Humber and North Yorkshire
Health and Care Partnership

Local Maternity and Neonatal System

Perinatal Care for Trans and Non-Binary People

Adapted from Brighton and Sussex University Hospitals Trust with permission.

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Table of Contents

Key Principles 4
Scope 4
Responsibilities 4
1. General Approach 5
Validity and Rights 5
Environment 6
Communication 6
Documentation 7
2. Antenatal Care 9
Booking & Referrals 9
Community Midwifery Care 9
Obstetric Considerations 10
Physical Changes 10
Emotional Health 11
In-patient Care 11
3. Intrapartum Care 11
Communication 11
Clinical Care 12
Catheter Care 12
4. Postnatal Care 13
Privacy 13
Emotional Health 13
Infant Feeding 13
Resumption of Testosterone 14
Birth Registration 14
Contraception and Screening 14
5. Appendices 16
Appendix 1: Trans and Non-Binary Antenatal Care Pathway 16
Appendix 2: Trans and Non-Binary Postnatal Care Pathway 17
Appendix 3: Pronoun Stickers 18
Appendix 4: My Language Preferences 19
Appendix 5: Resources 20

Appendix 6: Definitions 21
Appendix 7: Examples of trauma-informed care 26
Appendix 8: References 27

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This protocol applies to:

- All childbearing people who self-identify as transgender (trans), non-binary, or any other non-cisgender (non-cis) identity.
- All other protocols that refer to “women” and “mothers” receiving care, can also be considered to apply to all childbearing people, regardless of gender identity or intersex status.

Responsibilities

Midwives & Obstetricians:

- To access, read, understand, and follow this guidance.
- To use their professional judgement in application of this protocol
- This guidance is for midwives and doctors working in and with Humber and North Yorkshire LMNS Trusts. Hull University Teaching Hospitals NHS Trust (HUTH), York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).
- The guidance is not rigid and should be tailored to the individual circumstances of each person. If the guidance is not being followed, documentation of the reasoning and/or justification is essential, with clear documentation of alternative plans and discussions.

Management Team:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations.
- To ensure the protocol is accessible to all relevant staff.
- To ensure the protocol is available to service users on request.

1. General Approach

Validity and Rights

Transgender (trans) and non-binary people may face personal, social, economic, institutional, and structural barriers to accessing appropriate and affirmative care. They are likely to have had negative experiences in healthcare settings and may worry that healthcare professionals will not understand their specific identity, needs and concerns.

Gender reassignment is a protected characteristic under the Equality Act 2010.3 This applies whether the person has proposed, is currently undergoing, or has completed any part of their transition process. Medical assistance is not a necessary component of the transition process for this protection in law to apply.

When providing perinatal care to trans or non- binary people, the Trust and its employees should treat service users according to their self-identified gender, not the sex they were assigned at birth.

Respectful care recognises and affirms the gender identity of the pregnant person and normalises the experience of carrying a pregnancy whilst trans or non-binary. Professionals should recognise that the desire to conceive, birth and feed a baby can be shared by people of any gender identity.

It is unlawful to discriminate against, harass, or victimise a pregnant person due to their gender reassignment. This includes, but is not limited to, refusal to provide care to a trans or non-binary person; ongoing usage of wrong pronouns despite feedback; or treating someone badly because they have made a complaint regarding their treatment as a trans person. Negative treatment does not have to be intentional to be unlawful.

Remember that the presence of a trans or non-binary person in your ward or department is not a training opportunity for other staff. Many trans and non-binary people have had hospital staff call in others to observe their bodies and the interactions between a patient and healthcare provider, often out of an impulse to train junior staff, however this may not be conducive to a positive experience of health care for the person.

Environment

All care environments should be welcoming to service-users regardless of gender identity. Signs should use gender-neutral or gender-inclusive language. Posters and photo displays should recognise the diversity of our client base, including a variety of gender identities and expressions.

Toilets and changing facilities can be labelled according to who can access them, but this should not be in terms of sex or gender. For example, toilets in the Postnatal Ward should be labelled as “Birthing Women & People Only”, rather than “Women Only”. Sanitary bins should be provided in all toilets.

Communication

The ability to use appropriate language is an important skill that professionals should develop, particularly in perinatal care settings where feminine pronouns and descriptors are the norm.

The language used to refer to our service users, their bodies, and how they use their bodies, can impact on individuals’ emotional wellbeing and ability to access healthcare.

Every client should be asked which pronouns they use as part of routine enquiry. For example, when confirming demographic data such as name, professionals can ask:

- “Do you prefer to be known by a particular name? And what pronouns would you like me to use for you?”
- “What pronouns do you use?”
- “How would you like me to refer to you?”
- “How would you like to be addressed?”
- “Can you remind me which pronouns you like for yourself?”
- “My name is Sam and my pronouns are she/her. What about you?”

