Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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9 October 2020

Ms Moira Clunie

Email: fyi-request-13847-b1278cae@requests.fyi.org.nz;

Dear Ms Clunie

RE Official information request CDHB 10427

I refer to your email dated 20 September 2020 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. **Any communications or documents about the provision of services and funding for the LGBTQIA+ community and transgender and gender diverse populations, and any services that aim to address health inequities experienced by these communities.**

In 2019 a co-design team made up of three members of the transgender community, a member of Manawhenua Ki Waitaha, a GP with an interest in transgender health, and a Pegasus health manager developed services and pathways following international best practice [Telfer 2018] and national guidelines informed by Te Pae Māhutonga [Oliphant 2018].

A report of the process and outcomes of the co-design can be found at https://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/Co-design-gender-affirming-care-Jun-2019.pdf

This work was translated into practice as the following Community (CHP) and Hospital (HHP) HealthPathways and a request page (attached as the following appendices):

Appendix 1 - Gender-affirming Hormones (CHP)
Appendix 2 - Gender-affirming Surgery (CHP)
Appendix 3 - Sub-fertility (CHP)
Appendix 4 - Transgender Health in Adults (CHP & HHP)
Appendix 5 - Transgender Health in Children (CHP & HHP)
Appendix 6 - Transgender Health in Youth (CHP & HHP)

General practice can make requests for services aligned to the agreed access criteria as documented on HealthPathways, for Fertility, Mental Health, Endocrinology, Gender-affirming surgery, Primary Care, Speech Therapy, and Fertility Preservation.

Updated information for the public is available on HealthInfo https://www.healthinfo.org.nz/gender-identity.htm

A Canterbury Clinical Network Transgender Health Working Group has been established to continue this work by strengthening the partnership between trans community and health professionals and advise the Canterbury Health system on ways to improve equity of health outcomes for transgender and non-binary people. Please find attached as **Appendix 7** the Terms of Reference for this working group.

2. **Any communications or documents about cutting or reducing funding towards services for the LGBTQIA+ community and transgender and gender diverse populations, and any services that aim to address health inequities experienced by these communities.**

There are no communications or documents about cutting or reducing funding towards services for the LGBTQIA+ community and transgender and gender diverse populations as there have been no reductions or cuts in services.

3. **Any communications or documents about cutting or reducing funding to the Canterbury Clinical Network, or any services or programmes the CCN provides.**

There is no recent correspondence or documents received by CCN regarding contribution to the savings plan, but rather a verbal discussion signalling this requirement (this discussion also took place at ALT (Alliance Leadership Team). The total amount of savings through prioritisation and rationalisation across the CCN and related services for Financial Year 2021 is $286,428, broken down as follows:

- CCN operating budget $195,337
- CCN pass through (CCN work programme) $70,584
- CCN integrated services $20,327

There was correspondence received by the Canterbury Clinical Network dated 25 January 2019 regarding reducing expenditure across CCN. Please find attached as **Appendix 8.**

I trust this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

APPENDIX 1

Community HealthPathways Canterbury

Gender-affirming Hormones

This pathway is about gender-affirming hormone treatment and ongoing management. For puberty blockers, see Transgender Health in Children. See also:

- Transgender Health in Adults
- Transgender Health in Youth

Background

About gender-affirming hormones

About gender-affirming hormones

There are 3 types of hormone treatments which can be used in transgender health

- Puberty blockers using gonadotropin-releasing hormone (GnRH) agonists to suppress puberty and secondary sexual characteristics. This treatment is reversible. If discontinued, the young person will go though endogenous puberty a. er approximately six months – including retained ability to ovulate or produce sperm. These are not discussed in this pathway, see Transgender Health in Children.
- Gender-affirming hormone therapy or gender-affirming hormones – estrogen and testosterone. These are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteriscs of the appr opriate gender. These are considered irreversible.
- An-andr ogens, which block the effects of testosterone on the body – spironolactone or cyproterone.

Gender-affirming hormone therapy usually starts at 16 years of age, though there is recognion of consideraon in y ounger people in special circumstances.

There is no upper age limit to starng hormones.

Assessment

1. Assess medical, sexual health and mental health condions
2. Consider any precauons be fore hormonal treatment.

Precauons be fore hormonal treatment

- Current or recent smoker
- Heart failure, cerebrovascular disease, coronary artery disease, atrial fibrillaon (AF)

- Cardiovascular risk factors – Body mass index (BMI) > 30, hyperlipidaemia, hypertension
- History of hormone-sensiv e cancers, e.g. breast, prostate, uterine
- Possible drug interacons
- Sleep apnoea
- Some intersex disorders of sex development (DSD) condions
- Pregnancy

Estrogen only:

- History or family history of venous thromboembolism (VTE)
- Migraine

3. Check if the paen t meets the criteria for hormone treatment

Criteria for hormone treatment

- Persistent well documented gender dysphoria
- A single psychological assessment for gender dysphoria (see Transgender Health in Children, Transgender Health in Youth, or Transgender Health in Adults pathway for provision of this service in Canterbury)
- Capacity to make a fully informed decision and the consent for treatment (see Transgender Health in Youth to assess)
- Age of consent 16 years, except under special condions
- If significant medical or mental health concerns are present, they must be reasonably controlled.

4. Examinaon – measur e body mass index (BMI) and blood pressure (BP). A physical examinaon of secondary sexual development is rarely indicated.
5. Invesg aons:
   - Arrange baseline tests before feminising therapy

Baseline assessment before feminising therapy

Blood tests:

- Electrolytes and creanine if s tarng spir onolactone
- HbA1c and lipids if risk factors
- Prolacn, lut einizing hormone (LH), and pre-9am testosterone levels.

   - Arrange baseline tests before masculinising therapy

Baseline assessment before masculinising therapy

- Blood tests:
  - CBC, LFT, lipids.
  - HbA1c if risk factors.
  - Luteinizing hormone (LH), estradiol, and testosterone levels.
- Urine HCG if appropriate. Testosterone is contraindicated in pregnancy.

Management

1. Ensure informed consent.

Informed consent

It may take a number of consultaons t o start treatment. This is to ensure the paen ts understanding of the treatments and the potenal f or irreversible outcomes. Provide hormone therapy form for informaon and c onsent:

- Consent Form for Feminising Hormone Therapy
- Consent Form for Masculinising Hormone Therapy

2. Provide informaon and supports .
3. Discuss ferlity pr eservaon, as hormonal therapy may affect future ferlity .

Ferlity pr eservaon

- Discuss the paen t's desire for ferlity pr eservaon.
- Decisions are best made before starng puberty block ers, hormone therapy, or undergoing surgery to reproducv e organs.
- Sperm preservaon:
  - For paen ts on feminising therapy, tescular v olume is greatly reduced by long-term estrogen use, which impacts on the maturaon and molity of sperm.
  - If the paen t is in late puberty or post-puberty, consider sperm storage as mature sperm are likely to be present. For younger people, request ferlity assessmen t or advice regarding the viability of ferlity pr eservaon. Advice and pr eservaon is publicly funded.
  - Provide ferlity pr eservaon in formaon f or those starng es trogen.
- Ovarian ssue or eg g preservaon:
  - Paen ts on masculinising therapy who retain their ovaries and uteri may regain ferlity after stopping testosterone. The likelihood of successful pregnancy is related to the person's age.
  - Discuss ovarian ssue or eg g preservaon. These r equire invasive procedures that are not currently publicly funded unless the paen t is having a publicly funded

hysterectomy or oophorectomy.

- If the paen t has complex quesons r egarding sperm or egg viability, storage mes, and treatment opons in the futur e (e.g. tescular biop sy and storage), request ferlity specialised assessment (this is publicly funded).

4. Inia te hormone therapy or refer for inia on if outside of sc ope. Inia ng hormone ther apy usually occurs in secondary care (endocrinology) or, if the paen t is older than 20, is carried out by a general praconer with an in terest in transgender care.

- Inia ng f eminising hormone therapy

Inia ng f eminising hormone therapy

- Consider whether a puberty blocker should be used in addion t o gender-affirming hormone therapy – see Transgender Health in Children.
- Prescribe estrogen.

Estrogen opons

Transdermal estrogen has lower risk for venous thromboembolism (VTE) so should be considered, especially in paen ts older than 40 years, with raised BMI or with other risk factors for VTE.

- Estradiol valerate (Progynova) – starng dose 1 mg daily , usual maintenance 2 to 4 mg, maximum 6 mg
- Estradiol patch (Estradot) – starng dose 25 micr ogram patch twice weekly, usual maintainence 100 to 200 microgram patch twice weekly

- Prescribe anandr ogens unless the paen t has had an orchidectomy or genital reassignment surgery.

Anandr ogens

- Cyproterone – starng dose 25 t o 50 mg daily, usual maintenance 25 to 50 mg daily although smaller doses of 12.5 mg may be effecv e
- Spironolactone – starng dose 50 t o 100 mg daily, usual maintenance 100 to 200 mg daily

- Progesterone therapy is not recommended as it is not effecv e at improving breast development and is associated with breast cancer, depression, weight gain and cardiovascular disease (CVD).
- Discuss effects and reversibility of feminising hormones.

- Inia ng masculinising hormone ther apy

Inia ng masculinising hormone ther apy

- If the paen t is prepubertal or in early puberty, consider whether a puberty blocker should be used prior to or in addion t o gender-affirming hormone therapy, see Transgender Health in Children.
- Discuss:
  - whether testosterone is appropriate. Testosterone is:
    - contraindicated in pregnancy.
    - not recommended while breastfeeding as it inhibits lactaon.
  - the effects and reversibility of masculinising hormones.
- Prescribe testosterone.

