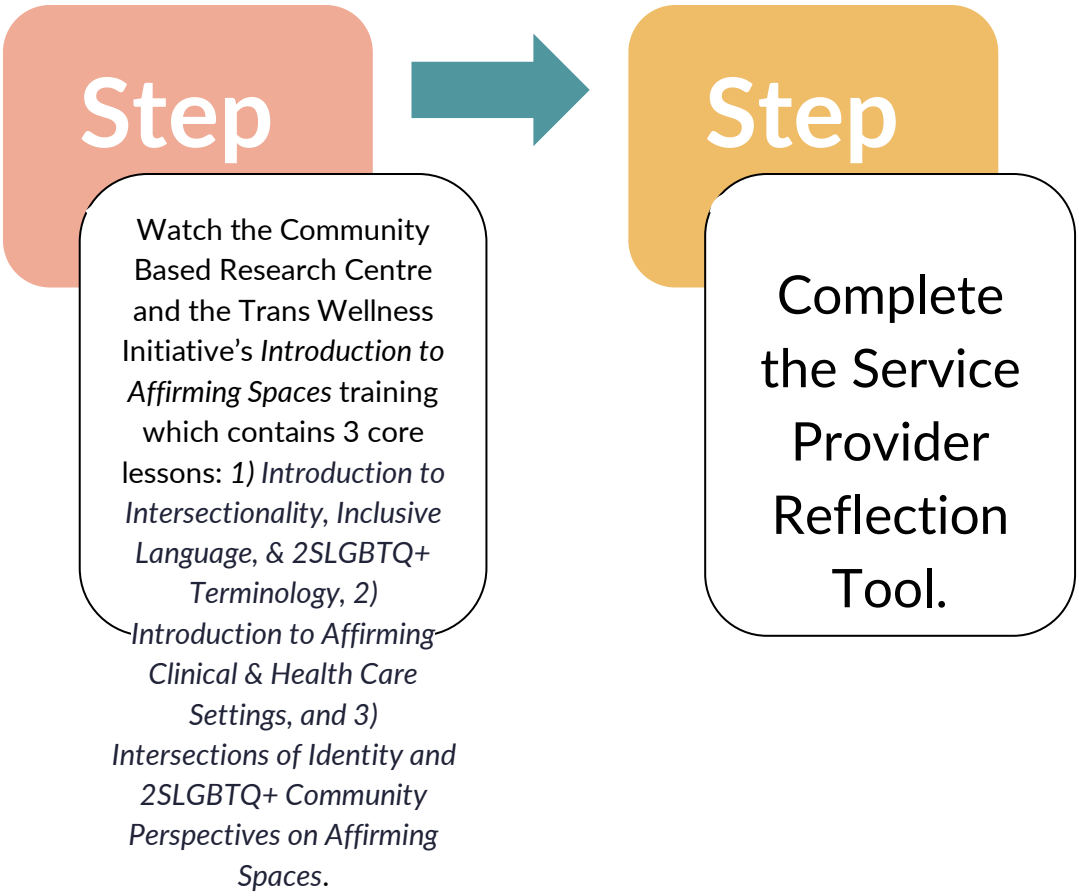
For more detailed information on surgical care, please see Section 5: Gender-Affirming Surgery. It should be noted that a 2SLGBTQIAA+ elder, senior, or older person's age should not limit their ability to access surgical care. PCPs should work collaboratively with an individual's surgeon to determine potential risk factors (including those posed by general anesthesia and any preexisting conditions) just as they would for cisgender patients requiring surgical care.

Part 3: Introduction to Gender-Affirming Care

The following section outlines introductory information pertaining to the provision of gender-affirming care for Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) individuals. The materials in this section are both visual and written, and review the following topics: **creating affirming clinical spaces, informed consent model, gender-affirming health care options, and the role of the PCP.** Each section provides instructions or an explanation of how to engage with the material, as well as an estimation of the length of time the section will take to complete. Although it is not required, we recommend that Trainees complete each sub-section in chronological order.

Creating Affirming Clinical Spaces

The following section outlines the most up to date practices in creating affirming clinical spaces using a community-informed approach. This section is comprised of both visual and written material, and should be completed in the following order:



Link to e-learning lesson: cbrc.teachable.com/p/trans-wellness-initiative-affirming-spaces-training
Link to reflection tool: www.phsa.ca/transcarebc/Documents/HealthProf/Service_Provider_Reflection_Tool.pdf

Informed Consent Model

The following section outlines the most up to date practices in delivering gender-affirming health care using an informed consent model. This section is comprised of both visual and written material, and should be completed in the following order:

Step

Read and review the written guidelines and information outlined below.

Step

Watch the Community Based Research Centre's *Gender-Affirming Hormone Prescription Training for Healthcare Professionals* which contains a 24 minute presentation Approaching Trans Health care through Informed-Consent Model. This step may be completed in conjunction with part 5 of the education package.

Link to e-learning lesson:
docs.google.com/forms/d/e/1FAIpQLSeNlFUQ1rMGJ1ImjVH0kfwkwVHSY_1-4X6B0xAVmD92k3YkBQ/viewform

Capacity to Consent

As with any other medical intervention, patients must demonstrate an understanding of the risks and benefits of GAHT. Obtaining informed consent is a process that PCPs engage in daily, and when prescribing hormones to Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) patients, the same basic principles apply. Questions may arise around capacity to consent in individuals with cognitive or developmental disabilities, significant mental health challenges, and/or in younger patients. In Canada, there is no specific age at which an individual is considered eligible to provide consent for medical interventions; this is determined on a case-by-case basis and at the discretion of the provider in collaboration with the patient. If there are persistent, **evidence-based** concerns regarding a patient's capacity to consent, a referral to a mental health professional with experience working with 2STIGD people may be helpful.[86] For instance, while a mental health diagnosis is not reason enough to deny a patient GAHT, a patient who is actively experiencing mania or psychosis may need to see a mental health professional before beginning GAHT.

Both historically and contemporarily, patients who are disabled and/or neurodivergent have experienced barriers in accessing gender-affirming care as a result of their perceived lack of capacity to consent. It is important to make sure Disabled and Neurodivergent patients have all the necessary information to make informed decisions regarding their gender-related goals. However, it is just as important to make sure that they are able to exercise autonomy over their own bodies, and that they are supported and affirmed in the decisions they make for themselves. If there are evidence-based concerns regarding an individual's capacity to consent, the PCP should work with a mental health provider to help determine the individual's ability to make an informed decision. For more information about working with Disabled and Neurodivergent patients, please see **Disability and Neurodivergence**.

See also **Informed Consent for Youth**.

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[86] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

Gender-Affirming Health Care Options

Gender-affirming health care must be individualized according to a patient's needs and goals and can involve many different aspects of social, medical, and legal care. The care and support provided by PCPs is intended to provide 2STIGD patients with the means to safely reach their goals. This approach has many benefits, including improved mental and physical health outcomes for patients, and improved PCP social and occupational capacity.

PCPs have an important role to play in discussing gender identity and gender-related health goals with patients, whether they provide or make a referral for gender-affirming care. The options outlined in this guide include the social, medical, and legal care that individuals may seek out. ***Importantly, individual patients may require some, all, or none of these options.***

Social Options

Social forms of transition involve the non-medical options for changing how one presents, including changing one's name, gender marker, pronouns, and the way someone dresses and expresses themself. Some 2STIGD people may look to their PCPs for support with non-medical aspects of gender affirmation and PCPs can take initiative to ask patients about their pronouns, as well as to confirm the name they use. Simply ask, "What are your pronouns?" rather than using the term "preferred" pronouns (as it implies their pronouns are optional, which is not the case for many 2STIGD individuals). See **Pronouns** for more information. Additionally, when navigating a patient's name (which they may not have legally changed yet), simply ask, "What is your name?" or, "How would you like me to refer to you?" to know the name they use, as well as "Is the name on your Medicare card different?" rather than asking for their "real name." The name that the patient uses (rather than what is on their Medicare card) should always be used and respected, with the exception of on medical forms that need to be submitted.

Some other social forms of transition 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. In most instances, the PCP should have the knowledge base to be able to provide guidance on the social aspects of transition (i.e. safer chest-binding or genital tucking). However, in other instances it would be appropriate for the

PCP to facilitate connecting a patient to a mental health professional who could provide further support and guidance.

Legal Options

Legal forms of transition involve the non-medical/social options for changing one's gender identity marker and legal name. Legal forms of transition can be time consuming, frustrating, and a financial burden to many 2STIGD folks.

Process for Legal Name Change in NB

Each individual will need to submit different documents to change their name depending on their age. The fee for this change is $115 to $175 depending on the documents needed.

All ages must meet the following requirements:

- Have been a resident of New Brunswick (NB) for at least three months, or live with a parent/guardian who has been a resident of NB for at least three months if under 16 years of age
- Those born in Canada must submit all original birth certificate(s), including a long form birth certificate if requesting a last name change, and any original documents if the name has already been changed. (For those born in NB, an additional fee can be added to the application to obtain NB birth certificates on your behalf.)
- Canadian citizens born outside of Canada must submit a photocopy of both sides of their Canadian Citizenship card, a photocopy of their original birth certificate or of their certified copy of birth registration, and a photocopy of their current passport.
- Those who are a landed immigrant or permanent resident must submit a photocopy of their Canadian Record of Immigration Landing or a Confirmation of Permanent Resident document, a photocopy of both sides of their Permanent Resident card, a photocopy of their original birth certificate or of a certified copy of birth registration, and a photocopy of their current passport.

Adults (age 16 or older) follow the following steps:

1. Complete the form Change of Name for Adults
2. Compile the necessary documents depending on where you were born
3. Submit the application to Service New Brunswick

Youth (age 15 or under) follow the following steps:

1. Complete the firm Change of Name for Children
2. Compile the necessary documents depending on where you were born
3. Disclose and include any relevant information where a custody order or ongoing legal proceedings in relation to the parentage or custody may be concerned
4. Submit the application to Service New Brunswick

Source: Service New Brunswick – Change of Name

Process for Sex Marker Change in NB

Each individual will need to submit different documents to change their gender marker depending on their age. There is no fee for this change and gender affirmation surgery is not a requirement. The gender marker can be changed to F, M, or X.

Adults (age 16 or older) follow the following steps:

1. Must be born or reside in New Brunswick
2. Complete the form Change of Sex Designation - Adult
    a. Sections 1 and 2 completed by applicant
    b. Section 3 completed by a health professional (physician, psychologist, nurse practitioner, registered nurse, or social worker) confirming their gender identity
3. Submit these documents, along with all previous birth certificates by mail or in person, to Vital Statistics

Youth (age 15 or younger) follow the following steps:

1. Must have been born in or reside with a parent/guardian in New Brunswick
2. Complete the form Change of Sex Designation - Child
    a. Section 1 completed by applicant or parent/guardian

b. Section 2 signed by every person who has care and custody of the child, or proof that any other parent or guardian has been notified of their right to object to the change, or apply in court to have the consent requirement removed
c. Section 3 completed by applicant if 12-15 years old, witnessed by a physician, psychologist, or person authorized to solemnize marriages under the New Brunswick Marriage Act
d. Section 4 completed by a physician or psychologist confirming their gender identity

3. Submit these documents, along with all previous birth certificates by mail or in person, to Vital Statistics

Source: Service New Brunswick Sex Designation Change

Medical and Surgical Options

Medical care may involve the use of a progesterone-releasing IUD or medroxyprogesterone (e.g., Depo-Provera®) for suppression of monthly bleeding, leuprorelin (e.g., Lupron®) for puberty suppression, sexual and reproductive care, electrolysis for hair removal, or GAHT.[87]

Surgical care may include chest or breast surgery, gonadectomy, genital reconstruction, and a range of other procedures, including tracheal shave and facial surgery. It is important to note that some 2STIGD individuals may choose to socially and medically transition, but not surgically transition. Alternatively, individuals may socially and surgically transition, but not desire to medically transition. Each patient will have different goals and expectations, therefore, it is important to take the time to understand the specific goals of each individual.

[87] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

Role of the Primary Care Provider (PCP)

Historically, the lack of education and formal training provided to PCPs on gender-affirming care has caused gender-specific care to fall exclusively under the domain of specialist care. However, since PCPs usually have familiarity and a sustained relationship with patients, they are ideally situated to facilitate and support a patient's gender-affirming health care needs. In most cases, providing GAHT is within the scope of primary care practice, as is providing affirming sexual, reproductive, and mental health supports or referrals.

The primary role of the PCP is to provide patients with gender-affirming social, legal, and medical care, and/or to make appropriate referrals when necessary (e.g., surgery or mental health). The PCP should do this in collaboration with patients to ensure they are meeting their individual needs and goals. In other words, the role of the PCP is **not** to investigate or interrogate an individual about their gender identity or expression, but rather to listen, validate, and help the individual explore the options available to them.

Extensive research has shown that access to a supportive PCP dramatically decreases depressive symptoms and suicidal ideation in 2STIGD patients, and is further attributed to positive social, physical, and mental health outcomes.[88] When equipped with the proper tools and information, PCPs are positioned to facilitate timely access to gender-affirming care and support patients in meeting their needs and goals.

Endocrinologist Involvement

Referral to an endocrinologist may be appropriate and helpful, particularly in the case of a medically complex patient, but it is not required for all 2STIGD patients. Notably, involving an endocrinologist may result in unduly long wait times due to limited capacity. If consultation is necessary, Rainbow Health Ontario suggests that it may be helpful to consider starting an androgen blocker with or without the addition of low-dose estrogen

[88] Treharne, G. J., Carroll, R., Tan, K. K. H., & Veale, J. F. (2022). Supportive interactions with primary care doctors are associated with better mental health among transgender people: results of a nationwide survey in Aotearoa/New Zealand. Family Practice.

for patients desiring feminizing effects or low-dose testosterone for patients desiring masculinizing effects until the consultation can be obtained.[89]

While most patients do not require referral to a specialist to begin GAHT, this does not negate the important role that endocrinologists can have for some patients. For instance, there is usually active involvement of an endocrinologist in the case of youth who have not completed puberty. If a patient has not completed puberty and the PCP is not knowledgeable in providing care to youth, Rainbow Health Ontario suggests providing care under the guidance of an expert or making a referral to another provider with expertise in supporting 2STIGD children and youth.

A Framework for Providing Gender-Affirming Care

Gender-affirming primary care falls into two distinct branches: delivering transition-related care and addressing general primary care needs of 2STIGD patients in a way that is tailored to the unique needs of these individuals. This section provides a high-level overview of what gender-affirming primary care includes, and in doing so introduces the various aspects of care detailed in the education package.

In Canada, the core protocols and guidelines addressing transition-related medical/surgical care are the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) and the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-V). While generally considered the gold standard, WPATH's SoC does not provide specifics for hormone provision or direction around certain aspects of primary care. As such, additional guidelines have been developed by Trans Care BC and Rainbow Health Ontario to include more specific details on their practices of gender-affirming care. As previously mentioned, the core of this education package has been developed from the guidelines provided by Trans Care BC and Rainbow Health Ontario.

The second broad area for delivering primary care to 2STIGD patients is consideration of how a patient's gender identity requires a different approach to providing care that is not

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[89] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

directly related to medical or surgical transition. For instance, 2STIGD patients can experience many of the same issues and conditions as cis patients, and, in most cases, there is nothing medically that needs to be done differently. The key difference in delivering general primary care to 2STIGD patients is in the language and approach used by the PCP.

Gender-affirming practices include, but are not limited to: inclusive posters on office walls, patient handout materials, and processes for data collection and management that can help eliminate suboptimal patient encounters and negative impacts on health (i.e., misgendering, using the wrong name, or failing to conduct proper preventative screening). During clinical encounters, the PCP should also reflect on their approaches for engaging 2STIGD patients, such as asking what would make them most comfortable or what terminology they use to refer to themselves or specific parts. For instance, because Pap tests can cause distress and discomfort for transmasculine or non-binary folks, you may want to consider: offering to use a side-lying rather than lithotomy position when doing a Pap test; asking what would be most affirming for them; and referring to body parts using the terminology each individual patient prefers (e.g. some transmasculine people will refer to their clitoris as a penis or "T-penis" and will refer to their vagina as a "second hole" or "frontal genital opening").

It is important to consider how 2STIGD patients may need a slightly different approach in some areas of primary care practice: disease prevention and screening (e.g., when and how to approach Pap or prostate testing with 2STIGD patients), or discussions about fertility, sex, and STBBI testing. Unfortunately, preventive and sexual health are often divided into gendered categories (i.e., F and M), with the assumption that these align with a particular type of body. For example, cisnormative assumptions lead us to think that breast cancer screening is part of "women's health," when, in fact, breast cancer does not just impact cisgender women. Providing gender-affirming care will require PCPs to work collaboratively with each individual patient to determine what their needs are and how best to meet them.

An Individualized Approach

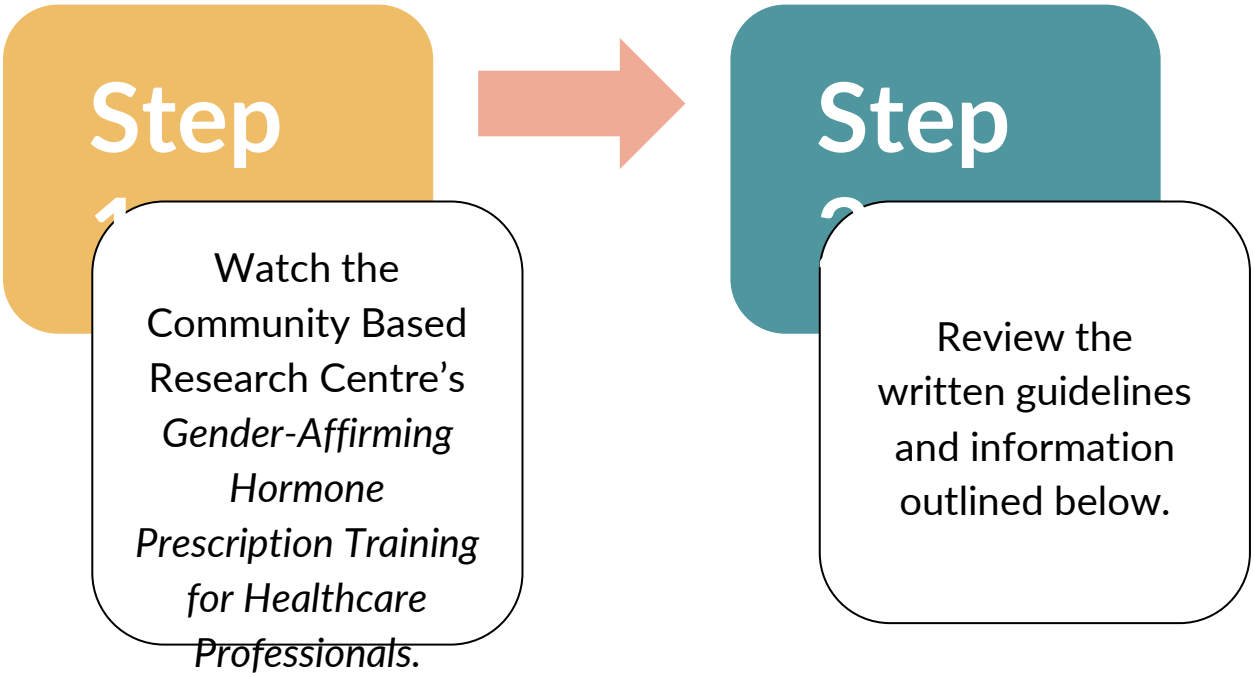
Given the spectrum of gender identity and the variation in each person's expression, there is no single pathway that 2STIGD people follow in order to meet their desired goals. While hormones and/or surgeries are medically necessary for many 2STIGD people, for others it may be sufficient to modify their presentation through changes in legal identification and modifications to their gait, dress, voice, and/or through hair removal. Additionally, medical transition tends to come with a significant financial barrier which can often delay or limit patients by what they can afford. Care should be taken to recognize the validity of all patients, regardless of the ways in which they choose to transition, and regardless of the reasons behind these choices.