Professionals should always refer to people using the pronouns and language of their choice. For some people, their pronouns may change over time, so professionals should be led by the way in which an individual refers to themselves. Misgendering someone may inadvertently cause harm to trans and non-binary people and intensify gender dysphoria.

If you misgender someone, briefly apologise, correct yourself, and move on with the conversation. Do not continue to draw attention to the error as it will continue to make you- and the person you are addressing-feel awkward.

If you hear another member of staff misgender a service user, correct them. If their behaviour is persistent or deliberate, escalate to a manager. Evidence suggests that allies from less marginalised groups can confront and address others' discriminatory behaviour more effectively than members of targeted groups alone.

Pronouns are essential information during handover of care, to allow respectful communication from all members of staff. This also applies to names, if someone uses a different name than is currently on their NHS record.

When asking sensitive questions, for example regarding hormone therapy or surgical history, professionals should explain why this information is relevant, and ensure enquiries are clinically meaningful rather than motivated by curiosity.

When talking to groups of people, such as during Antenatal Classes, always use gender inclusive language. For example, say, "Pregnant women and people can choose to birth at hospital or at home", rather than, "Pregnant women can choose to birth at hospital or at home". Using gender inclusive language is important, regardless of whether trans or non-binary people are known to be in the space. In this way, we validate and normalise the diverse gender identities of all those who give birth.

There is considerable variation in the experiences of trans and non- binary birthing parents. Professionals should be led by the pregnant person on how they view the narrative of their pregnancy and birthing journey.

Documentation

Some individuals may not have updated their health records to reflect their preferred name, gender identity or title. If the individual has not updated their name on SPINE, the preferred name should still be used in verbal and written communication, in addition to their NHS number, to ensure that the correct medical record is tracked. An exception may apply to laboratory samples, where all patient details must match information recorded on the electronic patient record at the Trust.

Individuals can be advised they have the right to change their name, title, and sex/gender marker on all health care records. This can be arranged through their GP surgery and does not require any legal recognition or process.

Pronouns may be documented on custom-made stickers (Appendix 3: Pronoun Stickers). Pronoun stickers should be available at all sites where antenatal, intrapartum, or postnatal care is given. The use of these stickers is specific to the context of perinatal care where gendered language (woman, mother, she etc.) is often used as the default.

They should be offered to clients who are trans or non-binary, whatever pronouns they use. For example, you could say, “You will meet a variety of professionals on your pregnancy journey. We offer pronoun stickers that you can put on your notes, to communicate your pronouns to staff—is that something you would be interested in?

Stickers should only be applied to patient notes with informed consent. They can be applied to the front or inside of the Pregnancy Care, Labour and Birth Care, and Postnatal Care Records. The intended benefits of using pronoun stickers are to reduce the burden on service users to disclose their pronouns to each new professional they encounter. These stickers may not be appropriate for individuals who prefer to disclose their gender identity and pronouns to only a select few professionals. These stickers will be most beneficial if they are just used for trans and non-binary people and may go unnoticed if used for everyone.

Preferred terms for anatomy or activities can be recorded on a custom made insert (Appendix 4: My Language Preference) which can be attached to the Antenatal Care Record. On admission in labour, this should be photocopied, and copies placed in the Labour and Birth Care Record and Postnatal Record.

2. Antenatal Care

Booking & Referrals

At the first booking appointment, the community midwife should ask all service users about the name they prefer to go by and ask for the client's pronouns. Since gender identity and expression exist on a wide spectrum, assumptions about gender and pronouns should not be made based on the individual's appearance or behaviour. Pronoun stickers should be offered to anyone who is trans or non- binary, whichever pronouns they use.

As part of medical history taking and risk assessment, it is acceptable to ask trans and non-binary clients if they have previously used hormone therapy, and if they have undergone any surgeries as part of their transition. These questions are relevant because they facilitate accurate information provision regarding mode of birth and infant feeding options. Many individuals may appreciate an explanation of why a thorough medical history is necessary, to allay potential concerns that questions are motivated by professional curiosity rather than clinical need.

Individuals who conceived whilst taking testosterone should be advised to stop taking it if they plan to continue with the pregnancy. Testosterone is considered a teratogen, with potential implications for reproductive development of the fetus. If a pregnant person reports taking testosterone at any point during pregnancy, please refer immediately to the Consultant Neonatologist to discuss potential implications and liaise with obstetric services for additional surveillance if required

Previous testosterone usage, that was discontinued prior to conception, does not require referral to obstetric or neonatal care.

People who have had genital surgeries should be offered referral to the Consultant Obstetrician to discuss options for mode of birth, and to formulate a plan for the birth.

Community Midwifery Care

Ongoing antenatal care may be offered as standard in the individual's Children Centre or GP surgery. Some people may prefer to book appointment slots at the beginning or end of the day when the waiting room is quieter. For those preferring greater privacy please discuss alternatives.