  Prescribe Testosterone

  - Testosterone cypionate (Depo-Testosterone) 1 g/10 mL. Commence 50 mg (0.5 mL) every 2 weeks. For adolescents gradually increase every 6 months by 50 mg per dose. Consider a more rapid increase in adults, increasing every 3 months by 50 mg per dose unl the pa en t is taking 200 mg every 2 weeks.
  - Other less favoured opons include:
    - Testosterone esters (Sustanon) 250 mg/mL. The usual final dose is 250 mg every 3 weeks but this can be built up over 3 to 6 injecons.
    - Testosterone patches (Androderm) 2.5 or 5 mg. The usual dose is 5 mg applied at night, but the paen t can start with 2.5 mg patch and increase to 5 mg dose after 3 to 6 months.
  - When on a full maintenance dose, transion t o Reandron 1000 mg intramuscularly every 10 to 14 weeks (second dose at 6 weeks to achieve steady state).
  - See guidelines for more informaon.
- Discuss contracepon.

  Contracepon

  Testosterone is not adequate contracepon e ven if periods have ceased. For contracepon and mens trual suppression if paen t is not on puberty blocker see Transgender Health in Adults.

5. Provide monitoring and ongoing prescribing of hormones:
   - Feminising hormones

     Monitoring and ongoing prescribing of feminising hormones

- Hormone prescribing consultaons

Hormone prescribing consultaons

- Blood pressure (BP) and body mass index (BMI)
- Effects of hormones on physical and emoonal health
- Review of doses and desire for change
- Side effects of hormones
- Mental health and body image assessment
- Social Supports
- Lifestyle, e.g. smoking exercise and nutrion

- Frequent measurement of estradiol levels is not advocated.

Frequent measurement of estradiol levels is not advocated

- Frequent measurement of estradiol levels may produce variable results.
- The main reason to measure estrogen levels is to avoid over-replacement.
- Oral estrogen preparaons ar e not accurately measured by the plasma estradiol assay and measurement is of lile v alue for paen ts using these preparaons.

- Annual and biennial invesg aons

Annual and biennial invesg aons

- Once a year:
  - Electrolytes – monitor more frequently if on spironolactone
  - LFT
  - HbA1c – if risk factors suggest it is indicated
  - Lipids – if risk factors suggest it is indicated
  - Oestradiol - avoid supraphysiological levels (target less than 500 pmol/L)
  - Testosterone (aim for level less than 2 nmol/L)
- Once every 2 years – Prolacn

- If major risk factors for osteoporosis, consider a bone density scan.
- Consider the adverse effects of feminising hormone therapy.

Adverse effects of feminising hormone therapy

- Venous thromboembolism (VTE) – reduced risk on transdermal estrogen.
- Liver dysfuncon, g allstones
- Insulin resistance
- Cardiovascular disease (CVD) – lipids and hypertension
- Alteraons in mood and libido
- Small risk of osteoporosis, breast cancer and hyperprolacnaemia

- Masculinising hormones

Monitoring and ongoing prescribing of masculinising hormones

- Hormone prescribing consultaons

Hormone prescribing consultaons

- Blood pressure (BP) and body mass index (BMI)
- Effects of hormones on physical and emoonal health
- Review contracepon requirements
- Review of doses and desire for change
- Side effects of hormones
- Mental health and body image assessment
- Social Supports
- Lifestyle, e.g. smoking exercise and nutrion

- Annual invesg aons

Annual invesg aons

- CBC – every 3 months for first year, then 1 to 2 mes a y ear
- LFT
- Lipids
- Testosterone – aim for normal male range. Measurement of hormone levels:
  - For Depo-Testosterone or Sustanon, measure at mid-point of injecons t o ensure levels are supraphysiological, and measure pre-injecon t o ensure correct dosing frequency.
  - For Reandron, measure immediately prior to injecon.
- HbA1c if risk factors

- If major risk factors for osteoporosis, consider bone density.
- Consider the adverse effects of masculinising hormone therapy.

Adverse effects of masculinising hormone therapy

- Polycythaemia – consider reducing testosterone dose if haematocrit is above 0.54
- Cardiovascular disease (CVD) risk
- Mood changes
- Acne
- Obstrucv e sleep apnea (OSA)
- Small risk of liver dysfuncon, insulin r esistance, and endometrial hyperplasia

Informaon

For health professionals

Further informaon

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Associaon of T ransgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Associaon f or Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identy

Printable Resources

- Canterbury DHB - Ferlity Pr eservaon In formaon f or Those Starng Es trogen

Paen t Support Informaon

- Ministry of Health – Transgender New Zealanders

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.

KEY LINKS

- Consent Form for Feminising Hormone Therapy
- Consent Form for Masculinising Hormone Therapy

Topic ID: 610143

APPENDIX 2

Community HealthPathways Canterbury

Gender-affirming Surgery

I

This page is about preparaon f or gender-affirming surgeries for paen ts aged 18 and over. See also:

- Transgender Health in Children for pre-puberty or early puberty
- Transgender Health in Adults
- Transgender Health in Youth

Background

About gender-affirming surgery

About gender-affirming surgery

While some transgender people are comfortable with the expression of their gender identy without some form of surgery, for others surgery is essenal t o alleviate their body dysphoria and/or live fully and authenc ally in their gender.[1]

Canterbury DHB offers a range of feminising and masculinising surgeries. Genital reconstrucon surgery is not provided in Canterbury, but paen ts from Canterbury DHB can be referred to the Gender Affirming (Genital) Surgery Service via a DHB specialist or any general praconer . There is currently 1 surgeon (based in Auckland) providing genital reconstrucon sur gery in New Zealand, so the waing lis t is long.

Assessment

1. Measure body mass index (BMI).
2. Check if the paen t meets the current inclusion criteria for surgery:
   - Chest reconstrucon sur gery – either mastectomy or augmentaon.

Chest reconstrucon sur gery

- Persistent, well documented gender dysphoria, having completed 1 psychological/psychiatric assessment. The readiness for hormones assessment done prior to hormones is acceptable. A paen t that has not had an assessment would require a formal assessment.
- Capacity to make fully informed decision and to consent for treatment.
- Aged 18 years or over

- 2 or more years of hormone therapy (not a pre-requisite for mastectomy/masculinising chest surgery.
- Significant reducon in quality of lif e. See Ministry of Health Impact on Life Scale.

> **Ministry of Health Impact on Life Scale**
>
> - English
> - Cook Island
> - Hindi
> - Māori
> - Simplified Chinese
> - Tradional Chinese
>
> The quesonnair e should be filled out by the general praconer or nur se with the paen t.

- If significant medical or mental health concerns are present, they must be reasonably controlled
- Non-smoker and nicone- free for longer than 3 months

> **Nicone- free**
>
> All products that contain nicone ha ve an adverse affect on wound healing. Paen ts must be smoke-free, and no longer using nicone r eplacement therapy and vaping products which contain nicone, f or at least 3 months before surgery.

- BMI less than 32

- Orchidectomy, hysterectomy, oopherectomy

> **Orchidectomy, hysterectomy, oopherectomy**
>
> - Persistent, well documented gender dysphoria, having completed 1 psychological/psychiatric assessment. The readiness for hormones assessment done prior to hormones is acceptable. A paen t that has not had an assessment would require a formal assessment.
> - Capacity to make fully informed decision and to consent for treatment.
> - Aged 18 years or over.
> - 2 or more years of hormone therapy.
> - Significant reducon in quality of lif e. See Ministry of Health Impact on Life Scale.

- If significant medical concerns are present, they must be reasonably controlled. If significant mental health concerns are present they must be well controlled.
- Non-smoker and nicone- free for longer than 3 months.

3. Check for exclusion criteria. These paen ts cannot be referred.

Exclusion criteria

- Current smoker. The paen t must be a non-smoker and nicone- free for at least 3 months.
- Poorly controlled medical health, e.g. chronic obstrucv e pulmonary disease (COPD), ischaemic heart disease (IHD), hypertension.
- Poorly controlled mental health.
- BMI greater than 32 (chest surgery only).

4. Invesg aons – Arr ange HbA1c, CBC, LFT, renal and any other blood tests relevant to a paen t's medical condion.

Management

1. Prepare the paen t for possible referral outcomes.

Possible referral outcomes

Ensure the paen t understands that the referral for surgery does not guarantee surgery, and that they can be declined at any step in the process.

The paen t may be invited for medical photography for chest surgery. This is to ensure adequate surgical planning. Acknowledge that the dysphoric paen t may find this difficult. Advise the paen t that they will be able to bring a support person if desired.

2. If referring for oophorectomy, hysterectomy or orchidectomy, discuss ferlity and se xual health:
   - Sperm storage is available on the public service in Canterbury DHB. Tescular biop sy, and egg retrieval and storage are not publicly funded. Consider private opons.
   - Ferlity tr eatment is a complex area which would usually require the paen t stopping gender-affirming hormone therapy for a me. Consider seeking advice fr om a general praconer colleague with an interest in transgender care, or wri en ferlity advice .
3. If a smoker, offer smoking cessaon .
4. If mental health issues which are not well controlled, offer mental health community support or specialist mental health referrals (as is appropriate to severity of symptoms) to achieve moderately to well-controlled mental health.
5. Ensure that any medical condions ar e well controlled, e.g. hypertension, diabetes.

