SAHCS
GUIDELINES

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY GENDER-AFFIRMING HEALTHCARE GUIDELINE FOR SOUTH AFRICA - EXPANDED VERSION: **OCTOBER 2021**

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Two guideline documents have been developed. The condensed guideline provides a quick reference and summary of the main aspects relating to gender-affirming healthcare in South Africa. This second, expanded version provides further detail for those requiring additional background information, resources and references.

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Guideline development committee: Anastacia Tomson,[1,2*] Chris/tine McLachlan,[3,4,5,6] Camilla Wattrus,[7] Kevin Adams,[5,8] Ronald Addinall,[5,9,10] Rutendo Bothma,[11] Lauren Jankelowitz,[12] Elliott Kotze,[13] Zamasomi Luvuno,14 Nkanyiso Madlala,[4,5,6] Savuka Matyila,[15] Anil Padavatan,[15] Mershen Pillay,[5,16,17] Mmamontsheng Dulcy Rakumakoe,[5,18] Mathilde Tomson-Myburgh,[2] W D François Venter,[19] Elma de Vries[5,20,21]

[1]My Family GP, Cape Town, South Africa
[2]Shemah Koleinu, Cape Town, South Africa
[3]KwaZulu Natal Department of Health, Pietermaritzburg, South Africa
[4]Department of Psychology, College of Human Sciences, University of South Africa, Pretoria, South Africa
[5]Professional Association for Transgender Health (PATHSA), Cape Town, South Africa
[6]Psychological Society of Southern Africa (PsySSA), Johannesburg, South Africa
[7]Southern African HIV Clinicians Society (SAHCS), Cape Town, South Africa
[8]Department of Plastic Surgery, Faculty of Health Sciences, University of Cape Town, South Africa
[9]Department of Social Development, Faculty of Humanities, University of Cape Town, Cape Town, South Africa
[10]Southern African Sexual Health Association (SASHA), Cape Town, South Africa
[11]Wits Reproductive Health Institute (Wits RHI), Johannesburg, South Africa
[12]Southern African HIV Clinicians Society (SAHCS), Johannesburg, South Africa
[13]Psychologist, Independent Practice, Cape Town, South Africa
[14]School of Nursing and Public Health, Centre for Rural Health, University of KwaZulu-Natal, Durban, South Africa
[15]Gender DynamiX, Cape Town, South Africa
[16]Department of Speech-Language Therapy, Faculty of Health Sciences, University of KwaZulu-Natal, Durban, South Africa
[17]Department of Speech-Language Therapy, Faculty of Health Sciences, Massey University, Auckland, New Zealand
[18]Quadcare, Johannesburg, South Africa
[19]Ezintsha, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa
[20]Cape Town Metro Health Services, Cape Town, South Africa
[21]School of Public Health and Family Medicine, Faculty of Health Sciences, University of Cape Town, South Africa

Corresponding author: Anastacia Tomson (doc.tomson@gmail.com)

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Endorsements:

This guideline is endorsed by:

Be True 2 Me, a trans-led organisation that provides a unified point of contact for Transgender & Gender Diverse individuals, and those interacting with, working with, educating, employing or caretaking Transgender & Gender Diverse people.

Centre for Sexualities, AIDS and Gender (CSA&G), University of Pretoria

Gender Dynamix (GDX), Africa-based public benefit organisation focussing on transgender and gender diverse communities.

Professional Association for Transgender Health South Africa (PATHSA), an interdisciplinary health professional organisation working to promote the health, wellbeing and self-actualisation of trans and gender diverse people.

Psychological Society of South Africa (PsySSA), the professional body representing psychology professionals in South Africa.

Same Love Toti, a registered non-profit organisation that helps parents to understand their LGBTI children, and supports LGBTI youth.

Sexuality and Gender Division (SGD) of the Psychological Society of South Africa (PsySSA), a division of PsySSA that promotes a psychological understanding of the fields of sexuality and gender diversity, including queer identities and position.

TransHope, an NGO bringing hope to the gender diverse community.

Triangle Project, a non-profit human rights organisation offering professional services to ensure the full realisation of constitutional and human rights for lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) persons, their partners and families

Uthingo Network, previously The Gay & Lesbian Network, a registered non-profit organisation that aims to create a non-discriminatory, supportive and accepting society in which members of all communities are uplifted and developed, and ensuring optimum commitment and services and programmes for the upliftment and recognition of the lesbian, gay, bi-sexual, transgender and intersex (LGBTI) communities.

Wits Reproductive Health and HIV Institute (Wits RHI), a leading multi-disciplinary research institute with a focus on sexual and reproductive health, vaccines and infectious diseases, and other emerging health challenges. The Wits RHI Key Populations Programme operates USAID-supported transgender healthcare centres in four health districts in Gauteng, Eastern Cape and Western Cape.

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ABBREVIATIONS

ACE-I	angiotensin-converting-enzyme inhibitor
AFAB	assigned female at birth
ALT	alanine transaminase
AMAB	assigned male at birth
ARB	angiotensin receptor blocker
ART	antiretroviral therapy
BMD	bone mineral density
Cr	creatinine
CRPD	United Nations Convention on the Rights of People with Disabilities
CYP	cytochrome P450
DSD	differences/diversity of sexual development
DSM-5	*Diagnostic and Statistical Manual for Mental Disorders Version 5*
DTG	dolutegravir
DVT	deep venous thrombosis
EFV	efavirenz
FBC	full blood count
FFS	facial feminisation surgery
FTC	emtricitabine
GnRHa	gonadotrophin-releasing hormone agonist(s)
GAHC	gender-affirming healthcare
GBV	gender-based violence
GP	general practitioner
Hb	haemoglobin
HBV	hepatitis B virus
HCV	hepatitis C virus
HEI	higher education institution
HPV	human papillomavirus
HSV	herpes simplex virus
Ht	haematocrit
HT	hormone therapy
IC	informed consent
ICD-11	*International Classification of Diseases and Related Health Problems Version 11*
ICM	informed consent model
ID	identity document
IUD	intrauterine device
IM	intramuscular
LFT	liver function test
LGBTQIA+	lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/agender, developing language and the inclusion of other diverse gender identities and sexual orientations
LGBTQQIP2SAA	lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual
MHC	mental healthcare
MHCA	Mental Health Care Act
MHP	mental healthcare provider/practitioner
MoCA-LD	Montreal Cognitive Assessment – Learning Disabilities
MSM	men who have sex with men
NG54	National Institute for Health and Care Excellence *Guidelines on Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management*
NHI	National Health Insurance
NIMART	nurse-initiated management of antiretroviral therapy
NVP	nevirapine
PATHSA	Professional Association for Transgender Health South Africa
PEP	post-exposure prophylaxis
POPIA	Protection of Personal Information Act
PrEP	pre-exposure prophylaxis
PSA	prostate-specific antigen
PsySSA	Psychological Society of South Africa
PTSD	post-traumatic stress disorder
PWIDD	person(s) with intellectual and developmental disabilities
SASL	South African Sign Language
SBIRT	screening, brief intervention and referral to treatment
SC	subcutaneous
SFF	speaking fundamental frequency
SHBG	sex hormone binding globulin
SLT	speech-language therapist
SoC-7	World Professional Association for Transgender Health Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TDF	tenofovir disoproxil fumarate
TGD	transgender and gender diverse/diversity
TGM	transgender man/men
TGW	transgender woman/women
UEC	urea, electrolytes and creatinine
ULN	upper limit of normal
VTE	venous thromboembolism
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health

EXECUTIVE SUMMARY

We support an affirming approach to managing the transgender and gender diverse (TGD) client, centring on the individual's agency, autonomy and right to self-determination, as opposed to practices that pathologise and stigmatise TGD identity, imposing barriers to accessing healthcare.

TGD persons have long faced discrimination on multiple axes, both globally and in South Africa. Although South Africa enshrines the protection of human rights in its Constitution, TGD persons continue to face marginalisation, prejudice and threats to their safety. Challenges persist – including homelessness, unemployment, poor social support, bullying, harassment and violence – indicating failures of policy development and practice implementation, and a disregard for the human rights of persons in the TGD community.

This guideline has been developed primarily with the intention of centring and amplifying voices of TGD persons in order to facilitate access to healthcare that is sensitive, skilled and respectful. We recognise that there are significant gaps in the knowledge and skills of healthcare providers, and a lack of understanding of the unique experiences faced by TGD persons. The prevailing sentiment that many healthcare providers hold around TGD individuals, informed by ignorance and conditioning within social and societal structures, are malevolent towards this community and often include harmful assumptions and generalisations. We believe that healthcare providers have an ethical obligation to interrogate these notions, and we promote an attitude of respect for diversity that upholds human rights.

It has been well established that access to competent and dignified gender-affirming

healthcare (GAHC) is not only safe, but also

plays a significant role in improving measurable outcomes for TGD clients. It has also been well established that pathologising approaches and practices that limit access to care can be damaging and harmful.

Finally, we recognise that TGD persons have historically endured being undermined, condescended to and pitied by the healthcare system and its providers. We affirm a commitment to upholding a strength-based perspective that values and respects the experiences of TGD clients and celebrates individual identity rather than merely accepting or tolerating it.

This guideline, which will undoubtedly require ongoing revision, reflection and refinement in consultation with TGD communities and healthcare providers, represents a first step made in good faith towards creating a practical tool founded in robust scientific evidence, lodged within a human rights framework, and is intended to facilitate access to skilled and sensitive care that will yield tangible benefit to this unique and important group.

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SCOPE AND PURPOSE

- Provide evidence-informed best practice recommendations to enable South African healthcare providers, including psychosocial and allied healthcare professionals, to offer quality, affirming services to TGD clients
- Provide a support to TGD clients when accessing healthcare services
- Note: this publication is the expanded version of the guideline; the condensed guideline can be accessed here: **https://doi.org/10.4102/sajhivmed.v22i1.1299**

AUDIENCE

This includes all healthcare providers, particularly those working in a primary care setting (public or private) and/or who care for TGD clients.

METHODS

The guideline development committee comprised 17 individuals, chaired by Dr Anastacia Tomson and Rev Chris McLachlan. This committee was inclusive, with representation of GAHC providers, advocates and civil society organisations in the TGD space, and many with personal experience as a TGD client. Development was predicated on the necessity to amplify the voices of those within the TGD community in order to better meet their needs, rather than presuming that healthcare providers can address those needs alone. This guideline was informed by evidence-based research as well as sprovider experience from within the field. The committee worked from a gender-affirming, non-gatekeeping, depathologising perspective, using a participatory approach that centres on the TGD client's agency and humanity, and upholds their dignity.[1,2,3] In order to ensure applicability to the South African context, focused effort was made to review local research studies. Resources from the global South were then accessed, and only key resources from the global North were incorporated. An extensive external peer review process was conducted which included both health provider and community review. Guideline development and publication was supported by the Southern African HIV Clinicians Society (SAHCS), through Dr Camilla Wattrus and Dr Lauren Jankelowitz.

The committee has used the term 'client' which, for the purposes of this guideline, includes service users, patients and participants.

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CHAPTER 1

INTRODUCTION

1.1 Background

'I don't think we really know what freedom is in South Africa. What will it take for me to have the freedom and safety to stand up in public and say, "I am gender fluid"? I don't just feel marginalised, I feel like there is no space for me at all.' - Anonymous TGD client, pers. comm., 2020

South Africa is a country with a progressive Constitution and Bill of Rights that provide for dignity, equality and access to healthcare.[4] This is echoed by the South African Health Professions Act and associated general ethical rules for health professionals;[5] the *Social Service Professions Act*,[6] the Constitutions of the Professional Association for Transgender Health in South Africa (PATHSA)[7]and Psychological Society of South Africa (PSySSA)[8]; and the Department of Health's Batho Pele principles.[9] Despite this, many transgender and gender diverse (TGD) persons struggle to access gender-affirming healthcare (GAHC) in South Africa.

GAHC attends holistically to a TGD individual's mental, physical and social well-being and health needs, while respecting their self-identified gender.[10] Each individual has unique needs, and the gender-affirming process is rarely linear. This process may include social and/or medical elements, or none at all.[11] A client with a non-binary identity may have unique and specific treatment goals.[12]

Transition is not necessarily medical. Persons who do not or cannot access GAHC can still affirm their gender expression and transition socially.[13]

'Because for me, my transitioning is more spiritual than physical. I live as a woman every day. My nieces and my nephews, they call me mom, and finding peace within myself and being able to fight for them to have a representation of what love looks like makes me feel fulfilled. Your womanhood is within you more than what is here on the physicality.'[13]

It is important to note that, as a healthcare provider, withholding or delaying treatment is not a neutral action. It can impact the client's mental health and, in adolescents, may have implications for what medical or surgical treatment is required later in life. Gatekeeping (delaying treatment until the healthcare provider feels a particular subjective degree of certainty) is potentially harmful.[14]

1.2 Values underpinning the guideline

The values underpinning this guideline are shown in **Box 1** and discussed below.

BOX 1: Values underpinning this guideline.

- Affirmation
- Dignity
- Equity
- Inclusion
- Informed consent (IC)
- Ethical principles in healthcare
- *Ubuntu* – the participatory approach
- *Batho Pele* – "People First"
- Trans giftedness

1.2.1 Affirmation

We affirm and respect TGD persons and acknowledge that the full spectrum of gender identities and diversities is valid.[3]

Transgender and gender diversity (TGD) is an 'expression of gender characteristics, including identities that are not stereotypically associated with one's assigned sex at birth [that] is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative'.[15]

We understand that the concept of gender varies in relation to political and sociocultural contexts, personal and intergenerational trauma, migrant and disability status, among others.[16] We avoid assuming links between gender role, sexual orientation and gender identity based on traditional, binaried, cis-heteronormative understandings of femininity and masculinity.[17,18]

In the past, TGD was defined as a mental illness, but in 2018 the World Health Organization (WHO) published the International Classification of Diseases and Related Health Problems Version 11 (ICD-11), which removed transgender identity from the chapter on mental health disorders and included it in a new chapter on conditions related to sexual health. This acknowledges the fact that, while TGD persons may require gender-affirming mental and physical health interventions, gender diversity itself is not a mental health disorder.[19] While gender diversity is increasingly being understood and accepted as a normal part of human diversity, there is still a long way to go to address this legacy of stigma.[18]

In the Diagnostic and Statistical Manual for Mental Disorders Version 5 (DSM-5), the Gender Dysphoria diagnosis is still used[20] to describe the distress that TGD persons may experience, as their sex assigned at birth is incongruent to their gender identity and/or expression. The DSM-5 articulates explicitly that 'gender non-conformity is not in itself a mental disorder'. Although this is a controversial term, the DSM-5 is a document that originated in the United States of America and the inclusion of gender dysphoria was also about ensuring access to healthcare in an American context of managed healthcare.[21]

We support the notion of depathologisation of TGD identities[7,22] and adopt an affirmative stance towards gender diversity. As affirmative healthcare providers, we acknowledge that some of the past practices often pathologised gender diversity and that this caused harm to TGD persons.[3] Gender diversity is natural and a normal feature of the human experience.[2,3] As GAHC providers, we strive to be ethical, accountable and respectful towards the TGD persons with whom we engage. Non-discrimination stands central in our approach and support of all TGD clients.[3]

The discrimination, marginalisation and lack of affirmation experienced by members of the TGD community have a major impact on access to economic and educational opportunities and contribute to vulnerability to health risks.[23] Access to GAHC can have a powerful impact on well-being and quality of life of those seeking such care, beyond the immediate psychological and physical benefits.

1.2.2 Dignity

All persons have the right to dignity,[4] and this should be respected and protected. We acknowledge that persons whose gender identity and gender expression fall outside of narrow societal norms are subject to stigma, discrimination and even violence.

The dignity of TGD community members is often undermined in interactions with institutions, including the healthcare system.[13] TGD clients frequently have negative experiences within the healthcare system, including having their identities repeatedly scrutinised and questioned, and being treated with paternalism and condescension by healthcare providers.[24] There are many reports of public humiliation, negative value judgment, and use of inappropriate names and pronouns, experienced by TGD clients when attempting to access the healthcare system.[25]

'When I want to access health services and I go to the nurses at the clinic, there is no one that will assist me, and they will interrogate me instead to produce an ID that matches my gender.' – Anonymous TGD client, pers. comm.,2018[13]

It is therefore essential that, in addition to striving to provide clinically sound and competent healthcare services to the TGD community, service providers must do so with the overarching goal of ensuring that a client's dignity and right to identity and expression are respected. Competent medical care that does not uphold personal dignity fails to fulfil the fundamental requirement of protecting and promoting the rights of all human beings.

1.2.3 Equity

We uphold the Yogyakarta principles that state all persons are equal, should have equal access to their basic human rights, and no-one should be subjected to unfair discrimination.[26] The Yogyakarta Principles plus 10 (YP+10) further stipulate the 'right to freedom from criminalisation and sanction on the

basis of sexual orientation, gender identity, gender expression or sex characteristics'.[27]

While working towards equitable access to quality medical care for all persons, it is important to recognise that some persons are subject to intersecting layers of discrimination; such as race, socio-economic status, geographic area, age, health disparities, transphobia and homophobia, sexism and gender discrimination, and the oppression of women.[2] It is the role of healthcare providers to challenge all forms of stigma, abuse, inequality and oppression directed at the TGD minority.[3]

We seek to uphold the principle of equity by recognising the need to ensure access to medical treatment to the most vulnerable and marginalised sections of the community.

Alex Müller describes four aspects of care:[28]

- **Availability:** lack of public health facilities and services, both for general and LGBTQIA+-specific concerns
- **Accessibility:** healthcare providers' refusal to provide care to LGBTQIA+ clients
- **Acceptability:** articulation of moral judgment and disapproval of LGBTQIA+ clients' identity, and forced subjection of clients to religious practices
- **Quality:** lack of knowledge about LGBTQIA+ identities and health needs, leading to poor-quality care.

In the South African context, the stark reality is that GAHC is only available at a few tertiary hospitals in the state sector, at four clinics providing HIV care and hormone therapy (HT), and from a small number of private practitioners. Research has shown that whether a client is able to access GAHC largely depends on whether they are fortunate enough to find a healthcare provider who has knowledge of GAHC and is sympathetic to the needs of TGD clients.[29] The same research identified the urgent need for national guidelines to ensure that GAHC services are made available throughout the healthcare system.[29]

Historically, GAHC has been easier to access for clients who already enjoy a higher degree of societal privilege than others.[29] For example, wealthier clients have easier access to GAHC in the private sector than those who use public sector facilities;[29] clients who identify within the gender binary and express themselves in ways that conform to traditional societal gender roles, enjoy better access to services than non-binary persons; clients who identify as heterosexual are seen as more valid than their gay/lesbian/bisexual/asexual counterparts;[30] geographical privilege, with access to GAHC more readily available in certain provinces[31] and educational-level privilege, for example a person who is able to understand and read English, will be able to access information more easily than a person who only speaks an indigenous language.

'Even with the health system, it contributes to the barriers too, because you find that people can't afford the medical aid. And most of our people go to the public hospitals and clinics where the nurses only know about gay and lesbian people. Then you come with a new term and they don't even know where to box you.' – Anonymous TGD client, 2019.[13]

Access to GAHC has been geographically restricted in ways that prejudice clients in rural, remote and under-resourced areas.[13] Due to South Africa's colonial and apartheid past, the divide between those who have access to resources and those who do not, continues to fall along racial lines.

Recognising and addressing these inequalities is an essential part of providing equitable access to GAHC. It is acknowledged that healthcare has a historical complicity in oppressive systems, for example gender hierarchies. As healthcare providers, we need to create a space that contributes to social justice for all, including gender and sexually diverse persons, where we add to the well-being and mental health of all.[2,32,33,34] The National Health Insurance (NHI) aims to ensure equitable access to health services for all persons, and this has to include the health needs of TGD individuals.[35]

1.2.4 Inclusion

TGD persons should be included as equal partners in making decisions about their bodies and healthcare, as well as in broader decision-making regarding laws, policies and guidelines that impact their access to healthcare.

To address the history of gatekeeping, paternalism, cis-heteronormativity and exclusion, we adopt the principle of inclusion. Gatekeeping refers to a

situation where a healthcare provider decides what is in the best interests of the client, because the client is viewed as being unable to make their own choices. Gatekeeping (intentionally or unintendedly) may take the form of healthcare providers refusing to provide access to GAHC until a client proves that they are 'really transgender' or 'transgender enough'. Some healthcare providers have insisted that the client must openly express their gender identity for a particular period of time (commonly and problematically termed 'living as' their gender) before beginning GAHC.[36,37,38]

Gatekeeping can also take the form of healthcare providers guarding access to resources, and deciding which clients are 'worthy' of medical care.

'It's a waiting list [to see a psychologist] of at least three months. I was there at the clinic to do some sensitisation and then she said "transgender is not something urgent. It is just for beauty. We'll start with those people who have committed suicides" (...) and I said, "if I cannot be a female, I will commit suicide". And then they said "no, transgender is not something that is urgent"' PN (2018).[13]

1.2.5 Informed consent

Healthcare providers and clients are partners in making choices about medical treatment: the provider should inform the client of the risks and benefits and the client should make an informed decision about their healthcare, based on the information provided.[39] This approach respects a client's agency over their own body and is both clinically safe and ethically sound. We uphold the notion of self-determination.[7] This is discussed in more detail in **Chapter 2: Informed consent.**

1.2.6 Healthcare provider's ethics and principles

The healthcare provider is ethically obligated to treat the TGD client with dignity and respect, and to facilitate access to care (both general and gender-affirming) without gatekeeping or judgment.

The framework of medical ethics has four fundamental concepts and provides a lens through which scenarios can be determined to be the most ethically sound course of action.[14] A human rights-based approach, focusing on human dignity and equality, which offers GAHC based on informed consent (IC) is consistent with the healthcare principles of autonomy, non-maleficence, beneficence and justice.

- **Autonomy:** The principle of autonomy respects a person's right to self-determination. The client is recognised as an independent person, capable of making their own decisions regarding their own bodies. It is clear that this principle is best respected and upheld by an approach that empowers a client with information and then allows that client to make an informed choice about their care and respects such a decision; i.e. an informed consent model (ICM). In contrast, a gatekeeping model deprives the client of the ability to make an independent choice and fails to respect the client's autonomy.[14]
- **Beneficence:** The principle of beneficence deals with ensuring that one's practice offers benefit to the client. Numerous scientific studies have validated the notion that access to GAHC provides better outcomes for TGD individuals, and so this principle is consistent with the ICM of care.
- **Non-maleficence:** Non-maleficence is the principle of medical ethics that advocates that one's practice should not intentionally harm clients. As the side effects of GAHC are well-known, and it has been shown to be safe, giving clients full information on the risks and benefits of the treatment and allowing them to make a choice cannot be seen as causing harm. In fact, as noted above, gatekeeping approaches that deny or delay access to treatment have been shown to cause harm, particularly in terms of mental health and well-being.[14]
- **Justice:** Justice describes the principle of medical ethics devoted to fairness and equity in the allocation of healthcare resources. Gatekeeping approaches to GAHC tend to unfairly favour those who start with greater resources, or those who fit within societal models of gender and gender expression. On the other hand, IC does not privilege or disadvantage persons based on identity, background or experience. By removing the barriers created by gatekeeping approaches, healthcare providers can contribute towards building a more just and equitable healthcare system.

Although these ethics are central in healthcare, one cannot ignore that an imbalance of power may exist between the healthcare provider and the TGD client. The medical model is often very paternalistic with the provider being placed into the expert position. The healthcare provider needs to be aware of and challenge this power imbalance. Cultural humility becomes important which calls the healthcare provider to reflect and self-evaluate the potential power imbalance between the clinician and the TGD client,[3] and to use the opportunity to practically analyse what knowledge and service-related skills that they may possess, and those which they may need to develop, abrogate or accommodate.

Community psychologist Prilleltensky (2012)[40] provides a definition of well-being that frames these guidelines: 'well-being is a positive state of affairs, brought about by the simultaneous and balanced satisfaction of diverse objective and subjective needs of individuals, relationships, organisations, and communities.' Prilleltensky[40] emphasises that well-being must be understood as being influenced by the wider context in which individuals are embedded. This perspective challenges mainstream approaches to wellness which tend to focus on the level of the individual who is seen as responsible for their well-being, while overlooking the influence of multiple and intersecting levels of influence: the personal level, the interpersonal level, the organisational level and the community level. Importantly, these levels of influence are intersecting and dialectical, and characterised by justice, which includes:

- **Personal/intrapersonal justice:** Personal empowerment, control and responsibility for one's well-being
- **Interpersonal justice:** Treating others with dignity and respect
- **Organisational justice:** Information about existing resources, culture of health promotion, equity and respect
- **Community justice:** Treated fairly by social systems.

Prilleltensky[40] proposes that optimal conditions of justice at all levels promote well-being.

Murray et al.[41] propose a number of values and assumptions that underly an approach to health and wellness and acknowledge that well-being is the outcome of a complex set of intersecting levels of influence:

- **Oppression and empowerment:** Social structures and processes can lead to internalised, psychological experiences of disempowerment. Self-determination, democratic participation, and negotiating power across clinical decision-making leads to empowerment.
- **Social justice:** Health requires participation in social movements and social action in pursuit of social justice.
- **Caring, community and compassion:** Health is predicated on a sense of community, social support and inclusion.
- **Health promotion and prevention:** A multi-level, ecological, systems framework is needed to analyse health problems and design interventions and organisations that promote health and prevent ill-health.
- **Diversity:** Creating the conditions of health requires challenging cultural norms that are disempowering, celebrating diversity, amplifying the voices of marginalised persons, and being sensitive to the unique context of individuals and their unique identities.

1.2.7 *Ubuntu* – the participatory approach

Umuntu ngumuntu ngabantu – A person is a person through other people. The African concept of Ubuntu is central to South Africa's democracy. It calls on us to see the inherent humanity in all people and helps us to understand human interdependence within the indigenous context. All persons need to be seen, recognised and affirmed as who they are, in order to live fulfilling human lives.[42,43]

Incorporating a participatory approach in GAHC, the TGD client's support network, family, friends and community, as well as a multidisciplinary team of healthcare providers, become part of the journey of the TGD person.[2]

1.2.8 *Batho Pele* - "People First"

The eight *Batho Pele* principles aim to enhance the quality and accessibility of government services

by improving efficiency and accountability.[43,44,45] Although these principles stem from the South African government for all public services, they are applicable to private facilities and non-profit organisations as well.

- **Consultation:** All stakeholders should be consulted on the nature, quantity and quality of services to be provided in order to determine and meet the specific needs and expectations of the client.
- **Service standards:** Citizens should be informed of the level and quality of public services they will receive so they can understand the process and are aware of what to expect.
- **Access:** All citizens should have equal access to services to which they are entitled, including decentralised offices, use of indigenous languages, sign language and improved service delivery to physically, socially and culturally disadvantaged persons.
- **Courtesy:** Citizens should be treated with courtesy and consideration, including utilising tools and systems which are inclusive to positively affect customer care.
- **Information:** Citizens should be given full, accurate information about the public services to which they are entitled, including information available in various official languages, South African sign language(s), Braille and, when necessary, via the use of augmentative or alternative communication (AAC) methods. Induction training should be compulsory to all new employees.
- **Openness and transparency:** Citizens should be informed of the administration of departments, and the management should be open and transparent to all staff members.
- **Redress:** Accessible and anonymous mechanisms for recording public dissatisfaction must be established and staff must be trained to handle complaints fast and efficiently.
- **Value for money:** Public services should be provided economically and efficiently to give citizens the best possible value for money.

1.2.9 Trans giftedness

TGD persons are generally resilient, self-aware, possess inner strength and have unique perspectives and insights.[46] This enables them to engage with the world of gender in new and diverse ways.[47] We acknowledge this and utilise a strength-based perspective rather than condescending to, undermining or pitying TGD persons.

1.3 Key terms

Definitions of important key terms from within the field of GAHC were drawn from a variety of academic sources but have been adapted through consultation with members of the TGD community in South Africa. Please note that the list of key terms provided in **Table 1** is not exhaustive, and that the usage of terms and associated meanings may change over time. It is important to allow TGD persons to self-identify and not impose the use of terminology on them. It is also useful to listen to the experiences described by clients, rather than expecting them to use specific terminology.

TABLE 1: Key terms.	
Term	**Explanation**
Cisgender	Abbreviated as 'cis', describes a person whose gender identity and expression matches their sex assigned at birth.[3]
Gender	'An institutionalised system of social practices for constituting people as two significantly different categories, men and women; and organising social relations of inequality on the basis of that difference.'[48] Gender is based on social norms and expectations. In many cultures, people are divided into a gender binary of either men or women, but there are also cultures that recognise other genders, sometimes as a third gender category, or as a range of non-binary identities, for example genderqueer, gender fluid, bigender or agender. Most societies have a history of systemic gender inequality, with men occupying a privileged position and women being subjected to socioeconomic disadvantage, discrimination and violence. In addition, in South Africa, colonisation has meant that the binary Western perspective has been entrenched within our society.
Gender dysphoria	The psychological and/or physical distress caused by the incongruence between sex assigned at birth and gender identity. Not all TGD persons experience gender dysphoria, but it can be debilitating for some. Although gender dysphoria is a medical diagnostic classification in the DSM-5,[20] TGD persons' experiences of it are diverse and may affect their lives in various ways.
Gender expression	Aspects of a person's physical appearance and behaviour, defined culturally or socially to be either masculine or feminine. Every society has its own normative assumptions and prescriptions about how women and men should feel, dress, act, and work. Gender expression can also be fluid or non-conforming.[49]
Gender identity	Defined by the Yogyakarta Principles (South Africa is a signatory to these Principles), as 'each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms'.[27]
Cis-heteronormativity	Refers to the hierarchical system of power, prejudice and discrimination in which cisgender and heterosexual individuals are privileged above sexual and gender diverse (or perceived sexual and gender diverse) persons.
Intersex	Refers to persons born with sex characteristics, such as chromosomes, gonads or genitals that do not fit typical binary notions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations.[22] Some persons with intersex traits self-identify as intersex, and some do not. Some prefer the term **differences of sex development** or **diversity of sex development (DSD).** The medical term 'disorder of sex development' is often considered derogatory by intersex persons as difference or diversity should not automatically be pathologised.
LGBTQIA+	An umbrella term for communities who, for different reasons, have a shared experience of marginalisation and discrimination in society, and who have shared goals of improving access to human rights and basic freedoms. L stands for lesbian, G for gay, B for bisexual, T for transgender, Q for queer or questioning, I for intersex, A for asexual or agender, and + indicating developing language and the inclusion of other diverse gender identities and sexual orientations.
Misgendering	Intentionally or unintentionally using an inaccurate pronoun or description in a way that undermines a person's gender identity. Similarly, **deadnaming (necronym)** refers to using a TGD person's previous given name, despite them having changed their name, or asked to be addressed by a name that reflects their gender identity.