Inform the scan department to notify an awareness of pronouns.

Liaise with Health Visiting to ensure information is shared according to the family's wishes.

Offer 1:1 antenatal classes.

Offer appointment with Specialist Infant Feeding Midwife if a personalised plan is required.

Offer my Language Preferences sheet.

Offer personalised care plan.

Obstetric Considerations

Some trans and non-binary people may request elective Caesarean due to gender dysphoria surrounding physiological birth. Gender potential dysphoria is a valid reason for elective Caesarean, and individuals should be supported in this choice, alongside other supportive measures such as tour of the hospital facilities.

People who have had lower surgery (gender affirming genital surgery such as metoidioplasty, scrotoplasty or phalloplasty; without hysterectomy or vaginectomy) will be offered referral to a consultant obstetrician to discuss mode of birth and any additional considerations Depending on the individual's surgical history, Caesarean birth may be recommended, although this decision should be made on a case- by-case basis. Since there is a wide range of surgical techniques, discussion with the person's surgeon may be beneficial.

The role of previous testosterone treatment, discontinued prior to conception, in relation to obstetric complications is not known, so management should be according to current obstetric best practice, not according to testosterone usage or gender identity.

Physical Changes

Parents may have questions about how their body will change during pregnancy, with respect to their previous medical treatments, and professionals should endeavour to answer these questions as far as their knowledge allows.

- Medical literature reports that many changes induced by testosterone are permanent.
- However, some people report partial reversal of some of these changes on cessation of testosterone, and during pregnancy.
- Reversible changes are most likely to include muscle and fat redistribution and may include reduced facial hair and a higher-pitched voice.
- Some people who have had top surgery report increase in chest size during pregnancy, with varying degrees, while other parents report no change in chest size at all.

Emotional Health

Identifying as trans or non-binary is not classified as a mental illness, but some individuals will have experienced gender dysphoria. Gender dysphoria may be exacerbated, remain the same or be improved during pregnancy, depending on the individual.

Gender dysphoria during pregnancy may be separated into two sources, which health care providers should understand. Dysphoria can be rooted in an individual's feelings about their body, and the physical changes that are associated with pregnancy. Dysphoria may also be triggered by social interactions, both with individual practitioners, and through engaging with a gendered system.

Professionals should be alert to the potential for worsening dysphoria and encourage pregnant people to seek the support of a gender aware therapist or counsellor if required.

Referrals to Perinatal Mental Health Team should not be made due to trans or non-binary identity alone. Assessments and referrals should be made according to standard criteria.

In-patient Care

Care should be taken to meet service users' needs for privacy and dignity whilst receiving care in hospital. This includes taking into consideration who may overhear conversations about medical history, or discussions of emotional wellbeing, which may include references to gender dysphoria or previous gender-related treatments.

On the maternity unit, trans and non- binary individuals should be offered the choice between a side room, or shared accommodation on the ward.

If a single room is not available, the situation should be discussed with the person concerned and a joint decision made as to how to resolve it. This may depend on the clinical situation, for example, stay on the labour until a single room is available on the postnatal ward.

3. Intrapartum Care

Communication

Professionals should refer to the Birth Plan page and My Language Preferences insert to facilitate respectful communication during labour.

If a My Language Preferences sheet has not been completed, or the clinical scenario has not been covered, ask the individual how they refer to their body parts.

Clinical Care

Professionals should be aware of the potential history of sexual abuse and trauma for all service users. A significant proportion of trans and non-binary people have experienced sexual harassment and report a history of childhood abuse. A universal approach of trauma-informed care can benefit all service users, including trans and non-binary individuals.

Always maintain the individual's privacy and dignity.

(See Appendix 8 for examples of trauma-informed care).

Catheter Care

Insertion technique is the same for all people who do not have a prostate. Therefore, all health care professionals trained to insert or remove catheters for women are also suitably qualified to undertake these procedures for pregnant and birthing people who have had lower surgery.

Standard length catheters (40cm) should be used for all pregnant and birthing women and people, whether they have had lower surgery or not, in line with your Trust guidance.

People who have had lower surgery may have also had their urethra relocated and/or lengthened. In these situations, professionals should ask the individual about the location and length of their urethra prior to attempting catheterisation. Potential locations for the urethra include:

- In its original position
- At the tip of the penis/phallus
- At the base of the penis/phallus
- Behind the scrotum

An aseptic non-touch technique should be used for catheter insertion, using the non-dominant hand to stabilise the penis/phallus, or any other tissues, as necessary.

In/out catheters may be too short for people who have had lower surgery which includes urethral lengthening. In these circumstances, standard length indwelling catheters (40cm) can be inserted temporarily, effectively functioning as in/out catheters.

4. Postnatal Care

Privacy

On shared wards, trans and non- binary individuals should be offered the choice between a side-room or shared accommodation on the ward, including the Postnatal Ward. When a trans or non-binary service user's preference is for a side room, but one is not currently available, alternative accommodation should be sought.