When hormones are required as part of a persons care, some patients may seek maximum feminization/masculinization, while others may seek a more androgynous appearance. GAHT may also be helpful for patients who do not wish to make a social transition or who are unable to do so. Both the dose and route of GAHT should be individualized to meet a patient's specific goals. The duration of GAHT may also be personalized depending on patient goals. For example, patients who have not undergone gonadectomy (i.e., surgical removal of either the testes or ovaries) may opt to discontinue GAHT if the irreversible changes are adequate to maintain their desired presentation.

While GAHT is generally required prior to genital surgery or gonadectomy (unless contraindicated), it is not considered a requirement prior to breast, chest or other gender-affirming procedures (see **Part 5: Gender-Affirming Surgery** for more details). The decision to undergo surgical interventions is also highly individual.

Part 4: GAHT (Gender-Affirming Hormone Therapy)

The following section outlines the information that pertains to assessing, prescribing, and monitoring GAHT. This section is comprised of both visual and written material, and should be completed in the following order:



Link to e-learning lesson:
docs.google.com/forms/d/e/1FAIpQLSeNlFUQ1rMGJ1ImjVH0kfwkwVHSY_1-4X6B0xAVmD92k3YkBQ/viewform

See also the section Substance Use Disorder (SUD) for important interactions with GAHT.

Gatekeeping and Bias

Gatekeeping happens when health professionals create unnecessary and unfair hurdles for those accessing gender-affirming care, requiring Two-Spirit, trans, Indigiqueer, and

gender-diverse (2STIGD) patients to 'prove' who they are and that they really want or need access to medically-affirming care. Gatekeeping can look like: requiring unnecessary steps in order to access gender-affirming care; denying or delaying gender-affirming care; requiring 2STIGD patients to adopt a binary identity (i.e not accepting of non-binary identities); or using a deficit/distressed-based approach when discussing gender identity (i.e requiring a diagnosis of or centering gender dysphoria as opposed to **gender euphoria**).[90]

Asking questions that are unrelated to the direct care of the patient can feel invasive and can sometimes be referred to as microaggressions. This can also look like expressing cisnormative and heteronormative ideas about 2STIGD people's bodies, sexuality, and their goals for transition.

Questions to Ask Yourself

1. What assumptions am I making about the needs (or lack thereof) of a patient who self-identifies as 2STIGD?
2. Am I thinking critically about my implicit biases and the ways they impact care delivery?
3. Am I listening to the needs of my patients?
4. Are the questions I am asking related to the direct care of the patient?
5. Am I creating unnecessary barriers for patients to receive the care they need?
6. How can I broaden my understanding of what gender-affirming care looks like beyond the gender binary framework?

Patient Misconceptions

As with any other process, patients may have some false (or partially false) assumptions about GAHT. In particular, it has been anecdotally noted that some patients see the higher dosage levels as the goal, in thinking that the maximum amount will produce the strongest results, however this is not always the case, and can in fact increase health risks. That said, in cases where patients are experiencing **gender dysphoria**, they may be experiencing

[90] Gatekeeping. TransHub. (2018). Retrieved September 2, 2022, from https://www.transhub.org.au/gatekeeping

distress and wanting the quickest results possible. It is important to navigate this with care and understanding, as it may be difficult for some patients to accept. In these cases, being clear and transparent about the process of how dosages are determined may be helpful.

Patients will also need to be carefully instructed in what to do should they miss a dose, as well as the dangers of overdosing. While a patient's pharmacist should provide them with dosage information, it is important for a PCP to be extra clear, as it is not guaranteed that a pharmacist will adequately provide patients with this information.

Hormone Readiness Assessment

A hormone readiness assessment is an evaluation conducted by a health care professional to determine if a patient is ready to begin GAHT.

The **World Professional Association for Transgender Health** Standards of Care requires an assessment before GAHT is started. Gender-affirming care in N.B. is guided by **Version 7 of the Standards**, which were published in 2011. In N.B., a WPATH letter of recommendation for the initiation of hormones is not required. However, it should be noted that **version 8 of the standards of care** have recently been published and will soon replace SoC-7 on all NB forms.

While there is no waiting period required prior to initiating GAHT, there are a number of preparatory steps needed to ensure GAHT is provided in the safest manner possible.

The decision to initiate GAHT is a collaborative, patient-centered process that focuses on both psychosocial preparation and informed consent (see **Informed Consent Model** for more information). The PCP (with or without the support of a multidisciplinary team) can facilitate a decision-making process that informs, educates, and supports patients. For each patient seeking GAHT, it is important to not only consider the possible risks of GAHT but also to consider the often substantial risks of withholding treatment, as gender-affirming care is life-saving care.[91]

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[91] *Gender-affirming care saves lives*. Columbia University Department of Psychiatry. (2022, March 30). Retrieved September 2, 2022, from **https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives**

Assessment by a psychologist or psychiatrist is **not** required for most people, however the PCP should assess both mental and physical health as part of the hormone readiness assessment and refer to appropriate specialists as needed (see **Part 7: Mental Health** for more information). Where the PCP feels a referral is necessary, they should be as transparent and honest as possible with the patient about their own lack of expertise around mental health care, rather than it being the "fault" of the patient (as this is how it can often sound). Additionally, care should be taken to refer the patient to a mental health provider who is supportive of 2STIGD individuals to ensure as safe an environment as possible for the patient.

Assessment often takes place over a number of visits, depending on the length of time available per visit, the clinical situation, and the experience of the clinician. More visits may be required for patients with complex physical or mental health issues, or for patients who are socially isolated. That said, care should be taken to not lengthen the process more than is necessary, as many patients will want to move forward with their transition as quickly as possible. Fewer visits may be appropriate for a "straightforward" patient, for more experienced clinicians, if appointments are longer, or if the patient has a referral from a WPATH mental health provider. Fewer visits may also be recommended in situations where harm reduction is the priority (e.g., extreme distress, is currently taking hormones unprescribed, etc.).

The purpose of these visits is to ensure the patient is ready from a medical and psychosocial perspective to begin GAHT. This is ideally done within a primary care setting using a gender-affirming, informed consent approach. This period of time is referred to as the Hormone Planning Period and involves the provider establishing rapport with the patient, conducting an overview of patient history, collecting baseline data including blood work, providing education about the anticipated effects and potential risks of GAHT, determining the need for services such as fertility prevention, and obtaining informed consent.

The checklist below covers the important considerations and steps to take when getting ready to initiate GAHT with a patient.

Hormone Readiness Assessment Steps	
PATIENT HISTORY	• Discuss the rationale for assessment period: Establish rapport • Ensure optimal readiness • Ensure patient has all information they need to start GAHT • General medical intake & medical history
BASELINE DATA	• Vitals (incl. BP, T, HR, Ht, Wt, Waist & Abdo circ.) • Focused Physical Exam • Blood work • Health screening commensurate to age & risk profile

PATIENT EDUCATION, READINESS AND SUPPORTS	• Allow patient to articulate their transition goals
	• Ensure patient expresses reasonable expectations
	  ◦ Patient understands timeline of changes
	  ◦ Patient understands limitations of GAHT
	• Discuss effects on fertility and options available for preservation[a] (see Part 6: Sexual Health and Reproduction)
	  ◦ Discuss pregnancy risk and options for contraception & implement these if needed
	• Discuss psychosocial readiness
	  ◦ Ensure supports are in place to facilitate healthy adjustment
	  ◦ Refer to psychological support/counselling if necessary (see Referrals to Mental Health Care)
	  ◦ Review potential costs (e.g. medication, hair removal, fertility)
	• Discuss risks, side effects, potential benefits and expected changes (reversible vs. irreversible) associated with treatment and ensure patient demonstrates understanding
	• Ensure patient possesses capacity to consent (see Informed Consent Model)
	• Review medication options/treatment routes

RISK MANAGEMENT	• Ensure absence of absolute contraindications • Optimally manage precautions • Manage psychiatric comorbidity, if present • If smoker, advise smoking cessation counselling[b]
DIFFERENTIAL DIAGNOSIS	• Rule out other possible diagnoses (i.e. psychiatric disorders that could mimic **gender dysphoria** such as psychotic or dissociative disorders) • Ensure patient meets DSM Criteria for Gender Dysphoria • No evidence of Intersex condition (e.g. ambiguous genitalia, abnormal baseline hormone profile) See **Intersex Considerations**
NEXT STEPS	• Choose initial hormone regimen • Patient signs Consent Form (**Estrogen Form** / **Testosterone Form** / **Progesterone Form**) • Discuss interest in gender-affirming surgery • Offer support for changing patient's sex designation on Government ID

A. GAHT can impact an individual's reproductive health, and they should be made aware of options and consequences before treatment begins. This is discussed in specific detail in **Part 6: Sexual Health and Reproduction**.

B. Smoking cessation is recommended for individuals looking to start hormones due to increased health risks of smoking tobacco products while on hormones (e.g., blood clots, heart attacks, strokes, diabetes, and cancer). In addition, most gender-affirming surgeries require that an individual stop or restrict smoking to access surgery. Currently, there is not enough research on the effects of smoking cannabis while on estrogen- or testosterone-based hormones. However, patients will be required to stop or restrict smoking cannabis to undergo surgery.

Initiation of GAHT in some cases may be undertaken without completing the usual tasks of the planning period and from a harm reduction perspective. Examples of this include a patient who is already using hormones without a prescription, or someone who is experiencing extreme distress regarding their gender presentation. Other situations may warrant a degree of fast-tracking through the planning period, such as when a patient and

their medical and/or gender history are well-known to the provider prior to the patient seeking GAHT, or if the patient has a WPATH referral letter from a mental health provider.

Exploration of Gender Identity and Expression

Speaking with patients about their history and experience with gender is not something that health care providers are typically taught during their training. It is, however, an important part of getting to know a patient, and it informs the discussion around the development of an individualized care plan.

Reassure your patient that there are no 'wrong answers', nor any specific narrative that you are looking to hear. Not all 2STIGD people experience gender dysphoria or display gender diversity in childhood; gender is fluid and therefore gender diversity may emerge at any point in the life cycle.

Possible Questions to Explore Gender Identity and Expression

* All questions listed below are intended to be guiding questions. When establishing a rapport with a patient it is important that you make these questions your own, personalize them, or come up with questions that better suit your patient.

- How do you identify in terms of gender?
- How do you feel about your gender identity?
- What actions, words, and attitudes from others help you feel the most affirmed in your gender?
- What has prevented you from feeling positive about your gender identity?
- What types of support have been helpful to you?
- How do you relate to the gender binary? In what ways do or don't you identify with expectations based on gender binary?

- What does it mean to you to transition? How do you understand the starting and ending points of transition, if they exist? Transition can include many different components and stages. Which parts are necessary for you to feel affirmed in your gender?
- 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?

Adapted from: Trans Care BC: Primary Care Toolkit, 2018 and A Clinician's Guide to Gender-Affirming Care by Chang, Singh & Dickey, 2018

Psychosocial Preparation and Support

Part of the hormone readiness assessment involves discussing a patient's psychosocial readiness and support networks. The purpose of this portion of the assessment is not to make judgements about a patient's socio-economic status, but to identify areas where the PCP can facilitate access to additional resources and support.

While some patients may benefit from individual therapy with a gender-positive therapist, it is important to note potential financial barriers that make obtaining adequate and consistent mental health support difficult. As previously mentioned, **mental health counselling is not a requirement to initiate GAHT**. However, should patients be interested in mental health support, referrals should be made. Moreover, support in a peer group setting can also be immensely beneficial for some patients.

It is not a requirement for patients to discuss their transition with family members (including chosen family) and friends before the initiation of GAHT. Although it is ideal for a patient to have an established support network, it is not uncommon for there to be safety concerns that accompany social transition. It is important to take the time with each patient to understand their support network and help them identify possible supports should they not already have a supportive network.

Asking about how transitioning may influence the employment or educational situation of the patient is important, though it should be made clear that this is not meant to deter patients from transitioning. Instead, providers can help the patient develop positive strategies for dealing with transition-related changes in school or the workplace and/or refer to another provider (i.e., mental health) or support network (i.e., community groups).

In the past, WPATH advocated for a three-month period of life experience in the congruent gender role prior to GAHT. The rationale for this step was to enable the establishment of coping mechanisms for the above mentioned social stressors. In reality, however, this requirement served as a **gatekeeping** strategy. This requirement for a "real life experience" has been shown to be both stressful and harmful, since it involves longer wait times and the invalidation of already very real lived experience.[92] Additionally, some individuals may not feel comfortable or safe presenting publicly until they have achieved certain results from GAHT. Accordingly, this is no longer a requirement for GAHT or surgical interventions, with the exception of external genital surgery (see **Part 5: Gender-Affirming Surgery**).

[92] GenderGP. (2022, February 28). Real life experience and social transition - who should choose? GenderGP Transgender Services. Retrieved September 2, 2022, from **https://www.gendergp.com/real-life-experience-and-social-transition-who-should-choose/**

Asking about psychosocial preparation and supports

* All questions listed below are intended to be guiding questions. When establishing a rapport with a patient it is important that you make these questions your own, personalize them, or come up with questions that better suit your patient.

- What concerns or thoughts do you have about how transition will affect and be affected by your work/school life?
- Who has supported you along the way? *If the patient has not spoken with anyone else yet:* Who do you think might be supportive if you bring this up with them?
- 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? Have you done any reading or research?
- Some people find it helpful to have the support of a counsellor for either decision-making or ongoing support after beginning hormones—would you be interested in a referral to a trans-competent counsellor?
- In what ways do concerns related to your gender affect your mental health or emotional well-being and vice versa?
- What sources of support do you have to help buffer the stressors that you are facing?
- What kinds of support and advocacy do you need at this time?

Adapted from: Trans Care BC: Primary Care Toolkit, 2021 and *A Clinician's Guide to Gender-Affirming Care by Chang, Singh & Dickey, 2018*

Diagnosis

The provision of GAHT has generally been preceded by a diagnosis of Gender Dysphoria as outlined in the Diagnostic and Statistical Manual, Volume 5 (DSM-5).[93] However, there has been a great deal of debate in both medical and 2STIGD communities around the appropriateness of using a psychiatric diagnosis (or a diagnosis at all) for 2STIGD individuals. The aim to destigmatize gender diversity while securing access to care has been a central dilemma in this debate.

[93] Diagnostic and statistical manual of mental disorders : DSM-5 (Fifth edition.). (2013). Arlington, VA: American Psychiatric Association.

Since "transvestism" first appeared in the World Health Organization's (WHO)'s 8th Edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-8) in 1965 (and 'transexualism' in the DSM-III in 1980),[94] the evolution of the name, criteria and categorical placement for diagnoses about 2STIGD experiences has been continuous.

The revision of the diagnosis and its criteria in 2013's DSM-5[95] represented a step toward depathologizing gender diversity and validating the spectrum of gender identities. In addition, a distinction was established between "gender nonconformity" and the diagnosis of **gender dysphoria**:

"Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex."[96] "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). Only some gender nonconforming people experience gender dysphoria at some point in their lives."[97] The WHO has taken a step further in depathologizing gender diversity in the ICD-11,[98] released in May 2019. They have renamed the diagnosis Gender Incongruence and removed the diagnosis from the category of mental health disorders, placing it instead in a category of "Conditions Related to Sexual Health." Additionally, in contrast to the DSM diagnosis, there is no criteria for significant distress or impairment.
This represents a concerted effort to abandon the psychopathological model of gender diversity, and supports the provision of gender-affirming care to a wider population of 2STIGD folks. As societal acceptance and access to supportive communities and care

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[94] Soll, B. M., Robles-García, R., Brandelli-Costa, A., Mori, D., Mueller, A., Vaitses-Fontanari, A. M., Lobato, M.-I.-R. (2018). Gender incongruence: a comparative study using ICD-10 and DSM-5 diagnostic criteria. Revista Brasileira de Psiquiatria, 40(2), 174–180.

[95] Diagnostic and statistical manual of mental disorders : DSM-5 (Fifth edition.). (2013). Arlington, VA: American Psychiatric Association.

[96] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: **https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf**

[97] ibid

[98] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: **https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf**

increases, the distress experienced by some 2STIGD people is likely to decrease. The absence of the criteria for significant distress or impairment as a prerequisite for those seeking GAHT allows for the timely provision of care as a preventive measure, rather than waiting for distress and impairment to manifest through the withholding of care.

2SQTP-NB/P2SQT-NB advocates for the provision of gender-affirming care in a manner that supports the self-determination and bodily autonomy of 2STIGD people. Although establishing a diagnosis of **gender dysphoria** is required by NB Medicare to obtain access to GAHT and surgery, PCPs should not require patients to experience significant distress or impairment as a prerequisite for care. Notably, 2STIGD people should not be faulted for a health care system that has not yet abandoned the psychopathological model of gender diversity. For more information please see **Part 7: Mental Health**.

The Criteria For The DSM-5 Diagnosis of Gender Dysphoria[99]

A. 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 (or some alternative gender different from one's assigned gender).
    4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

[99] Diagnostic and statistical manual of mental disorders : DSM-5 (Fifth edition.). (2013). Arlington, VA: American Psychiatric Association.

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).

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

Description of gender incongruence in the ICD-11[100]
Gender incongruence of adolescence and adulthood is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to "transition" in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individuaĺs body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Physical Exam and Baseline Investigations

A focused physical exam is recommended prior to the initiation of GAHT. The exam should include screening for conditions such as hypertension and active liver disease, which may increase the risks of GAHT. Physical examination, particularly of the chest and genitals, may be uncomfortable for patients. A physical examination of the chest and genitals is not required before the initiation of GAHT.

In addition to practicing trauma-informed care, it is advisable to use gender-affirming terms (e.g., "chest" for transmasculine patients, "breasts" for transfeminine patients) or general language (e.g., "genitals," "gonads"). Whenever possible it is best to use gender neutral anatomy terminology or to ask patients if they prefer a particular term. Further discussion regarding sexual and reproductive care is located in **Part 6: Sexual Health and Reproduction**. To download the gender-affirming terms quick reference, please see the **Body Terminology Quick Reference**.

[100] International Classification of Diseases, Eleventh Revision. (2011)., World Health Organization.

Vitals

Baseline measures include blood pressure, temperature, heart rate, height, and weight.

Bloodwork

Laboratory tests should reveal any existing health problems such as liver dysfunction, high cholesterol or diabetes. If present, these conditions should ideally be managed prior to or concurrently with the initiation of hormones. The values will also provide a useful baseline to help with future monitoring for endocrine changes. Measurement of hormone levels may reveal whether any exogenous hormones are being taken. Any major irregularities could also indicate if a person is Intersex (see Intersex Considerations).