Non-binary	A range of gender identities that do not fall into the traditional binary categories of male or female. It is important to recognise that this gender binary does not describe the identity of many people. Persons with non-binary gender identities may identify as gender fluid, gender diverse, agender, genderqueer, gender non-conforming, transmasculine, transfeminine or various other non-binary identities.
Sex	A complex interplay of multiple physical characteristics (including hormones, internal reproductive organs, gonadal tissue, genitalia and chromosomes) that cannot be categorised into a binary of male or female. When a child is born, they are usually assigned as either female – assigned female at birth (AFAB) – or male – assigned male at birth (AMAB) – based solely on the observed external genitalia at birth. This does not account for intersex individuals, or for DSD, which is problematic.
Sexual orientation	Describes who one is intimately attracted to, and with whom one has emotional and/or sexual relationships and the sexuality with which one may identify. **Sexual orientation is not the same as gender identity.** Gender identity refers to a person's experience of their own gender, and sexual orientation refers to their attraction to others. A person's gender identity does not in any way predict their sexual orientation.
Transgender	A term that describes a person who does not identify (wholly or partially) with their sex assigned at birth. A **transgender woman** (TGW) is someone who was AMAB but who identifies as a woman. The previous term MTF (male-to-female) is no longer considered widely acceptable or accurate. A **transgender man** (TGM) is someone who was AFAB but who identifies as a man. The previous term FTM (female-to-male) is no longer considered widely acceptable or accurate.
Transphobia	An irrational and systemic hostility towards persons who are transgender, gender diverse, or who otherwise do not fall into traditional gender categories and norms.

AFAB, assigned female at birth; AMAB, assigned male at birth; DSD, diversity of sex development; DSM-5, Diagnostic and Statistical Manual Version 5; TGD, transgender and gender diverse.

1.4 Gender-affirming healthcare

In recent years, GAHC has moved beyond the narrow and medicalised approach of diagnosing and treating gender dysphoria, and instead, the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 (SoC-7) focus on providing TGD clients with 'safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment'.[18]

GAHC is safe and effective, and the risks and benefits of the various treatment options are well understood.[18]

Components of GAHC are summarised in **Table 2**.

Because of the very individual needs of TGD persons, the relationship and communication with their healthcare providers is extremely important. Providing a safe, welcoming and culturally appropriate healthcare environment is essential to ensure that a TGD client not only seeks care but returns for follow-up.[51] An affirmative approach is part of our ethical response to providing healthcare, both in the public and private healthcare setting.[1] Through affirmation and building rapport, the TGD client will be free to disclose their gender identity.[2,52]

TABLE 2: Gender-affirming healthcare components.[50]	
Component	**Description**
Primary and preventive care	• General healthcare that is affirming • Care following violence • Mental health screening and support • Screening for substance use • Fertility and contraception • Cancer screening (cervical, breast and prostate) • Sexual health • STI screening • HIV prevention and care
Psychosocial care	• Counselling and psychotherapy to support the client in making choices, improving resilience, dealing with trauma and navigating the psychosocial aspects of transition; and provide a safe space for clients to explore and develop their own dynamic gender identity/expression
Medical therapy	• HT for masculinisation • HT for feminisation • Puberty blockers for adolescents • Fertility preservation through gamete storage
Gender-affirming surgery	• Masculinising: mastectomy with chest reconstruction, phalloplasty or metoidioplasty • Feminising: breast augmentation, facial feminisation, orchidectomy, vaginoplasty
Voice and communication therapy	• Voice and communication interventions, both verbal and non-verbal aspects
Hair removal	• Electrolysis and/or laser treatment
Advice on the safe use of non-medical gender-affirming practices	• Binding, tucking, padding and packing
Peer support groups	• Source of information, emotional support and empowerment
Structural interventions	• Ensuring an affirming space – see practical tips below and **Chapter 8: Institutions**

HIV, human immunodeficiency virus; HT, hormone therapy; STI, sexually transmitted infection.

1.4.1 How to create an affirming space – practical tips

1.4.1.1 Ensure staff are capacitated to provide gender-affirming healthcare[36]

- Provide sensitisation training for all staff, including security, reception and administrative staff
- Provide GAHC training for clinical staff to ensure that they are competent to provide services to TGD clients.

1.4.1.2 Create a welcoming and supporting physical environment[53]

- Provide gender-neutral toilet facilities (discussed in more detail in **Chapter 8: Institutions**)
- Ensure signage is gender neutral.

1.4.1.3 Administrative processes[53]

- Recognise that TGD clients may have an identity document (ID) that does not match their gender expression.
- Ensure registration records and intake forms reflect the client's name-in-use, legal name and surname (if relevant, and in consultation with the client), pronouns and gender.
- Ensure data systems that allow information on TGD identities to be captured. Electronic data systems that assign gender according to national ID documents prove quite problematic for TGD and have been implicated in healthcare avoidance among TGD.
- Practice discretion with billing information in terms of differentiating between the client's legal name and name-in-use; and consult with the client directly to avoid any breaches of confidentiality.

- Ensure the client's gender identity and treatment information are kept confidential and protected under the Protection of Personal Information Act (Act No. 4 of 2013)(POPIA).[54]

1.4.1.4 Clinical encounters

- Routinely ask clients which name and pronouns they use (see below)
- Use sensitive language when taking a sexual history – see **Table 3** in Chapter 3: Primary care[55]
- Ensure sensitivity during physical examination – see **Box 2** in Chapter 3: Primary care

1.4.1.5 Other supportive services

- Produce educational materials that include the needs and experiences of TGD clients (see **APPENDIX D: Community resources**)

'Our educational materials that we find at the hospitals and at the clinics, they are only talking about (cisgender) male-female relations. So, our educational material, they need to be inclusive (...) If they are inclusive, they will be able to reach other people' – Anonymous TGD client, 2018.[13]

1.4.1.6 Language use

Language is an important tool for creating an affirming environment.[55] The following simple steps can go a long way towards creating trust and building a positive relationship:

- Avoid assumptions and ask clients to provide their names and pronouns (e.g. he/they/she).
- If a client's name-in-use is different to the legal name on their ID, then only use the legal name where there is a legal requirement to do so.
- Allow clients to define their own identities and expression, and be aware that some non-binary identities may not fit in to existing categories.[56]
- Ask open-ended questions.
- Be aware that in South Africa, gender identity and expression and sexual orientation are often conflated, and it may therefore be useful to listen to the experience clients describe, rather than focus on the terminology used.
- If you accidentally get someone's name or pronouns wrong, simply apologise and move on, but never insist on using a name or pronoun against a client's wishes.
- Limit language as a barrier by ensuring that there is staff competency in more than one of South Africa's eleven official languages and, if required, basic South African Sign Language (SASL). South Africa has eleven official languages, with SASL additionally recognised as an official home language in the education system, but English is the dominant language in healthcare settings. This can create a barrier when accessing GAHC. Clients may only be able to describe their personal gender identity and/or expression in a language that is comfortable to them. When a TGD client is expected to give IC when accessing GAHC, the healthcare provider needs to ensure that the client understands what they are consenting to (see **Chapter 2: Informed consent**).
- It is important that we need to strive to make the IC process available in all eleven official languages, as well as basic SASL.

CHAPTER 2

INFORMED CONSENT

2.1 Background

Informed consent (IC) in GAHC is complex and nuanced.[57,58] The IC process should empower the individual, by upholding their autonomy and maintaining their integrity.[14] The client and healthcare provider should be collaborative partners in decision-making.[59,60] It is the responsibility of the healthcare provider to inform the client of the risks and benefits of the various treatment options with the aim of enabling the client to make an informed decision about their own healthcare.[61] IC should be seen as a continuous process, rather than a singular event, and the discussion of IC with the client should be repeated as necessary during follow up.[62] Documentation of IC is important. Examples of IC forms for HT can be found in **Appendices B** and **C**.

The autonomy of the TGD client must be respected and upheld at all times.[62] Furthermore, guidelines should facilitate access to care. Access to care must be conducted in a responsible and safe manner, with the best interests of the TGD person uppermost.[62] Health providers have an ethical duty to prevent harm (non-maleficence).[14] In the context of GAHC, such harm can include a health providers taking advantage of power relationships and gatekeeping access to care, as well as not disclosing the psychosocial and physical risks of treatment, and the risk of regret.[57]

Given recent legal challenges to GAHC such as Bell vs. *Tavistock*[63] – to which WPATH,[64] the Professional Association for Transgender Health South Africa (PATHSA)[65] and Psychological Society of South Africa (PsySSA)[66] objected – it is important to outline what would be best practice in the South African setting. It should also be noted that the Bell vs. Tavistock ruling was subsequently overturned by the UK Appeal Court on the 17th September 2021.

Furthermore, it needs to be acknowledged that even in the most supportive and affirming environment, there is often an unequal power relationship between the client and the healthcare provider.[67] This, therefore, begs the question: is it ever possible to give full and empowered IC in a space of duress, anxiety, ill health, unequal power relations, fear of displeasing a healthcare provider, or missing treatment?[68] As healthcare providers we need to be aware how this unequal power relationship can have a negative and distressing impact on the TGD client. A TGD person's right to make choices about their own body are often impacted by this dynamic [69] and, as healthcare providers, we need to respect body autonomy without external coercion.[68]

Communication is a key part of this partnership: the healthcare provider needs to be able to give evidence-based information in an appropriate language that the client can understand, and the client needs to be able to give the healthcare provider all the necessary information about their health status. Creating a relationship of trust is important.[60] If a client feels that their rights will be respected, then they are more likely to disclose personal information to the healthcare provider, which in turn enables the provider to give them appropriate advice. At times, the TGD client has more knowledge regarding GAHC than the clinician.[70] A healthcare provider who upholds the paternalistic medical model may find this challenging.

IC is a critical factor in GAHC but is fraught with historical trauma and distrust, due to its abuse, especially in the form of gatekeeping,[14,71] while also being an essential factor in ensuring the actualising of ethical, evidence-based practice, holistic comprehensive support, care and allyship, with the best interest and well-being of the TGD client at the centre.

Based on the relevant literature and practice-based expert experience, IC intersects with factors such as: age of consent laws, duty to disclose ethics, rules governing confidentiality, existing standards of care guidelines for professional practice generally and specific to GAHC, professional ethical codes, and the various models of IC that are found in practice.[57,58] All these factors need to be considered and guidelines formulated that will ensure a client-centred model of GAHC support with a participatory approach, respecting the right to self-determination and autonomy of the client.[65]

2.2 Informed consent in children and adolescents

2.2.1 Broad legal principles for consent in children

Based on the legal opinion obtained from the South African Women's Legal Centre and the Centre for Child Law,[72] guidance has been sought from the Constitution of the Republic of South Africa (No. 108 of 1996)[4] and the Children's Act (No. 38 of 2005, Section 129(2))[73] as follows: 'A child may consent to medical treatment if over 12 years and the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.'[73]

The term 'medical treatment' is understood to be a manifestation of the right to health as provided for in Section 27 of the Constitution[4] and includes access to psychosocial and mental health services.[74]

Therefore, in South Africa, a child who is over 12 years of age, and meets these stipulated criteria, may independently give IC to both psychosocial and medical assessment/s and intervention for GAHC without legally requiring the support or consent of their parents/legal guardians. All children aged 12 years and younger legally require the consent of their parents/legal guardians. In the context of consent for surgical treatment in a child over 12 years, the child must be assisted by their parents/legal guardians (Children's Act, Section 129(3)).[73]

Section 129(10) of the Children's Act[73] indicates that the parents/legal guardians of a child that is younger than 12 years, or a child over that age but of insufficient maturity or unable to understand the benefits, risks and social implications of the treatment, may not withhold consent for medical or surgical treatment, based on their subjective beliefs. The best interest of the child is the guiding principle, as stated in Section 28(2) of the Constitution: 'a child's best interests are of paramount importance in every matter concerning the child'.[4]

2.2.2 Informed consent for psychosocial care for children younger than 12 years

Since a child younger than 12 years of age cannot give consent to engage in psychosocial/mental health evaluation, support and counselling,[73] the mental healthcare provider (MHP) must engage the parents/legal guardians in obtaining consent for both the TGD child and the parents/legal guardians to participate collaboratively in evaluation, support and counselling. This is also the ideal considering that the evidence shows that the best well-being outcome is achieved when family support is obtained in GAHC.[17,18,75]

In most prepubescent children presenting with indicators that they may be TGD, it is the parents/legal guardians that request a psychosocial/mental health evaluation, support and counselling. Here, the MHP, after confirming consent, can move to assessment. The duty to disclose and the MHP's ethical code should inform the process of obtaining IC. Consent involves explaining what the process of evaluation involves with the parents/legal guardians, other relevant and involved family members and with the child. Addressing the limitations of confidentiality with the child and the parents/legal guardians is very important at this stage. It is critical at this point that the MHP also assures the child that their role is to support and affirm them and their family, and to assist them to be their authentic self.[17,18,75] Once IC has been obtained and the evaluation process is completed, it is essential to explain to the child (in an age-appropriate way) and to the parents/legal guardians, the findings of the evaluation, followed by disclosure of the recommended intervention, such as a social transition. All the factors involved in a social transition process should be explained and discussed, including the benefits and risks. It should also be included that, should the child at any point express a change of mind and no longer wish to continue with the social transition, this too would be supported. Once assent from the child and IC from the parents/legal guardians is obtained, then the social transition process can begin.[76]

A situation may arise where a source other than the parents/legal guardians refers a child to an MHP and attempts to engage the parents/legal guardians are unsuccessful. When there is reason to believe that the parents/legal guardians are not acting in the child's best interest and the child is believed to be at risk of harm, the case must be referred to the appropriate statutory authorities empowered to investigate such a case. If need be, a court order may be obtained to allow the child to access the GAHC they need.[73] The MHP with expertise in GAHC for children needs to serve as a consultant and possible

witness to support such proceedings. This process may also need to be followed if the parents disagree about GAHC for their child. This situation should be avoided at all costs, and all attempts to get the parents/legal guardians to participate in the child's best interests should be exhausted, but not at the risk of undue harm to the child.[73]

2.2.3 Informed consent for psychosocial care for children older than 12 years

IC for TGD children older than 12 years is more complex, as GAHC for these children potentially involves elements of psychosocial/mental health evaluation, support and counselling, as well as medical intervention in the form of puberty suppression and possible hormone therapy (HT) for older adolescents.[17,18,75]

Some older TGD children may have been assessed earlier in childhood and already undergone social transition by the time they reach Tanner Stage 2 of puberty.[18,64] In most of these cases, parents/legal guardians are already working together with the MHP when this next stage in the young person's gender-affirming journey arrives. At this stage, it is the role of both the MHP and the medical professional to engage the TGD adolescent collaboratively in the process of full disclosure with regards to the option of puberty suppression, and later introduction of gender-affirming HT.[17,18,75] This requires that, between the MHP and the medical professional, all of the short- and long-term benefits and risks of puberty suppression and gender-affirming HT are discussed with both the adolescent and their parents/legal guardians. All aspects of emotional, psychological, social, physical and reproductive factors must be addressed.[18,58] The discussion should also address the possibility that, should the adolescent at any time come to a changing or different awareness of their experience of their gender identity, this too is valid and the adolescent should feel free and safe to express this and inform their parents/legal guardians and supporting healthcare professionals. This is so that the needed adjustments and changes to their transition process can be made, including the possibility of a diversion in their transition process. It is important to ensure that the adolescent and their caregivers fully understand which changes, resulting from puberty suppression and gender-affirming HT, are reversible and which are irreversible, and at which point in treatment the irreversible changes will be in effect.[17,75] In addition, the irreversible effects of endogenous hormones (if no treatment is provided) should also be explained.

As a consequence of minority stress (see **Chapter 5: Psychosocial care**) some adolescents may be facing challenges navigating environments that are prejudiced, discriminatory and ignorant about gender identity and gender diversity. There is also the possibility that some adolescents may be facing additional life stressors and traumas or have a genetic predisposition to, and/or may be dealing with a number of possible mental health conditions such as anxiety, depression, gender dysphoria, body dysmorphia, adjustment disorders, substance abuse, onset of bipolar mood disorder or schizophrenia.[17,18,75] Evidence indicates that both autism spectrum disorder (ASD) and autistic traits are more common in TGD youth than in cisgender youth.[77,78] The MHP, therefore, also needs to address how the management of these conditions may impact the GAHC process for the adolescent, as part of the IC process.[18] It is critical that the MHP makes it clear that having these mental health concerns is not a feature of being TGD, nor are they an exclusionary factor in accessing GAHC support. It needs to be made clear that any adjustments to the GAHC process as a consequence of also needing to address a mental health difficulty are done with the best interests of the adolescent in mind and in collaboration with them, along with the expressed intention of ensuring the best possible outcome for their overall well-being.[17,18,75]

There are also cases during adolescence, most often around the time of the onset of puberty, that gender incongruence and gender dysphoria may be expressed and/or experienced for the first time. In many cases, parents are receptive and supportive of their adolescent, and together with them will reach out to healthcare providers for support. All of the principles and factors already described in relation to age of consent and IC apply in these cases as well. A challenge often experienced here is the time pressure felt and expressed by the adolescent to engage as quickly as possible in social transition, as well as in elements of medical transition. They may request support with puberty suppression and gender-affirming HT (depending on their age and Tanner stage of puberty), to halt or alter the development of secondary sex characteristics of their sex assigned at birth. At the same time, parents/

legal guardians often feel overwhelmed, anxious and concerned about the implications of GAHC interventions. The MHP and medical professionals need to work collaboratively with each other, the adolescent client and their parents/legal guardians, appreciating these pressures while ensuring that due diligence regarding IC, as described earlier, with the best interests and integrity of the adolescent as the central principle.[17,18,75]

A situation may arise where an adolescent requests assessment and intervention or a referral to an MHP is received from the school, or any other source other than the parents/legal guardians, and where attempts to engage the parents/legal guardians are unsuccessful. Another situation may arise where the parents of the TGD adolescent disagree about GAHC for their child. If there is reason to believe that the parents/legal guardians are not acting in the best interest of the adolescent, as above with younger children, appropriate referral should take place.[76]

2.2.4 Informed consent for puberty suppression or hormone therapy in adolescents

International evidence-based research and expert authorities in GAHC for adolescents recommend that pubertal suppression should be offered to adolescents who are experiencing persistent gender incongruence and who wish to alter the development of unwanted secondary sex characteristics that occur in puberty from Tanner Stage 2 onwards.[17,18,75,79,80] In South Africa, an adolescent aged 12 years and older, deemed competent and of sufficient capacity, can give IC to this treatment.[72] This IC principle would also apply in cases where the introduction of gender-affirming HT in later adolescence is considered appropriate and necessary for the adolescent. IC is a continuous process, rather than a singular event.[62] Clinicians may observe that adolescents have evolving capacity over time as they mature.

Obtaining IC from the adolescent should ideally occur:

i. in the collaborative, supportive context of a multidisciplinary team with noted expertise in assessing and intervening in adolescent physical, psychological and social development.[79]
ii. with an appreciation of the influence of family dynamics, as far as possible with the support and involvement of the parents/legal guardians. Better family support for TGD youth is associated with better mental health outcomes.[81,82] The lack of parental/legal guardian support does not, however, preclude access to treatment.[17]
iii. with emphasis that the adolescent needs to understand all risks and benefits of the treatments and have considered the reproductive health implications and options (discussed in more detail in **Chapter 6: Hormone therapy**).[17,18,75,79,80]

More caution needs to be taken when deciding on medical treatments in the context of a TGD adolescent with ASD. As noted by Strang[83] 'it is often harder for an adolescent with ASD to comprehend the long-term risks and implications of gender-related medical interventions, consenting for treatment may be more complex in this population … it is important for the clinician to present the benefits and risks in a concrete manner, appropriate for the young person's cognitive and communication abilities'. TGD adolescents with ASD often have unrealistic expectations of interventions, including the belief that hormones alone will result in a perfect or complete transition and may not always appreciate the vital need to include their parents in the decision-making processes around hormones.[83] Professionals managing GAHC in this context should consider collaboration with professionals skilled in assessing and managing ASD. Adolescents and their parents/legal guardians should receive psychoeducation, and parental/legal guardian involvement is a crucial support.[83]

2.2.5 Informed consent for surgery in adolescents

Section 129(3) of the Children's Act states:[73]
'A child may consent to the performance of a surgical operation on him or her or his or her child if:

a) the child is over the age of 12 years; and
b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
c) the child is duly assisted by his or her parent or guardian.'

At the Center for Gender Surgery at the Boston Children's Hospital, a policy is followed for two-parent consent for surgery for adolescents under 18 years, except for cases in which such a requirement appears to interfere unduly with the informed choices of minors and raises the possibility of significant

harm.[84] Their position is that the involvement of both parents, as well as psychosocial health providers in the process of determining eligibility for surgery, as well as a frank and open discussion with the interdisciplinary team of the benefits and risks (including possible regrets), serves as a check on the possibility of impulsivity and reduces the likelihood that age-related cognitive factors would lead to decision regret.[84] The role of parents is regarded as more than IC, as they provide support throughout the gender-affirmation process. Boskey et al.[84] point out that many transgender youth have complicated family situations, which may make acquiring two-parent consent to perform surgery on an adolescent unfeasible or even impossible. Additionally, in South Africa many children and adolescents do not live with both parents, and some do not live with either parent. Therefore, consent is further complicated legal guardians may be reluctant to agree to treatments with long-term effects, given their temporary care of the child (e.g. a social worker in a children's home).

In line with international best practice for GAHC, we recommend that the IC process for gender-affirming surgery for an adolescent should involve a multidisciplinary team that includes an MHP, surgeon, the TGD adolescent and the parents/legal guardians.[17,18,84]

2.3 Informed consent in adults

2.3.1 Informed consent for psychosocial care for adults

According to South African law, a person is considered an adult at 18 years of age. A client's "decisional capacity" is presumed to be intact if they can understand relevant information, appreciate the consequences of the situation and reason about proposed gender-affirming treatment. A client's decisional capacity should not be judged simply based on their demographics and mental health history. Referral to a MHP may be appropriate if there is doubt regarding the client's decisional capacity, such as may occur in the case of severe mental illness. There are a few other situations, although rare, where decisional capacity may be of concern. Some examples might be active severe substance use disorders, active psychotic disorders, neurocognitive disorders, severe mood disorders and severe personality disorders.

The MHP needs to inform the client about the nature of the therapy/counselling/support and the limits of confidentiality.[85] The client can then consent to possible evaluation, support and counselling as discussed with the MHP. 'The informed consent model for gender-affirming treatment seeks to acknowledge and better support the patient's right to, and capability for, personal autonomy in choosing care options without the required involvement of a mental health professional. Clinicians' use of the informed consent model would enable them both to attain a richer understanding of transgender and gender non-conforming patients and to deliver better patient care in general'.[86]

2.3.2 Informed consent for hormone therapy for adults

Using the informed consent model (ICM), clinicians prescribing HT for TGD clients do not require a letter from an MHP. This model is understood along a continuum, with some professionals regarding IC as the only condition for HT, whereas others view it as a collaborative decision, giving weight to both the client's autonomy and the prescribing clinician's assessment.[58] Schulz[60] describes ICM: 'clients and practitioners are viewed as partners: the practitioner is viewed as having unique skills and clinical knowledge, while the patient is viewed as having knowledge of their own beliefs, personal value systems, and individual conception of self with regard to transgender identity'. The goal of the ICM is not to assess for a psychiatric diagnosis of 'gender dysphoria', which could be experienced as pathologising, but to facilitate thoughtful decision-making, preserving the client's autonomy.[71] An ICM recognises that, in many cases, transgender persons know more about their needs than many clinicians, given the lack of training in the field of transgender health.[87] A study of an ICM for HT in Australia reported high patient satisfaction,[61] with 92% of the individuals seeking HT only assessed by a general practitioner (GP), and 8% referred for a mental health assessment prior to HT initiation, mostly due to schizophrenia and post-traumatic stress disorder (PTSD). Although 56% of participants had co-occurring mental health conditions such as depression, anxiety, attention-deficit/hyperactivity disorder (ADHD), ASD or bipolar disorder, this did not affect their capacity to consent to HT.[61] The authors state that HT providers should have mental health experience, which is in the scope of practice of primary care, and that normalising GAHC into routine primary care practice will reduce barriers to

accessing care.[61]

2.3.3 Informed consent and psychosocial assessment for surgery for adults

Toivonen and Dobson[57] argue that a higher standard of care – and one that can be justified from a medical ethics perspective – is medically necessary for gender-affirming surgery, stating that 'letters of recommendation from mental health professionals are not meant to create unnecessary barriers for those who require intervention, but serve as a safeguard against uninformed decisions due to significant consequences' of gender-affirming surgery. Selvaggi[88] states that psychosocial care for TGD individuals prior to surgery is a form of responsible care, and not unjust discrimination: 'With regard to referral to mental health professionals, in our view, its aim is not to demonstrate that there is a pathology that needs to be cured'. The author argues that the MHP can assist the surgeon in evaluating the client's expectations, and whether the surgery could positively impact the client's life, especially when the surgeon is going to perform irreversible surgery.[88] The WPATH SoC-7[18] approach has been criticised as being 'overly cautious', though with recognition that professionals adjust the balance between autonomy and nonmaleficence based on risk.[89]

Florence Ashley, a lawyer who writes about her experience as a transgender woman, describes IC for gender-affirming surgery as a puzzle, with MHPs, surgeons and the TGD community holding different puzzle pieces.[90] She argues that, 'with the focus starkly placed on the anatomy, it can be easy to forget that trans patients seeking transition-related surgeries have a complicated relationship with their bodies and frequent mental health issues, especially anxiety and depression'.[90] In her view, MHPs are better equipped to attend to the client's overall well-being and integrate concerns of psychological and practical preparedness for surgery into their interactions. The MHP's role is described as ensuring the patient has realistic expectations, is ready to undertake the treatment plan, has an adequate support system, and has arranged aftercare. 'The expertise of mental health professionals complements that of surgeons' and they are tasked with assessing and supporting trans clients partly for that reason'.[90] In addition, trans communities can play a role in helping to ensure that a TGD person has adequate information related to the pre-operative preparation and post-operative care.

For gender-affirming surgery in South Africa, a documented process of thorough IC is essential and, ideally, should be done together with a multidisciplinary team that includes an MHP. If the client is able to consent, then their autonomy should be respected and facilitated,[18] and it is recommended that in the case of an MHP writing a referral letter to a surgeon, this is written in collaboration with the client in a participatory way.[2] We note that the WPATH SoC-7[18] states that a client should have two independent psychological evaluations prior to surgery. However, it has been convincingly argued that this is not necessary for all clients.[89,90,91] Version 8 of the WPATH Standards of Care is expected at the end of 2021 and is anticipated to include updated recommendations.

2.4 Informed consent for adults with intellectual and developmental disabilities and who have limited capacity to consent

The considerations discussed throughout this document apply to person(s) with intellectual and/or developmental disabilities (PWIDD) – across the lifespan. It goes without saying that they are not a homogenous group and the particularities of their disabilities and experiences vary. An individualised, person-centred approach is necessary. However, there are general considerations which can help to obtain true IC from someone with an intellectual and/or developmental disability. Ideally, a professional with competency in working with PWIDD needs to be a part of this process.

'Intellectual and developmental disabilities' is an umbrella term for a wide range of difficulties which impact on a person's intellectual and adaptive functioning, their ability to complete daily tasks and to learn new things, with the onset during the developmental period. The term 'intellectual disability' has replaced what used to be referred to as 'mental retardation', not only to minimise stigma, but to change the way we conceptualise neurodiversity. 'Retardation' implies that the person is 'stunted' or lacks in ability, whereas 'disability' speaks to a person's support needs. Similarly, it is no longer considered appropriate to refer to someone as 'high functioning' or 'low functioning'; instead, it should be framed as the degree of support needed. This is important to keep in mind when assessing

consent – your focus is on how you can support the person, not on their capabilities.

2.4.1 Relevant legislation and frameworks

Several laws should be considered: the Constitution,[4] Children's Act[73] (where applicable) and Mental Health Care Act (No. 17 of 2002)(MHCA).[92] However, these laws fall short of fully covering the rights and responsibilities of PWIDD.