Emotional Health

Professionals should discuss the potential for postnatal depression with all gestational parents. Those who have previously taken testosterone may be more at risk, or their experience of postnatal depression may present differently.

Infant Feeding

Trans and non-binary parents should be supported in their choices regarding infant feeding. Some parents may be very motivated to breast/chest feed and may have chosen to delay top surgery to do so.

Assessment of chest health is important, including for people who have had top surgery (gender affirming surgery to alter the size and shape of the chest), as usually some mammary tissue remains. Professionals should discuss signs and symptoms of mastitis, as some mammary tissue could remain. Particularly if the individual has had their nipples grafted or removed altogether.

Breast/chest feeding or expressing may still be possible after top surgery, if the nipples have not been permanently removed. In rare cases, successful expression of colostrum or milk has been reported even after free nipple grafting. It is not possible to predict the extent of milk supply in advance and full milk supply may not be possible in some cases. Parents should be especially aware of signs of effective milk transfer and expected newborn behaviour and output to ensure adequate milk intake.

Following top surgery there may be less soft tissue available for the baby to latch on to, however some parents have reported success with using their fingers to firmly shape their chest (known as the "sandwich" technique).

Parents who have not had top surgery may wish to bind their chest during times they are not actively feeding or expressing. Binding may increase the chances of mastitis, so parents

should be made aware the signs and management of mastitis and may wish to wear a larger size binder.

If a parent is certain they do not want to breast/chest feed or express, prevention of lactation can be offered which may contribute to dysphoria. This option can be offered regardless of whether they have had top surgery or not, as mammary tissue will still be present post-surgery. If prevention of lactation is desired, then cabergoline can be offered following birth to suppress lactation.

If breast/chest feeding is not possible, or desired, discuss other methods of infant feeding and promotion of attachment, including skin-to-skin contact and responsive bottle feeding.

Non-gestational parents may wish to participate in feeding their infants using their own bodies and may choose to use supplemental nursing systems with expressed milk or formula. Consider a referral to the Infant Feeding Lead if required.

Resumption of Testosterone

Some parents may be keen to initiate, or resume, testosterone therapy soon after they have birthed.

The literature is not clear regarding testosterone transmission into human milk, or potential impact on milk supply, although some evidence suggests high testosterone levels may impair lactation. Whilst there are possible risks to the infant, there is no clear evidence of harm, however it should be noted that the evidence-base for this conclusion is very limited. The individual should assess the benefits of resuming testosterone in terms of their own emotional, physical, social and mental wellbeing

Birth Registration

The current legal process for registration of birth in the UK stipulates that the birth parent is always recorded as “Mother” regardless of gender identity or legal sex. New parents may benefit from being advised of this in advance, as it may cause distress for some.

Contraception and Screening

Contraception is recommended for all birthing parents, if they engage in sexual activity that could result in conception.