6. For concerns about surgery or further discussion about the paen t's care or health navigaon, c onsider referral for discussion, or contacng a general praconer c olleague with an interest in transgender care.

7. Request a mental health assessment for gender dysphoria, if not already done, before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if paen t wishes to start hormones, puberty blockers or is considering surgical procedure.
>
> - If paen t is younger than 18 years, or aged 18 years and sll a t school, request non-acute child and adolescent mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervenon assessmen t".
> - If paen t is 18 years or older (unless aged 18 and sll a t school), request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervenon assessment".
> - For genital reconstrucon sur gery, naonal and in ternaonal guidelines s tate that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waing lis t is long, only 1 assessment is required. If a paen t has already had a psychological assessment before starng hormone tr eatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstrucon w aing lis t.
>
> As the waing lis t for public mental health assessments is long, paen ts may wish to consider private opons.

8. For chest surgery, orchidectomy, hysterectomy, oophorectomy, request a surgical assessment from the appropriate department.

9. For genital reconstrucon sur gery, refer to the the Gender-affirming (Genital) Surgery Service.

> **Gender-affirming (Genital) Surgery Service**
>
> This surgical service is provided in Auckland for all genital reconstrucon sur gery in New Zealand, but is funded by the local DHB. Previously referrals were only accepted from a Canterbury DHB specialist, but now any general praconer c an refer by filling in the Ministry of Heath referral form.
>
> For more info, see Ministry of Health – Updates from the Gender Affirming (Genital) Surgery Service
>
> Email referral forms to gender.surgery@health.govt.nz and include a copy to Ralph.Lasalle@cdhb.health.nz

Request

- For concerns about surgery or further discussion about the paen t's care or health navigaon, c onsider referral for discussion, or contacng a general praconer c olleague with an interest in transgender care.
- Consider seeking advice on ferlity tr eatment from a general praconer c olleague with an interest in transgender care, or wri en ferlity advice .
- For chest surgery, orchidectomy, hysterectomy, oophorectomy, request a surgical assessment from the appropriate department.
- For genital reconstrucon sur gery, refer to the the Gender-affirming (Genital) Surgery Service.
- Request a mental health assessment for readiness for surgery only if no previous assessment has been done. Only 1 assessment is required regardless of whether it is for hormones or for surgery.

Informaon

For health professionals

Further informaon

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Associaon of T ransgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Associaon f or Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identy

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.

Topic ID: 609837

APPENDIX 3

Community HealthPathways Canterbury

Sub-fertility

Background

About sub-fertility

About sub-ferlity

- 1 in 5 couples in New Zealand experience fertility problems.
- 80% of couples wanting to conceive will do so within a year.
- Age is the most important determinant of a woman's fertility. There is also some decline in male fertility from 40 years of age and a reduction in sperm quality with age.
- Smoking has a direct negative effect on fertility. In women, it halves the chance of conception each month. Smokers are not eligible for public fertility funding.
- Alcohol (> 8 standard drinks per week for women and ≥ 20 for men) is associated with reduced fertility.
- High caffeine intake may reduce fertility.

Assessment

1. Ask the couple about this history.

   History

   - Time trying to conceive
   - Previous pregnancies for either
   - Smoking and alcohol intake
   - Frequency and timing of intercourse

2. For women, check:
   - menstrual and gynaecological history.
   - previous investigations or treatments.
3. For men, check for significant history.

   Male significant history

- Erectile dysfunction
- Testicular, e.g. infection, trauma, tumour, surgery
- Congenital anomalies
- Genetic problem, e.g. cystic fibrosis, Klinefelter syndrome

4. Examination:
   - female – BMI, pelvic examinaon,` STI screen.

Sexually transmi ed infecon (S TI) screen

- If patient is asymptomatic, perform a clinician-collected or a self-collected vulvovaginal nucleic acid amplification test (NAAT) chlamydia swab. Do not screen for chlamydia using serological tests.[1] In Canterbury, both labs perform gonorrhoea tests on all chlamydia requests.

Nucleic acid amplificaon (NAA T) test

- Molecular test for the detection of organism-specific DNA.
- Relatively high sensitivity and specificity, but both false positives and false negatives do occur.
- The diagnostic test pla. orms have not been fully validated for extragenital and non-urine specimens, but NAATs are more sensiv e than culture and are recommended in these situaons.
- Local laboratory NAAT tesng of urine and s wabs checks for chlamydia and gonorrhoea.

Vulvovaginal nucleic acid amplificaon t est (NAAT) swab

Clinical collecon

- Canterbury SCL:
  - Use the pink shank swab.
  - Rub the swab around the external urethral area 2 to 3 mes.
  - Slide it about 5 cm into the vagina and rotate it around the vaginal walls for 5 to 10 seconds.
  - Insert the co on bud end of the swab into the orange-label tube, snap the sha off a t the black line, and replace the container top gh tly.
- Canterbury Health Laboratories – Use the orange-topped collecon tube f or all chlamydia swab tesng.
- See swab guides.

Swab guides

Canterbury SCL:

- Bacterial and Viral Swab Guide
- Sexually Transmi ed Infecon (S TI) or Genital Swab Guide

Canterbury Health Laboratories – Swab Idenfic aon Guide

Paen t instrucons – See Instrucons f or using Self-collected Pink Shank Swabs

Calculate BMI

Body mass index = kg/m^2 (weight divided by height squared)

Use the Ministry of Health's healthy weight calculator.

- Less than 18.5 = underweight
- Between 18.5 and 24.9 = healthy weight
- Between 25 and 29.9 = slightly unhealthy weight (overweight)
- Over 30 = very unhealthy weight (obese)

- male – assess genitals if any significant history.

5. The threshold for considering invesg aons is lo wer than the threshold for publicly funded specialist assessment. Consider invesg aons for both male and female partners if trying to conceive for either:

Invesg aons

The referral threshold for publicly funded specialist assessment of sub-ferlity is much higher than the threshold for considering invesg aons.

These invesg aons ar e required for all sub-ferlity r eferrals:

Male partner

Semen analysis:

- Use the Request for Semen Analysis form and give paen ts instrucons f or seminal fluid collecon. The ins trucons on the f orm must be followed.
  - Ashburton Seminal Fluid Collecon Ins trucons
  - Christchurch Seminal Fluid Collecon Ins trucons
- Both the male and female's NHI number must be included on the form to idenf y the partners.

- The sample needs to be taken to Canterbury SCL. There is no charge to the paen t for using this lab.
- If the first sample is abnormal, organise to repeat the sample in 4 to 6 weeks.

Normal ranges for ferlity analy sis

Volume	> 1.4 mL
pH	> 7.1 at 1 hour
Sperm Count	> 14 million/mL
Molity: Pr ogressive	> 32%
Molity: Pr ogressive + Non-progressive	> 39%
Morphology	> 3% normal forms

Female partner

- Day 3 FSH and oestrogen (estradiol E2) – It is essenal t o do this on day 2 to 4 of the cycle. Order ovulaon disor der blood tests at the same me, if an o vulaon disor der is suspected.

Tests for suspected ovulaon disor der

- Prolacn
- FSH, Free androgen index, free testosterone, SHBG (day 2 to 4)
- Thyroid funcon t ests
- See also – PCOS

- Day 21 progesterone. For women with a prolonged cycle, do a day 21 progesterone, then advise the paen t and write on the lab form that this needs to be repeated every 7 days unl mens truaon e. g., day 21, 28, 35. Progesterone levels > 20 nmol/L indicate ovulaon is likely.
- For paen ts who are amenorrhoeic or oligomenorrhoeic, appropriate ming c an be achieved by doing a progestogen challenge test following a negav e pregnancy test.

Progestogen challenge

Prescribe NZF norethisterone 10 mg twice a day for 5 days.

Menstruaon should s tart 48 to 72 hours later, blood tests can then be med and taken.

- Antenatal bloods (and HIV) – these include rubella.

  Rubella

  If the paen t is not immune, offer vaccinaon. Advise t o avoid pregnancy for one month after vaccinaon.

- Cervical smear and STI screen.

- > 6 months and the female partner is aged ≥ 35 years, or
- > 12 months if the female partner is aged < 35 years

and/or

- predisposing factors that may affect ferlity , e.g. oligomenorrhoea, undescended testes, signs or symptoms consistent with endometriosis.

Management

1. Discuss lifestyle advice for men and women.

   Lifestyle advice

   - Advise about smoking cessaon .
   - Discuss healthy body mass index (BMI)
     - if either partner is overweight, starng acv e steps to reduce weight will increase their ferlity and chance of qualif ying for funding of ferlity ser vices.
     - encourage physical acvity . Consider Green Prescripon .
     - underweight women may benefit from weight gain.
   - Discuss alcohol and advise women that there is no known safe limit of alcohol in pregnancy.
   - Discuss ferlity a wareness and frequency of intercourse (aim for three mes a w eek). Consider:
     - paen t informaon on ferlity fitness.
     - referral to Natural Ferlity Ne w Zealand
   - There is some evidence that a male vitamin supplement can support sperm health.[2]

2. If repeat semen analysis is abnormal, provide advice. Request sub-ferlity advice or assessment and consider arranging karyotype prior to assessment if there is azoospermia, or significant oligospermia (< 5 million/mL).