Baseline Blood Work Summary

Bloodwork	Estrogen-Based	Testosterone-Based
CBC	✓	✓
ALT	✓	✓
Creatinine/Lytes	✓	
HbA1c or Fasting Glucose	✓	✓
Lipid Profile	✓	✓
Total testosterone	✓	✓
Estradiol	✓	
Prolactin		
LH (Post-gonadectomy: Elevated LH in transmasculine individuals may have implications regarding bone mineral density)		✓
	Hep B, C	Hep B, C Pregnancy test (before first injection)

Other	Consider: HIV, syphilis, and other STI screening as indicated

Overview of Testosterone-Based GAHT

Testosterone is used to reduce estrogen-related features, induce testosterone-related features, and relieve gender-related distress. Generally, the desired effects of testosterone-based GAHT include deepened voice, cessation of monthly bleeding, clitoral growth, increased muscle mass, fat redistribution, and hair growth in androgen-dependent areas, including facial hair. A patient may also lose chest tissue glandularity, but generally does not lose mass or hemicircumference.

Voice deepening is considered an irreversible change. Should the patient wish for a deeper change in their voice than has been achieved through GAHT, they may benefit from voice therapy with a qualified and supportive speech and language therapist who can work with the patient to modify their vocal characteristics. Currently speech and language therapist services are not covered in NB for transition-related purposes. For more information about SLP services in NB go **here**.

Clitoral growth is also considered an irreversible change. Fat redistribution and increased muscle mass are generally considered reversible effects, but some degree of redistribution may be irreversible. The cessation of monthly bleeding is generally achievable within the first 3–6 months of GAHT.

Fertility is decreased during testosterone administration, but should not be relied upon as contraception. While there may be an irreversible reduction in fertility, many patients with a capacity to become pregnant have conceived healthy pregnancies following the discontinuation of testosterone (see ***Fertility and Birth Control*** section).

Typically, patients taking testosterone will experience associated changes over a period of months to years. The timeframe of physiological changes may be slightly slower with the use of transdermal preparations. The degree and rate of physical effects are also dependent on the dose administered, as well as patient-specific factors such as age, ethnicity, genetics, body habitus and lifestyle. The effects of testosterone and their expected time courses are shown below.

Effects and expected time course of masculinizing hormones

Effect	Expected Onset[a]	Expected Maximum Effect
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	4-5 years
Scalp hair loss	6-12 months	Variable
Increased muscle mass/strength	6-12 months[b]	2-5 years
Body fat redistribution	1-6 months	2-5 years
Cessation of menses	1-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	1-6 months	1-2 years
Deepened voice	6-12 months	1-2 years

A. Highly dependent on age and inheritance; may be minimal
B. Significantly dependent on amount of exercise

If cessation of monthly bleeding is not achieved within the first 6 months of GAHT, testosterone dosage may need to be increased if not already at a maximum dose. In patients who prefer low-dose testosterone, or occasionally in patients using transdermal preparations, a progestin may be used, either in the form of a levonorgestrel-releasing intrauterine system (IUS) (e.g., "Mirena"), or an injectable medroxyprogesterone acetate (MPA) (e.g., "Depo-Provera"). Alternatively, a GnRH analogue (leuprolide/"Lupron" or busrelin/"Suprefact") can be used to suppress monthly bleeding *and* the expression of endogenous estrogen-based hormones.

All patients with child-bearing potential (i.e., uterus and ova) who are considering testosterone should be counselled regarding its teratogenic impact (specifically hyper-androgenization of the fetus), regardless of current sexual practices. Patients should be aware of their ongoing risk of pregnancy, despite testosterone therapy or amenorrhea. It

is important not to make assumptions about the type of sex a patient is having or may have. If a patient with child-bearing potential is having receptive penetrative genital sex with a partner who makes sperm, an effective method of birth control should be employed (see **Part 6: Sexual Health and Reproduction** of this document).

If unintended pregnancy does occur while on testosterone, patients should be counselled regarding their options, and testosterone therapy should be discontinued immediately if maintaining the pregnancy is desired or under consideration.

In New Brunswick, options for testosterone administration include injectable and transdermal preparations (patch or gel). Injectable formulations are most commonly used, due to superior efficacy and affordability. Injectable, patch, and gel forms of testosterone are funded by the **NB Drug Plan** with premiums based on annual income. The NB Drug Plan is available to NB residents who have an active Medicare card and meet one of the following criteria:

- Do not have existing drug coverage through a private plan or other government program, or
- Have existing drug coverage with a private plan, however:
    - They have reached the annual or lifetime maximum for drug coverage with the private plan, or
    - They have been prescribed a drug that is not listed on their private plan formulary for the condition (indication) prescribed. (Prior to applying, contact the New Brunswick Drug Plan Information Line toll free at 1-855-540-7325 to confirm that the requested drug is included in the New Brunswick Drug Plan Formulary).

2SQTP-NB/P2SQT-NB recommends that PCPs ensure that patients are informed about the NB Drug Plan and direct them towards this **form**.

Additionally, patients may be able to access funding through the **Non-Insured Health Benefits Program (NIHB)** for Status First Nation clients, and by the **The New Brunswick Prescription Drug Program (NBPDP)** depending on **patient eligibility**. For more information, see **NIHB Program**.

Transdermal preparations provide a more relatively steady state of testosterone delivery, as opposed to the periodicity associated with injectables. However, some 2STIGD folks using transdermal preparation have noted experiencing local reactions, higher cost, fear of skin-to-skin transmission, problems with the adhesion of patches, inconvenience of gel application time, and an unpleasant odor with gel.

While intramuscular injection is the most common means of administering parenteral testosterone, subcutaneous (SC) delivery has also been used with clinical efficacy and is very well tolerated. While the IM route remains better studied and often more familiar to both patients and providers, we feel that enough evidence exists to suggest reasonable safety and efficacy for the SC route and so are comfortable offering this as an option for our patients. PCPs should work collaboratively with their patients to determine which method of testosterone-based GAHT is right for them.

If patients want to self-inject, it is important to instruct them on techniques for safe injection and sharps disposal. Directly observing a patient self-inject is helpful for the correction of any problems with technique and to reassure patients that they are injecting correctly. Ideally patients would complete their first hormone administration in a PCP's office. A written step-by-step guide on self-injection for patients is **here**. Additionally, it may be helpful to have patients record the injection training on their phone to refer to after.

Application Tips

Injection

- Testosterone cypionate is compounded in cottonseed oil, while testosterone enanthate is compounded in sesame oil, making both formulations non-irritating but quite viscous.
- Warming the vial in the palm of the hand for a few moments will reduce viscosity.
- Generally, testosterone is drawn up with larger-gauge needles (18–20G) and then injected intramuscularly with medium- gauge needles (22–23G) or subcutaneously with smaller-gauge needles (25–26G). This can be adjusted to manage patient discomfort as needed—smaller gauge needles may mean longer injections, but less pain.
- Needle lengths are determined by body habitus and route of administration.
- The use of a 1 ml syringe can improve accuracy when drawing up smaller doses of injectable testosterone and will decrease the force required to press the plunger of the syringe upon injection, compared to a 3 ml syringe.

Gel

- Gel should be applied to the upper arms, shoulders and/or abdomen (the axillary gel formulation AxironTM is unfortunately no longer being manufactured).
- If a gel formulation is used, patients should be counselled regarding the risk of inadvertent exposure to others who come into contact with the patient's skin. This is of particular importance for patients who care for young children and/or have intimate partners who are pregnant or considering pregnancy.
- Testosterone gel should be allowed to dry prior to getting dressed, and the site of application should remain dry for at least two hours (to allow for absorption into the dermis).
- Thorough hand washing should be performed following application, and gloves worn if the gel is applied by someone else.

Patch

- Patches should be applied to a flat, clean, dry and undamaged area of skin on the back, stomach, upper arm or thigh.

Dosage (Testosterone-Based GAHT)

Below outlines the formulations and recommended doses of testosterone-based GAHT currently available.

Formulations and recommended doses for testosterone-based GAHT

Prescription	Starting Dose / Low Dose	Maximum Dose	Purchasing Cost*
Testim 1% (transdermal gel)	2.5–5g daily (2–4 pumps, equivalent to 25–50 mg testosterone)	5–10 g daily (4–8 pumps, equivalent to 50–100 mg testosterone)	(50 x 5g) $161.10 per unit $45.11-180.43 every 4 weeks
Taro. Testosterone 1% (transdermal gel)	2.5–5g daily	5–10g daily	(30 x 5g) $118.78 $55.43-221.72 every 4 weeks
Testosterone enanthate[a] (injection) "Delatestryl"	20–50 mg q weekly or 40–100 mg q2 weeks (IM and SUBQ)	IM injection: 100-200mg every 2 weeks or 50-100mg weekly	200mg/mL (5mL) $23.11 $9.24-46.22 every 4 weeks
		SUBQ injection: 50-100mg weekly	

Testosterone cypionate[a] (injection)	20–50 mg q weekly or 40–100 mg q2 weeks (IM and SUBQ)	IM injection: 100-200mg every 2 weeks or 50-100mg weekly	100mg/mL (5x2mL) $13.84 $11.07-27.68 Every 4 weeks
		SUBQ Injection: 50-100mg weekly	
Androderm (transdermal patch)	2-5mg daily	2-8mg daily	60x2.5mg patch $149.22 $69.64-208.91 every 4 weeks
			30x5mg patch $149.91 $139.92 every 4 weeks
			Using one of each patch for 7.5mg daily $209.55 every 4 weeks

Androgel 1% is 50 mg of testosterone (transdermal gel)	2.5 - 5 g daily (2-4 pumps, equivalent to 25 - 50 mg testosterone)	5 - 10 g daily (4-8 pumps, equivalent to 50 - 100 mg testosterone)	Single Pump 30x 5g $167.69 Up to $313.02 every 4 weeks
			2 pump unit set. Each unit 60 actuations of 1.25g gel $190.99 $89.13-356.51 every 4 weeks

*Price quotes provided by APSI, accurate as of August 2022 and represent the price of the generic brand of medication unless otherwise indicated (ranging from low dose to maximum dose). Prices reflect the actual customer cost for purchase within New Brunswick, including a dispensing fee, and not including Medicare or a drug plan.

a. Testosterone enanthate is compounded in sesame oil, and testosterone cypionate is compounded in cottonseed oil; patients with allergy to either of these compounds should use the alternative agent

Note: Testosterone (in all forms) is considered a controlled substance in Canada; prescriptions should be written in accordance with provincial requirements for controlled substances.

Monitoring and Dose Adjustments (Testosterone-Based GAHT)

Titration of doses will generally occur in the early phases of GAHT. For example, with injectable testosterone, a starting dose of 30 mg injected weekly could be increased by 10–20 mg every 4 to 6 weeks. Speed of titration will depend on lab results, patient goals, and side effects.

Some patients will intentionally seek testosterone levels midway between the male and female range. For patients seeking the maximum effects of testosterone, the target dose will bring the testosterone level into the physiologic male range. It is important to keep in mind, however, that clinical effects are the goal of therapy, not specific lab values. If a patient is happy with the rate and degree of masculinization, there is no need to increase the dose to achieve a certain range. Alternatively, if levels are at the lower end of the male range and patients are concerned about slow progress, or low energy, libido, mood or breakthrough bleeding, the dose can be slowly increased with close monitoring.

Monitoring should be done at 3, 6 and 12 months after starting therapy. Some PCPs may also prefer to see patients monthly until an effective dose is established. After the first year of GAHT, hormone levels can be monitored yearly in the absence of metabolic shifts such as substantial weight gain, concerns regarding regression of virilization, or the emergence of symptoms potentially related to hormone levels (e.g., cyclic symptoms such as migraines or pelvic cramping/bleeding).

Follow-up visits should include a functional inquiry, a targeted physical exam, bloodwork, and health promotion and disease prevention counselling. The suggested tasks for each of these follow-up visits are as follows:

Recommended parameters for monitoring testosterone-based GAHT

Type	Baseline	Month 3, 6, 12	Annually
Review	• Contraindications and precautions to testosterone • Education/Lifestyle • Health Maintenance • Old records • Mental Health • Psychosocial	• Cessation of monthly bleeding • Education/ Lifestyle • Hormone effects • Mental Health • Psychosocial	• See Preventive Care Checklist for Patients on Testosterone
Lab	• BP • Focused PE with PAPE if indicated • Height • Weight	• BP • Weight	
Exam	• Pregnancy test prior to 1st dose, See Section on for Part 6: Sexual Health and Reproduction		
Other	• Consider HPV, Hep A, B and routine vaccinations as indicated		

Functional inquiry should include noted positive or negative impacts on overall well-being, mood/mental health, and energy levels (including fluctuation). It is useful to inquire about how the patient is managing any changes in libido. Inquiry regarding physiological changes should include discussion of monthly bleeding. There may be some irregular bleeding or spotting in the first few months of treatment. However, once sustained cessation is achieved, any bleeding without explanation (e.g., missed dose(s) or lowered dose of testosterone) warrants a workup for endometrial hyperplasia or cancer.

When monitoring injectable testosterone, some clinicians prefer to check serum levels at trough (i.e., just before the next injection is due) while others prefer mid-cycle. The former adds convenience for patients who prefer to come into the clinic for their injections. There may be utility in varying the timing of bloodwork to gather information regarding serum levels throughout the cycle (peak, mid-cycle and trough), especially if a patient is reporting cyclic symptoms or breakthrough bleeding. In such cases, wide fluctuations should prompt consideration of increasing the frequency of injections or switching to a route with less periodicity.

Supraphysiologic levels should be avoided due to the increased risk of adverse events and side effects, as well as the potential for the aromatization of excess testosterone into estrogen. Dose adjustment is warranted if supraphysiologic doses are measured at mid-cycle or trough. Since changes to the integument occur with testosterone administration, patients on a transdermal formulation may require ongoing titration in order to obtain or maintain physiologic changes.

If the sex marker associated with the patient's health card has not been changed, the reference ranges reported from the laboratory will refer to the sex assigned at birth. Reference ranges vary between laboratories, so it is important to refer to reference ranges for the affirmed gender from the laboratory. It is advised to indicate AMAB or AFAB to reduce likelihood of sample rejection. Blood work should be completed according to the table below:

Recommended blood work for monitoring testosterone-based GAHT

In this table, smaller and lighter grey "x"s indicate parameters that are measured under particular circumstances

Test	Baseline	3 months	6 months	12 months[c]	Yearly	According to guidelines for cis patients or provider discretion
CBC[a]	X	X	X	X	X	
ALT/AST	X		X[d]			X
Fasting Glucose/ Hba1c	X		X[d]			X
Lipid profile	X		X[d]			X
Total testosterone	X	X	X	X	X	
LH[b]	x			x	x	
Other	Hep B, C, pregnancy test					
	Consider: HIV, syphilis and other STI screening as indicated, frequency depending on risk					

a. Male reference ranges should be used for Hb/Hct (lower limit of female range can be used if menstruating)
b. Post-gonadectomy only: elevated LH may have implications regarding bone mineral density. During first year of treatment only
c. Once at either 6 or 12-month mark

Note: Individual parameters should be considered more frequently if concerns are identified or existing risk factors are present.

Special Considerations For Aging Patients (Testosterone-Based GAHT)

There is little information in the literature to guide recommendations for the initiation or maintenance of testosterone-based GAHT in older or aging patients. Unique considerations in older populations include changes in endogenous hormone levels; physiologic changes that may affect response to medications; a higher burden of existing medical conditions; and multiple concurrent medications leading to the increased potential for drug interactions.

As patients age, dose reductions can be discussed and considered in accordance with patients' goals. Some guidelines suggest considering complete discontinuation for patients over 50, however those without gonads may experience symptoms of hypogonadism, along with potential bone mineral density loss. Those with or without gonads may be expected to experience reduced muscle mass, body hair and libido, though in some cases the irreversible changes induced by testosterone may be sufficient to maintain a presentation that is consistent with a patient's needs.[101] As with all patients, decisions about GAHT at an advanced age should be individualized, following a thorough discussion of risks and benefits.

Precautions and Risk Mitigation (Testosterone-Based GAHT)

Providers may have concerns about the safety of testosterone, particularly with respect to metabolic impacts, cardiovascular (CV) events, and malignancies. Pre-existing medical conditions and risk factors may impart increased risks with testosterone administration and should be considered in order to enable individualized discussions with patients regarding the risks and benefits of treatment. Measures available to reduce associated risks should be considered and discussed with patients, and, if possible, undertaken prior to or concurrently with the initiation of GAHT.

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[101] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

In some cases, patients may wish to begin GAHT in the setting of ongoing increased risk, e.g., immitigable risk or having declined measures for risk mitigation. In such situations, a careful informed consent process should be followed which takes into consideration: individual capacity to make an informed decision, the severity of potential harms from treatment, and the harms that may result from not treating.

Initiating testosterone should ideally be done in collaboration with relevant specialists who may already be involved in a patient's care. In some cases, a new referral may be helpful in informing decisions about risks and their mitigation. However, efforts should be taken to ensure that this does not cause undue delay. If access to a specialist is limited, an e-consult can be both timely and beneficial.

Precautions with testosterone-based GAHT and minimizing associated risks

Precaution to testosterone therapy	Considerations in minimizing associated risks
Androgen-sensitive epilepsy	• refer to neurology
Autoimmune conditions (e.g., RA, MS, IBD)	• consider low dose/slow titration with monitoring in collaboration with any involved specialists
Chronic respiratory disease that may be worsened by erythrocytosis/ polycythemia	• consider transdermal route of administration, and/ or low dose/slow titration with monitoring • consider referral to respirology
Hepatic dysfunction	• dependent on etiology, e.g., minimize alcohol consumption, weight loss in NAFLD • consider referral to hepatology/gastroenterology • consider low dose/slow titration with monitoring

History of DVT/PE or hypercoagulable state	• identify and minimize existent risk factors • prophylactic anti-coagulation if indicated per current national guidelines • consider referral to hematology/thrombosis clinic • consider transdermal route of administration and/or low dose/slow titration with with close monitoring for polycythemia
Inter-menstrual bleeding/ menorrhagia	• work up per national guidelines • gynecology referral as needed
Migraines	• consider daily migraine prophylaxis • consider transdermal route of administration
Oligo-/Amenorrhea	• identify etiology (e.g. PCOS, rule out pregnancy) • consider pelvic ultrasound (transvaginal if possible) • consider progesterone-induced menstrual bleed prior to testosterone initiation
Polycythemia	• identify etiology and address contributing factors • consider referral to hematology • consider transdermal route of administration and/ or low dose/slow titration with monitoring
Severe/uncontrolled sleep apnea	• initiate CPAP or oral device • refer to dietitian and encourage lifestyle changes if overweight • monitor for changes in CPAP pressure requirements
Smoker	• encourage and support smoking cessation • consider referral to smoking cessation program/offer NRT and/ or bupropion/varenicline, or negotiate a decrease in smoking • consider cardiac stress test

Stable ischemic cardiovascular disease	• consider referral to cardiology • ensure optimal medical (including prophylactic antiplatelet agent(s) if indicated per national guidelines) and/or surgical management as indicated • optimize risk factors • consider transdermal route of administration, and/ or low dose/slow titration with monitoring
Uncontrolled diabetes	• identify and address barriers to optimal glycemic control • refer to dietitian • encourage lifestyle modification • initiate antiglycemic agent(s) per national guidelines • consider endocrinology referral • consider cardiac stress test • consider low dose/slow titration with monitoring
Uncontrolled dyslipidemia	• identify and address barriers to optimal lipid control • refer to dietitian • initiate antilipemic pharmacologic therapy per national guidelines • consider endocrinology referral • consider cardiac stress test • consider low dose/slow titration with monitoring
Uncontrolled hypertension	• identify and address barriers to optimal BP control • initiate antihypertensive(s) as needed • consider cardiac stress test • consider low dose/slow titration with monitoring • consider referral to cardiology
BP: blood pressure; **CPAP**: continuous positive airway pressure; **DVT**: deep vein thrombosis; **IBD**: irritable bowel disease; **MS**: multiple sclerosis; **NAFLD**: non-alcoholic fatty liver disease; **NRT**: nicotine replacement therapy; **PCOS**: polycystic ovary syndrome; **PE**: pulmonary embolus; **RA**: rheumatoid arthritis	

For more information on the specific conditions associated with testosterone-based GAHT, risk mitigation, and long-term preventive care, see Sherbourne's guidelines for

gender-affirming primary care with trans and non-binary patients. These guidelines include information and research on the following:

- Acne
- Atrophic changes
- Breast cancer
- Cardiovascular disease and related metabolic risk factors
- Cervical cancer and Pap tests
- Hair loss
- Hepatic dysfunction
- Human immunodeficiency virus (HIV)
- Obstructive sleep apnea
- Osteoporosis and bone mineral density screening
- Ovarian cancer
- Pelvic pain
- Polycythemia
- Psychiatric effects
- Vaginal bleeding and endometrial cancer

Long-Term Follow-Up (Testosterone-Based GAHT)

The long-term follow-up of patients on testosterone-based GAHT should involve (at least) annual preventive care visits. Preventive Care Checklists© endorsed by the College of Family Physicians of Canada exist for cisgender patients; however, the use of these forms for 2STIGD patients is awkward, unaffirming, and can lead to missed elements important in their comprehensive primary care. 2SQTP-NB/P2SQT-NB has assembled recommendations from Sherbourne Health and Rainbow Health into an adapted Preventive Care Checklist for the ongoing primary care of patients on testosterone-based hormone therapy. The use of these gender-specific forms assumes familiarity with the standard forms and their explanations. The recommendations represent an effort to incorporate expert opinion, relevant research on cisgender populations and limited gender-specific evidence, with standard national and provincial primary care practices.