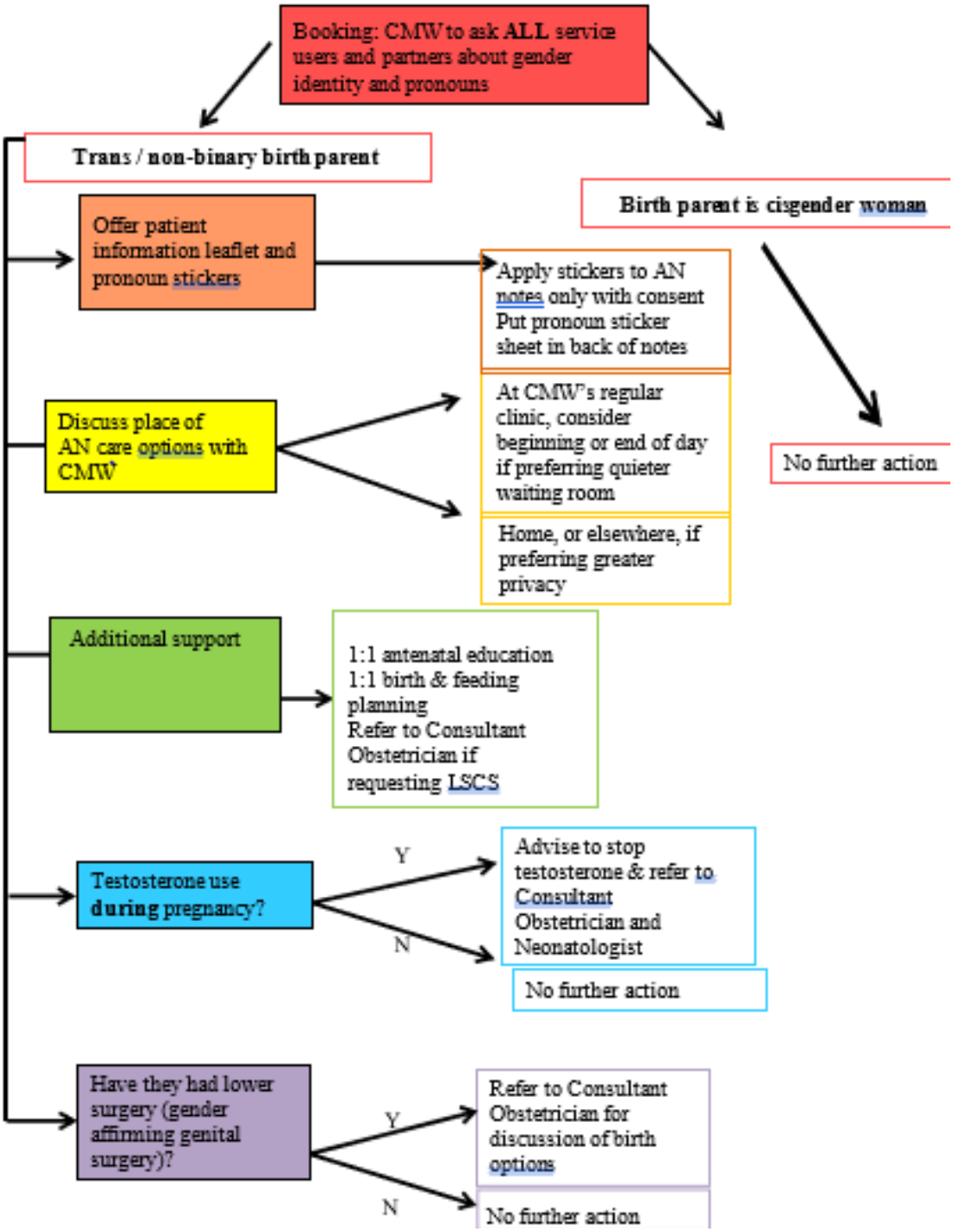
Contraception is still advised for people considering resuming testosterone, if they have sexual activity with a partner who produces sperm. Copper intrauterine devices are safe and do not interfere with hormonal treatment. Progestogen-only contraceptive methods are not

thought to interact with hormonal treatment and are generally acceptable. The use of combined hormonal contraceptives are not recommended for trans men and non-binary people who are taking testosterone.

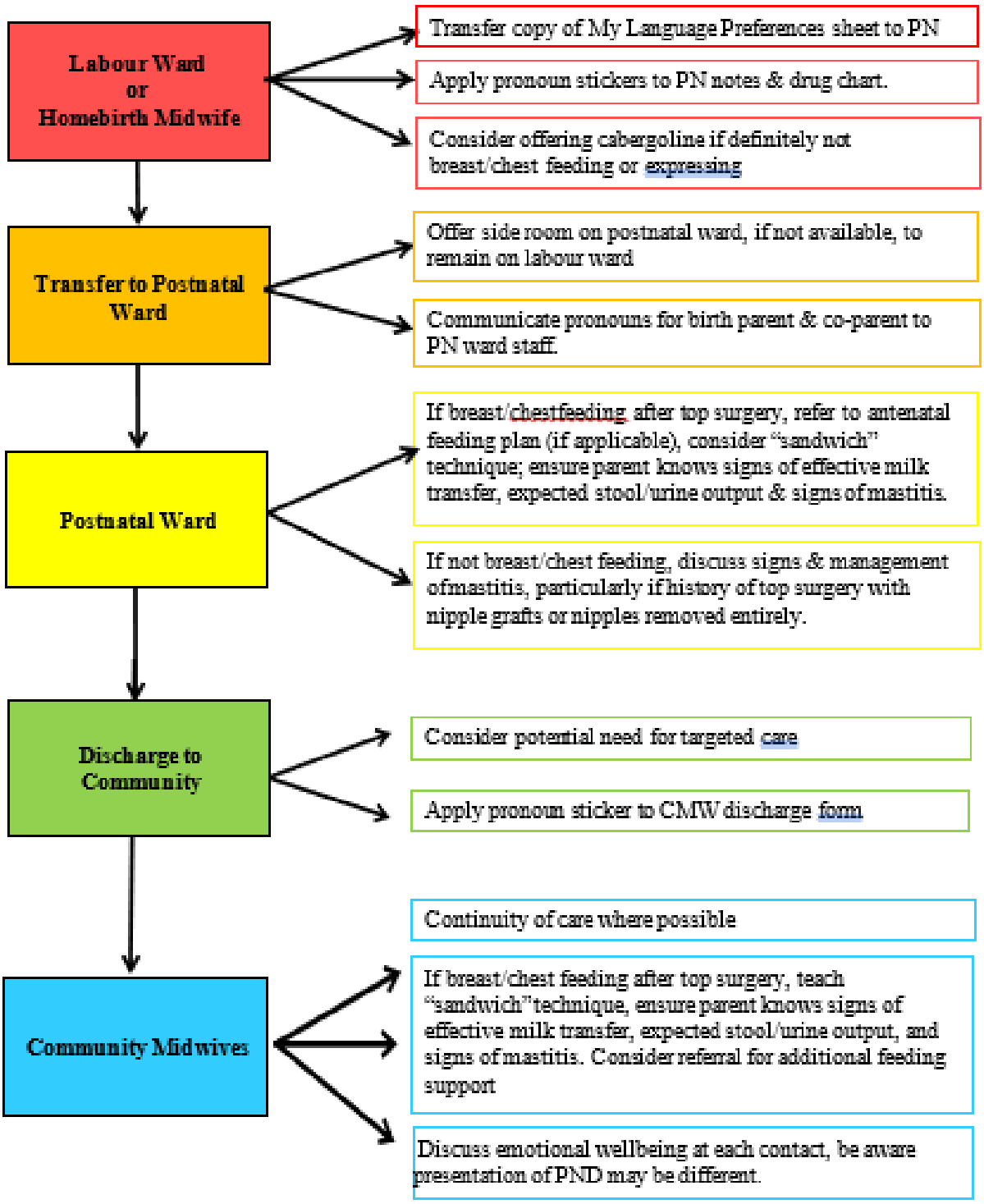
Trans and non-binary people are often omitted from sex-specific screening algorithms if their NHS gender markers have been updated to reflect their gender identity. Therefore, birthing parents can be reminded postnatally that they are eligible for routine cervical screening but may not receive invitations to appointments.