   Repeat semen analysis is abnormal

- Discuss lifestyle factors e.g., smoking, alcohol, and medicaons tha t may impact sperm health.
- Advise wearing loose fing under wear and to avoid saunas or hot tubs.
- Consider prescribing menevit which contains ano xidants that may improve sperm health. Sperm producon cy cles take 74 to 78 days, so ideally paen t takes for 3 months.

3. Offer vaccinaon f or rubella if non-immune. Avoid pregnancy for 1 month after this.
4. Connue or s tart folic acid .

Folic acid

- Start folic acid at least 4 weeks before concepon and c onnue up t o 14 weeks.
- 0.8 mg once daily for most women.
- 5 mg once daily if paen t has diabetes, BMI > 30,[3] coeliac disease (or other risk of malabsorpon), sickle-cell anaemia, thalassaemia, is on an -epilep c medic aon, or if either partner has personal or family history of spina bifida or a previous pregnancy affected by a neural tube defect.
- For informaon and other medic aons and c ondions see: Minis try of Health – Folate/folic acid

5. If anovulaon is r elated to PCOS, consider management as outlined in the PCOS pathway first. Guidelines recommend that clomiphene is not inia ted without cycle monitoring in view of the risk of mulple pr egnancy. See also Dietary informaon f or Women with PCOS.
6. Consider publicly funded assessment if eligible for publicly funded health services and criteria are met, and if:

Criteria

- BMI 18 to 32
- Non-smoker or ex-smoker > 3 months
- Aged < 40 years
- < 2 children aged ≤ 12 living in the home.

- > 2 years sub-ferlity , or anovulaon (other than premature ovarian failure), or

Anovulaon crit eria

- > 2 years sub-ferlity and blood t ests indicav e of anovulaon in one cy cle
- < 2 years sub-ferlity and blood t ests indicav e of anovulaon in tw o cycles, and the paen t has been trying to conceive for:
  - > 6 months if aged ≥ 35 years, or

- > 12 months if aged < 35 years.

- sub-ferlity c ondions and > 1 year of sub-ferlity .

Sub-ferlity c ondions

- Azoospermia or oligospermia (< 5% normal forms)
- Bilateral salpingectomy
- Oophrectomy
- Premature ovarian failure

Where one of the couple has had a sterilisaon, the duraon of f erlity dela y starts from the date the couple first see a doctor about having a child, not from the date of surgery.

Sterilisaon

A history of surgical sterilisaon of either partner r educes the Clinical Priority Assessment Criteria (CPAC) score for publicly funded treatment. See Resources below.

7. If not eligible for publicly funded health services, consider private ferlity specialised assessmen t.

Request

- If > 2 years sub-ferlity , or anovulaon (other than premature ovarian failure), request publicly funded ferlity specialised assessmen t from Christchurch Women's Hospital.
- If sub-ferlity c ondions and > 1 year of sub-ferlity , request publicly funded ferlity specialised assessment from Ferlity Associa tes.
- If not eligible for publicly funded health services, or criteria are not met, request private ferlity specialised assessment.
- If unsure of the significance of the invesg aons, e. g. two abnormal semen analysis, seek ferlity specialised advice.

Informaon

For health professionals

- BMJ Learning – The Royal New Zealand College of General Praconer s Modules [requires registraon] – In ferlity in primar y care
- Canterbury SCL – STI Genital Swab Guide

- Ferlity Associa tes:
  - Public Funding Eligibility
  - Informaon f or GPs
- Naonal Ins tut e for Health and Care Excellence (NICE) – Ferlity Pr oblems: Assessment and Treatment

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "ferlity".
- HealthInfo – Ferlity pr oblems

Printable Resources

- Ferlity Associa tes – Public Funding
- SCL – Instrucons f or Seminal Fluid Collecon

Paen t Support Informaon

- Ferlity Ne w Zealand

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.

Topic ID: 16204

APPENDIX 4

Community HealthPathways Canterbury

Transgender Health in Adults

See also – Transgender Health in Youth

Background

About transgender health

About transgender health

For some people, their sex assigned at birth is different to their gender identity.

Gender identity is the personal sense of self as a gendered individual.

Respecting a gender diverse person means respecting their gender identity and not referring to them based on their sex assigned at birth.

Transgender, trans, and gender diverse are umbrella terms used to describe individuals who identify their gender as different to the legal sex that was assigned to them at birth. This includes people who are transitioning from one sex to another (i.e. male to female, female to male) but also includes people who identify as non-binary, that is, within, outside of, across or between the spectrum of the male and female binary.

Withholding gender-affirming care is not a neutral opon as this maȁy cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. Ask the patient about their pronoun, name, tle, and` gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identy descrip on

Ask:

- "What would you like to record as your gender identity?"

The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relaonship and aàvoiding poor mental health outcomes.[1]

Pronoun

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

2. History – ask about:
   - ⌄ gender-specific history ⌃.

Gender-specific history

- Duraon of aàwareness of gender identity issues.
- How they would describe their gender to others.
- Care received to date.
- Who they have disclosed to and their main support (family or other).
- How comfortable or distressed they are with currently living in the gender they are expressing.

   - medical, drug and alcohol, and sexual health history.
   - ⌄ mental health and suicidal ideation and intent ⌃.

Mental health and suicidal ideaon and in tent

Gender diverse people are at higher risk of anxiety, self harm, and depression, and have high rates of suicide and suicide a empts. They are at risk of abuse, bullying, and drug and alcohol abuse. The best mental health outcomes are achieved with support and early intervention.

- medications – prescribed and non-prescribed.

> **Medicaons**
>
> - Ask about:
> - complementary therapies.
> - self-medicating with hormones.
> - previous or current use of puberty blockers.
> - The patient may already be buying and taking unregulated hormonal therapy products, often via the internet.
> - Discuss risks if the patient is self-medicating.
> - If the patient is already on hormonal therapy and has experienced improvement in their gender dysphoria do not suddenly stop hormones as this may have unpredictable psychological consequences.

3. Depending on the patient's goals, consider recording height, weight, body mass index, and blood pressure, and sexual health checks. Specific examination and investigations are not needed unless the patient is being referred for surgery or hormone treatment.

Management

Timely and appropriate management reduces the risk of self-harm and suicidal intent, and leads to be er health outcomes.

1. Do not withhold gender-affirming treatment as this may cause or exacerbate any gender dysphoria or mental health problems.
2. Discuss patient's individual goals and needs which may include:
   - social transition.

> **Social transion**
>
> Social transition involves changing or experimenting with gender presentation, including:
>
> - personal appearance, e.g. haircuts, clothing, genital tucking, breast binding.
> - asking other people to use a different name, gender pronoun or both.

   - hormone treatments.

> **Hormone treatments**
>
> Gender-affirming hormones are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteristics of the appropriate gender. These are considered irreversible.

> Gender-affirming hormones usually start at 16 years of age, though there is recognition of consideration in younger people in special circumstances.
>
> There is no upper age limit to starting hormones.
>
> See Gender-affirming Hormones.

- surgical treatments.
- other supports, e.g. psychological, family, legal, education, work.

Do not assume that all transgender people want to conform to binary gender norms. Each person's gender expression (how they present to the world) is unique.

3. Provide information and supports. Include information on non-medical body interventions, e.g. safe binding and tucking.
4. If any identified mental health condition, seek appropriate mental health support. Treat mental health diagnoses as for any condition (dependant on severity) but seek trans-friendly services.

   Access to hormones and surgery requires mental health concerns (excluding gender dysphoria) to be well controlled.

5. Ensure appropriate cancer screening according to national guidelines.

> **Cancer screening**
>
> - Gender diverse people who have not undergone the surgical removal of breasts, cervix, uterus, ovaries, prostate, or testicles remain at risk of cancer in these organs.
> - Manage this carefully, as many gender diverse people find cancer screening physically and emoonally challenging. Ask the paàtient what terms they would prefer are used for body parts.
> - Cervical screening:
>   - Screening should be carried out unless the patient has had surgical removal of the cervix.
>   - Frequency of screening is as per national cervical screening recommendations.
>   - Consider use of internal estrogen for a few weeks before smear to make this more comfortable.
> - Breast screening is recommended for all transgender people with breast tissue. Frequency of screening is as per national breast screening recommendations.
> - Prostate screening:
>   - There is minimal research around risks and indications for screening for transgender women. The prostate remains a. er orchidectomy and genital reassignment surgery. Estrogen is likely to be somewhat protecv e. Discuss with each individual.
>   - Ensure transgender women treated with estrogen undergo individualised screening for prostate cancer according to their personal risk. PSA should be considered pre-treatment and paen ts advised that once on hormone therapy PSA levels become a poor screening test for prostate cancer.

6. Ensure appropriate support for ⌄ older adults ⌃.

> **Older adults**
>
> - These paen ts are likely to have experienced discriminaon, non-accep tance, and significant barriers to healthcare during their life.
> - If cogniv e impairment and chronic disease are concerns, consider a muldisciplinar y approach including primary care, endocrinology, geriatric medicine, and other speciality input.
> - If the paen t is receiving support within the aged-care system, or is a resident in an aged care facility, offer to act as an advocate to ensure a safe and inclusive environment.
> - There is no upper age limit for the use of hormones.