Overview of Estrogen-Based GAHT

The goal of estrogen-based GAHT is to reduce the endogenous effects of testosterone and to induce feminine secondary sex characteristics in keeping with the patient's

individual goals, as determined by their experience of gender incongruence and associated dysphoria, if present.

Physiologically, this requires the suppression of endogenous androgens and the addition of estrogen. This treatment results in both reversible and irreversible feminization. General effects such as reduction in muscle mass, reduction of body and (to a lesser extent) facial hair, and changes in skin as well as sweat and odour patterns are reversible.

Changes in facial and body subcutaneous fat distribution are generally considered reversible effects but to some degree may not be. Sexual and gonadal effects, including changes in libido and reduction in erectile function, are generally considered reversible, while reduced testicular and prostatic size, sperm count reduction and the resulting impact on fertility may be irreversible. For a more detailed discussion of the impact of estrogen-based GAHT on reproductive health, please see **Part 6: Sexual Health and Reproduction**.

Breast development is considered irreversible and would require surgical intervention to reverse. In adolescent patients, the initiation of estrogen therapy prior to the completion of skeletal growth may lead to an earlier cessation of long bone growth, and therefore shorter adult height—an effect that would be irreversible. The degree and rate of physical effects are also dependent on the dose administered, as well as patient-specific factors such as age, ethnicity, genetics, body habitus and lifestyle. The effects of estrogen-based GAHT and their expected time courses are shown below.

Effects and expected time course of estrogen-based hormones

Effect	Expected Onset[a]	Expected Maximum Effect[a]
Body fat redistribution	3-6 months	2-3 years
Breast growth	3-6 months	1-2 years

Decreased libido	1-3 months	3-6 months
Decreased muscle mass/strength	3-6 months	1-2 years[b]
Decreased sperm production	Unknown	> 3 years
Decreased spontaneous erections	1-3 months	3-6 months
Decreased testicular volume	3-6 months	2-3 years
Scalp hair loss stops, no regrowth	1-3 months	Variable
Softening of skin/decreased oiliness	3-6 months	Unknown
Thinned/slowed growth of body/facial hair	6-12 months	> 3 years[c]

A. These are the average expected onset and maximum effect timelines, however, each ultimately varies for each individual.
B. Significantly depends on amount of exercise
C. Complete removal of unwanted facial and body hair requires electrolysis, laser treatment, or both.

Adapted from: Hembree et al. 2017, The Endocrine Treatment of Gender Dysphoric/ Gender Incongruent Persons: An Endocrine Society Guideline.

Anti-Androgens

Treatment with physiologic doses of estrogen alone is not usually sufficient to suppress testosterone levels into the physiologic female range in patients who have not undergone gonadectomy. Due to the potential for adverse effects with higher doses of estrogen, androgen-suppressing agents are used as part of a GAHT regimen in patients with gonads.

The anti-androgens most commonly used are **spironolactone** and **cyproterone**. Spironolactone is a potassium-sparing diuretic, which acts as an anti-androgen at higher doses through direct blockade of peripheral androgen receptors. It also exerts secondary suppressive effects on androgen synthesis and has weak estrogenic and progestational activity. Given that its primary mechanism of action is at the receptor level, it will not always cause a significant change in blood testosterone levels. As a result, effectiveness should be evaluated by a patient's reported response (i.e., absence of spontaneous arousal, slowing of facial and body hair growth, skin changes) rather than serum levels.

Cyproterone is a synthetic steroid with progestin-like activity. Like spironolactone, it exerts anti-androgenic effects by binding to androgen receptors. In addition, its progestational activity exerts negative feedback on testosterone production through a reduction in gonadotropins. Anecdotally, cyproterone has been shown to be a more potent anti-androgen than spironolactone, with more rapid effects and a more marked suppression of libido and erectile function.

In the absence of sufficient data to guide a preferential choice of one anti-androgen over another, the decision can be made individually for each patient based on medical history and preference regarding risk and side effect profiles. Both spironolactone and cyproterone are covered by the **NB Drug Plan** with premiums based on annual income and by the **The New Brunswick Prescription Drug Program (NBPDP)** depending on **patient eligibility**. For more information, see **NIHB Program**.

Effects, side effects and contraindications of anti-androgens

	SPIRONOLACTONE	CYPROTERONE
Drug Effects	Breast growth* Decreased androgenic alopecia Decreased fertility** Reduced erectile function** Reduced prostatic and testicular volume** Slowed growth of facial/body hair	
Side Effects	Gastrointestinal side effects Hyperkalemia Hypotension Orthostasis, dizziness Polyuria Polydipsia Rash Renal impairment Risk of dehydration Somnolence	Anemia Depression, especially in first 6-8 weeks Hepatotoxicity (acute liver failure, rare) Liver enzyme elevation Myelosuppression (rare) Prolactinemia Possible increased risk of prolactinoma (esp. with estrogen) Possible increased risk of VTE CBC changes Thrombocytosis
Contraindications	Addison's disease or other conditions associated with hyperkalemia (type IV tubular acidosis) Hyperkalemia Renal insufficiency Avoid concomitant use of:	Active liver disease and hepatic dysfunction Existing thromboembolic process Presence or history of meningioma Previous or existing liver tumors Severe chronic depression

	- ACE Inhibitors, - ARBs, - Other potassium-sparing diuretics (if concomitant use is not avoidable, use with caution; consider low dose, slow titration and frequent monitoring due to the high risk of hyperkalemia) - Trimethoprim-sulfamethoxazole potassium supplements eplerenone, heparin, and low molecular weight heparin.	(caution in all patients with a history of depression) Severe renal insufficiency Avoid concomitant use of hepatotoxic medications
ACE: angiotensin converting enzyme **ARB**: angiotensin II receptor blocker **CBC:** complete blood count **VTE:** venous thromboembolism * Irreversible ** May be irreversible		

Generally, spironolactone can be started at 50 mg once daily, and increased every 2–4 weeks or more barring negative effects. Doses can be divided twice daily, or given once daily in the morning (for those who experience problematic nocturia) or at night (for those who have concerns around daytime bathroom safety). Total daily doses up to 300 mg/ day have been used but are rarely required.

Cyproterone can be initiated at 12.5 mg and increased by 12.5 mg every 2–4 or more weeks (to a rare maximum of 50 mg) if required. Lower doses and/or less frequent dosing (e.g., one-quarter of a 25 mg tablet twice weekly, one-eighth of a 25 mg tablet every other

day, etc.) have been used with success for patients who wish to maintain sexual function or minimize other side effects.

Time intervals for dose titration should take into consideration existing medical conditions, bloodwork results and individual transition-related goals. If an adequate response is not achieved with maximum doses of the initially chosen agent, or if side effects prohibit titration to adequate effect, we suggest initiating a trial of the alternative agent (in the absence of contraindications). When discontinuing spironolactone, consider a taper in patients with hypertension or renal dysfunction, with monitoring of blood pressure and volume status. The chart below shows the starting/low, customary and maximum doses for spironolactone and cyproterone.

Formulations and recommended doses of anti-androgens in feminizing GAHT

Prescription	Starting/low dose	Usual dose	Maximum dose	Purchasing Cost*
Spironolactone (oral)	50mg daily-bid	100 mg bid	150mg bid[a]	30 x 25mg $12.97 $48.42-145.26 every 4 weeks
				30 x 100mg $17.02 $15.89-47.67 every 4 weeks
Cyproterone (oral)	12.5mg (¼ 50mg tab) daily	12.5mg (¼ 50mg tab) - 25mg (½ 50mg tab) daily	50mg daily[a]	30 x 50mg $61.48 $14.35-114.76 every 4 weeks
Leuprolide	≤25kg Initial:	Dosage depends on body weight		22.5mg/kit

acetate (IM injection) "Lupron"	7.5mg every 4 weeks >25 to 37.5kg Initial: 11.25mg every 4 weeks >37.5kg Initial: 15mg every 4 weeks	and desired dosage schedule. Titrate dose in 3.75mg increments every 4 weeks until clinical or laboratory tests indicate adequate suppression.	$1193.44 $397.81-1591.25 every 4 weeks (starting dose)
	3 month formulation: 11.25mg or 30mg every 12 weeks		
Leuprolide acetate (SUBQ injection) "Eligard"	Dosage depends on body weight and desired dosage schedule. Monthly Dosage: 3.75mg 3 Month Dosage: 11.25mg		22.5mg/kit $994.55 $165.76 monthly
*Price quotes provided by APSI, accurate as of August 2022 and represent the price of the generic brand of medication unless otherwise indicated (ranging from low dose to maximum dose). Prices reflect the actual customer cost for purchase within New Brunswick, including a dispensing fee, and not including Medicare or a drug plan. a. Rarely required or used. Maximal effect does not necessarily require maximal dosing. Use clinical judgment in selecting optimal individual dosing.			

If contraindications exist or if intolerance is a concern for both spironolactone and cyproterone, GnRH analogues (leuprolide/"Lupron" or busrelin/"Suprefact") may be considered. GnRH analogues flood the pituitary gland's GnRH receptors, leading to a downregulation of the response to endogenous GnRH and sustained suppression of luteinizing hormone (LH) and follicle-stimulating hormone (FSH) release. GnRH analogues are commonly used for pubertal suppression in youth and have also been used in adults undergoing GAHT.

Drawbacks include high cost, repeat (often painful) injections or frequent nasal spray dosing, and possible side-effects, including headache, mood changes and weight gain. It should be noted that the administration of a GnRH analogue in the absence of exogenous hormone use, for a significant amount of time (i.e., > 2 years), can decrease bone mineral density. If providers lack experience with the use of GnRH analogues, Sherbourne Health recommends consultation or communication with an endocrinologist or another experienced provider prior to initiation.

If the administration of anti-androgens is problematic, another option is the removal of the major source of endogenous testosterone (i.e., orchiectomy). For patients who are unable to access or are not seeking vaginoplasty (during which orchiectomy is routinely performed), orchiectomy alone is a choice that may be considered and is covered under New Brunswick Medicare (for more information see **Part 5: Gender-Affirming Surgery**).

For the vast majority of patients who have undergone gonadectomy, androgen suppression will no longer be required. The androgen-blocker can be stopped immediately after surgery or tapered over the course of 4–6 weeks or more post-operatively. In some cases, the effects of anti-androgens may be sought without the additional effects of estrogen, or when estrogen is contraindicated.

In addition to potential hot flashes, low mood, and fatigue, there may be a loss of bone mineral density, akin to that demonstrated in cisgender men who have undergone long-term androgen blockade without hormone replacement for the treatment of prostate cancer. This treatment may, however, be considered in some circumstances, following detailed discussion with the patient, and with preventive measures and monitoring for bone loss in place. Periodic bone mineral density testing for those on prolonged monotherapy with an anti-androgen can be used to identify any concerning loss of bone density.

The table below displays the monitoring parameters for both spironolactone and cyproterone. Note that additional parameters are required once estrogen is initiated (see **Estrogen**).

Recommended parameters for monitoring anti-androgen GAHT

		Baseline[a]	3-6 months	12 months
Spironolactone	History	Screen for contraindications/ potential drug interactions	Side effects (polyuria, orthostasis)	
	PE	| _____ BP _____ | +/- breast inspection[b] (baseline)		
	Key Labs	Cr, lytes, total testosterone		
Cyproterone	History	Screen for contraindications/ potential drug interactions	Side effects (depression, low energy), desired effects)	
	PE	Wt, BP +/- breast inspection[b]	Wt, BP, abdominal exam	
	Key Labs	CBC, AST/ALT, Cr, lytes, total testosterone	CBC[c], AST/ALT, total testosterone , Cr, lytes	CBC[c], AST/ALT, total testosterone, fasting glucose or Hba1c, lipid profile, +/-Cr, lytes[d]

a. If not done in the preceding 3 months
b. Breast inspection at baseline with attention to Tanner stage (+/- measurement), for patients who may have interest in breast augmentation.
c. Red blood cell parameters can be expected to decrease with androgen blockade, female reference ranges for lower limits of normal should be used
d. Necessary only if risks/concerns identified

Note: Additional parameters required as per guidelines with estrogen; pre-existing conditions or risk factors may require earlier/more frequent monitoring of specific parameters.

Estrogen

Estrogens act directly on estrogen receptors to initiate feminization. The degree and rate of physical effects are largely dependent on patient-specific factors such as age, genetics

and body habitus, and to some extent the dose and route used, selected according to a patient's specific goals and risk profile. There is a lack of consensus among clinicians on the preferred timing of the initiation of estrogens in relation to an anti-androgen. Common approaches have included both the initiation of an anti-androgen prior (usually 1–3 months) to the addition of estrogen, or alternatively, the simultaneous introduction and subsequent titration of both components.

When deciding on the relative timing of anti-androgen and estrogen introduction, take into consideration that:

- The effects of anti-androgens are generally considered reversible, so the initiation of an anti-androgen first may be a preferred first step for patients seeking to explore the impact of subtle bodily changes before proceeding with estrogen, or for those wishing to take a gradual approach to medical transition;
- Staggering the initiation of an anti-androgen and estrogen allows for more readily identifying the problematic agent in the case of unusual side effects or drug allergy;
- In the absence of estrogen replacement, some patients may experience hot flashes, low mood, and/or fatigue; and
- There is weak evidence (one small study) suggesting that spironolactone used alone may prematurely inhibit breast development. Whether other anti-androgens may have a similar impact is unknown.[102]

Several forms and routes of estrogen have been used for GAHT. The most common form used is oral 17-β estradiol (Estrace) - 17-β estradiol, whether in tablet or topical form, is a bio-identical hormone, structurally identical to estrogen made by the ovary in humans. Premarin, an estrogen derived from pregnant mare urine, is not bio-identical.

Oral formulations are subject to first pass gastrointestinal (GI) and liver metabolism which, according to the "first-pass hypothesis," contribute to negative hepatic and prothrombotic effects. Sublingual, transdermal and injectable routes all bypass this stage during which much estradiol is oxidized to the less potent estrone.

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[102] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

The administration of estrogen via the sublingual route has gained interest in recent years given its accessibility (oral formulations of micronized estradiol can be dissolved under the tongue), affordability (compared to the transdermal route) and the proposed benefits of bypassing first pass metabolism.

Similar to the sublingual route, injectable estrogens bypass first pass metabolism and result in higher peaks and increased periodicity over oral forms. Injectable estrogen (in the form of compounded estradiol valerate) is available in Moncton; however, due to its high peaks and lows is not typically recommended. Moreover, injectable estrogen can have significant impacts on mental health and is difficult to find a therapeutic dose. However, PCP may still come into contact with a patient who is using IM estradiol valerate. PCPs should inform patients of other estrogen-based hormone regimes as if and when necessary.

If a patient is continuing to use IM estradiol valerate it is important to instruct them on the technique for safe injection and sharps disposal. Directly observing a patient self-inject is helpful for the correction of any problems with technique and to reassure patients that they are injecting correctly. Ideally patients would complete their first hormone administration in a PCP's office. A written step-by-step guide on self-injection for patients is **here**. Additionally, it may be helpful to have patients record the injection training on their phone to refer to after.

Transdermal estradiol bypasses first pass metabolism, results in relatively steady serum levels and seems to have the best overall safety profile. It is most commonly administered in the form of the estradiol patch ("Estradot"), which is available from most pharmacies in New Brunswick but is unfortunately more expensive than oral forms. While it is often covered by private drug insurance, it is only covered by the NB drug plan in rare circumstances, such as a patient having the inability to swallow.
Other transdermal options include creams and gels. Estradiol creams are only available via compounding. Gel is available in a product formulated for the treatment of menopausal cis women ("Estragel"), however the area of skin needed for absorption of the gel is quite large, even for low/starting doses, so it is not a first choice for most trans patients. Cream and gel formulations may be effective for some transfeminine patients, but physiologic estrogen levels may be difficult to achieve in others. Again, these transdermal forms are expensive and not covered by the NB Drug Plan, but may be fully or partially covered by

private drug plans. Note that specific details and dosing of compounded formulations should be discussed with the compounding pharmacist.