5. Appendices

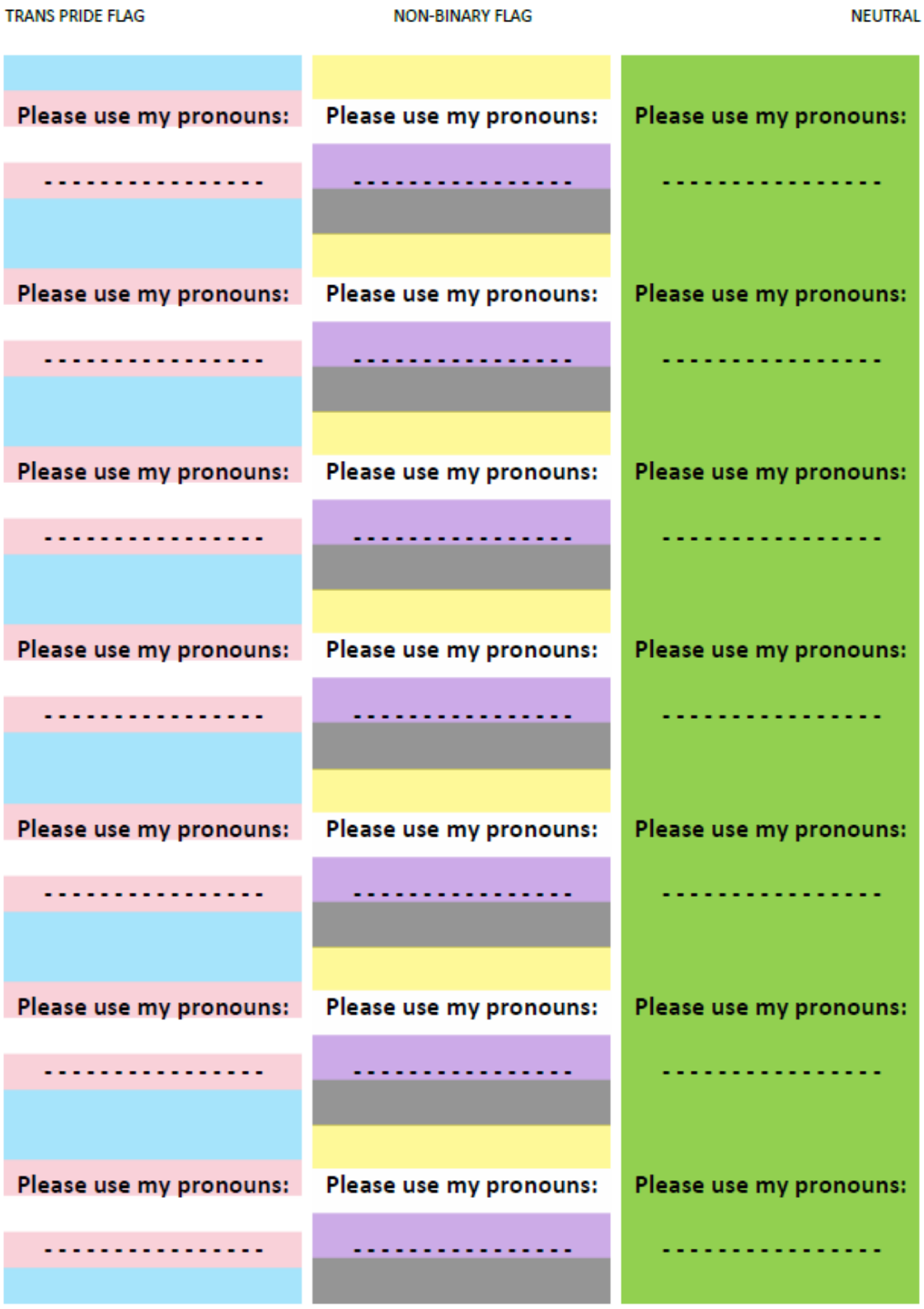
Appendix 1: Trans and Non-Binary Antenatal Care Pathway