7. For paen ts who wish to consider hormone treatments or gender-affirming surgery:
   - discuss lifestyle changes to address cardiovascular risk associated with hormonal treatments, e.g. smoking cessaon , weight loss, regular exercise, and ceasing drug or alcohol dependence.
   - request a ⌄ mental health assessment ⌃ for gender dysphoria before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if paen t wishes to start hormones or is considering surgical procedure.
>
> - Unless the paen t has already had a readiness assessment, request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervenon assessmen t".
> - For genital reconstrucon sur gery, naonal and in ternaonal guidelines s tate that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waing lis t is long, only 1 assessment is required. If a paen t has already had a psychological assessment before starng hormone tr eatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstrucon w aing lis t.
>
> As the waing lis t for public mental health assessments is long, paen ts may wish to consider private opons.

   - discuss ⌄ contracepon ⌃.

> **Contracepon**
>
> - NZF Medroxyprogesterone acetate (Depo provera) 150 mg intramuscularly every 12 weeks.
> - NZF Medroxyprogesterone (Provera) orally 10 mg three mes a da y or 20 mg every night.

- Norethisterone (Primolut N) orally 5 mg to 10 mg three mes a da y – It is parally metabolised to ethylestradiol and at high doses is equivalent to the level of estrogen in the combined oral contracepv e.
- Levonorgestrel implant (Jadelle).
- Combined oral contracepv e taken connuously – Some people ma y be uncomfortable being prescribed estrogen.
- Levonorgestrel intrauterine device (Mirena) – Inseron ma y be very difficult with a masculinised cervix and uterus.

- offer medicaon t o suppress menstruaon.

Medicaons t o suppress menstruaon

- Norethisterone (Primolut N) 5 mg, 2 to 3 mes a da y
- Medroxyprogesterone (Provera) 2.5 mg to 5 mg once a day
- Combined oral contracepv e pill – acv e pills taken connuously . Some paen ts may not be comfortable with being prescribed estrogens.
- Medroxyprogesterone acetate (Depo Provera) 150 mg intramuscularly every 12 weeks
- Levonorgestrel intrauterine device (Mirena)

- provide access and informaon about hormone therapy.
- provide access and informaon about gender-affirming surgery.

8. Discuss voice training. If paen t has been on hormonal therapy for 12 months or more request adult speech language therapy assessment.
9. If concerns about the paen t's care or health navigaon, c onsider referral to a general praconer colleague with an interest in transgender care.

Request

- If concerns about the paen t's care or health navigaon, c onsider referral to a general praconer colleague with an interest in transgender care.
- Before an endocrine or surgery assessment, request a mental health assessment for gender dysphoria.
- If any idenfied men tal health condion which is poorly c ontrolled, seek mental health support. The type of support depends on the severity of the condion.
- If the paen t has been on hormone treatment for 12 months or more, request adult speech language therapy assessment.

Informaon

For health professionals

Further informaon

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Associaon of T ransgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Associaon f or Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identy

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.

Topic ID: 400110

APPENDIX 5

Community HealthPathways Canterbury

Transgender Health in Children

This page is for prepubertal and early-puberty patients where it may be appropriate to suspend puberty with puberty blockers.

Background

About transgender health in children

About transgender health in children

It is common for prepubertal children to express gender fluid and gender non-binary behaviour. This is not abnormal and does not necessarily signify gender dysphoria.

Many children who experience gender dysphoria in childhood do not go on to experience dysphoria in adolescence or adulthood.

There are some children that display persistent and fixed dysphoria from a young age and it is likely these children will need early intervention to support a healthy puberty.

No medical intervention is required pre-puberty. In early adolescence it may be appropriate to suspend puberty with puberty blockers. This is a reversible intervention to delay the development of secondary sexual characteristics.

Supporting all children requires a gender-affirming approach with educaon, naàvigation and mental health support. Withholding gender-affirming care is not a neutral opon as this maày cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. History – using age-appropriate questions, ask about:
   - gender diversity or gender dysphoria.

Gender diversity or gender dysphoria

Ask the child about:

- how they would describe their gender.
- duraon of their aàwareness (must be longer than 6 months to fulfil DSM-5 criteria) and any associated distress or dysphoria.
- level of impairment – social, school, sport, family, etc.
- dislike of their sexual anatomy.

- whether they have a desire to do the activities of another sex or whether they wish to be the other sex (DSM-5 criteria states that a strong desire to be of another gender or an insistence they are another gender is essential to the diagnosis).
- whether they have a play preference for non-assigned birth gender roles and friends.
- whether they have a preference for non-assigned birth gender clothing and strong avoidance of birth gender clothing.

- family/whanau support and relationships.

Family/whanau support and relaonship s

Often there are differing opinions within the family about gender diversity and whether to support a child's wishes.

- mental health.

Mental health

Gender diverse children are at higher risk of developing anxiety, self harm, drug and alcohol dependance and depression. They have high rates of suicide and suicide a empts. They are at risk of abuse and bullying.

Explain to parents that supporting their child's gender preferences greatly reduces these outcomes.

- traits of autism spectrum disorder (ASD), if appropriate.

Ausm spectrum disor der (ASD)

The prevalence of people with ASD and gender dysphoria is higher than the general population. It is important to refer for diagnosis of ASD before a mental health referral or referral for puberty blockers.

- sexual health and risk of STIs, if appropriate.

2. Ask the patient about their pronoun, name, tle, and gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identy descrip on

Ask:

- "What would you like to record as your gender identity?"

  The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relaonship and aàvoiding poor mental health outcomes.[1]

Pronoun

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

3. Examination – record height, weight, body mass index (BMI). No examination of pubertal stage is required.

No blood tests are needed before referral.

Management

Practice point

Priorise men tal health

Transgender patients often have significant mental health symptoms and management of this should take priority over medical intervention.

Patients should be referred promptly to access early interventions during pre-puberty and early puberty as timeliness is particularly important for long-term physical and mental health outcomes.

1. Use affirming language and call the patient by their preferred name and pronoun – this is essential to developing a respectful relaonship and aàvoiding poor mental health outcomes.[1] Continue to support the child's gender identity over me as it maày change.

2. Discuss the patient's individual goals and needs, which may include:

- social transition.

> **Social transion**
>
> Research shows that children supported by parents, their community, and school have good mental health outcomes. Most families want to know there is not something else going on and will ask for mental health assessment.

- puberty.

> **Puberty**
>
> If appropriate, ensure the child understands the concepts of puberty and that referral for endocrinology discussion will occur when they are aged 8 years or older.

- puberty blockers.

> **Puberty blockers**
>
> - Puberty blockers, also called gonadotropin-releasing hormone (GnRH) agonists:
> - suppress puberty and halt development of secondary sexual characteristics.
> - have a positive impact on future well-being.
> - are considered fully reversible and give a child or young person time prior to hormones to make a decision. If discontinued, the young person will go though endogenous puberty (including retained ability to ovulate or produce sperm) a. er 6 months.
> - are usually started in secondary care.
> - Goserelin (Zoladex) subcutaneous implants have sole subsidy status but leuprorelin (Lucrin) intramuscularly can be fully funded for children who cannot tolerate goserelin.
> - Adverse effects if used in early puberty include reduced bone mineral density, increased height (if used for a significant period), potenal r educon in scr otal and penile ssue.
> - Provide consent forms for informaon purposes:
> - Consent Form for Blocking Female Hormones
> - Consent Form for Blocking Male Hormones

- future availability of hormone treatment, and gender-affirming surgery and genital reassignment surgery, if appropriate.

3. Provide informaon and supports for both the child and family, and consider:

- sociocultural factors.

- requesng psychological support for the family to work through this process.

> **Psychological support**
>
> For general psychological support, request youth mental health counselling and therapy or child and parenng c ommunity support.
>
> Consider referral to a mental health clinician with a special interest in transgender health. A package of care for therapy may be available.

- pracc al assistance to facilitate social transion .

> **Facilitang social tr ansion**
>
> Explain to families that the best mental and physical health outcomes for children are obtained by supporng social tr ansion and lis tening to their child's wishes.
>
> - No harm is done if the child changes their mind. See Rainbow Health Ontario – If You Are Concerned About Your Child's Gender Behaviours.
> - Social transion ma y include:
>   - wearing different clothes.
>   - changing their name or pronoun.
>   - changing hairstyles.
> - Social transion ma y vary in different environments, e.g. school or home.
> - See HealthInfo – Social Transion .

- connecon t o other families through peer support.
- screening for negav e experiences such as episodes of bullying and discriminaon.
- advocang on the pa en t's behalf to ensure gender-affirming support is provided in their school environment. Communicate with the school about your management, after consent has been gained. Schools have a special role in supporng g ender-diverse children. See Leading Lights – Gender Identy and Gender Div ersity.

4. If ASD is suspected, request non-acute paediatric medicine assessment for a developmental assessment.

> **ASD is suspected**
>
> It is important to make a diagnosis of ASD before requesng a men tal health assessment or a referral for puberty blockers. Children with established ASD are managed the same as other children, but consultaon with their de velopmental team is recommended if they are sll under care.
>
> See Developmental Concerns in Schoolchildren.

5. Priorise men tal health concerns over hormone readiness assessment:
   - If significant mental health symptoms are causing significant distress and funconal impairmen t, request child and parenng c ommunity support or non-acute child and adolescent mental health assessment.
   - If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.

> **Gender dysphoria**
>
> Gender dysphoria describes the distress experienced by a person due to incongruence between their gender identy and their se x assigned at birth. Not all gender diverse children experience distress. The Child, Adolescent and Family Specialist Mental Health Service (CAF) will see a child with moderate to severe gender dysphoria at any age if there is significant funconal impairmen t and distress, e.g. not a□ending school, not maintaining peer relaonship s, etc.