The South African Department of Social Development's White Paper on the Rights of Persons with Disabilities[93] acknowledges that 'persons with disabilities remain the group whose legal capacity is most commonly denied in legal systems worldwide' and therefore includes a directive to 'develop supported decision-making services', especially for persons with 'intellectual, psychosocial, neurological and severe communication disabilities' (p.102). This directive is yet to see practical implementation.

It is for this reason that we can draw on the United Kingdom (UK) Care Act 2014,[94] which aims to safeguard vulnerable adults from neglect and abuse; the UK Mental Capacity Act 2005 (MCA)[95] – a legal framework which supports a person's right to make their own decisions; as well as the National Institute for Health and Care Excellence (NICE) guidelines and quality standards,[96] which provide insights on how to assess capacity in PWIDD. Additionally, South Africa ratified the United Nations Convention on the Rights of People with Disabilities (CRPD) in 2007, accepting all legal obligations demanded by the Convention. The CRPD aims to promote, protect and ensure the full and equal enjoyment of all human rights by persons with disabilities. However, South Africa is yet to integrate international prescripts into domestic legislation for PWIDD.[97]

2.4.2 Person-centred planning

'Person-centred planning is concerned ultimately with supporting people with intellectual disabilities to choose and experience the lives of their choice and with social change that enables people with intellectual disabilities to take their place as full members of local communities'.[98]

Several person-centred planning models exist which share the same key principles and values. First and foremost, the centrality of the PWIDD, who should be supported as much as possible to take a leadership role, so as to afford the freedom to plan a life with the requisite support, rather than merely access to a service. With this, comes acceptance of the PWIDD's authority and responsibility to contribute towards and control resources, with the backup from others of their choice. It is essential to include their families/carers/guardians and to consider wishes and feelings of these individuals, as they will also need to understand and appreciate the PWIDD's need for GAHC and be motivated to assist. Carers and families are the primary reason why PWIDD default on treatment and/or do not attend appointments. Their perceptions of the 'benefits and burdens' of GAHC will significantly influence the outcomes for the PWIDD.

Lack of choice is a common experience for PWIDD. It is preferable for PWIDD to be afforded a number of choices (within certain parameters) rather than to limit the opportunity for them to exercise preference. PWIDD have the tendency to be agreeable in an attempt to not upset others and, therefore, do not protect themselves. By giving them multiple options to choose from, the chances of this happening are minimised. For example, instead of 'Do you want x?', say, 'Do you want x, or do you want y?'

At the heart of person-centred planning is self-determination, so that PWIDD can direct and control their personal growth and development. They should be afforded the opportunity to set their own goals and be given help in identifying what they may need to achieve these, and to identify and address the barriers to their participation.

Persons with severe and profound intellectual disability will very rarely be able to communicate their gender identity preferences, let alone have the necessary executive functioning skills to make and communicate informed decisions. This is where alternative-augmentative communication (AAC) and substitute (or, surrogate) decision-making becomes relevant. Substitute decision-making comes into play after it has been determined that the person does not have the capacity to consent and that all practical steps to enable the person to make their own decision have been exhausted. Those who are responsible for the person's care and well-being, or who have been given the legal authority, will make the decision on their behalf, based on the best interest of the PWIDD. Respect of their right to bodily and psychological integrity must be upheld.[97]

Keep in mind that this may be one of the first times someone is listening to them and talking with them about their gender identity, and they may not have the language to describe their experiences or awareness of all possibilities. Their efforts to share their thoughts and feelings about their gender may have been dismissed or rejected, leading them to feel frustrated, lonely and depressed. This could manifest in psychological and behavioural problems. [99]

Because PWIDD have the right to be understood, the NICE Guidelines on Mental Health Problems in People with Learning Disabilities: Prevention, Assessment and Management (NG54)[96] provide clear and concise recommendations on involving PWIDD, and their family members, carers and care workers, in mental health assessment and treatment.

2.4.3 Communication (taken from NG54)[96]

Consider the client's communication needs and level of understanding throughout assessments:

- speak to the client directly rather than talking about or over them
- use clear, straightforward and unambiguous language
- assess whether communication aides (an advocate or someone familiar with the person's communication methods); assess communication difficulties/needs including augmentative-alternative communication (AAC) needs are needed
- make adjustments to accommodate sensory impairments (including sight and hearing impairments)
- explain the content and purpose of every meeting or session
- use concrete examples, visual imagery, practical demonstrations, and role play to explain concepts
- communicate at a pace which is comfortable for the person, and arrange longer or additional meetings or treatment sessions if needed
- use different methods and formats for communication (written, signing, visual, verbal or a combination of these), depending on the person's preferences
- regularly check the person's understanding
- summarise and explain the conclusions of every meeting or session
- check that the person has communicated what they wanted.

2.4.4 Informed consent in the context of intellectual and developmental disabilities

In the context of intellectual and developmental disabilities, it can be unhelpful to view capacity as 'all or nothing,' or 'have or have not,' but rather that it comes in varying degrees. PWIDD often have difficulties with working memory, self-motivation, inhibition, mental flexibility and abstract thinking, among other things, which can deter their capacity to make an informed decision. The UK MCA (2005)[95] advises that it must always be assumed that the person has capacity, unless it is proved otherwise, and that you must not assume incapacity simply because someone makes an unwise decision.[100] A PWIDD may not be able to completely make an independent or autonomous choice, but through a facilitative process they can be assisted to come to a decision.

It is important to be transparent and explain to the PWIDD that you are talking to them to confirm that they can consent; in other words, that you need to know if they can communicate their choice to you, that they have an understanding and appreciation of that choice, and are able to rationalise or explain why they have made that choice. Simply put, they need to be able to tell you what their situation is (i.e. that they want to transition, or want to know more about transitioning), what their options are and the possible outcomes, risks and benefits and why they are choosing one thing over another. Their account may be very concrete and focus more on descriptions of appearance or behaviour than abstract ideas about gender identity, expression and feeling.

It is important to remember that capacity to consent is situational and can change over time and place, and this is true too for PWIDD. Just because a client has intellectual or developmental disability does not mean that they do not have the capacity to learn and gain an understanding of GAHC, and so it must be considered whether they will have capacity in the future. In accordance with the legislation mentioned above, it

is therefore important to empower the client with accessible knowledge and understanding of gender identity and GAHC, and give the time needed to learn, explore and ask questions. The issue of consent should be revisited if there is concern that they do not have capacity at that point in time.

2.4.5 Consent, capacity and decision-making (taken from NG54)[96]

Assess the client's capacity to make decisions throughout assessment, care and treatment for the mental health concern on a decision-by-decision basis. Help clients to make decisions by ensuring that their communication needs are met, and if appropriate, by involving a family member, carer, care worker or other individual familiar with the person's communication abilities.

Staff delivering care to clients with learning disabilities and mental health problems should:

- discuss the assessment process and treatment options with the client and provide information in a format and language suited to their needs, including:
  - potential benefits
  - potential side effects or disadvantages – the purpose of treatment
  - outcome measures, including patient reported
- ensure that the client understands the purpose, plan and content of any meeting or intervention before it starts, and regularly throughout
- address any queries or concerns that the client may have at any stage
- allow enough time for the client to make an informed choice if they have decision-making capacity, and if they do not, then provide enough time for their family members, carers or care workers to contribute fully.

Additionally, the Montreal Cognitive Assessment – Learning Disabilities (MoCA-LD) has shown promise in assessing decision-making capacity in persons with intellectual disabilities. The MoCA-LD is an adapted version of the MoCA which uses the clock drawing, trail making, copy cylinder, naming, delayed recall, digit span (forwards and backwards) and orientation subtests. It can be used to increase objectivity in screening for the presence of capacity, but should not be used to confirm the absence of decision-making abilities.[101,102]

A significant barrier to GAHC for PWIDD is the lack of availability of information in accessible formats. An easy-read guide has been developed for TGD PWIDD to understand what they are experiencing and is freely available online.[103]

In summary, for healthcare providers working with PWIDD, it is key to prioritise transparency and accessibility to support the person's self-determination and right to access healthcare. Where full IC cannot be provided, shared decision-making practices can be adopted, which continue to uphold the autonomy and centrality of the person in setting out a clear vision for their GAHC. Referring to, or consulting with a health provider familiar with intellectual and developmental disability services is good practice and is highly recommended.

CHAPTER 3

PRIMARY CARE

This chapter discusses aspects of comprehensive care that are specific to TGD clients, including sexual and reproductive health. The process of hormone prescribing is detailed in **Chapter 6: Hormone therapy.**

3.1 Importance of the primary care provider

The TGD population is a marginalised group that faces many barriers in accessing healthcare.[25] A study conducted in KwaZulu-Natal reported that there is a paucity of facilities, resources and targeted programmes to cater for the TGD population's sexual and reproductive health needs.[24] Many of the participants confirmed that they engage in high-risk behaviour, comprising unprotected sex and the use of cross-gender hormones without medical supervision. Furthermore, the participants reported experiences of hostile and discriminatory behaviour by healthcare workers. The study concluded that the training of healthcare workers will contribute towards improvement of healthcare access for the TGD population.[24] GAHC requires an innovative approach with the key elements: person-centred, gender-responsive, comprehensive care; collaboration between TGD persons and practitioners; as well as continuity of care.[104]

To enable broader access, the provision of GAHC services, especially HT, needs to move away from specialist clinics and into primary care.[50,105] GAHC should be integrated into existing primary care services, as has been done with HIV care in South Africa. Primary care nurses are in a key position to ensure that TGD clients receive better care and experiences within healthcare facilities.[70] The role of primary care nurses can include the establishment of TGD-friendly primary care services, monitoring of TGD on HT, education on HIV prevention and treatment, initiation of clients on antiretroviral therapy (ART) when indicated, referral to higher levels of care when required, as well as post-surgical care.

Delivery of HT by primary care providers using the ICM can be done safely and effectively for adult clients, with specialist endocrinologist care needed only for complex cases,[106] such as underlying medical conditions that warrant careful introduction of therapy, or metabolic concerns where drug therapy may aggravate medical conditions. Specialist involvement may also be of great value for an adolescent client, but case-by-case decisions should be made within a multidisciplinary team context.[17] An analogy would be ART in South Africa, which was initially only prescribed by specialists, but has become part of the basic competencies expected of a medical graduate.[36,107]

Sexual health requires 'a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences'.[108] A sex-positive approach recognises that each person's sexuality is unique and multifaceted and emphasises the importance of sexual pleasure, freedom and diversity.[109] This approach is of particular importance for health professionals who provide care to TGD clients, to be open to diversity in sexual practices.[80]

3.2 Comprehensive care

Screening is part of prevention and providing comprehensive primary care. When caring for a TGD client, specific attention needs to be given to the following areas:

3.2.1 Violence

Many TGD persons are reluctant to access health services, even when experiencing violence.[28] A trauma-informed approach is to understand that many clients present with complex trauma histories with interpersonal, social and medical systems-based trauma experiences, that may impact on their current health.[51] Trauma-informed primary care includes screening for: 1) recent abuse, including intimate partner violence; 2) lifetime trauma; and 3) emotional and physical consequences of trauma, including PTSD, depression, suicidality, substance use and chronic pain.[110] A patient's disclosure of recent or past trauma can be potentially therapeutic, if the health professional's response is empathetic and supportive; validates individuals' experiences, choices and autonomy; and

builds on patient strengths. Referral for psychosocial and legal support may be required; while community resources and peer support can play an important role.[110] As the need for support may be beyond what is available at the health facility, it is important to be aware of TGD-friendly community resources for referral. See **Appendix D** for a list of community resources.

The World Health Organization (WHO) recommends the LIVES approach to violence (Listen, Inquire, Validate, Enhance safety and provide Support).[111] A client who has experienced sexual violence needs timely access to appropriate care, including post-exposure prophylaxis (PEP), sexually transmitted infection (STI) prevention and, if necessary, emergency contraception.[112] If a forensic examination needs to be performed, then this requires extreme sensitivity from the health professional, as a TGD client may find it very traumatic.

3.2.2 Mental health

Comprehensive care should include screening for mental health conditions, as well as consideration of the possible negative impact of gender dysphoria on the client's mental health, and the potential positive impact that gender-affirming treatment may have.[113,114] In South Africa, among a cohort of 85 transgender adults, the incidence of anxiety was 25.9%, substance use was 21%, eating or psychotic disorders was 2.3%, and lifetime prevalence of mood disorder was 21.2%.[115] Assessment should include that of the client's existing support structure, and support and psychoeducational needs related to their care.

A TGD client should always be offered mental health support[17,18] and continued support should be encouraged and facilitated, regardless of the client's mental health status.[60]

A mental health condition is not a contraindication to initiating HT, and can be managed concurrently.[18] Referral is required if there is concern about decision-making capacity or if a mental health condition needs to be addressed. While the presence of some mental health disorders (particularly those with manic or psychotic features) may affect an individual's capacity to provide IC, a recent meta-review showed that most clients with a severe mental disorder made appropriate decisions regarding their healthcare.[116] An Australian study[61] found that GPs needed to refer only 8% of their TGD clients to a MHP prior to hormone initiation. Most of these clients had either schizophrenia or PTSD. Over half (56%) of TGD clients in this study had a mental health condition, such as depression, anxiety, ADHD, ASD or bipolar disorder; however, this did not affect their capacity to consent to HT.[61]

3.2.3 Screening for alcohol, tobacco and drug use

A national survey reported much higher alcohol use in transgender participants (n=194), compared to the general population, with 48% of transgender women (TGW) and 49% of transgender men (TGM) consuming alcohol at hazardous, harmful or dependence levels.[25] These harmful drinking practices are associated with a lifetime experience of physical or sexual violence.[25] Tobacco use was reported in 54% of TGW and 50% of TGM. High levels of harmful and dependent drug use were found in TGW (29%) and TGM (16%).[25] In a survey of 258 TGW in eight provinces in South Africa,[117] 58% reported smoking cigarettes; 60% drank more alcohol than they thought was socially acceptable; 39% reported smoking marijuana and 31% disclosed that they used other habit-forming substances. Of participants, 36% responded that they had used alcohol or drugs to cope with the mistreatment that they face due to their gender identity.[117]

It is recognised that gender minority stress can contribute to harmful alcohol and drug use.[118] Clinicians must be mindful that tobacco, alcohol and drug use can be coping mechanisms for TGD persons,[117] thus screening is essential. Tobacco use in combination with oestrogen therapy is associated with an increased risk for venous thromboembolism (VTE).[17] A sensitive and client-centred approach within a harm reduction framework is recommended, as described in the Southern African HIV Clinicians Society Guidelines for Harm Reduction.[119] This includes screening, brief intervention and referral to treatment (SBIRT) for harmful substance use.[119] Clients should be reassured that use of substances will not preclude them from accessing HT.

3.2.4 Fertility and contraception

A discussion on the impact of HT on future fertility is essential prior to initiation of HT and is discussed in **Chapter 6: Hormone therapy**.

Reliable contraception options must be explored in an AFAB client who has a uterus and ovaries, as pregnancy is still possible, even if the client is taking testosterone.[120] Non-hormonal intrauterine devices (IUDs) are recommended, to avoid the hormone effect from hormonal birth control forms, but also the perception

of the hormone effect, which can be frightening to an AFAB client.[120] Hormonal options such as hormone-releasing IUDs, progesterone injections or implants can be discussed,[120] and would need to be tailored to the individual's needs, with an especially keen focus on the emergence of any side effects.

Transgender men (TGM) who desire children may consider pregnancy. A cross-sectional study of 41 TGM who experienced pregnancy, reported that in 80%, menstruation resumed within 6 months after stopping testosterone and most TGM became pregnant within 4 months of trying to conceive.[121] For lactation in TGM, the term 'chest feeding' is preferred.[122] There are reports of lactation even after chest masculinisation surgery, although surgery may alter the physical capacity for milk production.[122]

For transgender women (TGW) wishing to breastfeed, a protocol to induce lactation similar to one for non-birthing, cisgender women may be followed, including the use of medication and pumping.[122] Domperidone has been used to induce lactation in TGW and is effective in increasing milk supply with no adverse effects for infants.[123] Trans clients who choose to pursue these options need significant support to overcome barriers. Paynter[123] recommends that 'health care providers must bring open-mindedness, curiosity, compassion, and creativity to practice lactation support for transgender people.'

3.2.5 Cancer

Cancer screening is based on what anatomy (body part or organ) is present and whether the client meets the criteria for screening based on risk factors and/or symptoms. Relevant screening should be done regardless of HT use,[51] and there is no evidence for increased cancer risk due to HT.[51]

Cervical screening, human papillomavirus (HPV) testing and HPV vaccination is essential in a TGD client with cervical tissue.[124] In South Africa, cervical cancer ranks as the highest cause of cancer death in persons AFAB[125] and screening should be done regardless of sexual orientation or comorbidities.[126] This can be done with a Pap smear or a vaginal HPV swab test. Some AFAB clients may find a speculum examination traumatic, and client-provider communication that is sensitive and respectful is critical. In addition to causing cervical epithelial atrophy, testosterone treatment can induce vaginal epithelial atrophy that may make passage of a speculum uncomfortable.[127] Strategies to mitigate discomfort include the use of a small speculum and application of a small amount of lubricant to the speculum.[127] A self-collected vaginal swab for HPV is an option for a client who is reluctant to have a vaginal examination.[128] The vaginal swab test for HPV offers improved sensitivity compared to cytology.[124] Self-collected vaginal swabs have a sensitivity of 71% compared to provider-collected swabs for HPV testing and is a good option for AFAB clients who are reluctant to have a vaginal examination.[128] Several barriers to accessing cervical screening exist, particularly for TGM, and providers need to be aware of these and work to dismantle them.[129]

In TGW with breast tissue and TGM who have not undergone complete mastectomy, guidelines for breast cancer screening for cisgender persons should be followed. Top surgery dramatically reduces risk of breast cancer in transmasculine clients; however, a non-zero risk still remains, and this should guide screening. As a provider, it is important to enquire whether the client has a family history of breast cancer. The Radiological Society of South Africa (RSSA) recommends annual screening mammography from age 40–70 years and regular self and clinical examination.[130] Due to resource constraints in the public sector, screening mammography focuses on high-risk individuals.[131]

Prostate cancer has been documented in TGW, although the prevalence is lower than in cisgender men.[132] Screening should follow guidelines as for cisgender men; the Cancer Association of South Africa recommends prostate-specific antigen (PSA) testing for age 40–50 years if there is a family history or warning signs of possible prostate cancer, and PSA testing every two years for age 50–70 years.[133] If a PSA test is done in a TGW with a low testosterone level, the upper limit of normal (ULN) should be reduced to 1.0 ng/mL (rather than 2.0 ng/mL as in cisgender men).[134] If a prostate exam is indicated, both rectal and neovaginal approaches may be considered. TGW who have undergone vaginoplasty have a prostate anterior to the vaginal wall, and a digital neovaginal exam examination may be more effective.[135]

3.2.6 Sexual health

A client may engage in high-risk behaviour, and a detailed sexual history should aid screening and examination. Avoid assumptions about the client's sexual orientation and behaviour, and rather discuss this in a non-judgmental way with a sex-positive

approach.[80,109] The goal of the sexual history interview is not to classify or diagnose the client, but to assess risk for concomitant STIs, and to identify whether there is a need for PrEP, for example.

It is also important to note that, in African culture, the thought of sex as taboo limits the range of acceptable terms when discussing a sexual history.[136] Use of culturally respectful language can enable the reporting of truthful facts and minimise ambiguity or shame.[137]

This can be done jointly with visual aids or a bilingual lexicon when necessary.[138] **Table 3**, adapted from Stroumsa and Wu,[55] provides recommendations for how to take a sexual history and the provided isiNguni alternatives provided in the table acknowledge respect and personhood – principles which are largely characterised and embraced by Southern African ethno-cultural populations.

TABLE 3: Gender-inclusive language for taking a sexual history.[55]

Common practice	Recommended practice	Suggested culturally sensitive options for South Africa
• Addressing the client as Mr, Ms or Mrs	• Call the client in from the waiting room using their last name only. • Then ask them: 'How would you like me to address you?' (name and pronouns).	• Pronouns are not gender-related in Nguni. • Titles include: sisi/bhuti/ mfowethu/mama/baba/gogo/ mkhulu. • Addressing the client in a gendered manner is a form of respect for one's age. The title loses the last letter when prefixing one's name, for example, 'sis' Phumla'. • Using the client's Western name may not be respectful. Ask the client which name they would prefer to use as a sign of respect. • Asking for and using the client's clan name (Izithakazelo/iziduko) is gender- neutral and respectful.

• Use of binary sex markers (male or female)	• Use a 2-step gender question:
	  • What is your gender?
	  • What sex were you assigned at birth (i.e. what is stated on your original birth certificate)?
		• Gender = 'isini/ubulili'.
		• Ask: 'What was assigned on your birth certificate?'

• Obtaining a menstrual or obstetric history	• Avoid assumptions about anatomy. • Clarify whether the patient has a uterus.	• Ask: 'A person that was assigned-female-at-birth usually has a menstrual cycle. Do you get your cycle?' or 'Do you often go on your cycle?'
• Asking 'Are you sexually active?'; or • 'Are you sexually active with men, women, or both?'	• Advise the client who the questions asked might seem uncomfortable or intrusive but are intended towards assessing risk. • Understand that there are many sexual practices that do not include penile-vaginal penetration. • Therefore, rather ask: 'What kinds of intercourse do you have?', followed by appropriate questions regarding specific sexual practices (e.g. penis-in-vagina, penis-in-anus, vulva-to-mouth, etc. – be sure to use appropriate language as informed by the client).	• 'Sex' is not usually a term used. • Ask: 'In which ways do you and your partner make each other happy when you are together/in the bedroom?'

• Asking: 'Do you use condoms?'	• Rather ask: 'Do you use protection during sex?'; and 'What protection do you use?' • Ask directly around use of lubricants, and the nature of lubricants, to determine if they are condom-safe.	• Ask: 'Do you use protection? Does your partner use protection when you are together?'

3.2.6.1 Effects of hormone therapy on sexual health

In a client taking feminising HT, changes to libido and sexual response cycle are usually observed within 1–3 months of initiation of treatment.[80] Erectile dysfunction can be an expected side effect of feminising HT.[139] In some cases, this is desirable, but if it presents a problem for the client, treatment with phosphodiesterase type 5 inhibitors (such as sildenafil) may be considered.[140]

In a client taking masculinising HT, an increase in sexual desire and activity is often reported[80] and clitoral enlargement is likely to occur.[141] The clitoral growth can be significant, with a mean maximal clitoral length of 4.6 cm reported in one study, after one year of testosterone therapy.[142] These changes are often desirable, but clients should be counselled before initiating gender-affirming HT to ensure that they are aware of such possible changes.[143]

Vaginal atrophy may occur due to the hypo-oestrogenic effect that testosterone has on vaginal tissues[144] and can be ameliorated with lubricants. If this provides inadequate relief, topical oestrogen preparations can be used to return atrophic tissues to health, though these might give rise to fears in clients of the effects of oestrogen treatment.[120] Such clients should be reassured, as well as offered the opportunity to start with small doses and keep track of any unwanted effects. A combination of topical oestrogen and testosterone can also be compounded to offset any unwanted effects from topical oestrogen treatment alone.

A TGD client on HT may experience a shift in sexual orientation over time.[145] A qualitative study reported that TGD participants described shifts in their sexual attraction and sexual identities, and described their sexuality in ways that avoided the use of traditional sexual orientation labels, instead preferring descriptions that focused on the characteristics that guide their attraction, e.g. 'I like women'.[145]

When taking a history, the provider should elicit information about non-medical gender-affirming practices that the client uses, if any (see **Chapter 4: Non-medical gender-affirming practices**).

3.2.7 Sexually transmitted infections

High-risk sexual behaviours such as sex work, unprotected receptive anal intercourse and multiple casual sexual partners can increase the risk for STIs including HIV. There is, however, a paucity of data for non-HIV STIs such as chlamydia, gonorrhoea, syphilis, viral hepatitis and herpes simplex virus (HSV), and how they affect TGW.[146]

In addition, little is known about the prevalence of any STIs, including HIV, in TGM.[146] In studies of transgender sexual health, inclusion of TGM has been lacking as this population is historically difficult to recruit for research. Similar to TGW, TGM may be emotionally and sexually attracted to people of all gender identities and can identify as straight, gay, bisexual, queer, or with another sexual orientation, resulting in a range of sexual risk behaviours among this group.[146] A study in Vancouver found that a common goal of sexual behaviours among TGM was affirmation of their post-transition masculinity, leading many to have receptive anal sex with cisgender men and avoidance of vaginal sex.[147]

A study in Australia found that the prevalence of gonorrhoea has increased over the past decade among TGW attending sexual health clinics, but not TGM.[148] This change illustrates why we need to move beyond including all TGD persons in a single category, as epidemiological differences such as this require different responses for reducing infection and delivering appropriate sexual healthcare. Health systems must meet the specific sexual health needs of TGD communities. Not adequately accounting for gender undermines health surveillance, diminishes client confidence and reduces quality of care.

3.2.8 HIV

3.2.8.1 Epidemiology

TGD persons are disproportionately burdened by HIV and have a greater risk of acquiring the virus with an HIV prevalence of 46% among TGW in South Africa.[149] TGW are therefore included in South Africa's National Strategic Plan for HIV, TB and STIs 2017 - 2022 as a key population.[150] After receiving a diagnosis, HIV-positive TGW may have challenges accessing effective HIV treatment, as demonstrated by lower rates of virological suppression and higher HIV-related mortality.[151] Multiple sociocultural and structural barriers negatively affect TGW's engagement within the HIV care continuum, contributing to adverse HIV outcomes.[117] TGW, especially young adults, racial/ethnic minorities and undocumented individuals, often experience intersecting discrimination and high rates of trauma, unstable housing, poverty, incarceration and unemployment, which all negatively impact HIV risk, testing and continuing care.[152] Few data exist on HIV among TGM, likely due to much lower HIV prevalence.[153]

3.2.8.2 HIV screening and prevention

General guidelines for HIV screening, prevention and care do not differ for TGD persons; however, HIV services for TGD persons should address the specific biological, psychological and social needs of this population.[51] Public health programmes that reach marginalised TGD persons may need to be aware of the need to use specialised/differentiated approaches to reach persons at high risk who have not been engaged/tested – e.g., using social network strategies, HIV self-screening (HIVSS) or index testing, etc. Peer outreach workers can play a vital role in engaging with the TGW community and helping TGW to navigate clinical and social services.[154]

Condoms and condom-compatible lubricant continue to be important in HIV prevention. However, TGW taking HT may find the use of condoms difficult due to reduced tumescence.[51] TGW may also lack the agency to negotiate condom use, especially those who engage in sex work.[154] For TGM who engage in receptive vaginal sex, internal condoms may be an option.[51] HIV counselling and testing services should address TGD-specific needs, and options such as HIVSS, index testing and partner notification should be offered.[51]

3.2.8.3 Pre-exposure prophylaxis

Daily oral PrEP with the fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg has been shown to be safe and effective in reducing the risk of sexual HIV acquisition in TGW.[156] The 2020 Southern African guidelines on the safe, easy and effective use of pre-exposure prophylaxis recommend that PrEP should be offered to TGW.[157] Drug-drug interactions are not expected as TDF and FTC have different metabolic pathways from sex hormones.[158] A study with self-reported adherence to PrEP reported slightly lower TDF levels in TGW on HT,[159] but a study with directly observed dosing of PrEP found similar blood concentrations between TGW and MSM,[158] concluding that the effects of hormones are small and do not reduce the clinical protection from PrEP. The latter study also showed that taking PrEP had no impact on oestradiol or free or total testosterone concentrations among TGW or TGM, respectively, which can be reassuring for clients who are taking HT and PrEP.[158] As other HIV prevention options such as dapivirine vaginal ring and/or long-acting injectable cabotegravir become available, TGD clients should be presented with thorough information on all available HIV prevention options to facilitate informed choice. The continued use of PrEP should be encouraged for TGD clients who are at high risk of HIV infection.

3.2.8.4 Treatment considerations

HIV and its treatment are not contraindications to HT.[151] In fact, providing HT in the context of HIV care may improve engagement and retention in care as well as adherence and viral load suppression.[51] Modern integrase strand transfer inhibitor (InSTI)-based therapy is the ART regimen of choice for a TGD client with HIV.[160] A dolutegravir (DTG)-containing regimen is preferred over an efavirenz (EFV)-containing regimen because it is generally better tolerated (fewer neuropsychiatric, hepatic and metabolic effects) and has a very high resistance barrier.[161]

A concern among TGW of potential drug-drug interactions between HT and ART may lead to sub-optimal ART adherence.[162] This highlights the need for appropriate counselling to support adherence. Oestradiol is partially metabolised by cytochrome P450 (CYP) 3A4 and 1A2 enzymes, posing potential drug-drug interactions with other medications that induce or inhibit these pathways, such as non-nucleoside

reverse transcriptase inhibitors (NNRTIs), e.g., EFV and nevirapine (NVP) which are no longer commonly used.[160] The iFACT study measured plasma EFV, TDF and oestradiol in 20 Thai TGW on HT and who initiated ART with TDF/emtricitabine (FTC)/EFV. The study found that oestradiol was reduced by 36% (p=0.004), likely due to CYP induction by EFV.[162]

If the TGD client is on both spironolactone and cotrimoxazole, frequent monitoring of serum electrolytes and renal function is indicated due to a possible drug interaction which may lead to hyperkalaemia, severe illness and even death.[163] Particularly close attention should be given if the client is elderly.[163]

TGW with HIV are less likely to access HIV treatment or engage in care because of barriers such as poverty, violence, stigma and unemployment. As such, there are lower rates of virological suppression and higher HIV-related mortality in this group.[151]

3.2.8.5 Adherence

Adherence to ART and PrEP should be emphasised. TGD persons are less likely to be retained in HIV care due to a plethora of factors including sociocultural, economic, population and health facility determinants of HIV care.[117] The community-level issues must be paid special attention because of their role in creating social cohesion and establishing an enabling space for holistic health of TGD persons. Innovative approaches to ensure that TGD persons remain in HIV care are required. The use of social media platforms and other information communication technology should be used to encourage retention in HIV care services.[164] A study conducted in Mpumalanga[164] found that TGW may benefit from technological approaches such as a cell phone applications to serve as a digital reminder for taking medications. In addition to serving as a digital reminder, positive and affirming messaging can remind clients of the benefits of a healthy lifestyle, including being adherent to PrEP and ART.