Appendix 2: Trans and Non-Binary Postnatal Care Pathway



Appendix 3: Pronoun Stickers



Appendix 4: My Language Preferences

Name: NHS No.

My Language Preferences

Birth parent:	**Pronouns:**
Co-parent/s:	**Pronouns:**
Additional support person:	**Pronouns:**
How do you plan to be known as a parent?	**Do you want us to use these terms?**
Birth parent	**Preferred term**
Co-parent	**Preferred term**

Anatomical Term	Preferred Term	Example
Breasts		
Breastfeeding		
Breastmilk		
Cervix		
Clitoris		
Labia		
Perineum		
Uterus		
Vagina		
Vaginal examination		
Vulva		

Appendix 5: Resources

Gender Identity Research & Education Society

https://www.gires.org.uk/

Gendered Intelligence Network for Therapists and Counsellors

http://genderedintelligence.co.uk/professionals/therapists-and-counsellors

La Leche League breast/chestfeeding support

https://www.laleche.org.uk/support-transgender-non-binary-parents/

Birth for Every Body

http://www.birthforeverybody.org/

Appendix 6: Definitions

The language regarding gender identity is fast evolving, so the following definitions may be updated in subsequent editions of this protocol.

Bottom surgery	Colloquial term for genital surgeries that are gender affirming. These surgeries can form part of medical transition. Options for trans masculine people include metoidioplasty and phalloplasty. Options for trans feminine people include orchidectomy and vaginaplasty. Do not use the terms “sex change” or “the surgery” and be aware that not all trans or non-binary people seek bottom surgery.8 Also known as “lower surgery”.
Chest feeding	This is an alternative term for “breastfeeding”.
Cisgender	A person whose sex attributed at birth aligns with their gender identity and that is confirmed by them as an individual. The term cisgender is often shortened to “cis”.
Deadnaming	Calling someone by their birth name after they have changed their name. This term is often associated with trans people who have changed their name as part of their transition. Intentional deadnaming is a form of harassment and abuse and can trigger dysphoria in the person affected.
Gender	Gender is used to refer to a person’s gender identity, which is self-defined and not subject to external validation. Gender is all the socio-political meaning that we ascribe to sex and bodies, including gender norms, roles, expectations, and stereotypes, which differ across time and space.
Gender dysphoria	Used to describe when a person experiences discomfort or distress because there is a mismatch between their sex assigned at birth and their gender identity. This is also the clinical diagnosis for someone who doesn’t feel comfortable with the sex they were assigned at birth. Gender dysphoria can be rooted in the individual’s feelings about their own body, and/or be triggered by social interactions.

Gender expression	How a person presents themselves on any given day in terms of, for example: the clothes they wear, how they speak, how they walk and so forth. Gender expression does not always match gender identity.
Gender identity	A person's innate sense of their own gender, whether male, female, or something else (such as non-binary), which may or may not correspond to the sex assigned at birth.
Gender reassignment	Also referred to as gender affirmation or gender confirmation. Gender reassignment' usually means to undergo some sort of medical procedures which change the body to align with a person's gender, but it can also mean changing names, pronouns, dressing differently and for a person to live in their self-identified gender. Gender reassignment is a characteristic that is protected by the Equality Act 2010, and it is further interpreted in the Equality Act 2010 approved code of practice.
Gender Recognition Certificate	A GRC enables a trans person to be legally recognised in an affirmed gender and to be issued with a new birth certificate. Not all trans people will apply for a GRC, and at the time of writing they have to be over 18 to apply. They do not need a GRC to change their gender markers at work or to legally change their gender on other documents such as a passport.
Hormone therapy	Some, but not all, trans and non-binary people use hormone therapy. Hormone therapy induces physical, and sometimes emotional changes, aiming to reduce gender dysphoria while improving well- being and quality of life.
Lower surgery	Colloquial term for genital surgeries that are gender affirming. These surgeries can form part of medical transition. Options for trans men and non-binary people include metoidioplasty and phalloplasty. Options for trans women and non-binary people include, orchidectomy and vaginoplasty. Do not use the terms "sex change" or "the surgery" and be aware that not all trans or non-binary people seek lower surgery. Also known as "bottom surgery".