Following gonadectomy, most patients will not need androgen suppression; however, ongoing estrogen supplementation is generally needed to preserve bone mineral density. Reducing estrogen dosing is not required post-operatively, but some patients may find that a lower dose suffices to maintain desired effects in the absence of any endogenous testosterone. Consideration should be given to bone mineral density in agonadal patients on low dose estrogen.[103]

[103] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: **https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf**

Formulations and recommended doses of estrogen-based GAHT

Prescription	Starting dose	Usual dose	Maximum dose[b]	Purchasing Cost*
Estradiol (oral) "Estrace"	1-2mg daily	4mg daily or 2mg bid	6mg daily or 3mg bid	30 x 0.5mg $14.40 $26.88-161.28 every 4 weeks
				30 x 1.0mg $18.50 $17.27-103.60 every 4 weeks
Estradiol (transdermal patch)[a] "Estradot"	50mg daily/apply patch 2x/week	Variable[a]	200mcg daily/apply patches 2x/week	8 x 37.5mg patch $44.49 Up to $222.45 every 4 weeks
				8 x 50mg patch $36.08 $36.08-117.96 every 4 weeks
				8 x 100mg patch $39.58 Up to $79.16 every 4 weeks
Estradiol 0.6% (transdermal gel) "Estrogel"	2.5g daily (2 pumps, contains 150mg estradiol)	Variable[a]	6.25g daily (5 pumps, contains 375mg estradiol), may be limited by surface area requirements for gel application	80g pump (64 pumps total) $62.54 $54.72-109.45 every 4 weeks

Progesterone (oral) "Prometrium"	Variable[a]		100–200mg daily	100mg tablets 30 tabs $68.67 $2.289 each $64.01-128.18 every 4 weeks
				Generic brand 100mg tablets 30 tabs $23.83 $22.24-44.48 every 4 weeks
Medroxyprogesterone acetate (oral) "Provera"	2.5mg daily	Variable[a]	5–20 mg daily	2.5mg tablets 30 tabs $14.34 $13.38-107.07 every 4 weeks
Medroxyprogesterone acetate (oral) "Provera"	2.5mg daily	Variable[a]	5–20 mg daily	5mg tablets 30 tabs $18.69 Up to $69.78 every 4 weeks
				10mg tablets 30 tabs $16.14 Up to $30.13 every 4 weeks

Depo-medroxyprogesterone acetate (injection) Depo-Provera	150 mg IM every 120 days	Variable[a]	150mg/mL x 1 syn $45

*Price quotes provided by APSI, accurate as of August 2022 and represent the price of the generic brand of medication unless otherwise indicated (ranging from low dose to maximum dose). Prices reflect the actual customer cost for purchase within New Brunswick, including a dispensing fee, and not including Medicare or a drug plan.

a. Usual doses vary significantly between individuals. Use starting doses and titrate based on patient response.
b. Maximum doses are not often needed. Use clinical judgment in selecting optimal individual dosing.
c. The common doses of progestins are micronized bio-identical progesterone "Prometrium" 100–200 mg daily; or medroxyprogesterone acetate/"Provera" 5–20 mg daily. Risks are likely lower with micronized progesterone than with medroxyprogesterone, so the former is chosen preferentially by most clinicians. In addition, the former may be better tolerated and have a more favourable impact on the lipid profile than medroxyprogesterone. Injected depo-medroxyprogesterone acetate "Depo-Provera" is seldom used in transfeminine patients. If a progestin is prescribed, some clinicians advise limiting the treatment duration to a maximum of two to three years, or the use of cyclical dosing (i.e., administered 10 days per month).

Progestins

With the exception of cyproterone, the use of progestins in patients continues to be controversial.[104] Progestins have a suppressive effect on LH and therefore on testosterone production, and have at times been used as part of estrogen-based hormone regimens for patients. There have also been anecdotal reports of improved breast and/or areolar development, mood, sleep and libido with the use of progestins. However, a clear impact has yet to be demonstrated.[105]

[104] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf
[105] ibid

In addition to weight gain and edema, depression is an often-cited side effect of progestins. Anecdotally, some patients may experience a favourable impact on mood, while others may experience negative effects. Some protocols have suggested the adjunctive use of progestins when traditional treatments don't achieve adequate androgen suppression, while others suggest a trial of a progestin as an option for patients with low libido.

Due to the lack of research and the potential risks of progestin therapy Sherbourne Health does not currently recommend the routine use of progestins. However, if patients request progestin treatment, either in hopes of attaining anecdotal benefits, or due to a desire to more closely reflect the hormonal milieu of cis women they should be provided with all available information about the expectations and risks of progestin.

The common doses of progestins are micronized bio-identical progesterone "Prometrium" 100–200 mg daily; or medroxyprogesterone acetate/"Provera" 5–20 mg daily. Risks are likely lower with micronized progesterone than with medroxyprogesterone, so the former is chosen preferentially by most clinicians. In addition, the former may be better tolerated and have a more favourable impact on the lipid profile than medroxyprogesterone. Injected depo-medroxyprogesterone acetate "Depo-Provera" is seldom used in transfeminine patients. If a progestin is prescribed, some clinicians advise limiting the treatment duration to a maximum of two to three years, or the use of cyclical dosing (i.e., administered 10 days per month).

Special Considerations for Aging Patients (Estrogen-Based GAHT)

There is little information to guide recommendations for the initiation or maintenance of estrogen-based hormone regimens in aging patients. Unique considerations in older populations include changes in endogenous hormone levels, physiologic changes that may affect response to medications, a higher burden of existing medical conditions, and multiple pre-existing medications leading to the increased potential for drug interactions.

It is not uncommon for patients to seek to initiate GAHT at older ages, though estrogen-based effects may be slower and more subtle for those initiating therapy at an advanced age. There is no reason to withhold GAHT from aging or older patients simply due to age.

For some older patients who have had to delay transition until later in life, maximizing estrogen-based effects may take precedence over concerns about risk. For such patients, an "active period" of treatment with doses used for younger patients may be considered following an informed consent approach.

For patients over 50, it is reasonable to mimic physiologic hormone levels in menopausal cis women, which can usually be attained with estrogen doses typically administered to post-menopausal cis women, e.g., starting/low-dose topical formulations. For those with gonads, required anti-androgen doses may also be lower due to age-related decreases in serum testosterone.

The preferential use of spironolactone in older transfeminine patients (with healthy renal function) has been suggested by Sherbourne Health given the possible increased thromboembolic risk associated with cyproterone.[106]

For those over age 50 who have been on GAHT for some time, some guidelines suggest considering complete discontinuation of GAHT. However, those without gonads will likely experience symptoms akin to menopause along with potential loss of bone mineral density, and those with gonads may experience a return of virilization. As with all patients, decisions about GAHT at an advanced age should be individualized following a thorough discussion of risks and benefits.

Monitoring and Dose Adjustments (Estrogen-Based GAHT)

Standard monitoring of a estrogen-based regimen should be employed at baseline, three months, six months and one year (additionally, creatinine and electrolytes should be checked between four and six weeks following initiation of spironolactone). Some providers prefer to see patients monthly until an effective dose is established. Follow-up visits should include a functional inquiry, targeted physical exam, bloodwork and health promotion/disease prevention counselling as indicated.

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[106] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

Functional inquiry should include subjective positive or negative impacts on mental health as well as any noted physiologic changes. It may be helpful to remind patients that changes related to androgen blockade and estrogen administration may take months to years for full effect.

The first changes will likely be loss of spontaneous and morning arousal. Breast development, skin and hair changes, and fat redistribution take longer. Some patients may experience a small amount of physiologic galactorrhea early in the course of treatment. If galactorrhea is from more than one duct or bilateral, and non-bloody, no further workup is warranted.
Generally, physical changes are considered to be complete after 2–3 years on GAHT. Periodically, the clinician should counsel around monitoring for signs and symptoms of VTE, particularly in those at increased risk. Patients should be periodically reminded about the importance of adequate calcium and vitamin D intake. Examination should be focused and minimally include blood pressure and weight.

Blood work should be completed according to the table below, with more frequent monitoring as deemed necessary if concerns are identified.

Recommended blood work for monitoring feminizing GAHT

In this table, smaller and lighter grey "x"s indicate parameters that are measured under particular circumstances.

Test	Baseline	4-6 weeks	3 months	5 months	12 months[e]	Yearly	According to guidelines for cis patients, or provider discretion
CBC[a]	X		x	x	X	x	
ALT/AST[b]	X		x	x	X	x	X
Creatinine/ lytes[c]	X	x	x	x	x	x	
Hba1c or fasting glucose	X				X		X
Lipid profile	X				X		X
Total testosterone	X		X	X	X	X	
Estradiol	X		X	X	X	X	
Prolactin[d]	X				x	x	x
Other	Hep B, C						
	Consider: HIV, syphilis and other STI screening as indicated, frequency depending on risk						

a. At baseline for all, and regularly with cyproterone, for Hb/Hct use female reference for lower limit of normal and male reference for upper limit of normal
b. Baseline for all and regularly with cyproterone, otherwise repeat once at 6–12 months then as needed
c. Cr, lytes, should be monitored at each visit with spironolactone, but is only required at baseline and then once between 6–12 months with cyproterone unless risk factors or concerns re: renal disease are present, use male reference range for upper limit of normal for Cr
d. Prolactin should be monitored at least yearly with the use of cyproterone, and more frequently if elevation is noted
e. During first year of treatment only

Note: Individual parameters should be considered more frequently if concerns are identified or existing risk factors are present.

Dose titration of anti-androgen and estrogen may be performed over the course of 3–6 months or more, and will depend on patient goals, physical response, measured serum hormone levels and other lab results. A common titration might look like:

- Initiate therapy with 1 mg oral estradiol and 50 mg of spironolactone daily;
- Check creatinine and electrolytes at one month and, barring any concerns, increase estradiol to 2 mg and spironolactone to 50 mg twice daily;
- Following three-month blood work and check-in, increase estradiol to 3 mg daily and spironolactone to 75 mg twice daily; and
- Continue titration as needed until maintenance dose is achieved.

Titration schedules vary between clinicians and can be tailored to individual patient needs and variables. Some patients may be eager to begin maximal therapy, but there is some evidence to suggest that excessive estrogenic action may limit breast development, and that the estrogen-receptor agonist activity of spironolactone may contribute to this effect.[107] The evidence is considered weak, however it suggests potential benefits to a slow upward titration. These factors can be discussed with patients in order to facilitate collaborative and informed decision making.

Hormone levels for those seeking a more androgynous appearance may intentionally be mid-range between male and female norms. For many patients, the goal will be to achieve the suppression of testosterone into the female range. Be mindful that patients may experience clinically relevant results without total suppression of testosterone due to peripheral androgen blockade, which is not measured.

In the vast majority of cases, the measurement of total testosterone (rather than both total and free) is adequate to assess the degree of androgen suppression. Measurements and calculated estimates of free testosterone are imprecise and generally don't add value. In rare cases, the calculation of free or bioavailable testosterone may be helpful for fine-

[107] Sherbourne Health & Rainbow Health. (2019). Guidelines for gender affirming primary care with trans and non-binary patients. Retrieved from: https://rainbowhealth.wpenginepowered.com/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf

tuning hormone regimens. Again, it is important to keep in mind that clinical effects are the goal of therapy, not specific lab values.
In cases where there are very high estradiol levels reported, reviewing the dose (including use of estrogens without a prescription) and route (i.e., oral versus sublingual) with the patient may be helpful in elucidating the cause.

For those on injectable estrogen, levels taken at peak in the cycle may be expected to exceed recommended targets. When monitoring injectable estrogen, most guidelines recommend checking serum levels at mid-cycle, while some clinicians prefer to measure at trough (i.e., just before the next injection is due). The latter adds convenience for patients who prefer to come into the clinic for their injections. There may also be utility in varying the timing of blood work to gather information regarding serum levels throughout the cycle (peak, mid-cycle and trough), especially if a patient is reporting cyclic symptoms (e.g., hot flashes, headaches, fatigue). In such cases, wide fluctuations should prompt consideration of increased frequency of injections or a route with less periodicity.

If the sex marker associated with the patient's health card has not been changed, the reported reference ranges will refer to the sex assigned at birth. As reference ranges vary between laboratories, it is important to be able to refer to reference ranges for the affirmed gender from the specific laboratory. These can often be found on laboratory websites or can be obtained by request from the lab.

Ideally, labs would be able to report reference ranges in a patient's affirmed gender, regardless of their health card sex marker, or to report both male and female reference ranges with a patient's results. There are currently logistical and systems barriers to this practice in New Brunswick labs, though efforts are underway to make improvements in laboratories' direct service to trans patients as well as amendments to reference range reporting. It is advised to indicate AMAB or AFAB to reduce likelihood of sample rejection.

Limitations to Estrogen-based GAHT

In the vast majority of cases, hormone levels in the female range can be achieved fairly readily if that is the goal. Yet the physiologic results in transfeminine patients may not meet a patient's hopes and expectations for estrogen-based GAHT, and some may experience ongoing dysphoria or dissatisfaction. These limitations to estrogen-based GAHT should be reviewed with patients before initiation to minimize disappointment from unachievable expectations.

Estrogen-based GAHT does not affect the pitch of the voice in patients. Some patients may benefit from voice therapy with a qualified and supportive speech and language therapist who can work with the patient to modify their vocal characteristics. Currently speech and language therapist services are not covered in NB for transition-related purposes. A variety of surgical techniques have also been used to feminize the voice by altering the vocal cords. These procedures are also not covered by Medicare and carry risks for vocal and other complications, though some patients may benefit from these procedures if vocal therapy has not produced satisfactory changes. For more information about SLP services in NB go **here**.

Although estrogen-based GAHT slows the rate of growth of hair on the face and neck, it does not eliminate it. Plucking, waxing or depilatory chemicals are temporary measures, therefore many patients will seek permanent hair reduction by laser hair removal or electrolysis. Both of these techniques can be painful, require multiple sessions and may require lifelong treatment for sustained effect. Unfortunately, these procedures are not covered by Medicare. It should be noted that results can be directly impacted by whether the patient's hair has begun to turn grey.

Additionally, estrogen-based GAHT does not affect the underlying bone structure of the face. Some softening of the facial features (possibly through fat redistribution) is anecdotally reported by patients. Some patients may desire facial feminization surgery (FFS), however this procedure is not covered by Medicare.

Breast growth is an aspect of estrogen-based GAHT that is very important to many patients. Unfortunately, many patients will be dissatisfied with their degree of breast development. The extent to which the degree of testosterone suppression may affect breast development is unknown. Research to date examining factors impacting breast development in patients is scarce and of low quality. More research is needed to guide recommendations in regards to this aspect of estrogen-based GAHT. Unfortunately, Medicare does not cover augmentation mammoplasty.

Precautions and Risk Mitigation (Estrogen-Based GAHT)

Providers may have concerns about the safety of estrogen, particularly with respect to cardiovascular/VTE events and malignancies. As more evidence emerges on modern estrogen-based GAHT, fears of a significant negative impact on morbidity and mortality are being decreased.

Pre-existing medical conditions and risk factors may increase risks with estrogen administration, and should be considered to enable individualized discussions with patients regarding their unique risks and benefits of treatment. Available measures to reduce associated risks should be considered and discussed with patients, and, if possible, undertaken prior to or concurrently with the initiation of GAHT. In some cases, patients may wish to begin GAHT in the setting of ongoing increased risk, i.e., immitigable risk or having declined measures for risk mitigation. In these situations, a careful informed consent process should be undertaken which takes into consideration individual capacity to make an informed decision, the severity of potential harms from treatment, and the harms that may result from not pursuing treatment.

When necessary, the initiation of estrogen-based GAHT should ideally be done in collaboration with relevant specialists who may already be involved in a patient's care. In some cases, a new referral may be helpful in informing decisions about risks and their mitigation. However, efforts should be taken to ensure that this does not cause undue delay. If accessibility to a specialist is limited, an e-consult can be both timely and beneficial.

Precautions with estrogen-based GAHT and minimizing associated risks

Precaution to estrogen-based GAHT	Considerations in minimizing associated risks
Autoimmune conditions (e.g. RA, MS, IBD)	• start low dose, titrate slowly in collaboration with any involved specialists
Cerebrovascular disease*	• consider referral to neurology • ensure optimal medical management (including prophylactic antiplatelet agent(s) if indicated per current national guidelines) and risk factor optimization • use transdermal route of administration +/- lower dose
Hepatic dysfunction	• dependent on etiology, e.g. minimize alcohol consumption, weight loss in NAFLD • consider referral to hepatology/gastroenterology • use transdermal, sublingual, or injectable route of administration • consider spironolactone as preferred anti-androgen
History of benign intracranial hypertension	• consider referral to neurology/neurosurgery
Hypercoagulable state or personal history of DVT or PE	• identify and minimize existent risk factors, prophylactic anticoagulation if indicated per current national guidelines • consider referral to hematology/thrombosis clinic • use transdermal route of administration +/- lower dose • consider spironolactone as preferred anti-androgen
Hyperprolactinemia	• determine etiology and manage as indicated • if prolactin > 80 mcg/L or symptomatic - rule out prolactinoma • refer to endocrinology as needed • consider spironolactone as preferred anti-androgen

Marked hypertriglyceridemia	• identify and address barriers to optimal lipid control • refer to dietitian • minimize alcohol consumption • consider anti-lipemic pharmacologic therapy • consider endocrinology referral • use transdermal route of administration
Metabolic syndrome	• dietary and medical management of component disorders • consider cardiac stress test • consider transdermal route of administration
Other cardiac disease	• consider referral to cardiology
Personal or family history of porphyria (rare)	• consider referral to porphyria clinic or internist with experience in porphyria
Prior history of estrogen-sensitive cancer	• refer to oncology
Seizure disorder	• consider referral to neurology • consult with a pharmacist re: possible estrogen interaction with anticonvulsant medication
Severe, refractory or focal migraine*	• consider referral to neurology • consider daily migraine prophylaxis • ensure all other cerebrovascular risk factors are optimized • consider transdermal route of administration • consider spironolactone as preferred anti-androgen
Smoker	• encourage and support smoking cessation • consider referral to smoking cessation program/offer NRT and/or bupropion/varenicline, or negotiate a decrease in smoking

	• consider cardiac stress test • use transdermal route of administration +/- lower dose • consider spironolactone as preferred anti-androgen • consider low-dose ASA prophylaxis
Stable ischemic cardiovascular disease*	• consider referral to cardiology • ensure optimal medical (including prophylactic antiplatelet agent(s) if indicated per national guidelines) and/or surgical management as indicated • risk factor optimization • use transdermal route of administration +/- lower dose • consider spironolactone as preferred anti-androgen
Strong family history of abnormal clotting	• rule out genetic clotting disorder • consider transdermal route of administration • consider spironolactone as preferred anti-androgen
Strong family history of breast cancer	• refer to genetics/familial breast cancer program for further risk stratification and genetic testing as indicated
Uncontrolled diabetes	• identify and address barriers to optimal glycemic control • refer to dietitian • encourage lifestyle modification • initiate antiglycemic agent(s) per national guidelines • consider cardiac stress test • consider transdermal route of administration
Uncontrolled high blood pressure	• identify and address barriers to optimal BP control • use spironolactone as preferred anti-androgen • add additional antihypertensives as needed (avoid ACEs/ARBs with spironolactone) • consider cardiac stress test • consider transdermal route of administration • consider referral to cardiology
* Imparts moderate to high risk of an adverse outcome without risk mitigation	

ACEs: angiotensin converting enzyme inhibitors;
ARBs: angiotensin receptor blockers;
ASA: acetylsalicylic acid;
BP: blood pressure;
DVT: deep vein thrombosis;
GI: gastroenterology;
IBD: inflammatory bowel disease;
MS: multiple sclerosis;
NAFLD: non-alcoholic fatty liver disease;
NRT: nicotine replacement therapy;
PE: pulmonary embolism;
RA: rheumatoid arthritis

For more information on the specific conditions associated with estrogen-based GAHT, risk mitigation, and long-term preventive care, see **Sherbourne's guidelines for gender-affirming primary care with trans and non-binary patients**. These guidelines include information and research on the following:

- Breast cancer
- Cardiovascular disease and related metabolic risk factors
- Human immunodeficiency virus (HIV)
- Hyperprolactinemia/prolactinoma
- Liver and gallbladder
- Osteoporosis and bone mineral density screening
- Prostate cancer
- Seizure disorders and anticonvulsant therapy
- Sexual function and fatigue
- Venous thromboembolism (VTE)