3.3 Physical examination

It is important to note that a physical examination may cause the TGD client distress. **Box 2** provides an affirming approach to a physical examination.[51]

BOX 2: An affirming approach to a physical examination

- Adopt a trauma-informed approach, as many TGD clients find a physical examination uncomfortable or traumatic.
- Use correct pronouns and names. This is especially important in the context of a physical examination.
- Only conduct a genital examination if medically necessary.
- Explain to the client why the examination is necessary and what you will be doing. This can help reduce anxiety. It is also an important part of obtaining IC.
- Be aware that the client may use alternative terminology for body parts – ask them which terms they would prefer you to use.
- Where possible, adapt procedures to make the client feel more comfortable (for example, the client may be more comfortable with self-swabbing for HPV testing).

IC, informed consent; HPV, human papillomavirus; TGD, transgender and gender diverse.

CHAPTER 4

NON-MEDICAL GENDER-AFFIRMING PRACTICES

4.1 Background

Non-medical gender-affirming practices are strategies to modify an individual's gender presentation,[165,166] often employed daily by TGD persons, and include binding, tucking, padding and packing, for a variety of reasons, such as alleviation of dysphoria and a perceived need to 'pass' as cisgender in particular contexts (e.g., public spaces and the workplace).[166] Similarly, a TGD person may not feel the need for any non-medical gender-affirming practices, or may need only selected interventions.

Knowledge on the types of practices employed by TGD persons is limited, and very little is known about associated risks or side effects.[165,167] Resources on non-medical practices are often spread informally among TGD persons,[166] and while these tend to err on the side of caution when it comes to safety (see below list for example), the lack of empirical knowledge means that these common-sense approaches to safety remain unverified:

- **https://transcare.ucsf.edu/guidelines/binding-packing-and-tucking**
- **https://qwchealth.com/2020/11/09/essential-tips-for-tucking-strapping-packing/**
- **https://www.prideinpractice.org/articles/chest-binding-physician-guide/**

In one of the few studies on this topic, Rood et al. [168] showed that, while non-medical gender-affirming practices can function to affirm an individual's gender identity, they can also become a source of stress, especially when they prioritise 'passing', or visual conformity to gender norms. In fact, results obtained by Begun and Kattari[169] suggest a positive association between lower visual conformity and homelessness, as well as experiences of violence and discrimination. This implies that non-medical gender-affirming practices, applied for the sake of visual gender conformity, are important factors of psychosocial well-being,[168,169] including the alleviation of gender dysphoria.[18] While packing and padding carry little to no health risk, it is imperative for healthcare providers to be knowledgeable about safe binding and tucking practices. Where relevant, healthcare providers should proactively discuss the risks of binding and tucking with TGD clients, and encourage safe practices, including strategies for the prevention of pain, dermatological complaints, and infection.

4.2 Binding

Chest binding is a common practice for flattening chest tissue, using specialised compression garments, bandages, duct tape and other materials.[170,171,172,173] While the practice is widely acknowledged as uncomfortable and even risky,[171,172,173] it is associated with significant self-reported improvements in mental health outcomes.[172] A study by Peitzmeier et al.[171] explored the health impact of binding among AFAB clients. Of 1800 participants, 51.5% reported daily binding, with over 97% of those reporting at least one negative outcome. Negative outcomes were also linked to frequency of use (measured in days per week), suggesting that taking 'days off' (as opposed to taking shorter breaks) from binding could improve health outcomes.[171] In a much smaller study by Poteat et al,[173] 37 out of 46 (80.4%) AFAB participants reported lifetime use of some form of binder, most for 7 days per week, and most for 8–16 hours per day. Health problems most commonly reported with binding are back pain, shortness of breath and shoulder pain,[171,172,173] and larger chest size has been associated with skin and soft tissue symptoms.[171] Findings on care-seeking behaviour among transmasculine individuals who bind[172] hold important implications for healthcare professionals: while 88.9% of 1273 participants had reported experiencing at least one binding-related symptom, only 14.8% sought binding-related medical care. Care-seeking was associated with feeling safe and comfortable with a healthcare provider, implying the importance of provider competency in this regard.[174] Healthcare providers may be able to help their patients reduce negative outcomes associated with binding by recommending 'off-days' from binding when possible, practising good skin hygiene, and avoiding elastic bandages, duct tape and plastic wrap as methods for binding.[171]

4.3 Tucking

Tucking refers to the arrangement of the penis and testicles to present a flat pelvic area, often by pushing the testicles into the inguinal canal and taping the penis between and behind the legs toward the anus.[165,168,173,174,175] Gaffs (specialised tight garments, often homemade), tape and tight briefs are commonly used.[173,176] Empirical studies on the health effects of tucking are yet to be undertaken, although an exploratory study[173] found that, of 83 AMAB participants, 59 reported lifetime tucking, with close to 50 of those reporting tucking 7 days per week. Around 25 participants reported tucking for more than 17 hours per day. The most common health problems related to tucking were itching (27.1%), rashes (20.3%), testicular pain (17.0%) and penile pain (13.6%).[173] Zevin[174] also reports urinary reflux, symptoms of prostatism and infection. Pain related to HT initiation has also been reported.[174] Healthcare providers can advise safer ways of tucking to relieve pain, such as shorter periods of tucking or less tight tucking, as well as encourage good skin hygiene.[51]

4.4 Padding and packing

Padding is the use of prosthetics or padding under the clothes to give the appearance of breasts and/or phenotypical female curves, and packing is use of prosthetics or padding under the clothes to give the appearance of a penis and phenotypical male pelvic bulge.[165,166,167] Healthcare providers should be aware of the presence of specialised garments and prostheses during physical examinations, and sensitive to their purpose.

CHAPTER 5

PSYCHOSOCIAL CARE

This chapter is structured using a life course approach. After presenting the background and approach to psychosocial care and addressing the role of MHPs, this chapter addresses the psychosocial considerations for pre-pubescent TGD children, TGD pubescent adolescents, TGD adults and the TGD elderly. In each section, the micro-, meso- and macro-level psychosocial considerations are outlined and discussed.

5.1 Background and approach to psychosocial care

Gender-affirming psychosocial care is vital for the long-term well-being of TGD persons and goes beyond only transition-related support. Following minority stress theory,[176] we can assume that TGD persons are exposed to a range of stressors such as stigma, marginalisation, discrimination and even gender-based violence (GBV) related to gender identity or expression, impacting on all aspects of their well-being, and operating at various levels of the TGD experience.[17,177,178]

In line with the holistic focus of GAHC,[36] psychosocial care for TGD persons should consider both the presenting concerns of the TGD individual, and the broader sociocultural and economic contexts in which they live. The term 'mental healthcare provider' (MHP) used in this chapter refers broadly to all mental health/psychosocial-related providers whose scope of practice includes elements of mental health and psychosocial support for TGD persons.[179] These include, but are not limited to, clinical psychologists, counselling psychologists, educational psychologists, industrial and organisational psychologists, psychiatrists, social workers, clinical social workers, school social workers, registered counsellors, lay counsellors, child and youth care workers, occupational therapists, nurse practitioners, psychiatric nurses, and employee assistance practitioners. Each of these MHPs functions within their specific scope of practice, professional competencies, specialist experience and expertise appropriate to their profession.

5.2 The role of the mental healthcare provider

MHPs must appreciate that while the diagnosis of 'gender dysphoria' remains classified as a mental health disorder in the DSM-5,[20,180] the ICD-11[19] conceptualises 'gender incongruence' as a 'condition related to sexual health.' This reconceptualisation mirrors the increased shift towards gender-affirming mental healthcare (MHC) as opposed to the historically favoured, assessment-driven gatekeeping approach.[181] Gender diversity is part of diverse human experience. Moreover, in line with the Yogyakarta Principles and a human rights approach, TGD individuals have the right to freely determine their gender.[26,27] MHPs may be called upon to facilitate IC for some gender-affirming procedures (e.g. surgery), which may include elements of assessment. In such cases, MHPs should caution against assuming links between gender role, sexual orientation and gender identity based on traditional, binary understandings of masculinity and femininity[17,18] and advocate for a holistic assessment of the TGD client's needs.

Table 4 summarises the role of the MHP.

TABLE 4: Role of the mental healthcare provider.	
Role	**Description**
Understand the complexities of 'assessment' or 'evaluation'	The MHP needs to be cognisant that a mental health 'assessment' or 'evaluation' is particularly complex in relation to gender identity and GAHC in South Africa as it is a contentious concept that has historically been used to justify and maintain dominant ideology.[182] The TGD client's overall well-being and assessment or evaluation, is a process of 'coming to know and understand' the client and their context.[183] An asset-based approach should be used and the focus should be on establishing and maintaining a sufficient support structure[16] and ensuring that the client understands the implications of gender-affirming medical interventions.
Aid diagnosis	Recognise any mental health concerns in the client and develop interventions that centre the client and do not pathologise their gender identity. Depathologisation is evident in the ICD-11 as it conceptualises 'gender incongruence' as a 'condition related to sexual health',[19] as opposed to the DSM-5 in which 'gender dysphoria' is classified as a mental health disorder.[20]
Provide support	Ensure that the client knows what to expect of planned interventions, help develop strategies for strengthening their support system, and support the client through any mental health challenges that may arise as a result of contextual responses to their gender identity. These may vary between children, adolescents and adults and are affected by sociocultural and other factors.[17,18,184]
Provide psychotherapy	Provide supportive therapy, if desired by the client, before, during, and after social and physical transitioning. Intersectional challenges may increase the individual's risk of experiencing minority stress, which then exacerbate existing mental health disparities[3] and negatively affect continuity of care.[28] Uphold best practice of care by ensuring understanding of, and affirming the range of emotional, psychological and social outcomes that the client may experience, without imposing preconceived ideas.[1,18] Mental health difficulties may result from: contextual factors and environmental responses to the client's TGD identity; individual genetic predisposition, and non-gender identity related causative factors.
Provide documentation	In terms of the Alteration of Sex Description and Sex Status Act (No. 49 of 2003),[185] the South African Department of Home Affairs requires two letters from medical professionals to enable a gender marker change. In addition, letters or reports may be requested by other healthcare providers involved in the client's care. Respect the client's autonomy and uphold confidentiality in all communication and written documents, as far as possible, in collaboration with the TGD client and other role players. The MHP should be cognisant of ethical considerations and act within the scope of practice.
Enable support groups	Facilitate TGD support groups for individuals and for the community. This will enable TGD individuals to access support and guidance through the GAHC process. South Africa's National Strategic Plan for HIV, TB and STIs 2017 - 2022 encourages the use of peer support groups for mental health support[150]
Advocate	Counteract stigma and violence, including hate victimisation in all its forms, across all developmental stages. Advocate for the TGD client's human rights and challenge inequality and oppressive systems that discriminate against the client.[3,18]

GAHC, gender-affirming healthcare; MHP, mental healthcare practitioner.

Oliphant *et al*.[17] state: 'Trans and gender diverse people have the same inherent potential to flourish and thrive as other people, but currently experience increased risk of harm because of discrimination, social exclusion, bullying and assault, as well as institutional barriers'. This is one reason why TGD persons have a higher rate of mental health disparities and often struggle to function optimally.[25,186] Intersectional oppressive practices increase their risk for minority stress, further exacerbating mental health disparities.[3] MHPs should address such disparities, within their specific scope of practice and by drawing on a range of interventions, if required by the TGD client and in line with best practice guidelines.

Gender-affirming MHPs are encouraged to acknowledge and explicitly engage with the various power dynamics – gendered and otherwise – that exist in their relationships with TGD clients, their families, communities and broader society.[187] TGD clients should be provided with a safe, affirming space,[188] and their experiences should be privileged over the MHP's assumptions.[189] Continuing education on topics related to gender diversity is crucial.

Ultimately, the role of the MHP is to accompany their TGD client on their journey of gender discovery and affirmation.[59] This may include ensuring that the TGD client knows what to expect of planned gender-affirming interventions, developing strategies for strengthening their support system, advocating for them in their wider context, and advocating for the rights of TGD persons in general.

It is critical that the MHP, working from the position that TGD is part of a naturally occurring spectrum of gender identity, has contemporary knowledge and expertise appropriate to their scope of practice on the range of mental health concerns, challenges and disorders that may present in TGD clients.

In TGD children this could include mental health concerns such as low self-esteem, socially isolating, a range of acting-out behaviours, ASD, depression, anxiety, oppositional defiant behaviours, features of dissociation, gender dysphoria and suicidality.[18] In TGD adolescents and adults, mental health concerns may include depression, anxiety disorders, body dysmorphia, gender dysphoria, ASD, suicidality and attempted suicide, personality disorders, substance use disorders and eating disorders.[18] TGD adolescents and adults, like cisgender adolescents and adults, can develop a range of mental health disorders such as schizophrenia, bipolar mood disorders, and PTSD.[61]

It is the role of MHPs to appropriately assess the mental health concerns of their TGD clients and develop interventions that centre on the TGD client, without pathologising their gender identity. This involves appreciating the role that their client's gender identity status plays in their susceptibility to certain mental health concerns, along with its role in developing a supportive intervention for the client. MHP should also be able to discern when a TGD client experiences mental health concerns not linked to their gender identity and how such concerns may impact on their transition process.

MHPs should have contemporary, evidence-based knowledge and expertise in the range of emotional, psychological and social outcomes that TGD clients may experience as part of their gender-affirmation process.[3] For some, the outcomes are immediately positive, validating and affirming, and they feel closer to becoming and embodying their authentic selves, while others may experience anticipated or unexpected emotional, psychological and social consequences at various stages of their social transition, when starting gender-affirming HT. Having to stop HT before surgeries can also have a negative impact, and periods of low mood and even depression are often experienced after gender-affirming surgeries, due to various reasons.

MHPs should also read **Chapter 2: Informed consent** in this guideline, which addresses IC in children, adolescents and adults and offers further context to this chapter on psychosocial care.

5.3 Transgender and gender diverse children

All young children undergo a developmental period of gender exploration in early childhood, characterised by growing self-expression and experimentation with gender roles and gender expression through fantasy play.[17,184,190] Most will settle into a sense of comfort and congruence with their realised gender identity and gender expression in alignment with their sex assigned at birth – and all the social, cultural and contextual expectations that come with it. Some children will come to discover, through their gender exploration and growing awareness of self, various degrees of incongruence and/or dysphoria when their innate and spontaneous felt range of gender expressions

and gender identities finds itself in conflict with their sex assigned at birth, and all the social, cultural and contextual expectations that come with it.[18,190,191,192] This has many potential consequences for the child, their family and extended social context. The support, guidance and intervention of a gender-affirming MHP with appropriate expertise is of significant importance to the child, the parents, the family and all other systems involved.[18,65,178,184]

5.3.1 Working with a TGD child

5.3.1.1 'Getting to know' a TGD child

Physical, psychological, intellectual and social development occur rapidly during early childhood. The potential outcomes of the development of each child range widely.[190] TGD children can come to an awareness and expression of their gender identity from an early age, not uncommonly as early as 2 years, and children may begin to experience gender incongruence and dysphoria at any age.[17,18,193] Furthermore, children are exceptionally tuned into, dependent on, and vulnerable to their social context, and the influence of socialisation should not be underestimated, especially the social scripts informed by existing cultural and social constructions of gender that shape the parenting children receive.[190,191,192] Children are sensitively attuned to the subtle and overt cues and messages in their context, especially those of disapproval and judgment, and they may suppress and try and hide those aspects of themselves, which results in them experiencing such negative consequences including being shamed.

MHPs may be called upon to evaluate if a child is potentially TGD. Keeping in mind the developmental and social contextual factors above, it is important to take a history in the context of a child. This means creating an affirming, safe space where the child can tell their story and be heard. The goal of this is to determine and discern whether the child's described experiences fall within the more typical developmental range for the sex assigned to them at birth, and to identify any indicators of psychosocial distress (often characterised by persistence, insistence and consistence) resulting from experienced gender incongruence or dysphoria.[17,18,184,190]

All evaluations of TGD children must be complemented by an evaluation with their caregiver(s), while centring the voice of the child and advocating for their best interests.[3,18,73,193] Though more commonly a feature among adolescent TGD youth, the MHP also needs to keep in mind and assess for indicators of ASD, and its impact on the presentation of the child.[77,194]

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5.3.1.2 Assisting a TGD child

It is essential that the MHP affirms the TGD child

and helps the child understand that they are there to support and help them.[195] Social transition is the recommended intervention for TGD children if it is their expressed need to do so.[18] Social transition is the fully reversible intervention where the child is allowed and supported to express themselves and live as the gender identity they experience. This includes elements such as choosing an appropriate name, using appropriate pronouns, wearing appropriate clothes and other social aspects such as hairstyles, toy preferences commonly regarded as appropriate for their expressed gender identity. They often begin their social transition at home, after which the social contexts are expanded to include extended family, neighbours and their school.[1,191,192] No medical interventions, including gender-affirming hormones or gender-affirming surgery, are considered for a prepubescent TGD child. The psychosocial intervention needs to be facilitated by the MHP, working from a participatory approach, together with the child, their caregiver(s), and other family members.[1,191,192] The MHP may also need to work with parents, siblings, grandparents, extended family, other healthcare practitioners involved with the child, the school and other social contexts relevant to the child, such as their faith community, cultural leaders and practitioners relevant to the child and family, in facilitating their social transition.[4,73,196]

The MHP should also facilitate age-appropriate support for the TGD child by promoting access to resources such as video and book libraries where the stories of other TGD children can be seen, heard and read, and by linking families with TGD children so that they may meet other TGD children for support.

5.3.2 A TGD child and their family

The MHP, working from a family systems perspective[179,183,193] and with an appreciation of the diverse family structures present in the South African context,[196] needs to be cognisant of the impact that the coming out of a TGD family member, especially a child, has on the whole family system. The impact will differ for the various subsystems of the family, such as the caregiver, sibling, grandparent and extended family subsystems.[191,192] Various family structures – such as single-parent, blended, same-sex-parents, reconstituted, foster care families, adoptive families and poly-families – would also be impacted differently.

As with the individual child, the practitioner needs to take a history with the family. This means creating a safe and affirming environment and holding space for the family to tell their story.[183] The family evaluation has two significant aims: 1) to obtain the timeline and story from the perspective of the family, which further assists in the evaluation of the TGD child; and 2) to ascertain the experiences, concerns, needs, opinions and levels of knowledge and understanding of the family in relation to the child and the concepts of gender identity, gender expression and gender diversity. In the South African context, this would include an exploration of the family's existing cultural, religious and personal values and beliefs, as well as their fears, anxieties and resistances.

It is essential that the MHP affirms the family in acknowledging their story and experiences, while holding the best interests of the child in mind.[196] The MHP may offer caregivers supportive counselling to help them process their experiences in relation to their TGD child. The caregivers may also need psychoeducation to better their knowledge and understanding of gender identity and gender diversity, and how it pertains to their child, as well as on the recommended intervention of social transition, and any other information that speak to their cultural, religious and personal concerns. The MHP may also link parents or caregivers to resources such as parent/caregiver support groups, and online and other reading resources. The MHP, along with the TGD child, may need to assist the family in developing the social transition plan and process.[17,18,184]

The MHP may need to engage siblings in their own supportive counselling process, offering age-appropriate psychoeducation and linking them to available resources for further support. Acknowledging the diverse family structures common in the South African context, where extended family members such as grandparents, aunts, uncles and cousins may intimately be involved in the daily lived experience of families, the MHP may also need to engage in similar processes of supportive counselling, psychoeducation and resource-linking.[191,192,196]

5.3.3 A TGD child and their school

The MHP working with a TGD child and their family may need to assist with advocating for the social transition process within the child's school context (crèches, primary school or secondary school).[4,197] The MHP should be cognisant of the extensive diversity of school contexts within South Africa which includes: private and public schools; schools in metropolitan,

urban, peri-urban, rural and deep rural communities; vastly differently resourced schools; schools embedded within specific communities with dominant homogenous cultural, ethnic, language and religious values and beliefs; and schools with significant diversity of race, ethnic, cultural and religious values and beliefs. All these factors must be considered and assessed when engaging in the process of negotiating and facilitating a TGD learner's social transition, while appreciating that a school is a functional community in its own right.[198]

Once entry to the school has been negotiated, the MHP needs to assess the level of openness of the school principal and management to engage, as well as their level of knowledge and understanding of gender identity, gender diversity, the rights of TGD children, and the process of social transition.

The MHP, in partnership with the caregivers as far as possible, needs to negotiate entry to the school and management stakeholders, relying on the Constitution,[4] Children's Act[73] and South African Schools Act[197] in the absence of a National Department of Education policy, as the sources for their right to do so. The MHP may then need to engage in a process of psychoeducation with the school management team, the teaching and support staff, and the broader parent community, to develop their knowledge and understanding of the TGD learner and their role in facilitating a safe and inclusive space within the school context.[198]

The school may also need assistance in developing and executing the TGD child's social transition plan and offer ongoing support where needed. The MHP may need to assist the school management in developing or updating the school's mission, vision, values, policies (such as bullying policy) and operating procedures to be inclusive and affirming of gender diversity. Teachers, especially life orientation teachers, may also need assistance in updating curricular content to be more inclusive of gender diversity.[18,198]

MHPs should also read the section on schools in the institutional environments chapter of this guideline (**Chapter 8: Institutions**).

5.3.4 A TGD child and their community

Meso- and macro levels of communities may affect TGD clients, therefore MHPs may need to undertake a community evaluation of systems that interact with the TGD child and their family, and the nature and impact of these systems on the TGD child's well-being. This would include their peer system, faith community, as well as social, recreational and sport systems.[179,191]

Working from community intervention, community development and community action approaches,[179] if the evaluation finds that the interaction between the TGD child and wider community systems is a source of distress for the TGD child, then an appropriate MHP may negotiate entry into these systems and offer support and psychoeducation to facilitate better knowledge, understanding and acceptance of TGD children and their families, and to develop and promote affirming and safe spaces for the integration of TGD children and their families.[191,192]

5.3.5 A TGD child and broader society

Gender-affirming MHPs need to assess factors in the broader South African society that affect the lived experiences of TGD children and their families and pose barriers to accessing GAHC and quality of life. MHPs need to advocate alongside and in support of TGD activists for the rights of TGD children in legislative and policy reforms, and for the development and expansion of gender-affirming services and resources, and be active allies (e.g. by speaking out in the media to promote TGD awareness).[4,179,191] Cisgender MHPs must be cognisant of not 'talking for' but rather 'in support of' their TGD clients.

5.4 Transgender and gender diverse adolescents

PATHSA states:[195] 'PATHSA regards gender affirmation of transgender children and adolescents as evidence based, internationally recognised and in the best interest of the child and adolescent.[2,29,36,51,109,200] This includes being supportive of social transition of prepubertal transgender and gender diverse children and puberty suppression for the transgender adolescent.'[51,199,201,202,203]

Adolescence starts with the onset of puberty, when secondary sexual characteristics develop, including breast development, deepening of the voice, facial hair growth and menarche. For many TGD adolescents, it is also a time of heightened dysphoria due to the development and anticipated development of secondary sex characteristics.

Although most TGD adolescents and their families will benefit from psychosocial support, the level of support depends on the clinical and psychosocial circumstances and challenges present in the person's life. However, not all TGD adolescents need psychosocial support, especially if their family, community and school are gender-affirming and the adolescent has good health and well-being. South African society is very cis-heteronormative and many TGD adolescents experience marginalisation, stigmatisation, discrimination and various forms of oppression which can lead to minority stress.[59,176,204,205] For example, school curriculums are based on cis-heteronormative constructs that can invariably, though often unintentionally, lead to bullying. Furthermore, adolescents often experience pressure to conform to gender identity norms and gender roles within society and their peer group.[3]

In South Africa, most TGD adolescents, especially those facing intersecting challenges[3] will not be able to access GAHC[16,206] and MHPs should advocate for this care.

5.4.1 Working with a TGD adolescent

The MHP should have an affirmative stance towards their client's gender and sexual identity. Each TGD person has a unique gender identity development pathway, and the practitioner should be aware that these identities may change over time.[3] MHPs working with adolescents should be aware of gender diversity and be competent in GAHC or should seek the advice of an experienced practitioner in the field.[3] It is important for the MHP to be aware of their own inherent biases and expand their understanding of gender as fluid and not encapsulated within a binary construct.

Psychoeducation regarding diverse gender identities and expressions may be of value for TGD adolescents;[207] however, many adolescents already have a good understanding of their own gender identity. 'Transgender youth are invariably significantly/profoundly advanced in understanding gender identity as compared to their cisgender peers, as they are faced with prejudice and their gender dysphoria on a daily basis and usually constantly think and reflect critically and deeply about all the potential issues, including taking hormones and outcomes, on a daily basis'.[65] Furthermore, the TGD adolescent also deals with their emerging sexual identity and may explore, or want to explore, intimate relationships with their peers.

Due to the development of secondary sex characteristics during puberty, the possibility of puberty suppression and/or HT should be explored with the TGD adolescent and their caregiver(s).[17,184] In order to access puberty suppression medication and/or HT, the TGD adolescent's primary care provider requires an evaluation of their gender incongruence by an MHP. In such cases, the MHP needs to consider the maturity of the client, evaluate and treat mental health disparities, and be available to support the client through their journey.[18] The therapist may also consider an exploration of the adolescent's early developmental history and their history of gender expression and identity development. The adolescent's emotional, intellectual and educational functioning, as well as social relationships, peer and family functioning, and immediate and extended support, may have an effect on their readiness for accessing HT and/or surgery.

As MHPs we need to be very aware that we do not step into a gatekeeping position, but rather work and support our TGD client to a position where they are able to make an informed decision. Important to note, these aspects should not prevent an adolescent accessing puberty suppression as it will place the development of the secondary sex characteristics on pause, providing the TGD client with time to develop adequate functioning. Furthermore, the MHP needs to avoid medico-legal implications of not having done due diligence in terms of psychological intake, psychometric assessment, preparation and exploration of gender identity. The MHP always needs to focus on what is in the best interest of the TGD adolescent. For example, a TGD adolescent with supportive parents will mostly have a better experience when transitioning than a client whose parents are against transitioning – the MHP should then assist the parents to understand gender diversity, possibly enabling them to be more supportive.

Endocrinologists, surgeons and other medical practitioners usually require a report from a psychologist or clinical social worker before TGD adolescents can access GAHC.[18] The MHP should consider involving the TGD adolescent in this process, as it enables the client to engage with the process as they self-identify their gender identity, or understand their own gender identity, and empower themselves through the process of IC. Due to the impact of

hormonal treatment on fertility, this aspect also needs to be explored with the client, along with sperm/ova preservation options. This is discussed in Chapter 6: Hormone therapy.

Not all TGD adolescents want to access puberty suppression medication, HT or gender-affirming surgery,[18] but refusal of GAHC will most likely do harm and lead to mental health challenges, for example severe anxiety, depression and/or suicidality.[1,208] PsySSA's Sexuality and Gender Division (SGD) released the following statement in 2021: 'The SGD thus stands firmly in support of the statement from WPATH and others, noting that irreversible harm could come to young people denied puberty blockers. As always, our first guiding ethical principle should be to 'do no harm'. In this instance, harm is surely to come, and this harm is preventable.'[66] The South African Society of Psychiatrists stated: 'For parents whose children display gender non-conforming attributes and behaviours, or state that they wish to transition to their preferred gender … it was vital to understand and accept that this was not "just a phase"'.[209]

Supportive psychotherapy can add value before, during and after social and physical transitioning. Older TGD adolescents could also be supported in developing ways for further modification of gender expression (e.g. chest-binding) to reduce dysphoria. MHC interventions should address the negative impact of gender incongruence, gender dysphoria, stigma, prejudice and minority stress on the mental health and well-being of TGD adolescents, and practitioners should explore ways of developing coping skills and supportive structures.[17]

Adolescents presenting with existing mental health difficulties may require more intensive MHC. In such cases it remains important to create a safe, supportive and affirming space for TGD adolescents.

5.4.2 A TGD adolescent and their family

A supportive family contributes to the mental health of TGD adolescents,[17] and bolstering family support is an integral part of gender-affirming MHC. The MHP may assist the family members, including the TGD adolescent, to establish stronger relationships within the family.[210] The family may also need psychosocial support to process their perceived loss, as they may have projected their own understanding of gender identity and expectations onto the child, which may have created a set of expectations that are now perceived to be lost. The MHP should guide the family to understand that the TGD adolescent is still inherently the same person, and the family's understanding of the TGD adolescent's gender identity should conform to their self-identified gender.

The MHP should provide psychoeducation and psychotherapy/counselling for the caregivers to assist and affirm the TGD adolescent as they explore their gender identity, psychosocial challenges and the possibility of puberty suppression or HT.[18] By developing a common understanding of the adolescent's lived experience, the caregivers can meet their child's needs in a caring and nurturing way, and provide them with a safe environment.[18] The family may also require support to advocate for the TGD adolescent's rights, and as they embark on social transitioning in their schools and broader community.