6. If the paen t is considering puberty blockers to suppress the development of secondary sex characteriscs and mee ts the criteria, request non-acute child and adolescent mental health assessment or assessment with a private mental health clinician with a special interest in transgender health for a gender dysphoria hormone readiness assessment before a child health endocrine assessment.

> **Criteria for gender dysphoria assessment for puberty blockers**
>
> - Other mental health condions ar e moderately or well controlled (if not refer to appropriate community or DHB service)
> - Between age 8 and 15 years and considering puberty blockers.

7. If hormonal treatment of puberty suppression is part of the paen t's plan and they are aged 8 years or older, request non-acute paediatric medicine assessment:
   - Ensure the mental health gender dysphoria hormone readiness assessment is complete.
   - Advise the paen t that the endocrinologist will need to examine them to determine their puberty stage.

Ongoing management of puberty blockers

1. Prescribe puberty blockers as needed. These will be inia ted in secondary care and primary care may be responsible for ongoing prescribing.

> **Prescribe puberty blockers**
>
> - Leuprorelin (Lucrin) 11.25 mg intramuscularly every 12 weeks.
>
>   See Medsafe - New Zealand Data Sheet for special precauons f or disposal and other handling.

- Goserelin (Zoladex) 10.8 mg subcutaneous implant inseron in to lower abdomen every 12 weeks.

  See Zoladex – Dosing and Administraon for a video on how to administer Zoladex.

If evidence of insufficient pubertal suppression, e.g. luteinizing hormone greater than 2 IU/L, pubertal progression, or connued menses, the in terval between puberty blockers can be shortened to 10 weeks or the dose increased.

For ongoing administraon of puberty , families have the choice of self-administering, a□ending Children's day ward or vising a g eneral praconer .

2. If necessary, discuss ferlity pr eservaon with the paen t (this will have been discussed in paediatric endocrinology but should be revisited as the child ages).

Ferlity pr eservaon

- Puberty blockers are reversible and should not affect ferlity . However, children starng in early puberty who connue on t o hormone therapy will not develop mature gametes.
- Sperm storage may be possible in children who start puberty blockers later in puberty.
- Discuss ovarian ssue or eg g preservaon – ho wever, this requires invasive procedures that are not currently publicly funded. Decisions around ferlity c an be revisited again at any me during tr eatment.

3. Monitor paen t regularly.

Monitor paen t regularly

- Measure BMI every 3 to 6 months. Risk of increased height if blockers started in puberty.
- Encourage healthy eang and e xercise to reduce risk of future lowered bone density.
- Address mental health issues including bullying and offer support.

Paen ts will connue t o be monitored in paediatric endocrinology unl 16 y ears of age.

4. If concerns about the paen t's care or health navigaon, c onsider referral to a general praconer colleague with an interest in transgender care.

Request

- If concerns about the paen t's care or health navigaon, c onsider referral to a general praconer colleague with an interest in transgender care.
- If ASD is suspected, request non-acute paediatric medicine assessment for a developmental assessment.
- Request non-acute child and adolescent mental health assessment if:

- moderate to severe mental health concerns at any age that indicate a mental health diagnosis which may include gender dysphoria or any other mental health diagnoses.
- the child has a well-controlled mental health condion or g ood mental health, is 8 years or older, and is wishing to proceed to endocrine discussion. Request a gender dysphoria hormone readiness assessment.

- If child is 8 years of age or older and the gender dysphoria hormone readiness assessment is complete, request non-acute paediatric medicine assessment for consideraon of puberty block ers. Include the mental health assessment with the referral.
- For general psychological support, request youth mental health counselling and therapy or child and parenng c ommunity support.
- Consider referral to a mental health clinician with a special interest in transgender health.

Informaon

For health professionals

Further informaon

- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Associaon f or Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "transgender".
- HealthInfo – Gender Identy in Childr en and Youth

Printable Resources

- Rainbow Health Ontario – If You Are Concerned About Your Child's Gender Behaviours

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

> *Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.*

KEY LINKS

Leading Lights - Gender Identity and Gender Diversity

Topic ID: 462501

APPENDIX 6

Community HealthPathways Canterbury

Transgender Health in Youth

This pathway is for post-pubertal young people requiring gender affirming healthcare.

Background

About transgender health

About transgender health

For some people, their sex assigned at birth is different to their gender identity.

Gender identity is the personal sense of self as a gendered individual.

Respecting a gender diverse person means respecting their gender identity and not referring to them based on their sex assigned at birth.

Transgender, trans, and gender diverse are umbrella terms used to describe individuals who identify their gender as different to the legal sex that was assigned to them at birth. This includes people who are transitioning from one sex to another (i.e. male to female, female to male) but also includes people who identify as non-binary, that is, within, outside of, across or between the spectrum of the male and female binary.

Withholding gender-affirming care is not a neutral opon as this maȁy cause or exacerbate any gender dysphoria or mental health problems.

Assessment

1. Discuss confidentiality and capacity to consent to medical treatment.

Capacity to consent to medical treatment

Some transgender young people may not have the support of their parents or guardians, but this should not preclude them from receiving support and care.

The legal age of consent is 16 years old. The law assumes that those aged 16 years or older are competent to make their own decisions about their medical treatment.[1]

Patients aged younger than 16 years old can consent to their own medical treatment in the context of sexual health and contraceptive advice, and abortion.[2] [3]

A minor may be legally competent to consent if he or she has sufficient understanding and intelligence to understand fully what is proposed. Consider the patient's:

- age.
- level of independence.
- level of schooling.
- level of thinking:
- concrete or abstract thinking.
- ability to deal with more than one thought or idea at a time.
- ability to express their own wishes.

The nature of the decision is complex, which will require a more advanced thinking level. Make sure the young person fully understands:

- treatment options.
- what the treatment is for and why it is necessary.
- what the treatment involves.
- likely effects, risks, gravity, and seriousness.
- consequences of not treating.

Confidenality

Defining the limits of confidentiality is very important when caring for young people.

Discuss confidenality aȧt the beginning of the consultaon, i.e. "Whaȧt you tell me stays here within the clinic. If you tell me something that makes me worried about your safety or someone else's safety, then I may need to talk to someone else. I would not do this without discussing it with you first."

2. Ask the patient about their preferred pronoun, name, tle, and gender identity description and enter these details into the clinical records.

Enter these details into the clinical records

Changing gender on patient records or NHI does not require any legal documentation or proof. A patient can request or be offered a change. A patient's NHI remains with them for life and a change in gender will be registered under the NHI.

Gender identy descrip on

Ask:

- "What would you like to record as your gender identity?"

  The patient may identify with more than one category, or may change categories over time.

- "What legal sex were you assigned at birth (e.g. male, female, intersex, unspecified, indeterminate)?"

Evidence shows that using affirming language, calling the patient by their preferred name and pronoun is essential to developing a respectful relaonship and aàvoiding poor mental health outcomes.[4]

Pronoun

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

3. Take a psychosocial assessment using Heeadssssᵗ, to identify broader concerns, risks, and resiliencies in the patient's life.
4. History – ask about:
   - ⌄ gender-specific history ⌃.

Gender-specific history

- Duraon of aàwareness of gender identity issues.
- How they would describe their gender to others.
- Care received to date.
- Who they have disclosed to and their main support (family or other).
- How comfortable or distressed they are with currently living in the gender they are expressing.

   - medical, drug and alcohol, and sexual health history.
   - ⌄ mental health and suicidal ideation and intent ⌃.

Mental health and suicidal ideaon and in tent

Gender diverse people are at higher risk of anxiety, self harm, and depression, and have high rates of suicide and suicide a empts. They are at risk of abuse, bullying, and drug and alcohol abuse. The best mental health outcomes are achieved with support and early intervention.

- family support, including functioning and dynamics.

> **Family support**
>
> Transgender and gender diverse children have be er mental health outcomes when they are supported and affirmed by their family.[5]

- social, vocational and educaonal situaàtion.
- medications – prescribed and non-prescribed.

> **Medicaons**
>
> - Ask about:
> - complementary therapies.
> - self-medicating with hormones.
> - previous or current use of puberty blockers.
> - The patient may already be buying and taking unregulated hormonal therapy products, often via the internet.
> - Discuss risks if the patient is self-medicating.
> - If the patient is already on hormonal therapy and has experienced improvement in their gender dysphoria do not suddenly stop hormones as this may have unpredictable psychological consequences.

5. Examination:
   - Record height, weight, body mass index (BMI).
   - Check blood pressure.

   No further examination is required.

Management

> Practice point
>
> **Priorise men tal health**
>
> Transgender patients often have significant mental health symptoms and management of this should take priority over medical intervention.

Timely and appropriate management reduces the risk of self-harm and suicidal intent, and leads to be er health outcomes.

1. Discuss patient's individual goals and needs which may include:

- social transition.

> **Social transion**
>
> Social transition involves changing or experimenting with gender presentation, including:
>
> - personal appearance, e.g. haircuts, clothing, genital tucking, breast binding.
> - asking other people to use a different name, gender pronoun or both.

- hormone treatments.

> **Hormone treatments**
>
> There are 2 types of hormone treatments:
>
> - Puberty blockers using gonadotropin-releasing hormone (GnRH) agonists to suppress puberty and secondary sexual characteristics. This is reversible. If disconnued, thea young person will go though endogenous puberty a. er approximately 6 months including retained ability to ovulate or produce sperm.
> - Gender-affirming hormones. These are used to feminise or masculinise a person's appearance by inducing onset of secondary sexual characteriscs of the appr opriate gender. These are considered irreversible.
>
> Gender-affirming hormones usually start at 16 years of age, though there is recognion of consideraon in y ounger people in special circumstances.
>
> There is no upper age limit to starng hormones.
>
> See Gender-affirming Hormones.