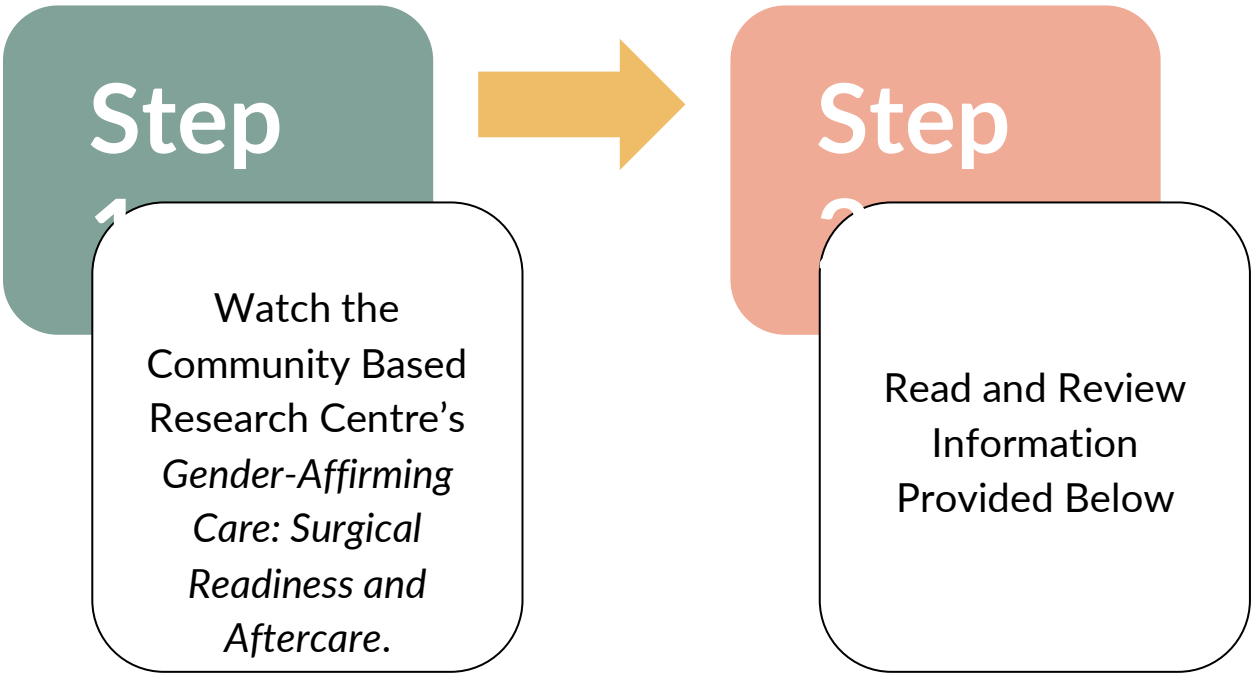
Long-Term Follow-Up (Estrogen-Based GAHT)

The long-term follow-up of patients on testosterone-based GAHT should involve (at least) annual preventive care visits. **Preventive Care Checklists©** endorsed by the College of Family Physicians of Canada exist for cisgender patients; however, the use of these forms

for 2STIGD patients is awkward, unaffirming, and can lead to missed elements important in their comprehensive primary care. 2SQTP-NB/P2SQT-NB has assembled recommendations from Sherbourne Health and Rainbow Health into an adapted **Preventive Care Checklist** for the ongoing primary care of patients on testosterone-based hormone therapy. The use of these gender-specific forms assumes familiarity with the standard forms and their explanations. The recommendations represent an effort to incorporate expert opinion, relevant research on cisgender populations and limited gender-specific evidence, with standard national and provincial primary care practices.

Part 5: Gender-Affirming Surgery

NB Medicare now covers certain gender-affirming surgeries for Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) folks living in New Brunswick. This section provides an overview of the NB system for surgery planning, referral, and coverage. This section is comprised of both visual and written material, and should be completed in the following order:



Link to e-learning lesson: cbrc.teachable.com/courses

We would like to recognize that there may be some unconscious negative undertones in the video for this section toward those engage in sex work. This is an important intersection to understand, as those who engage in sex work are valid and deserving of no less respect than anyone else. For more information to better understand this intersection,

please see Sex work, as well as the resource Stigma and Sex Work, put together by Peers Victoria, "an organization of sex workers for sex workers."

Please note as well that surgery is another area where Gatekeeping and Bias can easily negatively impact patient care. For more information, please refer to that section.

Surgical Readiness Assessment

Patients considering gender-affirming surgery that is covered by Medicare are required to approach their family physician, nurse practitioner, and/or mental health professional to undergo a surgical readiness assessment. A surgical assessment ensures that a patient is prepared for the surgery and will have the best possible post-surgical outcome. In NB, a surgical readiness assessment involves the following steps:

Surgical Readiness Assessment Steps	

GATHER BASIC SURGERY INFORMATION	• Gather the following information:
	  ● Patient's anticipated timeline for having surgery
	  ● Surgery type
	  ● Who the desired surgeon is
	  ● Pre-op requirements
	  ● If applicable, insurance coverage and requirements
	• Verify that the patient is physically fit and has no significant physical health problems that would contraindicate or complicate the proposed surgery:
	  ● Health screening commensurate to age & risk profile
	  ● Focused physical exam
	  ● Vitals (incl. BP, T, HR, Ht, Wt, Waist & Abdo circ.)

PRIMARY CLINICAL CRITERIA	• Verify that the patient has:
	  ● Reached the age of 18
	  ● Persistent, well-documented gender dysphoria diagnosis
	  ● Capacity to make a fully informed decision and to consent for

	treatment (see Informed Consent Model): ● Understands the procedure/s ● Understands associated risk/s and complications ● Reasonably well controlled medical or mental health concerns, if they are present ● An aftercare / follow-up plan
PATIENT EXPECTATIONS	● Verify that: ● The patient has realistic goals and expectations of the surgery ● The patient is informed of and understands any alternative procedures ● The patient is psychologically prepared for surgery
PATIENT SUPPORTS AND PLANNING	● Verify that the patient has: ● An adequate support network, a stable lifestyle, and the gender identity of the individual has remained stable over time ● Engaged in a responsible way with the assessment/treatment process ● A post-surgical plan (i.e., transportation, aftercare, caretaker, etc.)
NEXT STEPS	● Complete Gender Confirming Surgery Prior Approval Request form ● Complete/assemble Referral Letter(s) ● Upon approval, work with the surgical team to plan follow up care
BP: blood pressure **HR**: heart rate **Ht**: height	**T**: temperature **Wt**: weight

Surgical readiness assessments should use criteria established by WPATH. The WPATH assessment involves a comprehensive psychiatric assessment and prolonged medical management before surgery is considered an option. However, it should be noted that

version 8 of the standards of care (SoC-8) has recently been published and will soon replace SoC-7 on all NB forms.

WPATH Criteria

Criteria for chest masculinization surgery (one referral)

1. Persistent, well-documented gender dysphoria (will soon change with SoC-8);
2. Capacity to make a fully informed decision and to consent for treatment (see Informed Consent Model);
3. Age of majority in a given country (within NB, must be at least 18 - if younger, follow the SOC for children and adolescents; see Part 8: 2STIGD Youth);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a prerequisite.

Criteria for breast augmentation in MtF patients (not covered in NB):

1. Persistent, well-documented gender dysphoria (will soon change with SoC-8);
2. Capacity to make a fully informed decision and to consent for treatment (see Informed Consent Model);
3. Age of majority in a given country (within NB, must be at least 18 - if younger, follow the SOC for children and adolescents; see Part 8: 2STIGD Youth);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that patients undergo estrogen-based GAHT (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested (see Gender-Affirming Surgeries Covered By Medicare table below).

Criteria for hysterectomy and ovariectomy and for orchiectomy:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment (see Informed Consent Model);
3. Age of majority in a given country (within NB, must be at least 18);
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty and for vaginoplasty:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment (see Informed Consent Model);
3. Age of majority in a given country (within NB, must be at least 18);
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Beyond the specific criteria set forth by the WPATH Standards of Care, there are two other important areas for assessment of anyone undergoing major surgery for any reason, including hip replacements, organ transplants, open heart surgery, etc:

1) Insuring realistic expectations of what surgery can and cannot do, being emotionally prepared for the realities of potential complications or less-than-satisfactory outcomes.

2) Insuring adequate support during the pre- and post-surgery period. This includes having someone to take them to and from surgery, and be with them after surgery to assist with recovery needs. This could include anything from obtaining supplies at the pharmacy to preparing meals and assisting with domestic needs. For those who do not have someone to fill these roles, PCP's should work with patients to make arrangements for home health assistance.

Following the completion of a surgical readiness assessment a PCP and/or psychologist determines that someone is clinically eligible for surgery and completes the **Gender Confirming Surgery Prior Approval Request** form. Once prepared the request form is sent to the Executive Director of Addictions and Mental Health, who in turn forwards it to New Brunswick Medicare for consideration. Upon approval, a surgical plan is put in place by the patient's medical team.

In addition to completing the Prior Approval Request form the following are required to access Medicare covered gender-affirming surgery:

- Patients must be at least 18 years of age;
- Patients must hold a valid NB Medicare card;
- One or two referral letters;
- For all genital surgery: 12 continuous months of GAHT for all bottom surgeries unless there is medical contraindication, or inability / unwillingness to undergo hormone replacement therapy;
- For genital reconstruction: 12 continuous months of living in a gender role congruent with their identity unless a specific reason has been stated in a referral letter.

Referral Letters

According WPATH, a referral letter recommending surgery should include the following information:

- The client's general identifying characteristics;
- Results of the client's psychosocial assessment, including any diagnoses;
- The duration of the PCP and/or mental health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;
- An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
- A statement about the fact that **informed consent** has been obtained from the patient;
- A statement that the PCP and/or mental health professional is available for coordination of care and welcomes a phone call to establish this.

In New Brunswick, two letters are required for genital surgery. If two referral letters are required and the first referral letter is from a Physician or Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter must be from a different Physician or Mental Health Professional who had an evaluative role with the patient). To access a referral letter template, please click **here**.

Possible Questions to Explore Patient Expectations and Goals

* All questions listed below are intended to be guiding questions. When establishing a rapport with a patient it is important that you make these questions your own, personalize them, or come up with questions that better suit your patient.

- Who would you like to be your surgeon and where would you like to have surgery if possible?
- Which surgery are you planning to have?
- How do you foresee surgery helping to affirm your gender?

- Can you tell me what you know so far about the surgery itself and what to expect?
- Do you know anything about the pre-op requirements and expectations? If so, what do you know?

Possible Questions to Explore Patient Supports

* All questions listed below are intended to be guiding questions. When establishing a rapport with a patient it is important that you make these questions your own, personalize them, or come up with questions that better suit your patient.

- Have you identified a support person(s) to help you with your pre- and post-surgical care?
- What is your post-operative care plan? How can I assist you in this plan?
- What kinds of support and advocacy do you need at this time?
- Will you be able to access medication after surgery?
- Do you have adequate financial support for the procedure (*if necessary)*, transportation and/or accommodation, and for aftercare?

Financial Coverage

Gender-Affirming Surgeries Covered By Medicare			
Procedure	**Description**	**Requirements**	**Location**
Subcutaneous mastectomy & chest contouring	Removal of breast tissue and creation of a flatter and/or more sculpted chest	Only Partial Coverage One WPATH/ CPATH Supporting Letter	NB
Hysterectomy with bilateral salpingo-oophorectomy	Removal of uterus, ovaries, and fallopian tubes	Two WPATH/CPATH Supporting Letters	NB
Orchidectomy	Removal of testes Eliminates need for testosterone blocker	Two WPATH/CPATH Supporting Letters	NB
Vaginoplasty (including Vulvoplasty)	Creation of vagina and vulva (including mons, labia, clitoris, and urethral opening)	Two WPATH/CPATH Supporting Letters Orchidectomy previously performed in a public hospital in Canada.	Centre Métropolitain de Chirurgie, Montréal, Québec
Clitoral release	Ligaments around clitoris are cut releasing clitoris from the pubis and allowing creation of penis 4-6cm long	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed in a public hospital in Canada, the cervix must be completely removed, and a pathology report confirming this must be provided to the Centre Métropolitain de chirurgie in Montreal.	Centre Métropolitain de Chirurgie, Montréal, Québec

Gender-Affirming Surgeries Covered By Medicare			
Procedure	**Description**	**Requirements**	**Location**
Metoidioplasty	Clitoral release plus urethral lengthening and incorporation into penis, increased girth of penis using skin from labia Creation of scrotum from labia, +/- vaginectomy and scrotal implants	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed.	Centre Métropolitain de Chirurgie, Montréal, Québec
Phalloplasty	3 phase surgery to create penis, scrotal sac, and testes using genital and tissue grafted from forearm, thigh or back	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed.	Centre Métropolitain de Chirurgie, Montréal, Québec
Construction of the urethra	Performed either simultaneously with a phalloplasty or during second intervention after phalloplasty. This procedure will allow urine to flow through the tip of the phallus.	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed.	Centre Métropolitain de Chirurgie, Montréal, Québec
Insertion of testicular implants	Insertion of 1 or 2 gel-filled testicular implants into the scrotum	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed.	Centre Métropolitain de Chirurgie, Montréal, Québec
Insertion of penile implant	Insertion of an implant into the phallus that was formed during the phalloplasty.	Two WPATH/CPATH Supporting Letters Hysterectomy with bilateral salpingo- oophorectomy previously performed.	Centre Métropolitain de Chirurgie, Montréal, Québec

Gender-Affirming Surgeries Not Covered By Medicare		
Procedure	**Description**	**Location**
Breast construction	Implantation of prosthesis to enhance size and shape of breasts	New Brunswick and outside of province
Facial surgery	May include alterations to the facial bones, cheeks, forehead, nose, hairline and areas surrounding the eyes, ears, or lips	New Brunswick and outside of province
Tracheal shave	Reduction and reshaping of Private Variable BC thyroid cartilage	New Brunswick and outside of province
Voice surgery	Alteration of vocal fold mass and/or tension to elevate pitch	Offered outside of province
Pectoral augmentation	Implants placed beneath pectoral muscles to increase size and projection of muscles	New Brunswick and outside of province
Liposuction or lipofilling	Removal or transfer of body fat to achieve desired body contour	New Brunswick and outside of province

For information about NIHB coverage for eligible Indigenous patients, see **NIHB Program**.

Part 6: Sexual Health and Reproduction

The following section outlines the information that pertains to gender-affirming care in relation to sexual and reproductive heath. This section covers fertility, family planning, sexual health screening and pelvic exams, and HIV PrEP considerations for Two-Spirt, trans, Indigiqueer, and gender-diverse (2STIGD) patients.

Fertility and Birth Control

2STIGD people have the same range of reproductive desires as cisgender people do. Therefore, it is important that PCPs are aware of the options available to 2STIGD people. In this section, you will find information on fertility preservation, contraception, and family planning.

Every person will have a unique journey in their decision-making and planning around reproduction. Some may choose to pursue gender-affirming care before reproductive planning, and others may decide to postpone accessing GAHT or surgery until they have a reproductive plan in place.

Estrogen-based and testosterone-based GAHT regimens have variable temporary and long-term impacts on fertility. Accordingly, there is a need to discuss both birth control and fertility preservation with patients prior to the initiation of GAHT. Choosing to move forward with starting hormones or having lower surgery does not change a patient's ability to become a parent, however it may limit some of the reproduction options available to them.

Though there are numerous ways that people may create families without the use of their own gametes, many people have a wish for genetically-related children. Patients who are planning to conceive in the near future may even wish to delay medical transition in order to minimize the need for harvesting, storage and/or advanced reproductive technologies

(ARTs), which can be costly and involve procedures that can intensify feelings of gender dysphoria.

Options for fertility preservation in 2STIGD people are similar to those undergoing gonado-toxic therapies for malignancy or elective preservation. If indicated, referral for fertility preservation should be initiated as soon as possible as this process may take several months. While the cryopreservation of sperm is much less costly than the harvesting and cryopreservation of ova, in both scenarios, budgeting in the short and the long term for up-front and ongoing storage costs may be required.

Unfortunately, N.B. does not cover the costs associated with fertility preservation. N.B. does offer a **Special Assistance Fund** for Infertility treatment as a one-time maximum grant to alleviate the financial burden of those dealing with infertility. Please note that **Conceptia** is the only fertility clinic in N.B. However, they have been noted to support cisnormative views on family planning and do not directly market for 2STIGD folks' fertility preservation. After engaging in community consultation, 2SQTP-NB/P2SQT-NB **does not** recommend Conceptia for 2STIGD folks' fertility preservation. Instead, it is suggested that PCPs refer to the next closest fertility clinic located in Halifax, Nova Scotia - **Atlantic Assisted Reproductive Therapies** (AART). AART is well-known to welcome people of all genders, sexual orientations and family structures. Their services are available for people hoping to start or expand their family, as well as those planning to undergo gender affirmation surgery who wish to preserve their options for future fertility.

It is important to note that many 2STIGD people have conceived successfully following the discontinuation of GAHT. Whether long-term GAHT causes unique risks to the reproductive capacity of those undergoing GAHT is unknown. Several healthy live births have been reported, but patients should be counselled regarding the lack of knowledge in this area.

To help subsidize the lack of medical knowledge and expertise in this area, it can be beneficial to connect patients to community groups with experience in the areas of reproduction. Although medical communities are still in the early stages of understanding the needs of 2STIGD people who wish to conceive, 2STIGD communities have long engaged in knowledge sharing. While there is a time and a place for medical knowledge, it

is important to note the value of community knowledge when it comes to 2STIGD people's ability to navigate, access, and engage with health care.

Making decisions about fertility

While it is important to make sure a 2STIGD patient has all the necessary information to make decisions regarding their fertility, it is just as important to make sure that, no matter what decision they make, they are supported and affirmed – including if it results in potential or definite infertility.

2STIGD people are able and allowed to make decisions that affect their current or future fertility for any reason, including comfort, affirmation, or immediate relief. This is also the case for young 2STIGD people, who are allowed to make decisions about gender affirmation even if this might affect their future fertility.

It is also important to ensure any information shared is clear. When talking about fertility preservation with patients before hormone initiation or bottom surgery referral it can be helpful to provide them with some information to take home with them. For some folks, whether or not they wish to undergo fertility preservation is a clear decision; whereas, for other folks they may need more time to sit with information on their options. Patients may need time to reflect on the information provided to them and a handout can offer them the time to do this and consider any questions that they may have.

Finally, it is important to communicate to patients that people are not any less valuable or valid if they are infertile, and that fertility is not required to be a parent, carer, or family member. Families take many forms, and while some come from pregnancy, they can also grow from fostering, adopting, or finding chosen families.

Fertility Preservation & Birth Control for Patients With Uteri

In most cases, testosterone-based therapy leads to reversible amenorrhea without depletion of ovarian follicles. However, there may be an adverse effect on the growth of follicles, particularly in the more mature stages of follicular development. Unfortunately, research in this area remains limited.

While many 2STIGD people have intentionally become pregnant after discontinuing testosterone to pursue pregnancy, patients may wish to consider postponing testosterone initiation if they would like to become pregnant in the future, since fertility may be permanently affected. Patients should also be counselled regarding options for fertility preservation prior to starting hormones. While ideally completed prior to starting hormones, fertility preservation can also be performed following (temporary or permanent) discontinuation of testosterone.