5.4.3 A TGD adolescent and their school or higher education institution

MHPs should read the sections on schools and higher education institutions (HEIs) in **Chapter 8**.

5.4.4 A TGD adolescent and their community

Many TGD adolescents find it beneficial to join a support group with TGD peers, which often becomes a space of belonging and a safe space to experiment with aspects of social transitioning. Participants can also share their lived experiences. Support groups can be facilitated by the MHP.

Some TGD adolescents want to change their name and/or gender marker on their official documentation. The psychosocial provider can assist the TGD adolescent by providing the necessary information, as well as a letter of confirmation of GAHC, as stipulated by the Department of Home Affairs (see **Appendix A**).

The MHP should also advocate with their TGD adolescent within the broader society. This can be done through training and education, and engagement with schools and other social networks to provide information and guide them on how to support the TGD adolescent.

Promoting a participatory approach as the TGD adolescent lives out their true gender identity enables them to live freely within the community. The participatory approach places the TGD adolescent at the centre of the intervention, with a support base

consisting of their caregivers, family, GAHC team, therapist, school, peers and broader community.

5.4.5 A TGD adolescent and broader society

The MHP should focus on the dismantling of oppressive cis-heteronormative practices and policies in society. By challenging the stressors on a macro level, the impact on the TGD adolescent can be mitigated and minority stress reduced.

5.5 Transgender and gender diverse adults

TGD adults tend to seek MHC related to the exploration and affirmation of their gender identity; the process of coming out and social transitioning; and general mental health concerns.[211,212]

5.5.1 Working with a TGD adult

As TGD adults are likely to have experienced several traumatic experiences related to their gender identity over the course of their lives,[213] a trauma-informed approach to psychosocial support for TGD adults is recommended. Working from such an approach, MHPs should be responsive to, and understand the impact of trauma on all aspects of identity development. Trauma-informed care involves actively working with the client towards a non-hierarchical therapeutic relationship, and emphasises strength, resilience and empowerment.[213]

While TGD adults do not always present for psychosocial care in relation to their gender identity, MHPs should be aware of the potential mental health impacts of a client's gender identity and transition. For example, coming out and the transition process often places strain on TGD adults' relationships with family members, significant others, children, colleagues, and friends, which could be explored in individual, couples or family counselling, or with other appropriate interventions. TGD adults also often experience challenges around intimacy and sexuality, which could be addressed through tailored interventions by MHPs.

The MHP should accompany and support their TGD adult clients in exploring and affirming their gender identity, rather than providing an assessment of their gender identity, or level of gender dysphoria. Nonetheless, many TGD adults may present for MHC for this purpose, as such assessments are often required for official (e.g. name and gender marker changes) and medical (e.g. by request of a medical practitioner) purposes. In particular, the role of a psychiatrist may include a differential diagnosis to assist with treatment of coexisting psychiatric conditions.

5.5.2 A TGD adult and their family

It is important for the MHP to understand the TGD adult's family structure and dynamics, and to determine the role of the family in the client's life – both historically and currently. From a trans-centred perspective, the role of 'chosen family' should also be considered.

The MHP may need to assist the family in understanding and respecting the TGD adult's gender identity; general psychoeducation on gender identity and gender diversity can also be provided. Family members can also be referred to relevant support groups. If the TGD adult has children in their care, then the MHP could assist in developing age-appropriate explanations of the client's gender identity and gender diversity.

'Chosen family' structures, or family formed outside of biological or legal bonds,[214] may already be present in the TGD adult's life when they present for care, or may develop over time. Chosen family has been shown to bolster the mental well-being of TGD persons through sharing the emotional burden of navigating bureaucratic systems (including the healthcare system), and the provision of mutual aid.[215] Resilience gained through the support of chosen family should be explored, and their important role in the TGD adult's life should be acknowledged and celebrated.

5.5.3 A TGD adult and intimate relationships

MHPs also need to appreciate that when supporting a TGD adult client, issues relating to intimate relationships and sexuality may need to be addressed.[3] The TGD client who is in an intimate, committed, long-term relationship or marriage structure when needing to come out may need support in coming out to their partner(s) and addressing the relationship implications. Relationship therapy and sex therapy expertise are beneficial. Themes that may be addressed in the supportive counselling could include, among others:

- processing together the emotional, psychological and social consequences for the relationship(s) of the partner coming out as TGD
- addressing whether all involved wish to work on

maintaining or ending the relationship(s)

- exploring the intended adjustments in gender roles
- assessing the impact that the transition has on the sexual orientation identities of all involved
- discussing whether adjustments to the relationship structures and agreements need to be renegotiated regarding monogamy versus opening the relationship(s) to a more open non-monogamous structure to accommodate the changes brought about by the transition
- offering sex therapy support as partners explore the changes and adjustments needed to ensure that the sexual needs of all are understood, explored and affirmed.

For TGD adults who are not in a relationship, MHPs may need to offer support regarding the fears, concerns and anxieties that their client may have about the implications of their gender identity and transition for their sexuality, for dating and possible intimate relationships.[3]

5.5.4 A TGD adult and their workplace

TGD adults have varying needs related to their work, influenced by a range of aspects, including their organisation's perceived openness to, and acceptance of gender diversity, their employment status (e.g. casual, contract or permanent employee), their occupation and their mental health needs. MHPs are encouraged to refer to **Chapter 8: Institutions** in this guideline to understand how these aspects contribute to the overall well-being of TGD adults.

Within their scope, MHPs may provide appropriate organisational interventions to address institutional climate concerns and to provide guidance on the development of a gender-affirming workplace. MHPs are also encouraged to actively participate in policy making and similar activities to address their TGD clients' needs and concerns at a systemic level.

The TGD adult may need support in terms of transitioning in the workplace. The MHP can assist in terms of developing a transition plan – an iterative and collaborative process considering the TGD adult's family structures, social circles, employment status and other social aspects – to determine a course of action for coming out in the workplace. The MHP can also provide the client with relevant resources, and psychoeducation on gender identity and gender diversity at the workplace. Ongoing input in this regard may be needed, as organisations are rarely static.

5.5.5 A TGD adult and their community

The MHP needs to be aware of their TGD adult client's sociocultural context, and the influence various subsystems in their community have on their psychosocial well-being. Psychoeducational interventions may be needed in various spheres of the TGD adult's life (e.g. religious communities, workplace and social circles).

5.5.6 A TGD adult and broader society

The mental health of TGD persons is greatly affected by environmental and social stressors.[216] MHPs working at the macro level should attempt to address such stressors at a systemic level, through community organising, contributing to policy and legal reforms, advocating for broad-based gender-affirming MHC, and challenging cis-heteronormative assumptions and expectations of TGD persons.

5.6 Elderly transgender and gender diverse adults

Improved access to GAHC globally has resulted in a growing number of TGD elders.[217] These persons have a high likelihood of experiencing lifelong marginalisation and stigma, in combination with discrimination and stigma related to other aspects of their identity, such as race, level of education or disability. Consequently, older TGD adults require tailored interventions that are responsive to their immediate and longer-term needs, actively work to undo previous harms inflicted by the healthcare system, and are consistently gender-affirming.[218,219] Immediate and longer-term needs of older TGD adults include experiences common to the older cisgender adults (e.g., loss of a significant other, loss of cognitive and physical function, and increased sense of isolation), but may also include aspects of medical and social transition (particularly in those undertaking gender-affirmation late in life), continued struggles with internalised stigma and transphobia, and isolation due to a lack of TGD peers. Consistent gender-affirmation throughout the lifespan is crucial and should include access to gender-affirming treatment options in assisted living facilities, frail care units, rehabilitation and step-down facilities, and hospice facilities.

5.7 Conclusion

TGD persons can benefit from psychosocial support before, during and after transitioning. An affirmative approach where the person's gender identity is acknowledged and celebrated contributes to the TGD person's mental health and well-being. At times, the MHP will be requested to supply a report to support the GAHC journey. It is recommended that the MHP, in conjunction with the TGD person, composes this report. The TGD person's self-identification of their gender is respected and acknowledged.[2] Gender diversity is seen as part of diversity in the community and not as pathology. IC is seen as the ethical process with which the MHP should engage when a TGD person wants to access GAHC. The TGD person's resilience should be celebrated, and their self-identification respected.

CHAPTER 6

HORMONE THERAPY

6.1 Background

Gender-affirming hormones have been shown in formal clinical research to be safe[220,221] and effective[14] and were listed as essential medicines by the South African National Essential Medicine List Committee (NEMLC) in 2019,[222] for tertiary-level of care. The goal of hormone therapy (HT) is to affirm the client's experienced gender.[46] In a non-binary client, it is particularly important to understand their desired outcome before deciding on treatment.[223] Provision of HT should be based on the principle of informed consent (IC), rather than on specific diagnostic criteria that have previously, and often harmfully, been applied.[14] The focus is on empowering clients with information, allowing them to make their own choices, and supporting those choices with medical knowledge and expertise in order to render the process as safe and effective as possible.[14]

To do this, a comprehensive medical evaluation must be carried out, including a full medical history, physical examination, and laboratory investigations, prior to initiating HT. The process should account for identifying co-existing medical and mental health conditions, potential contraindications, and other risk factors, but should not be done with the intention to deny the client access to HT unless the client is objectively incapable of making an informed decision.

Not all clients will seek or desire HT,[224] and the reasons can vary, but in all cases their wishes should be respected. Moreover, clinicians should bear in mind that transgender identity is not validated by the use of HT – with or without hormonal intervention, a TGD client's lived experience should be respected.

Further, it should be noted that while HT may significantly reduce dysphoria, the existence of dysphoria per se is not a prerequisite for the initiation or maintenance of HT. The goal of providing treatment should be to affirm the client's experienced gender, and indeed the guiding beacon should not be the alleviation of gender dysphoria, but the promotion of a sense of well-being or contentment with one's gender.[47]

The process of IC is detailed in **Chapter 2**. It should be noted that during the counselling process, the clinician has a responsibility to discuss the process in detail with their client and ensure that the client's understanding is adequate to enable an informed decision. During this process, a psychosocial assessment should also be carried out by a qualified health professional – this may be performed by the prescribing clinician.[18] It should be noted that while psychotherapy is not a requirement for HT, the provider should make every attempt to ensure that the client has access to psychological and social support resources.[17]

6.2 Indications

In South Africa, the indications for accessing HT are:

- a desire to use HT
- persistent gender incongruence between one's experienced and assigned gender
- capacity to make a fully informed decision and consent to treatment.

Importantly:

- If the client is an adolescent, then consult with a multidisciplinary team to confirm gender incongruence and mental capacity to provide IC.[79]
- If a significant medical/mental health concern is present, then ensure it is managed concurrently without delaying HT.[61]
- Gender dysphoria and real-life experience (a period of time in which TGD individuals live full-time in their identified (discovered) gender role) are not prerequisites for the initiation or maintenance of HT.[18]

6.3 Process of prescribing hormones

- Perform a baseline assessment with history taking, clinical examination and relevant laboratory investigations
- Facilitate discussion around the effects, risks, side effects, benefits, reversibility, expected changes and timelines associated with HT (example of

IC documents provided in **Appendices B** and **C**) Elicit from the client their hopes, expectations and concerns regarding HT[17]

- Manage client expectations and explain that every individual will react differently to HT, and that there are limitations, e.g. feminising treatment does not affect the voice
- Discuss potential effects HT on fertility, and options for fertility preservation
- Afford the client the opportunity to ask questions at all points in this process, and once a comprehensive understanding has been reached, then IC should be obtained
- Agree on a mode of administration for HT
- Initiate HT at an appropriate starting dose, and plan for follow-up
- For clients already on HT (e.g. self-medicating), prioritise continuity of care and continue a similar dose, provided that it does not exceed the recommended maximum dose.

Figure 1 provides a visual representation of the recommended process to follow when providing HT.

6.3.1 Holistic treatment

Management should be as holistic in nature as possible, including referral to other members within the multidisciplinary team, and should account, insofar as possible, for variations in clients' social and cultural contexts, as well as their medical assessment. [17] There is no single universally applicable recipe for managing clients, and the management plan should be individualised and mutually agreed upon by the client and the clinician.[18]

6.3.2 Baseline assessment

It is necessary to conduct a comprehensive and thorough assessment of the client prior to initiating HT.[79] History taking should be performed as comprehensively as possible. Particular attention needs to be paid to a client's medical history including current or past liver disease, kidney disease, heart disease, hypertension, VTE disease, malignancy, dyslipidaemia, diabetes, and other endocrine or metabolic conditions. A family history should also be obtained, focusing inter alia on malignancy, especially breast carcinoma and VTE disease. Any surgical procedures, irrespective of whether these were for the purpose of gender-affirmation or not, should be detailed. Allergies to medications and other allergens should also be detailed.

The baseline assessment should follow the guidance in **Chapter 3: Primary care** regarding screening in the areas of violence, mental health, tobacco, alcohol and drug use, contraceptive needs, cancer screening, as appropriate, and STIs including HIV. Co-existing health conditions identified during screening are not a contraindication to initiating HT and can be managed concurrently.[18]

6.3.3 Clinical examination

The examination of a TGD client does not differ from the physical examination for any other client in a primary care setting. It should include a general clinical examination, an assessment of vital signs, as well as assessment for hallmarks of chronic illness, but the presence of chronic disease should elicit a more targeted examination. Routine inspection of breast tissue and genitalia are usually unnecessary, and should be conducted only if clinically justified, with extreme care and sensitivity (see **Box 2** in Chapter 3: Primary care).

Suggested baseline laboratory screening prior to HT initiation is detailed in **Table 5.**

6.3.4 Discussion of reproductive options

Prior to initiating gender-affirming HT, it is essential to discuss the potential effects of this therapy with the client.[79] Despite the effects on fertility, HT cannot be relied upon as a means of contraception (see **Chapter 3: Primary care**).

In AMAB clients, prolonged treatment is expected to result in hypo-spermatogenesis and eventually azoospermia, which may be irreversible.[226] It must be noted that germ cells and spermatogenesis will persist in some clients, and as yet, research has been unable to isolate the reasons determining whether a client on feminising therapy will retain reproductive potential or not.[227]

AFAB clients receiving testosterone treatment will have suppression of ovulation and may experience alteration of their ovarian histology.[228]

For AMAB clients, sperm cryopreservation is

FIGURE 1: Recommended process for provision of hormone therapy.
(AFAB, assigned female at birth; AMAB, assigned male at birth; IC, informed consent.)

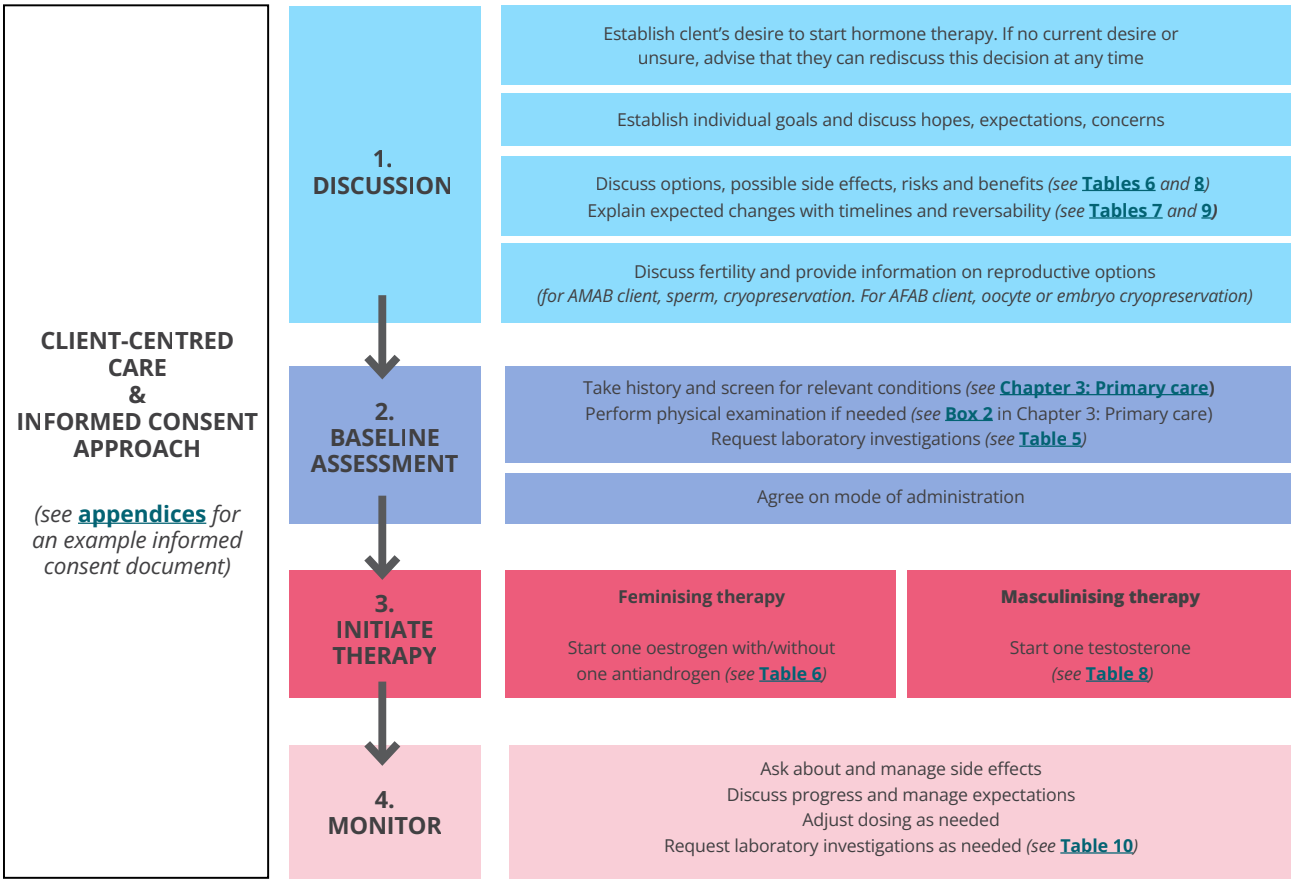

TABLE 5: Suggested baseline screening prior to hormone therapy initiation.[225]	
Suggested baseline screening and investigations†	**Resource-constrained setting**
FBC	Hb or Ht
UEC	Cr
Full LFT panel	ALT
Fasting plasma glucose	Finger-prick glucose
Fasting lipogram	TC
HIV, HBV, syphilis	
Pregnancy test if AFAB client starting masculinising therapy	

†, Note: Baseline sex hormone levels are generally unnecessary.

AFAB, assigned female at birth; ALT, alanine transaminase; Cr, creatinine; FBC, full blood count; Hb, haemoglobin; HBV, hepatitis B virus; HCV; hepatitis C virus; HIV, human immunodeficiency virus; Ht; haematocrit; LFT, liver function test; TC, total cholesterol; UEC, urea, electrolytes, creatinine.

the technique most commonly used, either via masturbation or testicular sperm extraction.[228] AFAB clients may have oocytes or embryos cryopreserved, a process which requires hormonal stimulation in order to facilitate egg retrieval.[229] Preservation of the uterus can allow AFAB clients to gestate.[228]

Developing experimental techniques exist that may have applications for prepubertal clients who have not produced mature gametes, and could potentially also be useful for patients with azoospermia. These techniques generally involve harvesting and preserving testicular tissue or stem cells.[228]

Many clients will decline these services, either through personal choice, or due to the often-excessive cost associated with accessing them.[230] The importance of having genetically related offspring may also vary greatly between different individuals, and clients may not see genetically related offspring as more desirable than pursuing adoption. The client's perspective should be accepted and respected by the provider.[231,232]

6.4 Feminising hormone therapy

The goal of feminising HT is to promote the development of feminising sexual characteristics, while simultaneously suppressing the effects of endogenous testosterone in either promoting development or maintaining masculinising effects.[233] The cornerstone of feminising therapy is the administration of exogenous oestrogen. Various forms are available, though bioidentical hormones are preferred as they confer a lower risk of adverse events. Parenteral administration of oestrogen is also associated with lower risk, compared with oral treatment,[234] likely due to bypass of first-pass metabolism of the drug in the liver, during which significant portions of oestradiol (E2) are converted to oestrone (E1). Additionally, parenteral treatments are often favourable in terms of financial cost.

The addition of an androgen receptor antagonist may be required to achieve full suppression of testosterone;[235] however, recent evidence suggests that this may not be essential to reduce testosterone levels to cisgender female ranges, as was previously thought.[236] Lower doses of cyproterone (10 mg) has been shown to be effective in supressing testosterone.[237] There also exists an option to combine appropriate oestrogen therapy with a gonadotrophin-releasing hormone agonist (GnRHa), such as leuprolide,[235] though this can prove costly.

Progesterone may be added, in the form of micronised progesterone. This may accelerate feminisation, decrease testosterone production, facilitate breast maturation, increase bone formation, improve sleep and vasomotor symptoms, and could also confer cardiovascular health benefits in some clients,[238] although further research is needed.[80] This may be administered orally, but bioavailability appears to be improved if administered as a rectal suppository. Synthetic progestogens are not recommended.[239] Studies in TGD populations are lacking, but data from other client groups suggests that no increased VTE risk exists with micronised progesterone.[240]

6.4.1 Risks and side effects of feminising treatment

Side effects associated with oestrogen therapy are outlined in **Table 6**. The most significant risk

associated with oestrogen therapy is the development of VTE disease, and the sequelae thereof.[241] The risk is greatest for those aged >35 years, smokers and those who are obese.[242] A cohort study (n=2842) in California, USA, found that transfeminine participants had an increased incidence of VTE, compared with cisgender men and -women.[243] In a retrospective study (n=330) in London, UK, 1.2% TGW on oestrogen developed VTE.[244] The relative thrombotic risk varies with different oestrogen formulations, with oral conjugated ethinyloestradiol (used in oral contraceptives) high risk, conjugated equine oestrogen moderately low risk, oral 17 beta-oestradiol and parenteral oestradiol valerate low risk, and transdermal oestradiol very low risk.[245] For this reason, conjugated ethinyloestradiol should be avoided.[246]

There is a paucity of well-designed studies comparing the risk profile of different oestrogen preparations in TGW; this important research gap needs to be addressed in order to identify the best means of providing gender-affirming feminising HT.[247]

The absolute clinical risk of VTE disease is very low; a meta-analysis estimated the crude incidence rate of VTE associated with oestrogen use in TGW to be 2.3 per 1000 patient-years.[248] For conditions that may be exacerbated by oestrogen, such as oestrogen-sensitive malignancies, coronary artery disease and cerebrovascular disease, careful evaluation should be done prior to initiation of HT[241] and treatment individualised.

In clients with a history of VTE, transdermal oestrogen may be considered after an IC discussion.[51,249] A consultation with a haematologist skilled in genetic coagulation disorders is recommended to determine their future risk. Persons with a family history of a hypercoagulative disorder, should be screened for prothrombotic mutations.[51] If present, a decision regarding anticoagulation should be made as per current guidelines for cisgender patients, following which transdermal oestrogen may be considered after an IC discussion.[51]

Feminising treatment options are indicated in **Table 6**, and effects and reversibility of treatment are shown in **Table 7**. Recommended baseline screening is indicated in **Table 8**.

TABLE 6: Feminising hormone therapy and antiandrogens.

Medication	Dose	Notes
Feminising HT		
Oestradiol (patch) (Estradot)	• Starting dose: 50–100 mcg twice per week • Increase by 100 mcg at a time • Usual maintenance dose: 300–400 mcg per week • Maximum dose: 400 mcg per week	• Safe and effective[246] • Anti-androgen coadministration usually unnecessary • Use of multiple patches at a time may be impractical • Very low risk of VTE[246] • Possible side effects (rare): allergy to adhesive, skin irritation, migraine, nausea,[17] mood changes, changes to libido and sexual response cycle[79]
Oestradiol valerate (IM or SC)	• Starting dose: 6 mg once a week • Increase by 2 mg at a time • Usual maintenance dose: 6–10 mg per week (can consider dividing dose and giving every 3.5–5 days, rather than once a week) • Maximum dose: 20 mg per week	• Safe and effective[79] • Antiandrogen coadministration usually unnecessary • Often a preferred treatment option[250] • Very low risk of VTE[79] • Possible side effects: migraine, nausea,[17] mood changes, changes to libido and sexual response cycle[79]

Medication	Dose	Notes
17–beta oestradiol (oral or sublingual) (Estrofem)	• Starting dose: 2 mg daily • Increase by 2 mg at a time • Usual maintenance dose: 6–8 mg daily • Maximum dose: 8 mg daily	• Often requires antiandrogen coadministration. • Not as safe as parenteral treatment[234,251] • Dose limitation due to associated risk of VTE[252] • Possible side effects: migraine, nausea,[18] mood changes, changes to libido and sexual response cycle[79]
Conjugated equine oestrogen (oral) (Premarin)	• Starting dose: 0.625–1.25mg daily • Increase by 0.625–1.25mg at a time daily • Usual maintenance dose: 1.55–2.5 mg daily • Maximum dose: 5 mg daily	• Use only where bio-identical oestrogen (oestradiol) is not available • Often requires anti-androgen coadministration • Dose limitation due to moderate risk of VTE[252] • Possible side effects: migraine, nausea,[17] mood changes, changes to libido and sexual response cycle
Antiandrogens[80,253]		
Spironolactone (oral)	• Starting dose: 25 mg daily • Increase by 25 mg at a time • Usual maintenance dose: 50 mg • Maximum dose: 200 mg	• Risk of hyperkalaemia: requires potassium monitoring. Use with caution if client on ACE-I/ARB • Possible side effects: diarrhoea, abdominal cramping, nausea, vomiting, headache, dizziness
Cyproterone acetate (oral)	• Starting dose: 10–12.5 mg daily • Increase by 5–6.25 mg at a time • Usual maintenance dose: 10–25 mg daily • Maximum dose: 25 mg daily	• Potent antiandrogen, low doses should be sufficient[237,254] • Possible side effects: Sweating, agitation, fluid retention at high doses
Bicalutamide (oral)[235,255,256,257,258, 259]	• Starting dose: 25 mg twice weekly • Increase by 25 mg twice weekly, or on alternating days • Usual maintenance dose: 25–50 mg daily • Maximum dose: 50 mg daily	• Preferred antiandrogen as less risk of neurosteroid depletion (does not cross blood-brain barrier readily) • Possible side effects: constipation, back pain, fatigue

ACE-I, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; IM, intramuscular; SC, subcutaneous; VTE, venous thromboembolism.

TABLE 7: Timeline and reversibility of feminising hormone therapy.[260]			
Effect	**Time from initiation to onset**	**Time from initiation to maximum effect**	**Reversible**
Body fat redistribution	3–6 months	2–3 years	Yes
Decreased muscle mass and strength	3–6 months	1–2 years	Yes
Skin softening	3–6 months	Unknown/variable	Yes
Change in sexual desire	1–3 months	3–6 months	Yes
Decreased erections	1–3 months	3–6 months	Yes
Breast growth	3–6 months	4 years	No
Decreased sperm production	Unknown/variable	>3 years	Possibly
Decreased terminal hair growth	6–12 months	>3 years	Yes
Scalp hair	Variable	Unknown/variable	Yes
Voice change	None	n/a	n/a

6.5 Masculinising hormone therapy

The goal of masculinising HT is to promote the development of testosterone-induced secondary sexual characteristics.[143] Suppression of oestrogen, and inhibition of ovulation, will almost always occur without any additional pharmacological intervention,[79] thus oestrogen antagonists are not required.

Exogenous testosterone is most commonly administered by intramuscular (IM) or subcutaneous (SC) injection, or as a topical transdermal preparation. Oral testosterone is unhelpful and should not be used as part of masculinising HT, as it can be hepatotoxic, while IM injection is non-hepatotoxic because it circumvents the first-pass hepatic metabolism.[141]

Should undesired cyclical bleeding persist despite the use of testosterone (or in the absence of testosterone treatment for those clients who do not wish to use it), agents such as leuprolide, medroxyprogesterone acetate and anastrazole may be considered.[51]

6.5.1 Risks and side effects of masculinising treatment[143]

Possible side effects are outlined in **Table 8**. Clients should be monitored closely for the development of dyslipidaemias, hypertension and polycythaemia.[143] Testosterone should never be used in clients who are pregnant, due to the likelihood of virilising a female pregnancy.[261] A client with severe hypertension, sleep apnoea or untreated polycythaemia (haematocrit (Ht) >55%) requires management prior to treatment initiation, as these conditions may be exacerbated by testosterone.[241]

Testosterone treatment options are indicated in **Table 8**, and treatment effects and reversibility are shown in **Table 9**. Recommended baseline screening and monitoring are recommended as indicated in Tables 5 and 10 respectively.

6.6 Laboratory monitoring of hormone therapy[51]

Follow-up should occur 1 month after commencing on treatment, and at 3-month intervals thereafter for the first year of treatment, after which clients can be seen twice per year. Recommended laboratory monitoring is shown in **Table 10**.

A client's experience on treatment should be the primary guiding factor in dose titration and maintenance, and treatment may still be provided in resource-constrained settings where laboratory measurement of hormone levels is not available. However, when these investigations are accessible, they can provide helpful guidance in optimising the dose.

Routine prolactin measurements were once advocated for clients on feminising medication; however, evidence now suggests that prolactin should only be measured in clients with complaints of visual disturbances, excessive galactorrhoea or new-onset headaches.