- surgical treatments.
- other supports, e.g. psychological, family, legal, educaon, w ork.

Do not assume that all transgender people want to conform to binary gender norms. Each person's gender expression (how they present to the world) is unique.

2. Provide informaon and supports :
   - Include informaon on non-medic al body intervenons, e. g. safe binding and tucking.
   - Advocate on the paen t's behalf to ensure gender-affirming support is provided in their school or work environment. See Gender Identy R esources for Schools and Sport Organisaons .
   - Connect to other families through peer support networks.
3. Priorise men tal health concerns over hormone readiness assessment:
   - If significant mental health symptoms are causing significant distress and funconal impairmen t, depending on severity, request youth mental health and counselling and therapy, youth community support, non-acute child and adolescent mental health assessment or refer to a private health

clinician with a special interest in transgender health. A package of care for therapy may be available.

- If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment or refer to a private health clinician with a special interest in transgender health. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.

> **Gender dysphoria**
>
> Gender dysphoria describes the distress experienced by a person due to incongruence between their gender identy and their se x assigned at birth. Not all gender diverse children experience distress. The Child, Adolescent and Family Specialist Mental Health Service (CAF) will see a child with moderate to severe gender dysphoria at any age if there is significant funconal impairmen t and distress, e.g. not a□ending school, not maintaining peer relaonship s, etc.

4. For paen ts who wish to consider hormone treatments or gender-affirming surgery:
   - discuss lifestyle changes to address cardiovascular risk associated with hormonal treatments, e.g. smoking cessaon , weight loss, regular exercise, and ceasing drug or alcohol dependence.
   - request a mental health assessment for gender dysphoria before an endocrine or surgery assessment.

> **Mental health assessment**
>
> One mental health assessment is required if paen t wishes to start hormones, puberty blockers or is considering surgical procedure.
>
> - If paen t is younger than 18 years, or aged 18 years and sll a t school, request non-acute child and adolescent mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervenon assessmen t".
> - If paen t is 18 years or older (unless aged 18 and sll a t school), request non-acute adult mental health assessment or refer to a private mental health clinician with a special interest in transgender health, and ask for "readiness for hormone or surgical intervenon assessmen t".
> - For genital reconstrucon sur gery, naonal and in ternaonal guidelines s tate that 2 psychological assessments are required for genital reassignment surgery. However, currently, as the waing lis t is long, only 1 assessment is required. If a paen t has already had a psychological assessment before starng hormone tr eatment or other gender-affirming surgeries, this assessment is sufficient for them to be added to the gender reconstrucon w aing lis t.
>
> As the waing lis t for public mental health assessments is long, paen ts may wish to consider private opons.

   - once the gender dysphoria hormone readiness assessment is complete request an endocrine assessment:
     - If younger than 16 years, request non-acute paediatric medicine assessment.

- If aged 16 years or older, request non-acute endocrinology assessment.

- discuss contracepon.

> **Contracepon**
>
> - Medroxyprogesterone acetate (Depo provera) 150 mg intramuscularly every 12 weeks.
> - Medroxyprogesterone (Provera) orally 10 mg three mes a da y or 20 mg every night.
> - Norethisterone (Primolut N) orally 5 mg to 10 mg three mes a da y – It is parally metabolised to ethylestradiol and at high doses is equivalent to the level of estrogen in the combined oral contracepv e.
> - Levonorgestrel implant (Jadelle).
> - Combined oral contracepv e taken connuously – Some people ma y be uncomfortable being prescribed estrogen.
> - Levonorgestrel intrauterine device (Mirena) – Inseron ma y be very difficult with a masculinised cervix and uterus.

- offer medicaon t o suppress menstruaon.

> **Medicaons t o suppress menstruaon**
>
> - Norethisterone (Primolut N) 5 mg, 2 to 3 mes a da y
> - Medroxyprogesterone (Provera) 2.5 mg to 5 mg once a day
> - Combined oral contracepv e pill – acv e pills taken connuously . Some paen ts may not be comfortable with being prescribed estrogens.
> - Medroxyprogesterone acetate (Depo Provera) 150 mg intramuscularly every 12 weeks
> - Levonorgestrel intrauterine device (Mirena)
> - Puberty blockers – specialist only

- provide access and informaon about hormone therapy.
- provide access and informaon about gender-affirming surgery.

5. Discuss voice training. If paen t has been on hormonal therapy for 12 months or more request adult speech language therapy assessment.
6. For ongoing management of puberty blockers, follow the Transgender Health in Children pathway.
7. If concerns about the paen t's care or health navigaon, c onsider a referral to a general praconer colleague with an interest in transgender care.

Request

- If concerns about the paen t's care or health navigaon, c onsider a referral to a general praconer colleague with an interest in transgender care.
- If significant mental health symptoms are causing significant distress and funconal impairmen t, request youth mental health and counselling and therapy, youth community support, non-acute child and adolescent mental health assessment or refer to a private health clinician with a special interest in transgender health. A package of care for therapy may be available.
- If significant gender dysphoria (with or without other mental health diagnoses) request non-acute child and adolescent mental health assessment. Specify that request is for assessment and treatment of gender dysphoria, not readiness for endocrinology assessment.
- Before an endocrine or surgery assessment, request a mental health assessment for gender dysphoria.
- Request an endocrine assessment once the gender dysphoria hormone readiness assessment is complete:
  - If younger than 16 years, request non-acute paediatric medicine assessment.
  - If aged 16 years or older, request non-acute endocrinology assessment.
- If the paen t wants voice training and has been on hormonal therapy for 12 months or more, request adult speech language therapy assessment.

Informaon

For health professionals

Further informaon

- Ministry of Health – Delivering Health Services to Transgender People
- Professional Associaon of T ransgender Health Aotearoa
- The University of Waikato – Guidelines for Gender Affirming Healthcare or Gender Diverse and Transgender Children, Young People and Adults in Aotearoa New Zealand
- World Professional Associaon f or Transgender Health (WPATH) – Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People

For paen ts

On HealthInfo

- Give your paen t a HealthInfo card and encourage them to search using the keyword "gender".
- HealthInfo – Gender Identy in Childr en and Youth

Search My Medicines for paen t informaon leafle ts for any medicaons not lis ted in this secon.

Contact the HealthInfo team at info@healthinfo.org.nz if you have any resources that you would like us to consider for this secon.

Topic ID: 462505

APPENDIX 7

TERMS OF REFERENCE

Transgender Health Working Group

BACKGROUND

The foundation of the Canterbury Clinical Network (CCN) Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SDG member will sign the Charter and agree to the principles contained within it.

The Canterbury Clinical Network was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliance (SLAs)
5. Service Development Groups (SDGs).

Time limited Working Groups may be established by Workstream, Service Level Alliance or Service Development Group to progress a specific piece of work.

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

This Working Group will acknowledge and supports the principles and the provisions of Te Tiriti o Waitangi. We will strive for equitable health outcomes across our population/focus area through accessible, culturally appropriate services.

BACKGROUND

Historically, gender affirming care (often referred to as transgender or trans health care) in Canterbury has been delivered by a few under-resourced champions with little coordination between primary and secondary care, and limited information about how to access services. Coordinating gender affirming health care is complex as it involves general practice, multiple hospital departments; mental health, endocrine, paediatric and surgical; and community peer support services. Transgender people access gender affirming health care services across their lifespan, sometimes moving from paediatric to adult services. Education about gender-affirming care for clinicians has been limited in the past. Previous attempts at improving access to and quality of gender affirming care services have been unsuccessful.

Though no Canterbury data is captured, anecdotal evidence confirms national and international findings of inequitable access to safe services and poor health outcomes for the transgender community [HRC 2008, Clark 2014, Delahunt 2016].

Data from two large surveys indicate that around 1.2% of New Zealanders identify as transgender, and another 2.4% are unsure [Clark 2014, NZAVS 2017]. This is in line with international data. Internationally and nationally there has been increasing awareness of the urgency to improve gender affirming health care. Inequities experienced by

transgender people in access, quality of health care services, and health outcomes are documented nationally and internationally. Data has shown worse mental and physical health outcomes, and increased barriers to health services compared with age matched peers [Clark 2014, WHO 2016, Veale 2017]. Current research links the experience of marginalisation and violence, rather than the experience of being transgender, with poor mental health outcomes [Bockting 2016, Russell 2016]

There is limited population data on the New Zealand transgender community, but the University of Waikato's "Counting Ourselves" survey (with 1,170 responses from trans and non-binary people living in Aotearoa aged 14 and older), recently published, highlights poor access to quality health care and inequitable health outcomes for transgender people in New Zealand.

The survey recommends the need to improve

- Gender affirming mental health care, medical and surgical care
- Understanding of gender identity and education of the health sector in gender affirming practices and healthcare, and
- Communication about available services and national consistency towards the delivery of gender affirming care.

Until recently, the Canterbury health care system provided minimal gender affirming care with paediatric, endocrinology and some mental health adult assessments. The availability of services and how to access them were unclear to patients, GPs and hospital clinicians. Furthermore, services were often offered in an ad hoc way. The lack of clarity increased the inequity in health care experienced by New Zealanders identifying as transgender, caused distress and compounded negative mental health outcomes for those unable to access services they needed.