For 2STIGD people with uteri who are concerned about fertility loss after testosterone use, or for those planning to have hysterectomies (removal of the uterus) and oophorectomies (removal of the ovaries), there are currently two options for fertility preservation:

Oocyte (Egg) banking involves hormone-induced ovulation and the retrieval of the eggs using a needle, guided by ultrasound, inserted through the vaginal wall into the ovary. Many cryogenically frozen eggs do not survive because they are sensitive to the freezing and thawing process. Additionally, cryopreservation can also be done concurrently with gender-affirming gonadectomy.

Embryo banking is egg retrieval (as above) followed by immediate fertilization and banking of the embryo. It has a better success rate, but the sperm donor (whether known or anonymous) must be chosen at the time of the egg retrieval.

Despite reduced fertility during testosterone administration, it should not be considered an adequate method of contraception. Given the teratogenic potential of testosterone, patients on testosterone should be counselled on the risk of pregnancy, and those who

are sexually active with people with sperm should be offered contraceptive options, such as progesterone-only contraception or an intrauterine system/device (IUS/IUD). It may be easier to insert an IUS/IUD prior to initiating testosterone due to the subsequent atrophic changes of the vaginal and cervical tissues.

Once testosterone is initiated, the provider should check with the patient periodically regarding their sexual health needs and reiterate the necessary precautions if the patient becomes sexually active with people who produce sperm. If an accidental pregnancy does occur, counselling regarding all options, including abortion care, should be provided. If termination is chosen, it may be helpful for the provider to directly contact a local abortion clinic to ensure that the clinic is gender-affirming.

Fertility Preservation & Birth Control for Patients With Sperm

The administration of estrogen-based GAHT results in a reduction of testicular volume and has a suppressive effect on sperm motility and density in a cumulative, dose-dependent manner. Sperm motility and density can also be further impacted by the practice of tucking. Nonetheless, it is important to counsel patients about their fertility preservation options and the potential need for birth control if they are sexually active with partners who may become pregnant.

A 2STIGD person who has external gonads and plans to have them removed must bank sperm beforehand to retain the option of having genetically-related children. Whenever possible, patients should be counselled regarding options for sperm banking prior to starting hormones. For those already using hormones, a suspension of hormone treatment is recommended for a few months so that sperm production and quality can recover prior to banking. If interrupting hormone treatment is not an option, poor quality semen can still be frozen for later use, which may include assisted reproductive technologies. In cases where sufficient sperm cannot be produced through ejaculation, fertility clinics can provide surgical options for sperm extraction.

For 2STIGD people with sperm who are concerned about fertility loss after estrogen use, or for those planning to have an orchidectomy (removal of enteral gonads/testes) there are currently two options for fertility preservation:

Sperm cryopreservation (freezing) is a technique utilized to store sperm at very low temperatures for future use. Sperm cryopreservation following ejaculation is the simplest and most reliable form of preservation. STBBI screening (i.e., chlamydia, gonorrhea, HIV, syphilis and hepatitis serologies) is required prior to banking, and PCPs can expedite the process for patients by completing these tests prior to referral.

Testicular sperm extraction (TESE) involves percutaneous removal of sperm from the testes or epididymis under local anesthetic. This procedure may be considered when ejaculation is overly burdensome or difficult. Resulting sperm counts are often low and thus multiple samples and/or the use of in vitro fertilization (IVF) or intra-cytoplasmic sperm injection (ICSI) may be required.

Patients with sperm may also attempt conception or undergo fertility preservation following the suspension of GAHT for three to six months, since testicular function may recover to a variable degree. In a variety of scenarios, semen analysis can be helpful in assessing current fertility and informing options.

Fertility Preservation for Children and Adolescents

It is recommended that children and adolescents, and their guardians (if applicable), also be informed and counselled regarding options for fertility preservation prior to the initiation of pubertal suppression and GAHT. In children who have initiated natal puberty, fertility preservation options include sperm, oocyte, and embryo cryopreservation. Currently, it is not possible for children who have not undergone natal puberty (and who may have used gender-affirming hormones) to preserve gametes.

Prolonged pubertal suppression using gonadotropin releasing hormone (GnRH) analogs is usually reversible and should not impair resumption of puberty upon cessation, though most children who undergo pubertal suppression go on to begin GAHT without undergoing natal puberty. For further discussion, please see **GAHT for Youth**.

Approximate Costs of Fertility Preservation

Fertility preservation is not covered by N.B. Medicare, and the cost can be extremely high. It may be possible to claim some uncovered medical costs as a personal tax credit on your

income tax, and/or apply for the **Special Assistance Fund** for Infertility Treatment. The approximate costs associated with fertility preservation (verified in August, 2022) are as follows:

- Consultations with a clinic may cost $200 or more. This amount may be billable to Medicare if the patient has a referral letter from a physician or nurse practitioner.
- Semen analysis (for motility and viability) can run from $85-350, and initial freezing and storage of semen can cost $125-300 and with an additional $200 per year in annual storage fees. If sperm must be retrieved surgically, this may cost from $550-1500.
- Preserving eggs can cost $5000 for the initial procedure, and as much again in annual storage fees. If drugs are needed to initiate the release of eggs these drugs can cost an additional $4000.
- Preserving frozen embryos costs approximately $480-650 with $150-300 in annual storage fees. Transferring a frozen embryo to a uterus for gestation can run between $540-1100.

Sexual Health and Sex

Many 2STIGD people become involved in sexual relationships; however, many also do not. This section provides information specific to the sexual health of 2STIGD people, while respecting those who identify as asexual, demisexual, grey-sexual, or otherwise on the asexual spectrum.

Unfortunately, it is not always easy for 2STIGD people to find accurate and inclusive information about sexual health and sex. As PCPs, it is important to have up-to-date and inclusive information to help support and affirm patients' sexual health needs.

There are many changes that may come along with a social transition, including shifts in one's sexual orientation and comfort with a changing sense of self. With a medical transition, people may experience new sensations with hormonal changes and different opportunities because of access to surgeries. Ultimately, to understand the sexual health needs of 2STIGD people, it is important to ask each individual patient affirming questions that will allow you to provide the best possible advice and care. With this being said, it is also important to let patients know that you will not be asking things that are not necessary to their health care. Asking invasive questions or encouraging physical exams

without explaining why they are essential to a patient's care can contribute to a patient feeling uncomfortable, and unlikely to return for care. While it can be important to ask for intimate information, it is equally as important to ask only about what you need to know, and to give the reason why you are asking. Being clear and honest at the start of the conversation can assist in normalizing this process and these questions, and let your patient know that you're there to support their health.

The Parts and Practices Model

The parts and practices model focuses on the body parts a person has, and what they are doing with them, rather than making assumptions based on a patient's gender, sexuality, or the language they use. This model can be helpful if you are struggling to find the correct language for a person's identities and experience. Some examples may include, but are not limited to:

1. Do you have sex with people with a penis, people with a vagina, or both?
2. During sex, do any parts of your body enter a partner's body, such as their genitals, anus, or mouth?
3. During sex, do any parts of a partner's body enter your body, such as their genitals, anus, or mouth?
4. Do you or any of your partners use any barriers, such as condoms, gloves, dental dams, or PrEP?
5. Is there a chance of pregnancy for any of sex that you are having?

It often can be helpful to provide an explanation for why you may be asking invasive questions, for example, "The reason I am asking about any receptive sex you are having is so we can figure out what STI tests you might need today."

Using Affirming Language

The language used always matters, but when talking about body parts, sexual health, and sexual activity that can cause distress or disphoria for 2STIGD people, it is important that PCPs do so in an affirming manner. The table below offers guidance on some ways neutral language can be used to talk about bodies, sex, and health, while remaining clear and precise.

Try	Instead of
Assigned female at birth	Biological female
Assigned male at birth	Biological male
Upper body	Breast / Chest
Chestfeeding (for non-binary or transmasc people)	*Breastfeeding (keep breast feeding for transfemme parents, unless another term is preferred)
Erogenous or erectile tissue	Clitoris
Physical arousal / Hardening or stiffening of erectile tissue	Erection
Internal reproductive organs	Female reproductive organs
Receptive IC / Insertive IC (IC = Intercourse)	Genital sex
Opening of the genitals	Introitus / Opening of the vagina
Looks healthy	Looks normal
External condom / Internal condom	Male condom / Female condom
Hair loss	Male pattern balding
Parenthood	Motherhood / Fatherhood
Phenotypical development	Natural / Normal development
Cisgender	Not trans / Normal / Real
Internal gonads	Ovaries
Sexual health screening / Internal exam / Cervical screening	Pelvic exam / Female reproductive exam
Erogenous or erectile tissue / External genitals / Genitals	Penis
Monthly bleeding	Period / Menses
Pregnant person	Pregnant woman

Common	Regular/ Correct / Right
External gonads	Testes / Testicles
Internal genitals / Genitals	Vagina
Thinning of the internal genitalia tissue	Vaginal atrophy
Erogenous or erectile tissue	Vulva

Of course, it is always best to ask patients about the language they prefer for their body and sexual activity. If possible, it is best to know this prior to their first appointment with you (i.e., by asking questions on your registration form). If you do not have this option, it is also perfectly acceptable to ask: "Before we get started, I am going to take a brief sexual history - do you have any language you prefer to use for you body, genitals, sexuality or sexual/reproductive activity, so that I can help you feel as comfortable as possible?" If you are ever unsure about what a term means, ask your patient to clarify. 2STIGD people may use a range of different words to describe their body and sexual practics.

Sexual function

For some 2STIGD people, hormonal and/or surgical affirmation may alter their sexual desires and function. If this is the case, it is important to ask how your patient may want to treat this, if at all (e.g., "Do you have any questions about your current sex life, or is there anything you are concerned about that I can help you with?"). For example, for some patients on estrogen-based GAHT, the impact of estrogen on sexual function is welcomed, whereas for others, these changes are not wanted at all. A conversation that asks what changes they have experienced, and what changes they feel comfortable or uncomfortable with can open up a space to talk about how you may be able to assist them.

This may look like:

- Prescribing topical vaginal/front hole estrogen for insertive sex, and talking about the benefits of lubricant;
- Supporting a patient exploring sex for the first time after an affirmative genital surgery;
- Directing your patient to a qualified mental health professional (see **Part 7: Mental Health**) to discuss any difficult feelings they are having about changing sexuality;

- Working with a patient to alter their hormones or to prescribe medication to better stimulate genital or reproductive function;
- Reassuring all patients that changing sexual inclination and function over a person's lifetime is common, but that you can support them if they want to explore changing what this looks like.

Sexual Health Testing

2STIGD people can be tested for all the same bacterial and viral infections as cisgender people, and should be assessed for risk and testing needs based on their sexual activity. 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, Chlamydia, Gonorrhea, HIV, and Hepatitis A, B & C as indicated. Assess the 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.

Below is a list of recommended sexual health screening based on anatomy that is inclusive of gender-affirming surgeries and GAHT.

Site	Asymptomatic	Symptomatic	Notes
Internal genitals after total hysterectomy	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 "Two-Spirit,

			trans, or gender-diverse patient" to reduce likelihood of sample rejection.
		Microbiological analysis: - Urine dipstick and/or urinalysis prn - GC culture - Yeast **If on testosterone*:** - C&S superficial wound **If not on testosterone:** - 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.

It is important to ensure that labs have been 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.

Site	Asymptomatic	Symptomatic	Notes
Internal genitals with cervix	CT/GC NAT (urine 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 "Two-Spirit, trans, or gender-diverse patient" to

			reduce likelihood of sample rejection.
		Microbiological analysis: - Urine dipstick and/or urinalysis prn - GC culture - Yeast **If on testosterone*:** - C&S superficial wound **If not on testosterone:** - 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	

*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.

Site	Asymptomatic	Symptomatic	Notes
Lesions (genital and oral) *For lesions suspected of LGV or Syphilis, consult with an experienced clinician.		HSV PCR	
		LGV (Use CT/GC NAT swab)	
		Syphilis **Syphilis PCR buffer:** Submit swab in Syphilis PCR buffer **No Syphilis PCR buffer available:** Use CT/GC NAT swab (orange Gen-Probe Aptima)	

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 and/or with the surgeon who performed the	CT/GC NAT urine	STI Screen: - CT/GC NAT (urine) - Trich NAT	All swabs may be self or practitioner collected. **Requisition tips:** - If applicable, specify site as "Urethra" prn - If 'female' or 'X' gender marker, indicate "Two-Spirit, trans, or gender-diverse patient" to reduce likelihood of

surgery, as swabs may be contraindicated.			sample rejection
		Microbiological analysis: - GC culture - Yeast - C&S superficial wound - Urine dipstick and/or urinalysis prn	Use liquid Amies culture yellow-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 and/or with the surgeon who	CT/GC NAT urine Some patients may find internal exam / cervical screening affirming. If patient preference is for internal exam / cervical screening:	**STI Screen:** - CT/GC NAT (urine or vaginal) - Trich NAT	All swabs may be self or practitioner collected. **Requisition tips:** - If applicable, specify site as “Vaginoplasty” prn - If ‘male’ or ‘X’ gender marker,

performed the surgery.	CT/GC NAT vaginal (clinician-collected) Note: This test has not been validated for use in vaginoplasty		indicate "Two-Spirit, trans, or gender-diverse 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 yellow-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
Throat	CT/GC NAT	GC C&S CT/GC NAT HSV PCR	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

Tips for Sexual Health Screening

For 2STIGD people sexual health screening may induce significant body dysphoria, as well as physical and emotional discomfort. In order to make patients feel as comfortable as possible, clear communication, patience, and flexibility in screening methods is required. Below are some suggestions on how to minimize discomfort and distress.

Clinical Implications

Keep in mind that patients may:

- Have experienced transphobic violence and discrimination;
- Have experienced sexual encounter that was non-consensual;
- Find it hard to remove affirming clothing, compression garments, or prosthetics that, in doing so, will reveal a part of their body that may not align with their gender and/or that may have changed from GAHT;
- Have had traumatic experiences with the health care system; and
- Have experienced unnecessary and inappropriate physical exams.

Safety and Trustworthiness:

- Work to create a stronger therapeutic relationship before providing a sexual health exam;
- Recommend assessments and exams only when they are clinically indicated;
- Provide rationales:
    - Explain why a specific exam, screening, or procedure is recommended
    - Distinguish between cancer screening and STI screening
    - Discuss possible outcomes and related follow up
    - Communicate what is involved in each part of the assessment, exam, procedure, or treatment;
    - Take your time – consider booking two appointments (one for teaching and one for screening);

    - Ask about affirming or neutral terminology before, during, and after the exam;
    - Ask for consent prior to each portion of an assessment, exam, procedure, or treatment.

Choice, Collaboration, and Connection:

- Ask about their goals for sexual health and screening, understanding that patients may not be mentally prepared for some examinations during that visit;
- Provide choices, including non-invasive options for STI screening (for example, the patient may feel more comfortable showing a photo they have taken rather showing the PCP directly);
- Ask what they would like to happen if they feel stressed or need to cry during the exam. For example:
    - Pause and practice relaxation techniques
    - Stop the exam right away
    - Proceed with the exam after a quick check-in;
- Provide alternatives to the dorsal lithotomy position (e.g. frog-leg position or side-lying with a raised upper leg);
- Get creative and collaborate with the patient to determine what will make them most comfortable. For example, it may be helpful for some patients to wear a pair of boxer shorts with a hole cut out in the bottom.

Strengths-Based and Skills Building:

- Remind patients that they are in control of the visit and can stop at any point, no matter what;
- Ask how they would like to engage in the exam, such as by:
    - Taking a step-by-step walkthrough, perhaps following along with a mirror
    - Introducing the speculum themselves (providing adequate privacy and time)
    - Distracting themselves with their phone
    - Playing music and practicing deep breathing or other stress management techniques;
- Invite them to bring a support person for part or the entire visit.

For clients with significant anxiety, PTSD, or difficulties tolerating the speculum, consider:

- Prescribing an oral benzodiazepine to be taken 20-60 minutes prior to the exam;
- Reminding them to arrange transportation to and from the appointment;
- Prescribing topical estrogen to be used for two weeks prior to the exam to decrease symptoms of genital discomfort related to genital atrophy.

HIV Considerations for 2STIGD Patients

HIV stands for Human Immunodeficiency Virus, a virus that can weaken a person's immune system. HIV lowers your body's self-defense mechanism against illness and disease. There are two main different strains of HIV, HIV-1 and HIV-2. The most common form of the virus is HIV-1, which accounts for around 95% of all world infections. HIV-2 is much less common and is genetically distinct from HIV-1. HIV-2 is known to be less infectious and to progress more slowly, resulting in fewer deaths. Among the existing HIV-1 and HIV-2 categories, there are different subtypes of the virus which represent a variety of transmission speeds and infection progressions.

When untreated, HIV can lead to AIDS, Acquired Immuno-Deficiency Syndrome. AIDS progressively compromises your immune system, leaving your body more vulnerable to different infections and diseases. Given modern advances in HIV research, HIV-positive people who have access to treatment do not develop AIDS, and live healthy lives without being able to transmit the virus.

There are **only five** bodily fluids that can transmit HIV. Transmission can occur when one of these fluids enters the bloodstream of somebody else:

- Anal fluids
- Blood
- Breastmilk
- Semen (including pre-cum)
- Vaginal fluids

These fluids can transmit HIV through broken skin, the opening of external genitals, internal genital linings, rectum, or foreskin. The main ways HIV is passed are through sex and by sharing needles. It can also be passed from parent to child through birth or breast/chestfeeding.

Myths and Facts About HIV & AIDS

Myths

- HIV only impacts men who have sex with men.
- HIV can be passed by hugs, kisses, coughs, spit, & sharing food.
- If someone has HIV, they will have symptoms and know about it
- HIV and AIDS are no longer a problem, that is a thing from the past.

Facts

- HIV does not discriminate, it can impact anyone.
- Some people do not show any HIV symptoms, the only way to be sure about HIV status is to get tested.
- HIV infections continue despite treatment as prevention (undetectable = untransmittable) and other prevention strategies, like PrEP.
- While HIV today is a manageable condition, care is inequitably distributed - meaning it's not easy for everyone to access. Overcoming these barriers is key to ending transmission of HIV.

Today, there are different ways to prevent HIV, such as consistent and correct condom use, daily use of Pre-Exposure Prophylaxis (PrEP), use of Post-Exposure Prophylaxis (PEP),

and HIV treatment. For people who inject drugs or hormones, accessing new needles and ensuring safe disposal of used needles can help in lowering HIV risk.

PrEP

Although there is no cure for HIV, treatment ensures that people living with HIV can live healthy lives without the risk of transmitting the virus to their sexual partners. HIV treatment ensures one's viral load is suppressed (reduced to undetectable levels), which means somebody cannot transmit HIV to others. The earlier somebody starts treatment after being diagnosed, the better for one's health. People with an undetectable viral load are untransmissable (U=U), as treatment keeps the virus under control.

HIV Pre Exposure Prophylaxis (PrEP) is an important and underutilized area of HIV prevention. HIV PrEP has two main components: emtricitabine and tenofovir-disoproxil-fumarate. These components are also used as treatment by people who have HIV. Rather than a physical barrier such as condoms, PrEP is a chemical barrier. It prevents the HIV virus from replicating in the body, leading it to die out and not get a hold of a person's immune system. Essentially, PrEP works by preventing the HIV virus from reproducing. Although PrEP prevents HIV, it does not prevent other STIs, like syphilis, gonorrhea, chlamydia, etc.