TABLE 8: Masculinising hormone therapy[80,262]		
Medication	**Dose**	**Notes**
Testosterone cypionate 100 mg/mL (IMI or SC)	• Starting dose: 50 mg (0.5 mL) weekly • Increase by 10 mg (0.1 mL) at a time • Usual maintenance dose: 50–80 mg (0.5–0.8 mL) weekly or 100–200 mg every 2 weeks • Maximum dose: 100 mg (1 mL) weekly or 200 mg every 2 weeks	• More affordable than long-acting injection • Avoid in pregnancy[261] • Possible side effects: polycythaemia, acne, androgenic alopecia, amenorrhea, loss of fertility, mood changes, dyslipidaemia and hypertension • Take sample for testosterone measurement at peak, halfway between doses; target the safe upper limit of reference range
Testosterone undecanoate (IM) (Nebido)	• Starting dose: 1000 mg; given every 10–12 weeks • Increasing the frequency, rather than raising the dose is required • Usual maintenance dose: 1000 mg every 10–12 weeks • Maximum dose: 1000 mg	• More expensive than the short-acting injection • Avoid in pregnancy[261] • Possible side effects: polycythaemia, acne, androgenic alopecia, amenorrhea, loss of fertility, mood changes, dyslipidaemia and hypertension • Achieving the correct dose can be difficult with long dosing intervals • Take sample for testosterone measurement at trough; target the lower limit of reference range
Topical testosterone (Androgel)	• Starting dose: 1 sachet (5 mL) daily topically • Increase by 1 mL at a time • Usual maintenance dose: varies for each client • Maximum dose: limited by body surface for application	• Only available from compounding pharmacies • Avoid in pregnancy[261] • Possible side effects: polycythaemia, acne, androgenic alopecia, amenorrhea, loss of fertility, mood changes, dyslipidaemia and hypertension

IM, intramuscular; SC, subcutaneous.

TABLE 9: Timeline and reversibility of masculinising hormone therapy[80,233]			
Effect	**Time from initiation to onset**	**Time from initiation to maximum effect**	**Reversible**
Skin oiliness, acne	1–6 months	1–2 years	Yes
Facial and body hair growth	6–12 months	4–5 years	No
Scalp hair loss	6–12 months	Unknown	No
Increased muscle mass and strength	6–12 months	2–5 years	Yes
Fat redistribution	1–6 months	2–5 years	Yes
Cessation of menses	2–6 months	n/a	Possibly
Clitoral hypertrophy	3–6 months	1–2 years	No
Vaginal atrophy	3–6 months	1–2 years	Yes
Deepening of voice	6–12 months	1–2 years	No

TABLE 10: Laboratory monitoring for feminising and masculinising therapy[51]					
	Investigation	Time since initiation of treatment			
		1 month	2 month	6 month	Annually
Only if on feminising treatment	UEC or Cr + K+ (only if on spironolactone)	x	x	x	x
	Oestradiol (E2)†	x	x	x	
Only if on masculinising treatment	Hb/Ht	x	x	x	x
If on feminising or masculinising treatment	ALT	x	x	x	x
	Total testosterone†	x	x	x	
	SHBG/free testosterone	x	x	x	

†, Note: Many laboratories will use references applicable to the client's sex assigned at birth and not their gender. Compare results to the reference ranges consistent with the client's gender.[51] For hormone levels, use the reference ranges of the testing laboratory.

ALT, alanine transaminase; Cr, creatinine; Hb, haemoglobin; Ht, haematocrit; K+, potassium; SHBG, sex hormone binding globulin; UEC, urea, electrolytes and creatinine.

6.6.1 Managing laboratory abnormalities[225]

Elevated transaminases: If alanine transaminase (ALT) is >3x ULN or >2x baseline (if chronically elevated), then discontinue hormones pending further evaluation. Screen for alcohol use and viral hepatitis. In the case of viral hepatitis, wait until transaminases have returned to normal. If aetiology is unclear and levels normalise after 2 months, then one may assume that transaminase elevation is a response to HT. Restart and maintain HT at a lower dose or try an alternative preparation. If transaminases remain abnormal, then the client should be referred.

Polycythaemia: Ht should be <45%; if >52%, then consider phlebotomy, smoking cessation, decreasing the dose of IM testosterone, or switching to transdermal testosterone gel.

6.7 A note on hormone therapy for non-binary clients[223]

When dealing with non-binary clients, it becomes even more important to enter into a discussion with the client around their goals, hopes and expectations. Of course, one cannot choose which physical changes will occur and which ones will not, but it is helpful to understand a client's desires before deciding on a regimen for HT. The provider should be aware that their primary role is to facilitate access to treatment in a way that is medically safe, and not to make judgments about a client's identity, nor decisions on their behalf. In non-binary clients, it may be helpful to start at lower doses and slowly titrate upwards, guided by regular follow-ups and discussions around a client's experience on HT.[223]

6.8 Adolescents

Medical treatment is not required for pre-pubertal TGD children. Pubertal suppression is needed when a TGD child experiences significant distress with the onset or progression of pubertal development and wishes to take treatment. Pubertal suppression has been shown to improve mental health and decrease suicidality.[264] Puberty can be suppressed with GnRHa once Tanner Stage 2 of puberty has been reached.[184] This suppresses the hormonal axis that results in secretion of endogenous oestrogen and testosterone responsible for induction of secondary sexual characteristics, such as breast growth and menstruation in TGM and voice deepening and facial hair development in TGW.[184] Suppression of early puberty typically relieves distress for TGD adolescents, by halting progression of physical changes.[79] Other physical changes such as longitudinal growth and weight gain can continue, permitting the adolescent to develop emotionally and cognitively, before making decisions on gender-affirming HT which is likely to have irreversible effects.[18] GnRHa treatment can be used later in puberty if the adolescent is not ready for HT, but it does not reverse established secondary sexual characteristics.

GnRHa options available in South Africa include leuprolide and goserelin, which are administered

every 12 weeks via IM or SC injection. Paediatric endocrinologists have experience with GnRHa for treatment of precocious puberty, for which it is registered and listed in the Tertiary and Quaternary Essential Medicines List.[222] It is recommended that a paediatric endocrinologist oversees this care,[17,79] and international guidelines are available.[17,79] A detailed description is beyond the scope of these guidelines.

Fertility preservation should be discussed with adolescents before medical treatment.[184] It is important to note that if puberty is suppressed from its onset, then it is not possible to harvest ova or sperm. This is irreversible unless the GnRHa treatment is stopped in time.[229] This is a complex discussion that should be done in a developmentally appropriate way by a clinician with experience and training.[229]

In adolescents who request HT, given that it is potentially irreversible, the Endocrine Society guidelines *(Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline)*[79] recommend initiating treatment after a multidisciplinary team has confirmed gender incongruence and sufficient mental capacity to provide IC. The timing of HT initiation should be individualised, and should consider family support, likely time on GnRHa treatment, potential impacts on height, risks of delaying HT and the adolescent's ability to consent.[184]

The hormone-prescribing physician and the MHP/team should confer on the appropriateness of initiating HT, ideally with the input of the client's parents/legal guardians.[17] When initiating hormones in younger adolescents, consider a gradual increase in dose while continuing GnRHa treatment as outlined in the Puberty Protocols described by the Endocrine Society.[79] This is to simulate normal puberty as far as possible, with more natural breast development in young women and achieving genetic final height.

6.9 Mature TGD clients

HT is indicated long term, as some body changes may reverse when HT is stopped.[51] There is no age recommendation for termination of HT and individual cardiovascular risk has to be considered with shared decision-making.[51]

CHAPTER 7

SURGERY

This chapter is intended to give medical professionals an understanding of the issues related to gender-affirming surgery and the management of TGD clients during the perioperative period. It is not intended to be a protocol or directive for client management.

7.1 Background

Gender-affirming surgery has evolved enormously since the 1950s. The vast majority of TGD clients wish to affirm their gender physically.[265] Therefore, there is a great demand for gender-affirming surgery and the challenge is to ensure that this is provided in a safe and accessible manner. The WPATH SoC-7 are a great place to start;[18] and a big step forward has been made with version 7 in that healthcare providers have realised that they should facilitate transition rather than prescribe it. The WPATH SoC-7 allow for modifications to be made so that these standards can be applied better in varying cultural and regional needs across the world. Version 8 of the WPATH standards of care is anticipated to have further changes and is expected at the end of 2021. One of the greatest drawbacks of surgery is that it cannot be undone. It is therefore important to recognise and respect the client's autonomy in making decisions about their life.[14]

Gender-affirming surgery comprises a range of treatments which help clients with gender dysphoria feel more comfortable within their bodies and therefore better able to interact with the rest of the world.[18] Satisfaction following surgery is usually high, with less gender dysphoria, reduced psychological turmoil, and resultant better integration into society.[267]
Historical terminologies include transsexual surgery, sex reassignment surgery (SRS), genital reconstruction surgery (GRS) and gender confirmation surgery (GCS). Clients will often use the terminology they think the healthcare provider wants to hear in order to access healthcare services. It is important for the provider-client relationship to use less stigmatising terminology and the preferred term is gender-affirming surgery.[266]

The role of the surgeon in TGD care is to provide sound information of the process leading up to surgery, to impart an unbiased understanding of the options that are available to the TGD client, and to provide a good understanding of possible complications and any improvements that can be made prior to surgery in order to reduce the risk of complications.[18] The surgeon needs to be affirming of the TGD client's gender identity. TGD persons often research surgical options prior to interacting with medical professionals. The provider's role is to give them perspective so that they can make informed choices. A common misconception is that gender-affirming surgery is cosmetic surgery. However, nothing could be further from the truth. If anything, it should be seen as true reconstructive surgery.[18] The goal of GAHC is to allow TGD clients to make their own decisions based on reliable information from their healthcare providers.

It is important to realise that there is no standard way of transitioning, and that there is diversity in the surgery requested by TGD clients.[265] A client may desire chest or facial or genital surgery only, or a combination of these. A non-binary client's request for surgery should be specifically individualised.[268] The client has a right to determine their own life and this approach can assist the surgeon.[12] When a surgeon finds it challenging to manage a non-binary individual, it is recommended that they have good communication with the psychologist for reassurance on correct management of the client. When in doubt, consultation with colleagues in a multidisciplinary team can ensure correct management of the client.

Access to surgery in South Africa is limited as the demand far outweighs the currently available resources. In the public sector, very few centres offer gender-affirming surgery, and as a result have very long waiting lists.[29] In the private sector, there are no waiting lists but the costs are extremely high. Currently (2021), Discovery Health and the Government Employees Medical Scheme (GEMS) are the only medical schemes that will contribute to gender-affirming surgery. For Discovery Health, such surgery is only covered if the client has been on either an executive or a comprehensive healthcare plan with the scheme for a minimum of three years, and the client is expected to make a 20% co-payment

(Adams K, pers. comm., 2021). The GEMS lists 'gender reassignment surgery' for all the scheme's plans apart from the entry level 'Tanzanite one' plan from 2021.[269] Most other medical schemes will suggest that the client applies for an ex-gratia payment, although this is often not granted.

7.2 Initial consultation

It is important to take a full history. The following should be done during the initial consultation:

- Document client's gender and preferred name and pronouns. Explain that they should correct you if you happen to get these wrong. See tips on creating an affirming space in **Chapter 1**.
- Document the client's MHP for liaison around the time of surgery and to ensure that a pre-surgical psychological consultation has been done.
- Document the client's HT prescriber; this may be a GP.
- Note any previous surgery and, particularly, any previous anaesthetic complications.[270]
- Ensure that the client has been given the available options regarding sperm or zygote banking prior to HT (see **Chapter 6: Hormone therapy**).
- Ensure that the client is aware of the procedure to follow for name and gender marker changes with the Department of Home Affairs, and which local home affairs offices are more TGD friendly and efficient. See **Appendix A** for information on letters to the Department of Home Affairs.
- Ascertain whether the client has joined local social media and other support groups so that they may have access to advice and support during the preparation for surgery as well as in the post-operative period. A list of organisations is provided in **Appendix D**.

7.2.1 Note on physical examination, particularly the genitalia

Some TGD persons have marked gender dysphoria. It is important to check with them whether it would be appropriate to examine their genitalia.[51] It is extremely important for the provider-client relationship that the client's wishes are respected if they indicate that they do not want you to examine the genitalia. If this is the case, then it is a good idea to illustrate the principles either via photographs or with hand-drawn pictures. See **Box 2** in Chapter 3: Primary care.

7.3 Transition pathway

For gender-affirming surgery, a documented process of thorough IC is essential and, ideally, should be done collaboratively with a multidisciplinary team that includes an MHP (see **Chapter 2: Informed consent**). If the client is able to consent, then their autonomy should be respected and facilitated.[18] Although most clients have had contact with a psychologist or psychiatrist before presentation to a surgeon, if this has not been the case, then a psychological consultation with a MHP who is familiar with transgender care is recommended.[270,271] We note that the WPATH SoC-7[18] state that a client should have two independent psychological evaluations prior to surgery. However, it has been convincingly argued that this is not necessary for all clients;[91] and in South Africa, one referral letter from an MHP who is familiar with GAHC is acceptable. If psychological issues are detected, they are best managed by a psychologist or psychiatrist.

7.3.1 Adolescents

Gender-affirming surgery in adolescents will most often entail breast surgery with chest reconstruction for AFAB clients. Multidisciplinary team support of the adolescent client is particularly important, as outlined in the Informed consent chapter. The adolescent, along with their parents/legal guardians and MHP need to agree on the appropriate timing of surgery. In addition, an established therapeutic relationship with a MHP familiar with TGD adolescents is recommended. This will enable the adolescent to discuss their planned surgery and address other relevant issues, particularly how they might cope if the surgical outcome is not what they had hoped i.e., the development of healthy coping mechanisms is needed if they are not already in place. The MHP can also provide valuable post-operative support. TGD adolescents with ASD might have limited insight into the need for psychological support and the possible negative outcomes and challenges of having surgery and a MHP can help in this regard.

7.4 Pre-operative considerations

Available options for feminising and masculinising surgery, are shown in **Tables 11** and **12** respectively. HT is usually recommended prior to surgery, but a client may be unable or prefer not to take HT prior to surgery.[18]

TABLE 11: Feminising surgery.		
Type	**Before surgery**	**Note**
Breast surgery • Insertion of silicone breast implants if larger breasts are desired[268]	• Recommend 1 year of prior HT for best outcome (maximum breast development occurs after 3–5 years)[18] • It is important to explain that there is much individual variation in breast development • It is important to explain that if a prosthesis is too large, then it may cause atrophy of the glandular tissue of the breast	• Breast implants carry a lifelong risk of infection[272] • Post-operative antibiotics (Gram-positive cover) are routinely given for 2 weeks
Facial feminisation • Tracheal shave is the commonest procedure[268] (to reduce laryngeal prominence/Adam's apple)	• No requirement for HT prior to surgery • Results are best when done before the cartilage starts to ossify (at 35–40 years of age)	• The bony abnormalities of masculinity (frontal bossing, square jaw, male nose) were historically treated with bony operations which have high complication rates • The modern trend is towards correcting the contours using hyaluronic acid fillers as an alternative to surgery[273]
Orchidectomy • Removal of testes	• Recommend 1 year of prior HT to provide gradual transition from testosterone,[18] as this is physiologically much safer • Discuss reproductive options (e.g. sperm cryopreservation)	• Haematoma is the commonest complication
Genital surgery[266] (to create a vagina) • Penile inversion vaginoplasty (using the foreskin of the penis to form the lining of the vagina); or • Colonic interposition vaginoplasty	• Recommend 1 year of prior HT[18] • Advise pubic hair removal with electrolysis or laser[266] • Penile inversion requires a reasonable amount of foreskin to create adequate vaginal depth; therefore, the client may b e required to stretch the foreskin prior to the operation.	• The clitoris is formed by using a small part of the glans penis which is kept connected to the sensory nerves and vessels to maintain erogenous sensation[266] • Penile inversion carries less risk of scarring and long-term closure[266] • Post-operative dilatation required for colonic interposition vaginoplasty[266] • Colonic interposition vaginoplasty carries the risks of abdominal surgery and permanent vaginal mucus discharge[266] • Shortening of the urethra may lead to urethral stricture[266] • Scarring or malposition of the urethra may lead to the urine stream being misdirected • Clients need to be advised that the urethra is much shorter and therefore the risk of a urinary infection and cystitis is higher; therefore, they should wipe from the front to the back after both urination and defaecation.

TABLE 12: Masculinising surgery.

Type	Before surgery	Note

Breast surgery with chest reconstruction[268]
• Mastectomy
• Areola and nipples often require size reduction[274]
• Most important operation for most TGM[268]
	• No requirement for HT prior to surgery[18]
	• Prior chest binding technique may affect outcome, due to reduced skin elasticity[275]
		• Surgical technique depends on size of breasts:
		  • Smaller breasts have simpler surgery with less risk of complications and scarring[274]
		  • Larger breasts have larger scars with greater risk of nipple necrosis and a poor cosmetic result[274]
		• Commonest complication is seroma formation therefore a drain is usually left in for 5–10 days[274]

Genital surgery (to create a penis, scrotum and testicles) • Radial forearm phalloplasty (using a flap of skin to resemble a penis)[266]	• Recommend 1 year of prior HT[18] • Advise donor site hair removal with electrolysis (to prevent hair inside urethra and on the shaft of the penis)	• Permits standing to urinate but not erection[266] • Erogenous sensation is a challenge and is often not achieved • Commonest complication is urethral fistula or stricture; about 50% will require secondary operations [266]
Or metoidioplasty conversion of clitoris into a penis[266]	• Recommend 1 year of prior HT[18] • Usually requires prior enlargement of clitoris using topical testosterone cream and a pump for tissue expansion[266]	• Has the benefits of erection and erogenous sensation • Penis may be too small for penetrative sex without pre-operative preparation[266] • Complications include urethral fistula or stricture; about 25% will require secondary operations[266]
Testicular implants • The scrotum is formed from the labia minora and testicles created using testicular implants[268]	• Testicular implants can be inserted 6 months after metoidioplasty or phalloplasty[266]	• As the implants are prosthetic material, the commonest complication is infection and clients are usually placed on prophylactic postoperative antibiotics (Gram-positive and -negative cover) for 2 weeks.
Hysterectomy • Removal of uterus[261]	• Recommend 1 year of prior HT[18] • Discuss reproductive options (oocyte cryopreservation)	• This is best done laparoscopically • Carries complications of abdominal surgery

HT, hormone therapy; TGM, transgender men.

7.5 Post-surgical care

Post-surgical care is vital to recovery and should include psychological care and physiotherapy. It is important to note that the continuity of GAHC does not end with the surgical procedure(s), and ongoing support should be provided. The TGD community can play a significant role in peri-operative care, through peer and organisational support groups.[90]

CHAPTER 8

INSTITUTIONS

This chapter makes recommendations for institutions, and is divided into sections that address three basic pillars of life:

- Where you stay
- Where you work
- Where you learn.

8.1 Where you stay

8.1.1 Care facilities

In addition to the recommendations on creating an affirming space and appropriate language use in **Chapter 1**, the following are recommendations for care facilities, including healthcare facilities,[53,206] assisted living facilities for the elderly[276] and shelters:[277]

8.1.1.1 Training of staff

It is important to ensure that all staff are trained to care for a TGD client and it is recommended that GAHC should be included in undergraduate curricula for all healthcare providers.[36] Healthcare providers who have already qualified will require training in the principles of GAHC,[70] and possibly more in-depth training, depending on their profession. This can form part of in-service training provided by workplaces, as well as continuing professional development (CPD) activities. In the context of assisted living facilities for the elderly[276] and shelters,[278] it is recommended that staff are trained to understand the needs of TGD persons. All facilities should have clear anti-discrimination and anti-harassment policies[277] and staff should be trained to prevent gender-identity discrimination.[276]

8.1.1.2 Registration records and intake forms

We recommend the following:

- Respect the client's name and pronouns, regardless of appearance, GAHC history, or sex assigned at birth. A person's use of their name and pronouns should be respected regardless of their appearance, GAHC history, or sex assigned at birth.
- Ensure registration records and intake forms reflect the client's name-in-use, legal name and surname, pronouns, and gender and sex assigned at birth.[53,206,279]
- Ensure the client's gender identity and treatment information is kept confidential and protected under the Protection of Personal Information Act (POPIA).[54]
- Practice discretion with billing information in terms of differentiating between the client's legal name and name-in-use; and consult with the client directly to avoid any breaches of confidentiality.

8.1.1.3 Access to toilet and bathroom facilities

It is important to ensure the TGD client's equal and fair access to toilet and bathroom facilities that are aligned with their self-identified gender (including fully private, and/or gender-neutral bathrooms). The concept of gendered toilets is a relatively modern Western concept rooted in the early nineteenth century; however, in much of the developing world, the concept of shared toilets has remained the norm.[280] Africa's Constitution[3] stipulates the right to dignity and privacy, as well as freedom and security of the person, thus all facilities should ensure that clients are able to use the bathroom that matches their gender identity, without harassment. In the context of non-binary clients, having only female and male bathrooms may limit their safe access.[1,206]

Gender DynamiX and the Legal Resources Centre's 2014 study on toilet usage found that safety concerns factored significantly for many participants.[280] TGW who appeared androgynous, or what is considered traditionally masculine, reported the most difficulty in accessing toilets due to safety concerns. Most participants indicated that a solution would be the introduction of gender-neutral toilets.[280] This concept allows everyone to transition to a situation where gender is no longer a precursor or qualifier to gain bathroom access, and it is therefore strongly recommended that gender-neutral toilets be made available.[280]

In assisted living facilities for the elderly, residents/clients should be allowed to access the bathroom which they are comfortable using, and gender-neutral bathrooms should be made available.[276]

8.1.1.4 Ward and room assignment

A TGD client should be assigned to a bed/room/ward based on their self-identified gender.
Failure to do so is a form of discrimination that jeopardises their dignity and privacy.[53] It is important to note that the client's views take priority over those of their family, or of the staff of the facility. A TGD client's health should not be compromised by unsafe room or ward assignments.

In a 2013 study, homeless TGW reported concerns about safety and privacy, as well as experiences of discrimination when accessing shelters in Cape Town.[277] Beds in shelters should be assigned based on self-identified gender identity rather than sex assigned at birth.[277]

8.1.1.5 Access to personal items that assist gender presentation

TGD clients, regardless of gender, should have access to personal items that facilitate gender expression to the same extent that cisgender clients have access to these items.[281] This may include makeup and shaving equipment, as well as other personal items that assist in their gender presentation, such as those used in binding, packing and tucking.[53] In shelters, TGD residents should be able to dress according to their self-identified gender identity.[277]

8.1.2 Correctional facilities

The majority of incarcerated or detained TGD offenders experience a multitude of challenges which include physical and sexual victimisation, bullying, sexual coercion, denial of essential healthcare, and denial of sexuality and gender expression.[282,283,284,285,286,287] Brömdal et al.[288] further argue that TGD offenders with ethnic minority backgrounds experience many other discriminations in addition to transphobia and/or homophobia. Core issues in correctional institutions that directly affect TGD offenders include housing/placement, access to GAHC and training of correctional staff on TGD issues. The following are specific recommendations for TGD offenders:

8.1.2.1 Housing

It is important to ensure safe and secure detention and incarceration, with appropriate section placement to reduce victimisation.[289] TGD offenders should be assigned to a single cell, if this is their preference, but it is also important to recognise that this protective placement may in itself result in victimisation.[287]

Safe and secure detention and incarceration of TGD offenders, especially TGW, starts with appropriate section or housing unit placement. This will reduce the likelihood of victimisation. In addition, TGM offenders may be vulnerable when placed within male facilities. In correctional facilities in the United States, progressive policies have been implemented that facilitate the appropriate placement of TGD offenders.[288,289]

In South African correctional facilities, single-cell sections or small sections are usually designated for LGBTQIA+ offenders and other offenders with special needs. This placement system has assisted in the reduction of victimisation of vulnerable offenders. However, it needs to be noted that TGD offenders are not a homogenous group: while some may feel safe in protective sections, others might prefer to be placed in communal sections; and while some might feel at ease in female facilities, others might prefer to be in all-male facilities.[287,288,289] Routh et al.[287] note that in some instances, protective placement itself constitutes a form of victimisation; e.g. involuntary placement in solitary confinement may lead to severe psychological problems. It is thus recommended that correctional administrators assess TGD offenders' preferences in terms of placement.[287] Steps should be taken to ensure that communal sections are made safe for the general offender population and for TGD offenders. Where appropriate and safe, TGD offenders' autonomy with regard to placement should be respected and facilitated. In cases where it can be foreseen that placement of the TGD offender in a communal section will invariably result in harm and victimisation, that information should be communicated to the TGD offender in a respectful manner. Engaging TGD offenders in this collaborative process regarding their safety constitutes an affirmative practice and will likely promote their adaptation to the correctional environment.

8.1.2.2 Access to gender-affirming healthcare

Access to HT [286] for TGD offenders should be facilitated. In addition, it is important to ensure that the offender

has access to sexual healthcare (provision of condoms, PEP and PrEP, given their increased exposure to HIV and STIs.[289]

Demeaning and discriminatory attitudes of correctional administrators and health service providers significantly compromise TGD offenders' access to GAHC and mental health care while simultaneously thwarting their health-seeking behaviours.[282,285,287] Lack of access to HT by TGD offenders has been shown to lead to mental health difficulties such as depression and substance abuse, as well as dangerous behaviours such as suicide and auto castration.[282,284,285,286,287,289] HT is an essential component of GAHC as it contributes significantly to the alleviation of psychological distress resulting from gender dysphoria. Access to HT has also been linked to better quality of life and improved mental health outcomes for TGD persons.[282,285,288,289] Unfortunately, in most, if not all correctional institutions, HT is not considered to be medically necessary by correctional administrators and health service providers despite evidence showing that such treatment is a medical necessity.[285,289]

Hughto and colleagues[285] note that TGD offenders who started HT prior to incarceration are required to provide proof of having been prescribed hormones before treatment can be continued. However, this requirement means that those who cannot access their GPs or specialists outside due to lack of social support and those who were taking street hormones are denied access to continued treatment. In South African correctional facilities, access to HT is highly bureaucratic and financially steep; TGD offenders who need to access HT are required to make a formal application to see their own, external medical practitioner who will come to the correctional facility, at the offender's costs. Should they opt to be transported to their medical practitioner, in addition to paying the practitioner, they also need to pay for a state car and the escorting correctional officials.

It is thus recommended that correctional institutions facilitate and support TGD offenders in accessing HT by streamlining their procedures. An example of such streamlining would be to allow and capacitate qualified in-house health providers including MHPs to evaluate TGD offenders to determine their treatment needs and prescribe hormones (medical doctors) if they constitute part of those needs. This will make the process of accessing HT easier for those who started treatment prior to incarceration, as well as those requiring initiation of treatment while incarcerated.

Sevelius and Jenness[289] point out that TGD offenders are highly exposed to blood-borne pathogens, primarily HIV and STIs; therefore, correctional facilities need to ensure that this population has access to sexual healthcare such as provision of condoms, as well as PrEP and PEP when indicated.

8.1.2.3 Training of correctional staff

All correctional staff should be trained on gender identity and diversity, and that all in-house health providers are trained in GAHC.[282] A lack of sound knowledge and information of TGD client as well as their needs breeds negative and discriminatory attitudes held by correctional staff including health services providers.[282,283,285,288] Routh *et al*.[287] comment that due to inadequate education and training about issues facing TGD persons, correctional staff are ill-equipped to deal with and accommodate the needs of transgender offenders. Hughto *et al*.[285] note that insufficient training of correctional healthcare providers creates an unsuitable environment for TGD offenders and contributes to healthcare access barriers through the refusal of care by providers or avoidance of care by TGD offenders. Addressing this problem requires the provision of training to all correctional facility staff to help them develop an understanding of gender identity and diversity inside and outside of carceral facilities.[289] Preliminary results of the feasibility study for a training intervention showed that the TGD-specific training equipped participants with the required cultural competence to provide GAHC for TGD offenders.[282] Indeed, educational efforts to increase healthcare providers with cultural competence have proved successful in improving providers' understanding and knowledge relating to TGD offenders' challenges and needs.[285] We recommend that the Department of Correctional Services intensifies training initiatives and interventions aimed at equipping correctional staff with information and competencies necessary for working affirmatively with TGD offenders in their care and supervision.

8.2 Where you work

8.2.1 Human resource support for TGD inclusion

Some work towards TGD inclusion in the workplace starts before the 'workplace transition' (whatever that may entail for the TGD individual). This can include

collaboration between organisational leadership, the management team and human resources to plot out clear guidelines for supporting current or future TGD employees no matter where they find themselves in their social transition journeys.[290] This 'pre-work' can also include sensitisation training for all employees, as engaging with TGD employees' identity and expression is not something only managers and HR do. It could be helpful to apply a TGD-specific lens to existing anti-harassment, management and diversity training materials and spaces, as a starting point.[291] Other 'pre-work' could include revising the office dress code: Replacing binary gender-specific language like 'women/men may/may not' with inclusive non-gendered language like 'staff may opt for a skirt/suit trousers'.[292]

Ideally, your title and email signature at work should be in line with your gender identity, and it is recommended to include pronouns in every signature and account name for online meetings (Zoom, Microsoft Teams, etc.). Coming out at work, Human Resources should assist with aligning the name-in-use your colleagues and clients interact with to who you are.