In 2018 following a small-group education topic on gender diversity, a group formed of General Practitioners interested in gender affirming care. Over the last 12 months a co-design team made up of three members of the transgender community, a member of Manawhenua Ki Waitaha, a GP with an interest in gender affirming care, and a Pegasus health manager was established supported by the Health and Quality Safety Commission a part of the Ko Awatea project. -. The co-design group's overall aim was to, develop relationships and pathways to improve access to, and quality of, gender affirming services in Canterbury. The group's desired outcomes were:

- To improve quality of information provided to both community and health care professionals
- To develop a clear pathway for gender-affirming care, and
- To develop a group of 'champions' within the Canterbury health system tasked with assisting in 'continuous improvement' of the services and communication.

The new services and pathways developed by the co-design group follow international best practice [Telfer 2018] and national guidelines informed by Te Pae Māhutonga [Oliphant 2018]. They acknowledge gender affirming care is a lifesaving treatment, requiring services based on the individual gender affirming journey, delivered closer to home, by a multidisciplinary team, and with a strong focus on whanau and community support.
The full report on the Gender-affirming care co-design project can be viewed here.

This Terms of Reference is for a time limited working group, made up of the co-design project group to consolidate this work and transition the health care services to business as usual.

1. PURPOSE

The purpose of the Transgender Health Working Group is to continue the work of the gender affirming care co-design project by strengthening the partnership between Trans community and health professionals and provide advice to the Canterbury health system on ways to improve equity of health outcomes for transgender and non-binary people.
The specific aims of the group are to:

- Embed the new HealthPathways established through the co-design project including responding to any emerging issues and changes needed to the pathways;
- Communicate the new pathways for accessing care to the trans community and health professionals;
- Support the upskilling and education on trans care for general practice teams

- Further strengthen relationships with clinicians across primary and secondary health care to increase knowledge within and between the services including with the Child, Adolescent and Family Community Services team; and
- Determine the requirements long term for an ongoing advisory / leadership group for trans health.

Regular updates and the completed work will be provided back to the Population Health and Access SLA for their consideration.

2. MANDATE

2.1. Regular updates will be provided back to the Population Health and Access SLA.

3. SCOPE

3.1. In Scope:

This group will:

- Provide recommendations on consolidating the work from the co-design project and transitioning to business as usual care to achieve equity of health outcomes for Canterbury transgender and non-binary people
- Interact with health organisations and services providers to improve delivery of services to the trans community
- Make recommendations on the health services and their funding

3.2. Out of Scope:

- Funding or contracting of services.

4. MEMBERSHIP

4.1. The membership of the Working Group is made up of members form the co-design project group, with additional members sought bring important perspective as required.

4.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the Work Group to achieve success;

4.3. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

4.4. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with the Working Group members; and

4.5. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, consideration will be given to revoking their membership status, following discussion with the member or reasonable attempts to contact the member.

5. MEMBERS

The composition of the Transgender Health Working Group is:

Perspective/Expertise	Name(s)
Community perspective	Joanne Neilson (Chair), Jennifer Shields, Nick Winchester
Specialist Mental Health Service perspective	Samantha Chow
Māori / nursing perspective	Wendy Dallas-Katoa
General practice perspective /	Rebecca Nicholls
Family / Population Health perspective	Ester Vallero
Facilitator	Vacant

Additional perspectives or expertise may be sought e.g. from the community, if required to assist with the development of services. Approval will be sought for any additional funding required to enable this engagement from CCN.

6. ACCOUNTABILITY

6.1. The Transgender Health Working Group is accountable to the Population Health and Access SLA who will establish direction; provide guidance; receive and approve recommendations.This includes endorsing the workgroup's terms of reference, providing guidance when needed, and considering endorsement of any changes in model of care or funding recommended by the work group where these are being progressed to ALT for endorsement.

7. FREQUENCY / NUMBER OF MEETINGS

7.1. An estimated 4 meetings in the next 12 months will be required to complete this work and generate recommendations back to the Population Health and Access SLA.

Extending the groups term beyond the 12 months will be considered with the Population Health and Access SLA, with endorsement sought from the ALT as required.

8. MINUTES AND AGENDAS

8.1. Agendas and minutes will be coordinated between the chair and facilitator;
8.2. Agendas will be circulated no less than 5 days prior to the meeting, as will any material relevant to the agenda;
8.3. Minutes will be circulated to all group members within 5 days of the meeting and minutes remain confidential whilst 'draft' and until agreed; and
8.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

9. QUORUM

9.1. The quorum for meetings is half plus one Work Group member from the total number of members of the Work Group.

10. CONFLICT OF INTERESTS

10.1. Prior to the start of any new Working Group or programme of work, conflict of interests will be stated and recorded on an Interests Register.
10.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
10.3. The Interests Register will be a standing item on Working Group agenda's and be available to the Programme Office on request.

11. REVIEW

11.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

ROLES

12. CHAIR

If required a Chair will be nominated from the group and will fulfil the following tasks.

12.1. Lead the team to identify opportunities for service improvement and redesign;
12.2. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;

12.3. Work with the project manager/facilitator to produce regular reports to the Population Health and Access SLA
12.4. Provide leadership when implementing the group's outputs;
12.5. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
12.6. Be well prepared for meetings and ready to guide discussion towards action and/or decision; and
12.7. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

13. GROUP MEMBERS

13.1. Communicate with colleagues and within community and professional networks
13.2. Bring perspective and/or expertise to the table;
13.3. Understand and utilise evidence and best practice in gender affirming care
13.4. Understand and utilise alliance principles
13.5. Demonstrate and promote effective communication and collaborative relationships amongst all key stakeholders
13.6. Analyse services and participate in service design;
13.7. Analyse proposals using current evidence bases;
13.8. Work as part of the team and share decision making;
13.9. Actively participate in group discussions, service design and the annual planning process; and
13.10. Be well prepared for each meeting.

TERMINOLOGY

- Charter – outlines the purpose, principles, commitments and mandate of leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- Service level Alliance – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Service Development Group – Similar to a SLA, a group of stakeholders or a community drawn together to develop a service in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SDG groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SDG groups.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SDG and specify expected outcomes, reporting and funding for the services to be provided.

DEFINITIONS

- Transgender, Trans and non-binary are used in this document as umbrella terms for anybody whose gender identity does not match their sex assigned at birth, including indigenous identities such as takatāpui, fa'afafine

and others, and non-binary identities. We acknowledge people may use transgender or other terms to refer to their identity.

- We use Canterbury trans community as an umbrella description of transgender and non-binary people in Canterbury, acknowledging the diversity of trans and non-binary people and their experiences, and the strength and validity of each individual in this community.

ENDORSEMENT OF MINUTES

Agreement and endorsement of these TOR should be dated and recorded in the minutes.

Date of agreement and finalisation by Population Health and Access SLA members: 10/02/2020

Date of endorsement from ALT: 24 /02/2020

APPENDIX 8

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4190
melissa.macfarlane@cdhb.health.nz

25 January 2019

Canterbury Clinical Network
Attention: Kim Sinclair-Morris
Executive Director
P.O. Box 741
Christchurch

Dear Kim,

As you are aware Kim, the Canterbury DHB is forecasting an unprecedented deficit in the current 2018/19 financial year and without strategies in place, the amount of shortfall in funding compared to expenditure will compound year on year. While we continue to engage with the Ministry of Health to reconcile our historical differences around funding post the Canterbury and Kaikoura earthquakes and we have identified a range of actions we will be implementing within the Canterbury DHB, we also need to reduce expenditure across the health system. This approach is supported by our Board. Under this remit I am approaching the Canterbury Clinical Network to request that options presented for reducing expenditure are explored and implemented as a priority in the coming weeks.

When considering a wide range of options for reducing expenditure the Executive Management Team and the Board evaluated each option against these seven criteria

- Risk of service failure
- Ability to achieve
- Size of the savings
- Impact on workforce and goodwill
- Reaction of the population
- Equity/Impact on Maori

The outcome of this process was that Canterbury Clinical Network (CCN), hosted by Pegasus, and funded by the Canterbury DHB, was identified as one of the options where contributory savings could be made across the health system. This option is to slow down and/or reduce the current programme of work delivered via the CCN Programme office. The desired saving identified by the above process is $75,000

this financial year to 30 June 2019. We would like to work with you on the implications of this so that together we can minimise the impact on patients.

I have provided this level of detail to inform you of our decision-making process and the amount of savings we are looking to achieve from CCN in this financial year. It is acknowledged that you, your leadership team and the Alliance Leadership Team will want to evaluate this option in terms of the criteria above and other relevant considerations and we hope and expect that this leads to open and direct conversations between us about the next steps.

It is also appreciated that you may have other alternative options for savings that fit the criteria above and we are open to consider these, however I need to stress that timeliness for implementation as well as achievement of savings are crucial factors.

As the Programme Office is hosted by Pegasus (Charitable) Limited (Pegasus) we trust the you will engage with Pegasus and advise them of the agreed next steps, prior to any action being undertaken.

I also need to acknowledge the difficult and challenging implications of this communication, but I trust that the strength of our collaborative relationship will enable us to work our way through this and other challenges ahead, together, and as part of the wider health system.

Yours sincerely

Melissa Macfarlane
Acting Executive Director
Planning and Funding and Decision Support
Canterbury and West Coast DHBs

Cc: Vince Barry, Chief Executive Officer, Pegasus Health (Charitable) Limited