Misgender	"Misgendering refers to the practice of using words (nouns, adjectives and pronouns) that do not correctly reflect the gender with which someone identifies. Recognise that misgendering can include misnaming (calling a person by the incorrect name), using the incorrect pronouns (for example, using he/him/his for someone who uses she/her/her), or using other incorrect gendered language (for example, using "sir" for someone who identifies as a woman, or calling a trans man's chest their "breasts"). Recognise that whether intentional or not, misgendering has a negative impact on trans people, and persistent misgendering is an act of transphobia."
Non-binary	Non-binary is an umbrella terms used to describe all people who do not experience themselves as being a man or woman (i.e. within the socially constructed gender binary). Non-binary people may feel neither 'man' nor 'woman' or may feel that they identify with both in differing degrees. Non-binary people fall under the wider definition of transgender given that they have not remained in the gender they were assigned at birth. However, not all non-binary people use the term trans to describe themselves. This is a general term which includes agender, bigender, gender-queer, gender-fluid and other gender identities.
Peri-areolar	A type of top surgery to remove a large proportion of mammary tissues and create masculine chest contour. Does not involve removal or repositioning of the nipple-areolar complex, so the nipple stalk is left intact.
Pronouns	Words we use to refer to other people in conversation - for example, "he", "she" and "they". Some people may prefer others to refer to them in gender neutral language and use pronouns such as they/their and ze/zir.
Sex	A term used to denote male/female/intersex variations, largely based on visible physical differences and attributes. In general, a sex attributed at birth is based on visual indicators. However, sex attributes are often (in most countries) tied to binary gender constructs – what it means to be a man/woman. So, sex and gender

	are related, although they are not the same. It is important to remember this, because people who have intersex variations are also located on the spectrum of sex attributes and do not have sufficient measures to protect their rights and bodily autonomy. This is an area that is currently without legal protection, which makes intersex individuals vulnerable to medical interventions without consent.
Top surgery	Colloquial term for gender affirming surgeries to the chest. For trans men and non-binary AFAB people, this refers to a variety of surgical techniques to remove a large proportion of mammary tissue to create a “masculine” contoured chest. For trans women and non-binary people, this refers to breast augmentation. Do not use the terms “sex change” or “the surgery” and be aware that not all trans or non-binary people seek top surgery
Trans	Short for “transgender”. Trans is an adjective used to describe a person whose gender identity does not match, or fully align with, the sex assigned at birth. (Note: please do not use the terms ‘transsexual’, ‘transvestite’, ‘sex change’ ‘gender identity disorder’ unless used by the person themselves – whilst some individuals may use them, they are now contentious and considered offensive by many trans people and allies.)
Transition	Used to describe the point at which a permanent change of gender role is undertaken, in all spheres of life – in the family, at work, in leisure pursuits and in society generally. Some people make this change gradually; however, others emerge much quicker. Transition is an umbrella term covering the variety of social and medical changes that affirm a trans or non-binary person’s gender identity. Some people describe their transition as directional, for example female-to- male transition (FTM) or male-to-female transition (MTF). Social transition may include changing name, title, pronouns, clothing, haircut and speaking style. Medical transition refers to a variety of treatments and surgeries that are gender affirming. These may include hormone therapy, surgery to the chest, and a variety of genital surgeries. Not all trans people pursue medical transition, and

	the combination of chosen therapies and/or surgeries is unique to everyone. Do not use the term “sex change”.
Trans man	A person who identifies as a man but was assigned female at birth.
Trans woman	A person who identifies as a woman but was assigned male at birth.
Transphobia	The fear or dislike of someone based on the fact they are trans/non-binary, including the denial/refusal to accept

Appendix 7: Examples of trauma-informed care

- Explaining the rationale and procedure of intimate examinations, before asking for informed consent.
- Ask if there is any part of the procedure that they feel anxious about, and what you can do to make it more comfortable for them.
- Discuss in advance that the patient can dictate the pace of the examination and can signal to you (through verbal or nonverbal signals) if there is any discomfort, or a break is needed.
- Ask the person if they would like someone else in the room with them for support.
- Discuss the procedure, gain consent, and gather all necessary equipment before the service user removes their clothing.
- Ask the patient to move their own clothing out of the way, instead of doing it yourself.
- Describe ways in which the examination may interact with senses (e.g., “You may hear clicks when the speculum is opened”, “The lubrication gel may feel cool”).
- Offer self-insertion for speculum examinations.
- Offer self-swabbing if appropriate.
- Practice suggestive instead of instructive language (e.g., replace the phrase “Take a deep breath and relax” with “Some people find it helpful to take a deep breath during this part of the examination”).

Appendix 8: References

1. Perinatal Care for Trans and Non Binary People Brighton and Sussex University Hospital, guidance number MP005, version 1 December 2020, Helen Green Ash Riddington

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