In terms of forms and official documents, it would be preferable to use gender-neutral language (they/them) in writing official communications and policies where it does not pertain to a specific person who has shared their pronouns. Exclusive language like 'maternity leave' can and should be replaced with inclusive terms like 'parent leave'. Where legal processes are being followed or payroll is being managed, it would be preferable to have the discretion of HR to differentiate between a TGD individual's name-in-use (how they are being referred to in the workplace) and their deadname/legal name/government name (the name on human resources documents, which may not match the employee's gender identity) and to facilitate updating these personnel records where the government has awarded a legal name change.[293] Titles (Mr, Ms, Mx, etc.) and gender identity should only be recorded where it is absolutely pertinent data, or offered by the individual, and should never be limited to binary osptions (male/female). Workplaces should offer the same benefits to TGD employees as to other employees, and ideally, benefits should not be awarded based on gender identity, or where it is possible and applicable, elect transition benefits can be made available to TGD employees.[294]

8.2.2 Office bathrooms

Office bathrooms should be safe to access for all employees. A gender-neutral bathroom is a fine option, but it would also be wonderful to let persons use the bathrooms that align with their gender identity or where they are comfortable. Where any employees express a need for increased privacy, regardless of, or without reasons given, access to a single-stall restroom should be granted, where available. This is also a possible solution for any employee who does not want to share a multi-person restroom with TGD employees.[295]

These workplace recommendations can be adapted to be applied to shared workspaces (like WeWork or 'hotdesk' concepts) and where working with contractors, consultants and freelancers is concerned.

Health providers can play an advisory role in needs assessment, intervention design and implementation, and policy development and employee benefits.

8.3 Where you learn

8.3.1 Schools

In accordance with the South African legislative framework as stipulated in the Constitution and Bill of Rights,[4] Children's Act[73] and South African Schools Act,[197] schools —private and public, co-educational and single gender — must ensure an inclusive, non-discriminatory and diversity-affirming environment. This supports basic human rights, actualisation of potential, human dignity, equality, right to education, protection from physical and emotional harm, and the best interests of all learners.[3]

8.3.1.1 Policies

Schools should have a policy that clearly operationalises these legislative imperatives, describes how they will be applied at the school and how they apply to the diversity of learners including TGD learners; with the stated intention of ensuring that the school environment is a safe space for all learners.[296,297] These values must be reflected in the school's mission and vision statement, and in all other policies, protocols and practices. Schools must formulate clear policies and directives that stipulate the actions and sanctions that will be taken and applied should any of these legislative and policy imperatives be contravened by any member of the school community (educators, support staff, parents, governing body members, learners and any guest on the school premises or participating in school

activities). These must be included and integrated in a range of policies that address bullying, staff codes of conduct, learner codes of conduct, etc.[298]

Schools need to anticipate the possibility that a learner may come out as TGD after being enrolled at the school for a period of time, and as part of their process of gender-affirming psychosocial healthcare, the learner may wish to initiate the process of social transition at the school where they are currently registered.[18,192] Schools should have the needed processes and protocols in place, informed by best practice guides, to supportively facilitate the social transition of the learner.

Schools should also anticipate the possibility that a parent/legal guardian may approach the school and disclose that their child is TGD when applying for school admission. The parent may request that their child wishes like to keep their gender identity status confidential and be allowed to be introduced into the school environment as the gender they identify as and express without it being disclosed.[192,297] Schools need to develop the appropriate processes and protocols, informed by best practice guides, to supportively facilitate the inclusion and integration of the TGD learner.

8.3.1.2 Documentation and record-keeping

Considering admission of learners to a primary or high school, the necessary administrative protocols and processes should be developed to anticipate that a school applicant may be cisgender or TGD, and for some applicants there may be a distinction between the name and gender reflected on the official birth certificate, and the name-in-use and self-identified gender, respectively. Protocols for such cases should reflect how the 'legal' name and sex assigned at birth will be recorded and applied to ensure administrative and legal integrity as required by the Department of Basic Education, and how the self-identified name and gender will be recorded and applied to ensure the learner experiences their social interaction in the school as safe, affirming, respectful and valuing of their dignity in respect of their self-identity.[17,18,184,198] Administrative aspects such as class attendance registers, grade registers, report cards, and documents issued/published where others have view access, should reflect the learner's gender identity (provided their gender identity status is not confidential); and where necessary, information relevant to documentation requiring their legal name and sex assigned at birth should be transferred confidentially.

Parents of TGD learners may undertake the process with the Department of Home Affairs to alter their child's legal names and/or gender marker. Schools must be supportive and accommodating of these processes, as it is in the best interests of the learner, and allow for the updating of the necessary school records including their National Senior Certificate.

8.3.1.3 Uniform and dress code

Schools must develop school uniform/dress codes that are appreciative and considerate of the gender diversity of learners. The school should include sufficient options to allow learners to select attire that is best suited to their gender identity while reflecting the standards the school wishes to set for the appearance of their learners.[198,297]

8.3.1.4 Bathrooms and changing rooms

As far as possible, schools should ideally establish gender-neutral bathrooms and change room facilities for staff and learners. Where this is not possible, the policy must clearly stipulate that staff and learners may utilise the bathroom and change room facilities that match their gender identity or where they would feel most comfortable.[17,184,198]

8.3.1.5 Sporting activities

Schools should allow learners to participate in sports and other social activities, if separated by gender, according to the gender identity of the learner. Where provincial and national sporting regulations begin to apply to school sports in high school and do not allow TGD learners to participate according to their gender identity, schools must deal with this sensitively, supportively and should advocate on behalf of their learners to challenge such discriminatory legislation.[296]

8.3.1.6 Boarding

Schools that have boarding facilities which are separated by gender should allocate rooms or dorms to learners according to their gender identity, and this includes the use of the ablution facilities; and as far as possible, also establish gender-neutral ablution facilities in such contexts.

8.3.1.7 Single-gender schools

Single-gender schools need to anticipate the possibility of a parent/legal guardian applying to the school for the admission of their child who has already socially transitioned. In such instances, the school should be inclusive and accommodating of a TGD learner whose self-identified gender fits the gender of the single-gender school.

Single-gender schools also need to anticipate the possibility that a learner may come out as TGD while enrolled at the school and need to undergo the process of social transition. The school should have the needed protocols in place to be supportive and accommodating of the learner in their social transition and, where needed, assist in the process of transferring the learner to a more appropriate school.

8.3.1.8 Diversity training, sensitisation and support spaces

Schools have already integrated awareness of diversity throughout the school curriculum at all grade levels and in the life orientation curriculum; however, the topic of Gender Diversity has not been included. [17,184,198] Schools need to correct this omission and work to update the curriculum appropriately.

Schools should offer and implement continued professional development workshops for staff, on a regular basis, that address Transgender and Gender Diversity as a topic.[17,18,184] Schools should also regularly offer workshops and information sessions on gender diversity for parents of the school community.

Schools, especially high schools, should be supportive of learners establishing Diversity or LGBTQIA+ societies/clubs where learners can engage with the recognition, celebration, inclusion and support of diversity.

Health providers can assist schools with the development of relevant policies and guidelines, and with staff sensitisation.[3]

8.3.2 Higher education institutions

In addition to the South African legislative framework described above,[4,73,197] the Higher Education Act (No. 101 of 1997)[299] applies in the context of higher education institutions (HEIs) such as universities, colleges, universities of technology, and so forth. All HEIs, whether private and public, must take an inclusive, non-discriminatory stance that is affirming of diversity. This stance must be in support of: basic human rights, full realisation of potential, human dignity, equality, representivity and equal access, protection from physical and emotional harm, optimal opportunities for learning, and the creation of knowledge for all students and staff; TGD students and staff included. [300,301]

8.3.2.1 Policies

HEIs should have policies that clearly operationalise these legislative imperatives, describing how they will be applied throughout the institution and how they apply specifically to TGD students and staff; with the stated intention of ensuring that the HEI environment is a safe space for all engaging in campus life.[302,303]

HEIs should anticipate that students and staff who apply for admission or employment to the institution may be cisgender or TGD, and for some applicants there may be a distinction between the name and sex assigned at birth reflected on their official birth certificate or IDs and their name-in-use and self-identified gender, respectively.[300]

Universities should have the needed administrative protocols and processes in place that allow the student or staff member to have their self-identified gender and name-in-use reflected on public documents such as student cards, class lists, grade lists, online collective platforms, etc., and where necessary, information relevant to documentation requiring their legal name and sex assigned at birth should be transferred confidentially.[300,302,303]

8.3.2.2 Documentation and record-keeping

HEIs should anticipate that, after being admitted or employed at the institution for a period of time, TGD students and staff members may begin their process of social and legal transition. HEIs should have the needed administrative protocols and processes in place to enable students and staff to update their records, allowing for distinction of their public details affirming their self-identified gender identity and name-in-use, and the discreet and confidential handling of their private information.[300]

HEIs should have the needed protocols and processes in place to accommodate the administrative updating

of records once TGD students and staff complete the legal changes to their names and gender markers through the Department of Home Affairs.[185] This includes the updating and issuing of degree or diploma certificates.

8.3.2.3 Residences

HEI residences that are not co-educational ('co-ed') and are separated by gender should allocate rooms to students according to their self-identified gender identity, and as far as possible, should have gender-neutral ablution facilities. Where this is not possible, students should be allowed to use the ablution facilities appropriate to their self-identified gender.[300]

8.3.3.3 Sporting activities

HEIs should advocate for allowing students to participate in sports codes that are divided according to gender, according to their self-identified gender. Where provincial and national sporting codes do not allow for this, HEIs should manage this sensitively and advocate on behalf of their TGD students to challenge such discriminatory practices.

8.3.3.4 Societies and student representation

HEIs should encourage and support the establishment and activities of LGBTQIA+ societies on campus that promote pride, celebration, awareness, visibility, inclusivity and education about diversity.

In employment equity and student representation in leadership structures on campus, TGD persons should also be considered a marginalised and minority group for whom representation is actively promoted.

8.3.3.5 Student health services

HEIs must ensure that their health and psychosocial services offered to students and staff are gender-affirming, sensitive and responsive to the healthcare needs of TGD students and staff. A non-pathologising and participatory approach to the GAHC must be a central ethical principle in these services.[300,304]

CHAPTER 9

VOICE AND COMMUNICATION

9.1 Background

We rarely think about how we produce speech or how our voice works until we alter how these multifaceted processes occur. Voice and communication are fundamental to how we express our gender. For TGD clients, voice and communication can be intimately connected to gender identity or expression. Congruence with one's identity is critical when considering voice and communication. Such congruence is necessary for various factors ranging from self-assurance to improved participation in activities of daily living.[305] Voice and communication congruence may mean increased safety as TGD persons belong to vulnerable populations and have increased susceptibility to gender-based violence (GBV). Masculinising HT can contribute to a desired voice change but may not be sufficient to achieve the client's goals. Feminising HT is unlikely to result in a desired voice change.[18]

Voice, speech and the overall way we communicate incorporates many physical body structures. Communication is always connected to our feelings. This is also relational as it is about what people in our social world expect us to be, and is connected to our conscious thoughts about what or how we wish to speak. Sex and gender contribute to the physical and social aspects of voice and communication. Needless to say, as sub-systems, speech and voice operate under a variety of environmental, personal and social factors. For example, smoking, alcohol and drug use impact vocal quality and breath support for overall speech production. Developmental factors such as age, or other factors such as hormones, influence speech, voice, language abilities and the so-called cognitive-communication skills. Occupational work conditions such as exposure to noise or environmental toxins affect the voice too. Jobs in the teaching professions and performing arts with professional voice users like singers or actors experience vocal abuse and related voice disorders.

For TGD persons who want to sound more feminine, more masculine or gender neutral, it is helpful to understand how sex and gender influence speech. However, this must not be filtered via sexist stereotypes like that of the dominant man promoted in mass media, literature, fictional novels or films. These stereotypes minimise the role of culture, age and other factors such as geographic location merely accentuating biology. Critically, gender neutral voice and communication options transcend the binaries of feminine or masculine voices. Therefore, there are many factors to consider when working with voice and communication in TGD populations.

9.2 Role of the speech-language therapist

The speech-language therapist (SLT) has a role in managing both the voice and communication of TGD persons, from childhood through to adolescence, and beyond.[18] SLTs may work with feminisation, masculinisation and/or gender neutralisation of speech, voice and communication. Additionally, the SLT may be involved in the communication assessment and management of associated cognitive-communication needs.

9.3 General considerations for voice and communication

It is well established that altering the speaking fundamental frequency (SFF) and resonance characteristics of one's voice results in the desired voice. Further:

- Resonance is a key, fundamental factor to alter in order for the gender perception of a voice to be established.[305] Cisgender women and children have a lower resonance than cisgender men.
- SLTs must consider vowel formants (labelled as 'F') – frequency peaks that correspond to resonance produced in the human vocal tract. While F1 and F2 are critical for shaping the vowel identity and quality, F3 may impact on the overall perception of reduced resonance. F3 may be altered by a lip retraction task. It is therefore important to measure all three vowel formants especially in relation to the speaking fundamental frequency.
- The generally accepted guideline is that the average SFF must move out of the cisgender male speaking range (±100–140 Hz) into a cisgender female range (±180–220 Hz) for a TGW's voice to be perceived as

female, and vice versa. Gender neutral ranges are also desirable, viz. when the SFF is 140–175 Hz. Gender neutral voices are considered less cisnormative and may, for a variety of reasons, be the desired pitch range for many TGD persons.

- Culture, age and language or dialectal factors may alter the target SFF.
- Women are considered softer than men when speaking. However, this is a factor which, based on a gender stereotype, must be developed for real world functional use. Vocal loudness needs to be altered in a variety of occupational and social settings.
- Speech rate and prosody alongside voice quality and inflection are considered pragmatic (social) as well as suprasegmental (e.g., tone, pitch, melodic) factors that may need to be focused in voice/ communication management.[306]

9.4 Voice and communication assessment

9.4.1 Personal profile

It is necessary to complete an initial, comprehensive assessment of the TGD client's voice and communication, including:

9.4.1.1 Gender identity

The client must be given an opportunity to state their gender identity. It is also encouraged that the SLT reveals their own gender identity, at their discretion or as needed to facilitate the conversation. This is to allow the client to choose their cultural fit with the healthcare provider, to initiate the beginning of a close, trusting relationship; and to assist in redefining traditional therapeutic relationships outside of an illness, medical metaphor.

9.4.1.2 Life history

- Traditional case histories are useful ways to profile a medical relationship. However, the development of a life history narrative profile aligns closely to the goal of humanising the clinical relationship.
- This life history narrative may comprise social, cultural, occupational, educational and medical histories including vocal health/use and related lifestyle (e.g. diet and use of tobacco, alcohol and caffeine).
- It is vital that the person's experiences and expectations regarding voice and communication are extracted from the life history narratives.
- Innovative methodologies may be used such as personal written, audio or video diaries, art-based methods and fiction like the engagement of imagined communication patterns inspired by movies, books, popular TV series and other fiction-based methods.

9.4.1.3 Quality of life

A suitable baseline, voice-related measure should be completed such as the Voice Activity and Participation Profile[307] or Voice-Related Quality of Life[308] tools. There are adult and paediatric voice-related quality of life instruments.

Several tools have been designed specifically for the purpose of measuring TGD clients' experiences with their voices. For example, the Trans Woman Voice Questionnaire (TWVQ; originally called the Transexual Voice Questionnaire) is a free resource which may be translated into other languages.[309]

9.4.2 Assessment of voice and communication

The following items should be completed and must include the SLT and the TGD client's (and significant others') subjective assessments. Objective assessments using instrumental measures should be completed, insofar as it is necessary and when indicated, especially when vocal pathologies are suspected, pre- and post voice surgeries. It is critical that goals are collaboratively planned with clients.

9.4.2.1 Auditory-perceptual assessment

Tools to consider may range from the use of Consensus Auditory Perceptual Evaluation of Voice (CAPE-V) [310] or Grade, Roughness, Breathiness, Asthenia, Strain (GRBAS) [311] It is also important to assess coughing, hard glottal attacks and simple tasks like counting to test vocal endurance or fatigue.

9.4.2.2 Laryngeal examination

The minimum of a mirror laryngoscopy should be

completed and used to direct the need for further instrumental assessments like rigid or flexible endoscopy, but only if clinically indicated. It is recommended that voice feminisation surgeries (vs. cosmetic procedures such as a thyroid chondroplasty) should be packaged with pre- and post-surgical instrumental assessments. Furthermore, voice masculinisation, often achieved via testosterone therapy, must be evaluated for whether the shift in the speaking fundamental frequency is sufficient.[312]

9.4.2.3 Acoustic analysis

The mean fundamental frequency should be assessed across several conditions like sustained vowel production and in connected speech. Other acoustic analyses include maximum phonational frequency range, frequency variability, mean intensity (also across sustained vowels and connected speech) as well as the calculation of factors like the harmonics-to-noise ratio or noise-to-harmonics and normalised noise energy ratio.

The vocal dynamic range, voice range profile and jitter/shimmer characteristics of the TGD client should be established.

Acoustic analyses may be completed using software programmes such as the popular (and free) Praat (**http://www.fon.hum.uva.nl/praat/**) or SFS/WASP (**http://www.speechandhearing.net/laboratory/wasp.htm**).

Commercial programmes may be bought and used as part of larger computerised speech analysis hardware and tools. These assessments are always better contextualised using audio-visual recordings.

9.4.2.4 Aerodynamic analysis

Glottal airflow, subglottal pressure and air volume are useful measures to record especially when analysing changes due to the use of strategies to alter resonance and SFF. These measures are closely related to phonatory/respiratory efficiency assessed using methods such as maximum phonation time and s/z ratio.

Client-reported outcome measures should be completed to assess especially pain/fatigue and perceptions of their own voice.[313]

Communication assessment

Political, cultural and psychosocial issues that interact with TGD persons must be completed to map their communication networks. This means mapping who they communicate with, viz. strangers and familiar persons. It also means investigating how communication interactions occur to identify communication stress factors with, e.g., cisgender strangers and in cisnormative conversations. It is important to identify communication stress responses such as communication avoidance, withdrawal from interactions, silencing and increased self-monitoring.[314] Assessment, at the micro-level, should occur regarding communication partners (strangers or familiar persons), non-verbal (e.g., expressions of disapproval, dismissal) and verbal behaviours such as intrusive questions, misgendering (intentional use of incorrect pronouns/names), displaying pity, sympathy and the overemphatic use of gender allyship language.

There are no standardised assessment tools (or other minimum practice standards) for detailed communication evaluation in South Africa for TGD persons. The evidence in this specific area of practice is poor. Until more research-based evidence is collated, it is strongly suggested that the SLT engages a practice-based evidence (PBE) strategy. In alignment with a more decolonised practice, a PBE strategy promotes meaningful engagement with stakeholders (the client) and practitioners' expertise. However, the trained SLT may skilfully use structured, informal and/or any adapted relevant language assessments to assess language areas focused on pragmatic aspects across (a) speech acts, intentions and functions; (b) conversational-; (c) discourse-; and (d) alternation parameters – all within relevant, culturally appropriate adult-adult and adult-child communication interactions across social, occupational and educational contexts.

Communication assessments should focus on verbal and non-verbal communication including oculesics (eye movements), facial expression, communication associated with kinesics and proxemics, including tactile communication methods.

It is highly recommended that SLTs avoid the use of cisgendered norm-based values for pragmatic language and consider criterion-reference values. An ecological, holistic and team-based approach is essential to perform all assessments – and management strategies.

Communication needs and diversity

TGD persons may be deaf, or living with communication disabilities due to hearing impairments, stroke, head and neck cancers, traumatic brain injuries, illnesses and diseases such as Parkinson's disease or cerebral palsy, among a host of other factors. They may be non-verbal communicators using assistive devices such as electronic or computer devices, viz. augmentative-alternative communication (AAC) users. Such diversity of communication needs requires bespoke, specialist intervention to accommodate appropriate assessment tools and methods towards a more accurate description of their verbal and non-verbal communication skills.

Specifically, in South Africa's multilingual communication landscape with the history of colonial language (English), the need to affirm indigenous African languages must be considered within the SLT's assessment (and management) of TGD clients.

9.5 Voice and communication interventions

- All TGD clients should be provided with the option of trial intervention (therapy, management) for their voice and communication needs.
- They also need to be provided with information about viable options such as phonosurgery, which will vary by province within South Africa. The SLT should investigate phonosurgery options that are locally available and work with the team to discuss if phonosurgery is the single choice and/or an optional part of the treatment plan. These surgeries may incorporate other treatments such as Botox, administered post-operatively, towards managing pitch increases.[315] Notably, phonosurgeries are not currently offered as an essential part of voice and communication intervention.
- Intervention may account for the lifespan – child, adolescent and adult needs.
- Initial goal-setting should consider negotiating on a range of options that include gender neutral, cismale or cisfemale voice and communication.
- The following should be covered, over a period deemed suitable to progress across each aspect:
- Trial voice therapy (recommended dose of four sessions across 2 months) should be offered toward assessing candidacy for therapy. This may be offered in person or via telepractice.
- Negotiate the format of the intervention to include a mix of personal, individualised, group and community-based interventions.
- In the absence of South African standardised protocols that are evidence-based, it is suggested that all interventions have self, peer and SLT practitioner intervention/therapy outcome measures.

Communication interventions are summarised in **Table 13**.

TABLE 13: Voice and communication interventions.

Voice	Communication
• Vocal stretches and voice conditioning • Increased/decreased speaking frequency and/or resonance • Perceptual-motor learning; e.g., targeting sensations or images[305,316]	Pragmatic aspects, viz.: • conversation • discourse • alternation Non-verbal communication • Kinesics • Proxemics • Oculesics • Facial expressions • Tactile communication

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APPENDICES

APPENDIX A: Role of health professionals in gender marker change at the Department of Home Affairs: Act No. 49

South African legislation allows a TGD person to change their gender marker as well as their forename. TGD persons can apply to change their sex description in the birth register in terms of the *Alteration of Sex Description and Sex Status Act* (No. 49 of 2003).[185] Section 2(1) states:

'Any person whose sexual characteristics have been altered by surgical or medical treatment … resulting in gender reassignment … may apply to the Director-General of the National Department of Home Affairs for the alteration of the sex description on his or her birth register.'

In terms of Section 2(2)(b),[185] an application must include two reports by medical practitioners. Examples of the reports follow below. The Act does not make gender reassignment surgery compulsory. Hormonal treatment is sufficient.

Application for forename change can be made in terms of Section 24 of the Births and Deaths Registration Act (No. 51 of 1992) [317] and does not require any letter.

A helpful resource that details the process for clients is available at **https://www.betrue2me.org/resources/be-true-2-me-guideline-legal-gender-marker-and-forename-change/**

A1. Suggested letter in support of application to the Department of Home Affairs for change in gender marker – medical doctor

Letterhead

Date: _____

Attention: Department of Home Affairs

Subject: Letter of Support for Application for Change in Gender Marker in terms of the Births and Deaths Registration Act (Act No. 51 of 1992) read with Section 27(A) of the Sex Description and Sex Status Act (No. 49 of 2003).

Transgender and gender diverse (TGD) masculine/feminine gender reassignment applicants:

To whom it may concern:

MEDICAL REPORT on: _____

ID No: _____

This is to certify that _____ is a patient of mine and has undergone **medical gender reassignment**.

This has altered _____sexual characteristics and he/she now presents as male/female. Please assist _____ in altering the gender on his/her Identity Document. Please feel free to contact me at the address below if you have any further queries.

Yours faithfully,

_____

A2. Suggested Letter in support of application to Department of Home Affairs for change in gender marker – surgeon

Wording for a letter by the surgeon following feminising surgery:

Letterhead

Date:_____

To Whom It May Concern:
Department of Home Affairs

MEDICAL REPORT on: _____

ID No: _____

In terms of the Sex Description and Sex Status Act (No. 49 of 2003).

This is to certify that _____ is a patient of mine.

She has had **gender-affirming surgery.**

She is also on oestrogen **hormone therapy,** which will continue lifelong.

As a result of this gender reassignment surgery, her body is **physically female.**

Please feel free to contact me at the above address if you have any further queries.

Sincerely,

_____

Wording for a letter by the surgeon following masculinising surgery:

Letterhead

Date:_____

To Whom It May Concern:
Department of Home Affairs

MEDICAL REPORT on: _____

ID No: _____

In terms of the Sex Description and *Sex Status Act* (No. 49 of 2003).

This is to certify that _____ is a patient of mine.

He has undergone **gender-affirming surgery.**

He is also on testosterone hormone therapy, which will continue lifelong.

As a result of this gender reassignment surgery, his body **is physically male.**

Please feel free to contact me at the above address if you have any further queries.

Sincerely,

_____

A3. Suggested letter in support of application to Department of Home Affairs for change in gender marker – clinical psychologist / counselling psychologist / educational psychologist / clinical social worker

Letterhead

Date_____

Attention: Department of Home Affairs

Subject: Letter of Support for Application for Change in Gender Marker in terms of the Births and Deaths Registration Act, 1992 (Act No. 51 of 1992) read with Section 27(A) of the Description and Sex Status Act (No. 49 of 2003)

Identifying details:
Surname: **Legal Name:**
Identity number:
Date of Birth:

I have been consulting with _____ regarding **gender reassignment.** Her/his gender identity is that of fe/male and s/he identifies her/himself as fe/male. This is to verify that s/he is receiving gender reassignment treatment from Dr _____.

Kind regards

_____
Clinical Psychologist / Counselling Psychologist / Educational Psychologist / Clinical Social Worker

APPENDIX B: Client information and informed consent form for feminising hormone therapy

Note: The IC forms contained herein are included as examples of what such a document might look like and the kind of information it may contain. These examples are not intended to be used 'as is', but should rather serve as a template or guideline to help practitioners craft their own IC forms specific to their practices.

Many transgender and gender diverse (TGD) clients choose to seek gender-affirming care in the form of hormone therapy. The decision to commence hormone therapy rests with you, the client, and not with your healthcare provider. The informed consent model of treatment gives you agency over this decision – it is the role of your doctor to support and guide you through this process **safely** and **effectively.**

You may have read up, or heard from other TGD persons, about hormone therapy. Some of the information that you may have come across could potentially be out of date or inaccurate.

If you have any questions or concerns at any time, you should always **feel free** to **raise these concerns** with your healthcare provider.

Please remember that every **client is unique** and will respond differently to medication, and that one client's treatment programme might differ substantially from another's due to a variety of physiological and medical factors. **Try not to compare** the treatment you are receiving with that of anyone else – your journey is your own. If you have concerns about the efficacy of your treatment, make a point to discuss this with your provider at your next appointment.

Before commencing hormone therapy, there are a few points that are worth considering. This informed consent document will draw your attention to some of these points, as well as outlining the expected effects, side effects, and risks associated with hormone therapy to ensure that you have all the information you need to make the best decision about your body and your health.

Role of psychotherapy in TGD clients

Seeing a psychologist **is not a requirement** for initiating hormone therapy. While previously, some healthcare providers required a letter of diagnosis or referral, this is no longer necessary under international best practice. Your doctor will ask you some questions to determine that you have a **good support structure** as you move forward. This is not because taking hormone therapy itself necessitates this; rather, as many TGD clients experience, navigating the world is already difficult, and hormone therapy – although often resulting in **many positive and beneficial changes** – can also lead to some **emotional lability.** A solid support structure looks different for everyone, but may include friends, family, support groups, therapists and counsellors. Your doctor may suggest or offer you referrals to support groups and therapists, if you indicate that you may benefit from these.

The role of endocrinologists and other specialists

Hormone therapy **does not need** to be prescribed or monitored by an endocrinologist. Prescribing hormone therapy is well within the realm of a suitably skilled **general practitioner (GP) or family physician.** Not all GPs, nor all endocrinologists, have experience in managing gender-affirming hormone therapy, and the expertise of the clinician should be the guiding factor in determining who prescribes and monitors your hormone therapy.

You may benefit from seeing other **allied health professionals,** such as **speech-language therapists,** and medical specialists such as **plastic surgeons.** Not every TGD client will necessarily want to pursue these options, and you should discuss your individual goals with your prescribing doctor.

Department of Home Affairs and gender marker

If you wish to update your gender marker on your birth certificate and identity (ID) document, then the Department of Home Affairs requires **two letters from healthcare professionals** which state that you have undergone **medical or surgical** gender reassignment. Either of these is sufficient; you do **not need to have had surgery** to update your gender marker.

Unfortunately, at present, gender markers in South Africa are binary; thus, an ID document can reflect either female or male. There is no unspecified or non-binary marker.

Your prescribing doctor can write one of your letters for the Department of Home Affairs and should be able to refer you to another healthcare provider to write the second letter.

If you wish to change your name, this process should be undertaken separately (either before or after) to the process of updating your gender marker. This **does not require supporting letters** from healthcare providers.

Other important aspects to explore:

Potential challenges with legal documents: Some TGD persons have trouble with banking, registration as a student and writing examinations, registration of motor vehicles, etc. while they are awaiting their new documents. Some are accused of potential fraud because they do not look the same as the photo in their ID or their name may be different from the name on their qualification certificates. To change one's gender marker and names will take a while. You may want to consider how you will deal with such challenges in the interim. You may also want to consider if you need to change other documentation, e.g., your matric certificate.

Potential impact on emotions: The impact of hormones can be very diverse and individualised. Your mood may fluctuate. For example, some TGD women may experience being more moody or tearful at times.

Potential impact on relationships with family and significant others: Have you thought about the possible impact on your relationship with significant others? If you are in an intimate relationship, this may change when you commence hormone therapy, and relationship roles may need to be re-negotiated. A partner may grieve the loss of aspects of who you were and the way the relationship used to be. What possible impact can it have on your family and how will you be able to deal with your family's response? Have you considered the impact of the change of gender role in your family? Have you considered the impact of potential loss of fertility? Are there children that may be impacted and are the children prepared?