It's important to understand PrEP is part of what's called 'combination prevention', which is the best method to prevent HIV and STIs. Combination prevention involves the use of multiple strategies that have each been proven to work:

- Pre-Exposure Prophylaxis (PrEP)
- Post-Exposure Prophylaxis (PEP)
- HIV Treatment
- Sexual health education
- Needle distribution programs and safe consumption sites
- Anti-poverty work, housing efforts
- Sex Work decriminalization and protections
- Condom use

For more information and training resources on PrEP, please see the CBRC's course on **Prescribing PrEP for HIV**.

Cost of PrEP

The **Prescription Drug Program HIV/AIDS Plan** provides prescription drug coverage for certain antiretroviral drugs used to treat HIV/AIDS to eligible residents of NB. Residents with an active Medicare card who have been diagnosed with HIV and have been registered in the plan by their PCP are eligible for coverage. If a patient has existing drug coverage with another drug plan, they must submit a letter from their existing drug plan confirming that the required drugs are not listed on the plan's formulary.

Beneficiaries of the HIV/AIDS Plan are eligible for certain antiretroviral drugs that are listed on the **NB Drug Plans Formulary** as benefits for the HIV/AIDS Plan.

The HIV/AIDS Plan has an annual registration fee of $50 and a copayment. The copayment is the portion of the prescription cost paid by the patient each time they have a prescription filled. The copayment is 20% of the prescription cost up to a maximum of $20. The copayment ceiling is $500 per family unit per plan year.

PrEP in the Context of Gender-Affirming Hormone Therapy

GAHT 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.

Estrogen-based hormones may reduce the efficacy of tenofovir, one of the ingredients of PrEP. Currently, it is unclear if this means PrEP is less effective but it does mean PrEP is slightly more complicated for people using estrogen-based hormones.

Nonetheless, it is important to discuss considerations specific to the impact of GAHT or surgery. For instance, different body parts respond differently to HIV PrEP. High adherence (daily dosing) is needed for high effectiveness in the genitals compared to the rectum, since Tenofovir takes longer to reach maximum levels in genital (vaginal) tissue compared with rectal tissue. For example:

- Time from PrEP initiation to effective prevention:
    - Anal sex: 7 days
    - Genital (vaginal) sex: up to 21 days
- Adherence for effective prevention based on type of sex:

- Anal sex: Studies have shown that taking HIV PrEP at least four days a week still provided adequate drug levels with effective prevention compared to those that took it two days or less a week. Regardless, the present recommendation is to take PrEP daily.
- Genital (vaginal) sex: Almost perfect adherence (daily use with very few missed doses) is required, suggesting on-demand PrEP is likely not effective for frontal sex, and use of PrEP in an on-demand fashion has not been evaluated in gender-diverse or heterosexual populations.

Genital atrophy (which may result from testosterone use) can put someone at higher risk of tissue trauma during receptive sex, resulting in increased risk for STI acquisition, including HIV. It is important to discuss using lube & treatment options for genital atrophy in an effort to reduce risks.

Patients who have had metoidioplasty or phalloplasty should be advised that there is no data on the effectiveness of PrEP drug concentrations in the urethral tissue.

Additionally, patients who are not part of a social subculture with regular discussion about routine STI screening and HIV PrEP may benefit from additional appointments for education and de-stigmatization.

Part 7: Mental Health

The following section outlines the information that pertains to gender-affirming care in relation to mental health. This section is written material only, and will outline the role of the mental health provider vs. the role of PCPs, how to make affirming mental health referrals, and how to support and affirm the mental health of Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) folks. See also the section **Substance Use Disorder (SUD)**.

Mental health support is something that people of all genders might need at some point in our lives. While mental health for 2STIGD people is very similar to that of cisgender people, there are a few important differences. In order to support and affirm your patients, understanding some of these differences will go a long way to establish a trusting relationship. Over the years, many terms have been used by medical professionals to describe the experiences of some 2STIGD people's experiences. These have included transsexualism (DSM-3), gender identity disorder (DSM-4), and **gender dysphoria**. As described in Section 4 the term *gender dysphoria* is the most recent diagnosis outlined in the DSM-5. The diagnosis of *gender dysphoria* was developed to more accurately reflect 2STIGD people's experiences and still enable access to necessary health care. However, it should be noted that while the diagnosis is often required to access care and coverage, it is not a term that all 2STIGD people identify with or accept.

Therefore, while the diagnosis is often a prerequisite to care, it is important to emphasize that no one's identity is a disorder. The historical, and sometimes contemporary, belief that gender diversity is a mental health condition is a myth that has been discredited multiple times over the last 30+ years. Although, 2STIGD people can shoulder a significant burden of poor mental health outcomes compared to cisgender people broadly, these outcomes may or may not be related to their gender. It is important to note that at times the bodily discomfort, depression, and anxiety that is associated with a diagnosis of **gender dysphoria** can be attributable to external experiences of stigma, discrimination, and a lack of access to adequate care, rather than simply being linked to body dissonance.

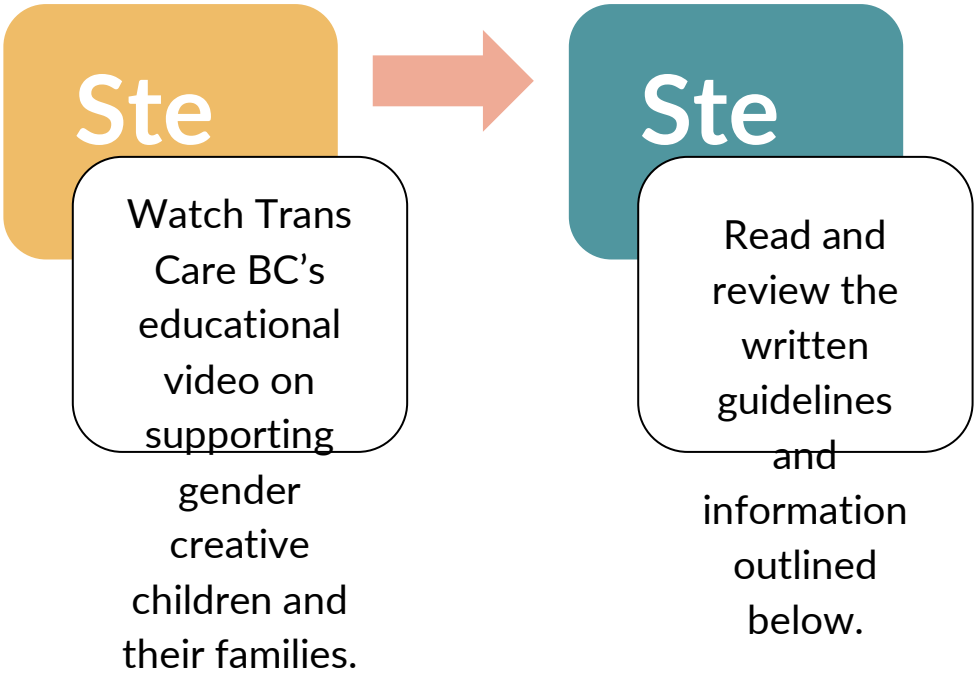
While 2STIGD people may require mental health support from PCPs (e.g., access to antidepressants or anxiety medication) or mental health specialists, it is important to frame this as similar to what any person may require during their lives, and not automatically associate 2STIGD people's mental health needs with gender diversity.

Referrals to Mental Health Care

Sometimes mental health services are not affirming of 2STIGD people and their experiences. This may look like not taking their experiences, identity, or language seriously, or causing harm through words or actions. It is important when referring to any service to ensure that your patient will be supported, including mental health services. It is important to be aware that the costs and/or wait times associated with mental health services make services inaccessible for patients. For a list of mental health providers who work with 2STIGD folks in NB, see **Mental Health Providers**.

Part 8: 2STIGD Youth

The following section outlines the information that pertains to gender-affirming care in relation to surgical options and interventions. This section is comprised of both visual and written material, and should be completed in the following order:



Link to e-learning lesson: learninghub.phsa.ca/Courses/26838/supporting-gender-creative-children-and-their-families

It should be noted that there are a number of limitations and knowledge gaps with the current WPATH SoC which directly impact Two-Spirit, trans, Indigiqueer, and gender-diverse (2STIGD) youth. These are discussed in the section Children and Youth.

Informed Consent for Youth

Though there is a more in-depth discussion of the Informed Consent Model in Part 3, there are extra considerations to keep in mind when working with youth. The Medical

Consent of Minors Act[108] states that at the age of sixteen, youth are able to consent to medical treatment just as if they had reached the age of majority. According to the act, those under the age of sixteen are also able to consent to treatment if, in the opinion of the legally qualified PCP, they are capable of understanding the consequences and nature of the medical treatment, and if the procedure is in the best interests of the youth, their continued health and well-being. Similarly, the mature minor doctrine states that those able to understand the consequences and nature of a proposed treatment are able to consent to treatment regardless of age, which has been used in court to justify a minor's right to consent.[109] It should be noted that, while in the past the written opinion of a second legally qualified medical practitioner was required, this was amended in 2000 and is no longer a requirement.[110]

Ideally, a supportive family member or guardian would be available to give consent on behalf of the patient. Unfortunately this is not always the case, and PCPs need to proceed with extra care with the awareness and understanding that in some cases, the patient may not have any adults in their life who support and respect their gender. In cases where the PCP will need to discern the patient's capacity to consent, the teach-back technique, or asking the youth to rephrase what they have been told, can be useful, as well as inviting them to ask questions.[111]

Privacy and confidentiality should also be carefully considered when working with youth, as in some cases they may not want their caregivers to be aware of their treatment. "In most situations, a capable young person has the right to determine who will be given access to their personal health information, including parents."[112] In these cases, it is essential to clearly communicate with the youth about how you plan to navigate this.

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[108] Medical Consent of Minors Act, SNB 1976, c M-6.1.

[109] New Brunswick Court of Appeal. Pole v. Region 2 Hospital Corporation, 385 APR 366.

[110] An Act to Amend the Medical Consent of Minors Act, SNB 2000, c 14.

[111] Can a child provide consent? CMPA. (2021, May). Retrieved September 2, 2022, from https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/can-a-child-provide-consent#:~:text=Consent%20to%20treatment%20in%20Qu%C3%A9bec&text=Although%20consent%20to%20elective%20care,guardian%20consent%20must%20be%20obtained.

[112] Mental health. CMHA Ontario. Retrieved September 2, 2022, from https://ontario.cmha.ca/documents/understanding-common-legal-issues-in-child-and-youth-mental-health/

Talking to Caregivers

Studies have shown that while there are high rates of depression/suicidal ideation in 2STIGD youth, this directly corellates with whether they feel accepted and supported. In one study in particular, "family support was the strongest predictor of depression, anxiety and resilience."[113] Many 2STIGD youth rely on friends and peers, however family support has the greatest impact. This can be increasingly relevant for Two-Spirit Indigiqueer, and Indigenous trans and gender-diverse youth as their families and communities are commonly very closely knit.

In cases where caregivers are struggling to accept their child coming out, seeking medical transition, or socially transitioning, it's important that the emotional burden of caregiver distress is not placed onto the youth. As a PCP, you can direct caregivers to resources (mental health services, support groups) that they can access to manage their reactions independently.

Medical Care for 2STIGD Children and Youth

Gender-affirming medical care is necessary for some 2STIGD people, including youth. Options for medical care differ depending on the age and stage of development. Youth in the early stages of puberty may benefit from a period of puberty suppression followed by initiation of hormone therapy at a later age, whereas those who present in the later stages of puberty may proceed directly to GAHT.

A readiness assessment needs to be done prior to initiating medical care and should include all elements described in **Part 4: GAHT (Gender-Affirming Hormone Therapy)**, as well as any necessary additional assessments (i.e., mental health) depending on the age and developmental stage of the youth and their social situation. In addition, PCPs must be prepared to work with families, educators, and others involved in the youth's life to ensure the youth has adequate social support. As with adults, a readiness assessment can be completed by a range of professionals, including pediatricians and endocrinologists. Some

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[113] Matsuno, E. (2022, June 23). How parents can support a child who comes out as trans – by conquering their own fears, following their child's lead and tolerating ambiguity. The Conversation. Retrieved September 2, 2022, from https://theconversation.com/how-parents-can-support-a-child-who-comes-out-as-trans-by-conquering-their-own-fears-following-their-childs-lead-and-tolerating-ambiguity-158275

clinical situations may warrant involvement of a specialist, either for consultation or for ongoing care. Things to consider are age and capacity of the youth, level of family support, youth's ability/capacity to include caregivers in treatment decisions, presence of unstable or complex physical or mental health conditions, availability of specialists, ability to pay for a private specialist (e.g. psychologist), and the potential harms of delaying treatment. As always, specialist consultation should be obtained whenever a clinical situation feels beyond your training, experience, or comfort level at the present time. The following sections provide an overview about medical options that are available for children and youth.

Prepubescent Children

While children are not able to access medical transition care before puberty, many children and families find it helpful to have access to this information so they can understand their options and plan for the future. Knowing that there are medical options available as a child approaches adolescence can help prevent or relieve anxiety about pubertal changes.

PCPs working with 2STIGD children should strive to understand the various aspects of a child's identity and experience: racial, ethnic, immigrant/refugee status, religious, geographic, and socio-economic, for example, and to be respectful and sensitive to cultural context in clinical interactions. Many factors may be relevant to culture and gender, including religious beliefs, gender-related expectations, and the degree to which gender diversity is accepted by a child's social supports.

Each child, family member, and family dynamic is unique, and can potentially encompass multiple cultures and belief patterns. PCPs should avoid stereotyping based on preconceived ideas which may be incorrect or biased (e.g., that a family who belongs to a religious organization that rejects gender diversity will be rejecting their child). Instead, it is essential to approach each family openly and understand each family member and family pattern as distinct.

As of 2017, all children and youth have the right to be free from discrimination because of sex, gender, sexual orientation, gender identity and gender expression. This right is

founded in Article 2 of the UN Convention on the Rights of the Child,[114] as well as in the Canadian Charter of Rights and Freedoms,[115] and provincial and territorial human rights legislation. This legislation includes the protection of children and youth from harmful home environments under the Family Services Act.[116] Although the legal age of consent to medical services in NB is 16, it is important that PCPs remain patient-centered when working with children. In the event that a caregiver refuses to support a child (including access to information, care, and community supports) and/or is actively withholding necessary mental and medical care to support a child's emotional and physical wellbeing, a PCP may be required to make a report to their local **Child Protection Unit**.

Puberty Suppression

Puberty blockers are medications that suppress the sex hormones that are produced by the body. These medications may be started soon after puberty begins. They put puberty on pause and can prevent changes such as voice lowering, body hair growth, breast growth and monthly bleeding. Effects will vary, depending on how far puberty has progressed before starting the blockers.

Youth in the early stages of puberty may benefit from a period of puberty suppression using leuprorelin (Lupron®) which is a GnRH analog. Leuprorelin safely blocks unwanted and distressing pubertal changes while allowing time for the youth to mature and for the youth and family to carefully consider decisions about further medical intervention.

Puberty blockers are often prescribed by an endocrinologist due to changing needs during adolescence. However, PCPs who are knowledgeable about gender-affirming care can work with an endocrinologist to provide this care and deliver routine monitoring.

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[114] Convention on the Rights of the Child. (1991). Ottawa, Ont: Multiculturalism and Citizenship Canada.
[115] Sharpe, R. J., & Roach, K. (2021). The Charter of Rights and Freedoms (Seventh edition.). Toronto, Ontario: Irwin Law.
[116] Family Services Act, SNB 1980, c F-2.2.

If a youth is under age 18, the criteria for getting a prescription for a puberty blocker according to WPATH are:

- A long-lasting and intense pattern of gender non-conformity or **gender dysphoria**.
- **Gender dysphoria** emerging or worsening with the onset of puberty.
- Any coexisting psychological, medical, or social problems are stable enough to start treatment.
- The adolescent having given informed consent. If 16 years or older, the consent of a guardian is preferred but not required under the NB Medical Consent of Minors Act,[117] though informed consent can be obtained from patients under the age of 16. See **Informed Consent for Youth**.

Please note that the criteria for prescribing puberty blockers to youth has changed (i.e., a diagnosis of gender dysphoria is not required) in WPATH SoC-8. However, this change is not yet reflected in the NB policies, forms, and procedures.

Effects of Puberty Blockers

For patients assigned male at birth, puberty blockers will stop or limit:

- growth of facial and body hair
- deepening of the voice
- broadening of the shoulders
- growth of the Adam's apple
- growth of the gonads and erectile tissue

For patients assigned female at birth, puberty blockers will stop or limit:

- breast tissue development
- broadening of the hips
- monthly bleeding

In both cases, puberty blockers will temporarily stop or limit:

- growth in height
- development of sex drive
- impulsive, rebellious, irritable or risk-taking behaviour (variable)
- accumulation of calcium in the bones

[117] Medical Consent of Minors Act, SNB 1976, c M-6.1.

- fertility

There are no known irreversible effects of puberty blockers[118], so if a patient were to stop taking them their body would continue through puberty, picking up where it left off. These medications have been safely used for decades. However, there are risks associated with a health care provider withholding puberty blockers[119]. Health care providers refusing to provide puberty blockers to youth can cause additional distress, and may lead to anxiety and depression. Withholding puberty blockers and hormone therapy is not a neutral option and can result in an increased risk of mental health issues, including suicidal ideation. Additionally, the financial costs associated with surgical transition later in life can be mitigated when patients do not experience the pubertal changes associated with their gender assigned at birth.

There are three main reasons that youth use puberty blockers:

- The onset of puberty and the idea or reality of developing secondary sex characteristics that do not fit with their gender identity can be very distressing. Puberty blockers can help alleviate this distress.
- If a child is still exploring their gender, puberty blockers allow additional time to explore without worrying about unwanted permanent physical changes.
- Preventing unwanted physical changes can eliminate the need for some surgeries and procedures later on, such as male chest contouring and electrolysis.

GAHT for Youth

Some youth who take puberty blockers early in adolescence go on to start hormone therapy. Youth who have not taken puberty blockers may also take hormones. GAHT allows people to develop secondary sex characteristics that are in line with their gender identity, such as breast growth, softer skin, facial hair, or deeper voice. While not all 2STIGD youth will need or want GAHT, it is important that youth who do require this care have access to it.

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[118] Trans Care BC. (2022). Puberty Blockers for Youth. Retrieved from: http://www.phsa.ca/transcarebc/child-youth/affirmation-transition/medical-affirmation-transition/puberty-blockers-for-youth

[119] ibid

Like puberty blockers, GAHT can be effective in alleviating a person's distress about their body and how they are perceived by others. Youth and their families or caregivers may work with an endocrinologist for GAHT and be monitored in partnership with their PCP. Youth, especially those who are older, may be able to access this care through a PCP depending on their case. PCPs can provide care planning, prescribing and monitoring of hormones if they have training in this area. Like adults, the same readiness assessment is required for youth. For more information, see **Part 4: GAHT (Gender-Affirming Hormone Therapy)**.

Surgery Options for Youth

In NB, gender-affirming surgery is insured under the Medicare Insurance Plan only when an individual is above the age of 18. For individuals under 18 who have the financial means, access to private gender-affirming surgery may be available and appropriate for youth ages 16 and above. More specifically, upper body surgeries may be appropriate; however, gonadectomy and genital surgeries are usually only done for youth 18 and older. Assessment by a PCP and the surgeon of choice is required (e.g., surgery readiness assessment).