Potential change in sexual orientation: It is possible that your sexual orientation may remain constant or shift, either temporarily or permanently (e.g. shift in attraction or choice of sexual partners, widened spectrum of attraction, or shift in sexual orientation identity).

Potential impact on safety: In some settings, the physical changes on hormones may affect your safety, with persons who do not fit into society's expectations of male or female being at increased risk of violence.

Potential impact on employment: Some TGD persons experience discrimination in the workplace, or struggle to obtain employment. This may be more difficult when your legal documents (e.g. ID) and your appearance do not match.

Potential grief and loss: Some TGD persons experience a sense of loss; e.g. a TGD woman may be treated differently by society when she is read as female. A TGD woman may also experience that she becomes physically weaker.

Taste changes: Some TGD persons experience a change in their taste sensations, and their likes and dislikes of certain foods.

Body odour change: Some TGD persons experience a change in their body odour when taking hormone therapy.

Appetite and sleeping patterns: Often the TGD person will experience an increase in appetite. This could cause weight gain. Sleeping patterns may also be affected.

Feminising hormone therapy

Feminising hormone therapy is prescribed for assigned-male-at-birth clients who wish to feminise.

The backbone of feminising hormone therapy is oestrogen therapy. Anti-androgens (spironolactone, cyproterone acetate or bicalutamide) are sometimes used, although many clients can achieve testosterone suppression using oestrogen therapy alone.

The biggest concern with oestrogen therapy is the risk of clot formation, which can lead to deep venous thrombosis (DVT) or life-threatening pulmonary emboli. It is this risk that limits the amount of oestrogen that healthcare practitioners can safely prescribe to clients. Oral oestrogen (Estrofem or Premarin, for example) carries a higher risk for these adverse events than parenteral (i.e. administered outside the digestive tract) oestrogen.

Comparison of oestrogen preparations			
Type	Examples	Advantages	Disadvantages
Tablet, taken orally	Estrofem Premarin	• Easy to use • Accessible at most pharmacies	• Higher thrombotic risk
Tablet, dissolved sublingually†	Estrofem	• Accessible at most pharmacies	• Time consuming (takes 30 minutes to absorb)
Injectable	Oestradiol valerate	• Safer • Affordable • Once-a-week dosing	• Available only from compounding pharmacy • Requires knowledge of injection technique • Requires disposables (syringes, needles, alcohol swabs)
Patch	Estradot	• Safer • Available at most pharmacies • Twice-a-week dosing	• Patches need to be applied and cared for correctly • May cause skin reactions due to adhesive

†, Taking an oestrogen tablet sublingually involves holding the tablet in the mouth – either under the tongue, inside the cheek, or between the lips and teeth, while the tablet dissolves. After dissolving, the residue must be held in the mouth for a further 30 minutes to fully absorb, and any remnants need to then be spat out and the mouth thoroughly rinsed. It is important not to swallow at all during this time, as any swallowed medication will go through the digestive tract and carry a higher risk of adverse events.

Your doctor will discuss with you the various options for hormone therapy that are available and help you to decide which form of treatment is best for you.

Costs of hormone therapy

It is important to remember that not only do different clients have different needs in accessing hormone therapy, but also that prices for medication may vary between different pharmacies, and that these prices may fluctuate over time. The majority of clients can expect to spend approximately R300–R500 per month on hormone therapy. This does not include the cost of monitoring blood tests or doctor's visits.

Changes that occur when using hormone therapy
The changes you will experience on hormone therapy often take some time to develop fully. Some of these changes are reversible and will disappear should you discontinue hormone therapy. Others are irreversible and will persist even if you stop taking your hormones.
The timeline for these changes to begin is variable, but most of them will only reach their maximum degree after 3–5 years on hormone therapy.

Reversible changes

Such changes include:

- loss of muscle mass and decreased strength
- changes in body fat distribution, possibly associated with weight gain (increased fat deposition in breasts, buttocks, hips, and thighs)
- softer and thinner skin
- reduced acne
- lighter and thinner body and facial hair
- cessation of male-pattern balding, possible scalp hair regrowth
- changes in sex drive (usually a decrease initially, followed by an increase together with a change in sexual response cycle)
- changes in strength and frequency of erections, and changes in the amount and consistency of ejaculate
- changes in mood and emotional response.

Irreversible changes

Such changes include:

- breast development; while the size of breast tissue may fluctuate, hormone therapy will cause permanent development of breast structures that will remain

even if hormone therapy is withdrawn
- testicular atrophy
- infertility
- changes in bone density.

Limitations of hormone therapy

It is important to understand that there are certain features that hormone therapy cannot alter. Among others, these include:

- presence of facial hair – although hormone therapy may make the hair thinner, or cause it to grow more slowly, hormone therapy will not eliminate facial hair
- pitch of the voice
- bone structure of the face
- presence of thyroid cartilage (Adam's apple).

Important risks associated with hormone therapy

As with any medication, hormone therapy carries with it certain risks. Some of these risks can be mitigated or reduced by lifestyle factors, while others are independent risks that cannot be altered. It is important to be fully aware of the risks associated with hormone therapy before making the decision to start your treatment.

Blood clots are the most prominent risk associated with feminising hormone therapy. A blood clot can lead to deep venous thrombosis (DVT), pulmonary embolism (a blood clot in the lungs), heart attack or strokes. These conditions may be severely debilitating or even fatal:

- cardiovascular disease
- nausea or vomiting
- migraines or other headaches
- gallstones and other diseases of the gallbladder
- elevated levels of prolactin can rarely occur in clients on feminising hormone therapy, due to the development of a prolactinoma, a benign (non-cancerous) tumour of the pituitary gland, that may interfere with vision. These can require surgical management, depending on the nature of the lesion.

Some of the risks mentioned are modified by other factors. Notably, cardiovascular and clot risk are worse in clients who:

- Are above the age of 45 years
- Smoke
- Use alcohol
- Have pre-existing medical conditions, such as diabetes, high blood pressure, or high cholesterol.

Some clients will experience a reduction in their blood pressure, and improvements in their cholesterol levels on hormone therapy. This is not a guarantee and is not a replacement for positive lifestyle changes.

Fertility

Although not all clients become infertile on hormone therapy, and some might regain fertility if they stop hormone therapy, many may become irreversibly infertile. Hormone therapy is not a replacement for effective and responsible contraceptive use.

All clients considering starting on hormone therapy should consider using a cryobank to preserve genetic material, in case they wish to conceive genetically related children at a later stage. Even if this is not a priority for you at this stage in your life, please consider the possibility that your perspectives might change with time, and that it is ideal to store material before starting hormone therapy, rather than trying to regain fertility once you are already taking hormones.

Your doctor can refer you to facilities that can aid in cryopreservation.

Monitoring and follow up

Your doctor will advise and guide you in monitoring your safety while you are on hormone therapy. Usually, this will involve regular check-ups and physical examinations, as well as certain blood tests.

At the outset, it is not uncommon for these evaluations to be done monthly, while you are still achieving the correct hormonal balance for you. Later, once you are stable on treatment, these intervals might be extended to six-monthly, or perhaps even annually. This schedule is different for every client.

Cessation of hormone therapy

If you decide to stop your hormone therapy, you should discuss this decision with your doctor. It can be dangerous to abruptly withdraw hormone therapy without adequate medical supervision.

More information

Please remember that you can discuss any questions or concerns with your doctor at any time.

Information on self-injection technique can be found at: **https://fenwayhealth.org/care/medical/transgender-health/**

Informed consent for feminising hormone therapy

I confirm that I have read and understand the information above.

I confirm that my doctor has told me about the effects of feminising hormone therapy, including the more common or serious risks and side effects as mentioned above.

I understand that some of these effects may be permanent.

I understand that as part of my treatment plan, I shall take my medication as prescribed and have check-ups including blood tests as required.
My doctor has offered me adequate opportunity to ask any questions that I have regarding feminising hormone therapy.

I hereby agree that my doctor starts/continues treating me with feminising hormone therapy.

Client name: _____

Client signature: _____

Signed at _____ on this ____ day of _____, 20___

Place _____ day _____ month _____ year_____

Provider name: _____

Provider signature: _____

Signed at _____ on this ____ day of _____, 20___

Place _____ day _____ month _____ year_____

APPENDIX C: Client information and informed consent form for masculinising hormone therapy

The IC forms contained herein are included as examples of what such a document might look like and the kind of information it may contain. These are not intended to be used 'as is', but should rather serve as a template or guideline to help practitioners craft their own IC forms specific to their practices.

Many transgender and gender diverse (TGD) clients choose to seek gender-affirming care in the form of hormone therapy. The decision to commence hormone therapy rests with you, the client, and not with your healthcare provider. The informed consent model of treatment gives you agency over this decision – it is the role of your doctor to support and guide you through this process **safely** and **effectively.**

You may have read up, or heard from other TGD persons, about hormone therapy. Some of the information that you may have come across could potentially be out of date or inaccurate.

If you have any questions or concerns at any time, then you should always **feel free** to **raise** these concerns with your healthcare provider.

Please remember that **every client is unique** and will respond differently to medication, and that one client's treatment programme might differ substantially from another's due to a variety of physiological and medical factors. **Try not to compare** the treatment that you are receiving with that of anyone else – your journey is your own. If you have concerns about the efficacy of your treatment, then make a point to discuss this with your provider at your next appointment.

Before commencing hormone therapy, there are a few points that are worth considering. This informed consent document will draw your attention to some of these points, as well as outlining the expected effects, side effects and risks associated with hormone therapy, to ensure that you have all the information you need to make the best decision about your body and your health.

The role of psychotherapy in TGD clients

Seeing a psychologist **is not a requirement** for initiating hormone therapy. While previously, some healthcare providers required a letter of diagnosis or referral, this is no longer necessary under international best practice.

Your doctor will ask you some questions to determine that you have a **good support structure** as you move forward. This is not because taking hormone therapy itself necessitates this; rather, as many TGD clients experience, navigating the world is already difficult, and hormone therapy – although often resulting in **many positive and beneficial changes** – can also lead to some **emotional lability.** A solid support structure looks different for everyone, but may include friends, family, support groups, therapists and counsellors. Your doctor may suggest or offer you referrals to support groups and therapists, if you indicate that you may benefit from these.

The role of endocrinologists and other specialists

Hormone therapy **does not need** to be prescribed or monitored by an endocrinologist. Prescribing hormone therapy is well within the realm of a suitably skilled **general practitioner (GP)** or family physician. Not all GPs, nor all endocrinologists, have experience in managing gender-affirming hormone therapy, and the expertise of the clinician should be the guiding factor in determining who prescribes and monitors your hormone therapy.

You may benefit from seeing other **allied health professionals,** such as **speech-language therapists,** or from medical specialists such as **plastic surgeons.** Not every TGD client will necessarily want to pursue these options, and you should discuss your individual goals with your prescribing doctor.

Home affairs and gender marker

If you wish to update your gender marker on your birth certificate and identity document (ID), then the Department of Home Affairs requires **two letters from healthcare professionals** which state that you have undergone **medical or surgical** gender reassignment. Either of these is sufficient; you **do not need to have had**

surgery to update your gender marker. Unfortunately, at present, gender markers in South Africa are binary; thus, an ID document can reflect either female or male. There is no unspecified or non-binary marker.

Your prescribing doctor can write one of your letters for the Department of Home Affairs and should be able to refer you to another healthcare provider to write the second letter.

If you wish to change your name, then this process should be undertaken separately (either before or after) to the process of updating your gender marker. This **does not require supporting letters** from healthcare providers.

Potential challenges with legal documents: Some TGD persons have trouble with banking, registration as a student and writing examinations, registration of motor vehicles, etc. while they are awaiting their new documents. Some are accused of potential fraud because they do not look the same as the photo in their ID or their name may be different from the name on their qualification certificates. To change one's gender marker and names will take a while. You may want to consider how you will deal with these challenges in the interim. You may also want to consider if you need to change other documentation, for example your matric certificate.

Other important aspects to explore:

Potential impact on emotions: The impact of testosterone can be very diverse and individualised. Your mood may fluctuate. For example, often a TGD man may struggle to cry, and their emotions may become less intense. Some also experience increased irritability.

Potential impact on relationships with family and significant others: Have you thought about the possible impact on your relationship with significant others? If you are in an intimate relationship, this may change when you start on hormones, and relationship roles may need to be re-negotiated. A partner may grieve the loss of aspects of who you were and the way the relationship used to be. What possible impact can it have on your family and how will you be able to deal with your family's response? Have you considered the impact of the change of gender role in your family? Have you considered the impact of potential loss of fertility? Are there children that may be impacted and are the children prepared?

Potential change in sexual orientation: It is possible that your sexual orientation may remain constant or shift, either temporarily or permanently (e.g. shift in attraction or choice of sexual partners, widened spectrum of attraction, shift in sexual orientation identity)

Potential impact on safety: In some settings, the physical changes on hormones may affect your safety, with persons who do not fit into society's expectations of male or female being at increased risk of violence.

Potential impact on employment: Some TGD persons experience discrimination in the workplace, or struggle to obtain employment. This may be more difficult when your legal documents (e.g. ID) and your appearance do not match.

Potential grief and loss: Some TGD persons experience a sense of loss. A TGD man may lose certain gender roles in the family.

Taste changes: Some TGD persons experience a change in their taste sensations, and their likes and dislikes of certain foods.

Body odour change: Some TGD persons experience a change in their body odour on hormone therapy.

Appetite and sleeping patterns: Often the TGD person will experience an increase in appetite. This could cause weight gain. Sleeping patterns may also be affected.

Masculinising hormone therapy

Masculinising hormone therapy is prescribed for assigned-female-at-birth clients who wish to masculinise. The backbone of masculinising hormone therapy is **testosterone** therapy. No additional medications are necessary to suppress oestrogen, since testosterone is able to do this alone.

The biggest concern with testosterone therapy is the **risk of liver and cardiovascular disease.** Testosterone use can adversely affect the liver, which is an organ vital to detoxifying the blood, and metabolising medications and dietary nutrients. Testosterone has also been observed to cause an increase in LDL (commonly known as 'bad') cholesterol, and a decrease in HDL (commonly known as 'good') cholesterol. These changes in metabolic profile can increase a client's risk of heart attacks or strokes to levels similar to those seen in cisgender men.

Comparison of testosterone preparations			
Type	Examples	Advantages	Disadvantages
Short-acting injection	Depo-testosterone	• Accessible at most pharmacies • Affordable • Once-a-week dosing	• Requires knowledge of injection technique • Requires disposables (syringes, needles and alcohol swabs)
Long-acting injection	Nebido	• Accessible at most pharmacies • A single dose lasts approximately 3 months	• Requires knowledge of injection technique • Requires disposables • Achieving the correct dose can be difficult with long dosing intervals
Topical gels or creams		• No injection needed	• Available only from compounding pharmacy • Skin absorption varies between clients

Your doctor will discuss with you the various options for hormone therapy that are available, and help you to decide which form of treatment is best for you.

Additional medications:

For clients who wish to achieve **suppression of menstruation,** but have not done so on testosterone alone, **progesterone may be added.**

Some clients will use topical minoxidil in order to achieve fuller facial hair growth.

Costs of hormone therapy

It's important to remember that not only do different clients have different needs in accessing hormone therapy, but also that prices for medication may vary between different pharmacies, and that these prices may fluctuate over time. The majority of clients can expect to spend R200–R600 per month on hormone therapy. This does not include the cost of monitoring blood tests or doctor's visits.

Changes that occur when using hormone therapy

The changes you will experience on hormone therapy often take some time to develop fully. Some of these changes are **reversible** and will **disappear should you discontinue hormone therapy**. Others are **irreversible** and will **persist even if you stop taking your hormones.**

The timeline for these changes to begin is variable, but most of them will only reach their maximum degree after 3–5 years on hormone therapy.

Reversible changes

Such changes include:

- gain of muscle mass and increased strength
- changes in body fat distribution, possibly associated with weight gain (increased fat deposition in the abdomen, and decreased fat in breasts, buttocks and thighs)
- coarser and thicker skin
- increased acne
- coarser and thicker body hair
- increased red blood cell count
- increase in sex drive
- changes in mood and emotional response (often initially an increase in anger and aggression, among other emotions)
- cessation of menses and ovulation
- dryness of the genital tissues.
- Irreversible changes

Such changes include:

- hair loss or male pattern balding may occur
- facial hair growth
- deepening of the voice
- enlargement of the clitoris
- infertility.

Limitations of hormone therapy

It is important to understand that there are certain features that hormone therapy cannot alter. Among others, these include:

- presence of breast tissue – hormone therapy can reduce fat deposition in the breasts, and make them smaller, but will not result in loss of actual breast tissue
- bone structure – hormone therapy will not change the structure of your pelvis or cause you to grow taller.

Important risks associated with hormone therapy

As with any medication, hormone therapy carries with it certain risks. Some of these risks can be mitigated or reduced by lifestyle factors, while others are independent risks that cannot be altered.

It is important to be fully aware of the risks associated with hormone therapy before making the decision to start your treatment:

- high cholesterol or blood fats
- increased red blood cell count
- high blood pressure.

All of the above can lead to, or worsen **cardiovascular disease,** or lead to **strokes.** These conditions can be life-threatening.

Liver disease

Psychiatric symptoms including mood disturbances, anxiety or psychosis, especially if there are pre-existing mental health conditions. If you have been diagnosed with a mental health condition and/or use psychiatric medication, then you need to discuss the starting of hormone therapy with your doctor. Using hormones can interact with various medications and have an impact on your mental health.

Some of the risks mentioned are modified by other factors. Notably, cardiovascular and clot risk are worse in clients who:

- smoke
- use alcohol
- have pre-existing medical conditions, such as diabetes, high blood pressure and high cholesterol.

Fertility

Although not all clients become infertile on hormone therapy, and some might regain fertility if they stop hormone therapy, many may become irreversibly infertile. Hormone therapy is not a replacement for effective and responsible contraceptive use.

All clients considering starting on hormone therapy should consider using a cryobank to preserve genetic material, in case they wish to conceive genetically related children at a later stage. Even if this is not a priority for you at this stage in your life, please consider the possibility that your perspectives might change with time, and that it is ideal to store material before starting hormone therapy, rather than trying to regain fertility once you are already taking hormones.

Your doctor can refer you to facilities that can aid in cryopreservation.

Monitoring and follow up

Your doctor will advise and guide you in monitoring your safety while you are on hormone therapy. Usually, this will involve regular check-ups and physical examinations, as well as certain blood tests.

At the outset, it is not uncommon for these evaluations to be done monthly, while you are still achieving the correct hormonal balance for you. Later, once you are stable on treatment, these intervals might be extended to six-monthly, or perhaps even annually. This schedule is different for every client.

Cessation of hormone therapy

If you decide to stop your hormone therapy, you should discuss this decision with your doctor. It can be dangerous to abruptly withdraw hormone therapy without adequate medical supervision.

More information

Please remember that you can discuss any questions or concerns with your doctor at any time.

Information on self-injection technique can be found at: **https://fenwayhealth.org/care/medical/transgender-health/**

Informed consent for masculinising hormone therapy

I confirm that I have read and understand the information above.

I confirm that my doctor has told me about the effects of masculinising hormone therapy, sincluding the more common or serious risks and side effects as mentioned above.

I understand that some of these effects may be permanent.

I understand that as part of my treatment plan, I shall take my medication as prescribed and have check-ups including blood tests as required.

Client name: _____

Client signature: _____

Signed at _____ on this ___ day of _____, 20___

Place _____ day _____ month _____ year_____

Provider name: _____

Provider signature: _____

Signed at _____ on this ___ day of _____, 20___

Place _____ day _____ month _____ year_____

APPENDIX D: Community resources

Organisation	Telephone number	Email address	Website	Services offered	Province/ City
Access Chapter 2	+27 (0)10 100 3177	info@ac2.org.za	http://www.ac2.org.za/	Equal access to services for women and LGBTQIA+ persons	Gauteng/ Pretoria
BeTrue2me	+27 (0)81 455 1183	contactus@betrue2me.org	https://www.betrue2me.org/	Support for TGD individuals seeking healthcare	Gauteng
Coalition of African Lesbians (CAL)	+27 (0)11 403 0007	info@cal.org.za	www.cal.org.za	Strengthening activism and leadership of lesbian women	Gauteng/ Johannesburg
Diamond Gays and Lesbians (D'gayle Diamonds)	+27 (0)82 816 8438	dgaylenc@gmail.com	https://dgayle.org/	Referrals and psychosocial support	Northern Cape
Durban LGBT Community Centre	+27 (0)76 981 1052	info@gaycentre.org.za	https://dgayle.org/	Drop-in centre, psycho-legal services to LGBTQIA+ including HIV services and human rights advocacy	KwaZulu-Natal/ Durban
Free State Rainbow Seeds	+27 (0)51 430 1023 +27 (0)78 810 1784 WhatsApp	info@fs-rainbowseeds.org.za admin@fs-rainbowseeds.org.za	http://www.fs-rainbowseeds.org.za/	Improving the quality of healthcare services	Free State/ Bloemfontein
GALA	+27 (0)11 717 4239	nobantu.nqolobe@wits.ac.za	https://gala.co.za/archive/	Produces, preserves and disseminates knowledge of the history, culture and contemporary experiences of LGBTQIA+ persons in South Africa	Gauteng/ Johannesburg
Gay Umbrella	+27 (0)60 383 3857 +27 (0)71 517 0485	director@gayumbrella.org.za finance@gayumbrella.co.za	http://www.gayumbrella.org.za/	Educates and supports LGBTQIA+ community	North-West/ Mafikeng
Gender DynamiX (GDX)	+27 (0)214474797	info@genderdynamix.org.za	www.genderdynamix.org.za	Advocates for advancements of legal, educational and health rights for TGD community	Western Cape/ Cape Town National
Health4Men	+27 (0)60 633 2512	info@health4men.co.za	https://www.health4men.co.za/	Response to HIV among gay, bisexual and other MSM	National

Organisation	Telephone number	Email address	Website	Services offered	Province/ City
Inclusive and Affirming (IAM)	+27 (0)21 975 8142	info@iam.org.za	https://iam.org.za/	Advocates for recognition, participation and celebration of LGBTQIA+ persons in faith communities	Western Cape/ Cape Town
Iphimbo Lothingo Linda Chamane	+27 (0)81 240 8236	nobantu.nqolobe@wits.ac.za	iphimbo.lothingo@gmail.com	Supports and advocates for visibility and awareness raising on issues faced by LGBTQIA+ persons, key populations, womxn and girls	KwaZulu-Natal/ Pietermaritzburg
Iranti-Org	+27 (0)11 339 1468	getinfo@iranti@org.za	http://www.iranti.org.za	Media advocacy defending rights LGBTQIA+ of trans, intersex and lesbian community in Africa	Gauteng/ Johannesburg
Isidima Collective	+27 (0)63 289 2581 +27 (0)67 949 5074	info@isidimacollective.org.za	http://www.isidimacollective.org.za/	Policy influencing and advocacy to improve quality of life of gender and sexual diverse community; piloted in Eastern Cape	Eastern Cape/ East London
LGBT + Forum		contact@lgbtforum.org	http://lgbtforum.org/	Capacitates companies across South Africa to create safe and equitable workplaces that enable lesbian, gay, bisexual, trans (LGBTQIA+) professionals	National
LifeLine	+27 (0)800 150 150 +27 (0)861 322 322	info@lifeline.org.za safetalking@lifeline.org.za	http://lifelinesa.co.za/	Psychosocial support	Gauteng/ Johannesburg
Lower South Coast LGBTI Community Projects Rural	+27 (0)64 035 5526 +27 (0)82 269 1193	zinhlendimeni78@gmail.com	http://lifelinesa.co.za/		KwaZulu-Natal/ Ugu

Organisation	Telephone number	Email address	Website	Services offered	Province/ City
Masivuke Community Development	+27 (0)83 359 5705 +27 (0)73 488 5996	masivukecom munityde v@gmail.com	www.masivuke.org	Safe space, linkages	Eastern Cape/ East London
Matimba	+27 (0)66 242 2888	info@matimba.org.za	www.matimba.org.za	Support for TGD individuals, with focus on TGD youth and their families	Gauteng/ Johannesburg
Nacosa	+27 (0)21 552 0804 +27 (0)12 940 2829	info@nacosa.org.za	www.nacosa.org.za	Promotes dialogue; builds capacity with accredited training, mentoring and technical assistance; and channels resources to support service delivery towards key populations	National
OUT	+27 (0)12 430 3272	hello@out.org.za	www.matimba.org.za	Confidential, professional and friendly health services and psychosocial support for gay men and LGBTQIA+ persons in Pretoria	Gauteng/ Pretoria
Pan Africa ILGA (PAI)	+27 (0)11 339 1139	admin@panafricailga.org	http://www.panafricailga.org/	Coalition of human rights-based LGBTQIA+ organisations	Gauteng/ Johannesburg
Passop	+27 (0)21 418 2838	office@passop.co.za	http://www.passop.co.za	Protecting and fighting for the rights of asylum-seekers, refugees and immigrants, and LGBTQIA+ persons in South Africa.	Western Cape/ Cape Town
Professional Association of Transgender Health South Africa (PATHSA)		info@pathsa.org.za	http://www.panafricailga.org/	interdisciplinary health professional organisation. Resource list of GAHC providers.	National
Same Love Toti/ PFLAG	+27 (0)826 548 635	samelovetoti@gmail.com samelovefamilies@gmail.com	https://www.pflagsouthafrica.org/	Support for parents of LGBTQIA+ children; psychosocial support; empowerment for LGBTI to access rights; food parcels	KwaZulu-Natal/ Amanzimtoti
SHE	+27 (0)43 722 0750	she.transmedia@gmail.com https://transfeminists.org/about-us/	she.transmedia@gmail.com https://transfeminists.org/about-us/	Awareness, visibility and support for transgender and intersex women	Eastern Cape/ East London
Sibanye LGBT	+27 (0)74 471 9800	sibanyelgbt@gmail.com	sibanyelgbt@gmail.com	Health advocacy, linkages and psychosocial support	Eastern Cape/ Uitenhage

Organisation	Telephone number	Email address	Website	Services offered	Province/ City
Sicebise Social Inclusion +(SSI+)	+27 (0)79 657 6429	sicebisessi@gmail.com		Gender inclusivity school programmes, psychosocial support to community and sensitisation programmes to the community, professionals and teachers; awareness campaigns, webinars	Eastern Cape/ Port Elizabeth
SWEAT	+27 (0)21 448 7875	info@sweat.org.za chiefofficer@myfalconyacht.com	http://www.sweat.org.za/	Organising and advocating for services towards sex work	Western Cape/ Cape Town
The Aurum Institute	+27 (0)10 590 1300	info@auruminstitute.org popinn@auruminstitute.org	https://www.auruminstitute.org/	Health services and psychosocial support for transgender women	National Gauteng Kwa-Zulu Natal
The Fruit Basket	+27 (0)64 215 7577 +27 (0)83 791 3351	tshamu2013 @gmail.com directorthefruitbasket@gmail.com		Create a space to accommodate every member of the LGBTQQIP2SAA community	Gauteng/ Johannesburg
TIA	+27 (0)79 367 7108	transgender.intersex101@gmail.com		Advocates from transgender and intersex human rights	Gauteng/ Pretoria
Trans Tec SA	+27 (0)78 062 9342	director.transtecsa@outlook.com	https://directortranstecsa.wixsite.com/website-2	Improve livelihoods for TGD persons	Western Cape/ George
Trans Wellness Project	+27 (0)83 426 5402	info@twp.org.za	http://www.twp.org.za/	Psychosocial support to trans persons and their significant others; advances health and equality for transgender persons	Western Cape/ Lutzville
Transhope	+27 (0)21 712 6699 (after 13h00)	kzntranshope@gmail.com info@transhope.co.za	http://www.transhope.co.za/	Advocates for the rights of TGD persons in KwaZulu-Natal	KwaZulu-Natal/ Durban
Triangle Project	+27 (0)21 712 6699 (after 13h00)	info@triangle.org.za	http://triangle.org.za/	Offering professional services to LGBTQIA+ individuals, their partners and families	Western Cape/ Cape Town

Organisation	Telephone number	Email address	Website	Services offered	Province/ City
Uthingo Collective	+27 (0)82 825 7926	uthingocollective@gmail.com	https://www.ourbees.co.za/uthingocollective	Advocacy and brands for individuals and allies of the queer community	KwaZulu-Natal/ Durban
Uthingo Collective	+27 (0)82 825 7926	uthingocollective@gmail.com	https://www.ourbees.co.za/uthingocollective	Advocacy and brands for individuals and allies of the queer community	KwaZulu-Natal/ Durban
Uthingo Network (Gay and Lesbian Network)	+27 (0) 33 342 6165	info@gaylesbian.org.za	https://gaylesbian.org.za/	Empowerment and recognition of the LGBTQIA+ community through institutional change and participation with rural communities, authorities and service providers	KwaZulu-Natal/ Pietermaritzburg
Wits RHI	+27 (0)11 358 5300	rhicomms@wrhi.ac.za	http://www.wrhi.ac.za/	GAHC and SRHR services for TGD persons	National
Youth 4 Change Global	+27 (0)21 699 3574 +27 (0)65 883 5091 +27 (0)66 244 9355	director.youth4changeglobal@gmail.com	http://www.youth4change.org.za/	Empowers and provides psychosocial support and health services to LGBTQIA+ in Manenberg	Western Cape/ Cape Town

Website: www.sahivsoc.org

Telephone: +27 (0) 11 728 7365

Email: sahivcs@sahivcs.org

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