

Perinatal Care for Trans and Non-Binary People

Maternity Protocol: MP005

Date agreed: 17th December 2020

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Version:	1
Approval Committee:	Women's Services Safety and Quality Committee
Date agreed:	December 2020
Review date:	December 2023
Cross reference:	BSUH Gender Inclusive Language in Perinatal Care: Mission Statement and Guide BSUH ED&I Guideline for Supporting Trans Patients and Staff BSUH MP001 Provision and Schedule of Antenatal Care BSUH MP040 Bladder Care BSUH MP071 Provisions and Schedules of Postnatal Care BSUH MP072 Newborn Feeding BSUH MP073 Pregnancy Loss BSUH C038 Chaperone Policy for Patients Undergoing Intimate Examinations and Treatment NICE CG190 Intrapartum Care for Healthy Women and Babies NICE CG110 Pregnancy and Complex Social Factors

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 Brighton & Sussex University Hospitals Trust Maternity Services. 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.

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1 General Approach

1.1 Validity and Rights

- 1.1.1 Transgender (trans) and non-binary people may face personal, social, economic, institutional and structural barriers to accessing appropriate and affirmative care.¹ They are likely to have had negative experiences in healthcare settings previously, and may worry that healthcare professionals will not understand their specific identity, needs and concerns.²
- 1.1.2 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.³
- 1.1.3 Maternity services have typically been designed as a cisgender (cis) women-only service, which may not serve the needs of trans and non-binary individuals. 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.⁴
- 1.1.4 Pregnant people and new parents are entitled to safe and respectful perinatal care regardless of gender identity, or history of medical and/or social transition. 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. ⁵
- 1.1.5 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.⁴ (BSUH ED&I Guideline)
- 1.1.6 Some staff may voice objections towards treating trans or non-binary service users on the grounds of their religion or beliefs – this would be classed as discrimination. Managers must be prepared to deal with this in the same manner as for any other similar objection (for example on the grounds of sexual orientation), in line with the Equality, Diversity and Inclusion Policy.

- 1.1.7 It is unlawful to disclose a patient's gender history without consent, and professionals should not disclose a patient's gender history unless it is directly relevant to the condition or its likely treatment.⁶ This guidance applies to general medical care that is unrelated to reproductive organs. However, in the context of providing perinatal care, the presence of reproductive organs is a pre-requisite to accessing these services. Respecting a person's identity and using correct pronouns and terminology is not a breach of this guidance.
- 1.1.8 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. (BSUH ED&I Guideline)

1.2 Language

- 1.2.1 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. 'BSUH Gender Inclusive Language in Perinatal Care: Mission Statement and Guide', provides detailed rationale and support for gender-inclusive language.

1.3 Environment

- 1.3.1 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.
- 1.3.2 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.

1.4 Communication

- 1.4.1 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.⁵
- 1.4.2 Every client should be asked which pronouns they use as part of routine enquiry.⁷ 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?”
- 1.4.3 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 (e.g. using “she” instead of “he”, using the wrong name, or referring to someone as “mother” when they do not identify that way) may inadvertently cause harm to trans and non-binary people, and intensify gender dysphoria.⁵
- 1.4.4 If you misgender someone, briefly apologise, correct yourself, and move on with the conversation.⁸ Do not continue to draw attention to the error as it will continue to make you-and the person you are addressing-feel awkward.
- 1.4.5 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.⁹

- 1.4.6 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.
- 1.4.7 Parents will make their own choices about how they wish to refer to themselves. Staff should not use terms such as “mother” or “mum” as default for trans and non-binary parents, unless this is their expressed preference, in order to avoid causing harm and intensifying gender dysphoria.⁵
- 1.4.8 Some individuals may have preferred terminology for their own anatomy, or for activities that they use their body for. These should be respected and used wherever possible. Professionals should refer to the “My Language Preferences” insert, where these preferences can be recorded ([see Appendix 7](#)). For example, some people may refer to their “chest” and “chestfeeding” rather than their “breasts” and “breastfeeding”. Some people may talk about their “front hole” or “genital opening” rather than “vagina”.
- 1.4.9 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.¹⁰
- 1.4.10 When talking about groups of people, or referencing statistics, use gender inclusive or neutral language. For example, if discussing vaginal birth after Caesarean, say, “The success rate for women and people planning VBAC is 72-75%”, rather than, “The success rate for women planning VBAC is 72-75%”.
- 1.4.11 When talking to groups of people, such as during Parentcraft 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.
- 1.4.12 There is considerable variation in the experiences of trans and non-binary birthing parents.⁵ Professionals should be led by the pregnant person on how they view the narrative of their pregnancy and birthing journey.

1.6 Documentation

- 1.6.1 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 ICE.
- 1.6.2 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.⁶
- 1.6.3 Pronouns may be documented on custom-made stickers ([Appendix 5: 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?”
- 1.6.4 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.
- 1.6.5 Preferred terms for anatomy or activities can be recorded on a custom made insert ([Appendix 7: 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.
- 1.6.6 It is not yet known how the Trust’s various IT systems will handle coding perinatal care for sex/gender markers other than female. Problems encountered with IT systems should be referred to the Digital Lead Midwife and Gender Inclusion Midwives CC’d in (bsuh.genderinclusionmidwives@nhs.net).

1.7 In-patient Care

- 1.7.1 Care should be taken to meet service users' needs for privacy and dignity whilst receiving care in hospital.¹¹ 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.
- 1.7.2 On shared wards that are typically used for cis women, trans and non-binary individuals should be offered the choice between a side room, or shared accommodation on the ward. Examples include the Antenatal Ward and 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. For example, a parent who has just recently given birth may remain on Labour Ward/Central Delivery Suite until a side room on Postnatal Ward is available.

2 Pre-conception Care

- 2.1 Trans and non-binary individuals may wish to access the patient information leaflet “Support for trans and non-binary people during pregnancy, birth and afterwards”. This can be accessed via the [BSUH Maternity website](#).
- 2.2 Trans and non-binary individuals may seek clinical advice before starting a family, especially if they are using hormone therapy. Testosterone is a teratogen, and often suppresses ovulation, but is not an effective form of contraception. Therefore, all individuals taking testosterone should be advised to discontinue use prior to conception.¹⁰
- 2.3 Conception and successful pregnancy can occur even after long-term testosterone usage.¹⁰ Stopping testosterone therapy can result in the return of menstruation and fertility.¹² The potential need for assisted reproductive technologies will depend on the resumption of a normal menstrual cycle, the reproductive capacity of the co-parent, parental preferences and medical advice.
- 2.4 Lower surgeries (gender affirming genital surgery - such as metoidioplasty, scrotoplasty or phalloplasty; without hysterectomy or vaginectomy) do not, by themselves, impair future reproductive options in terms of conception, but would likely necessitate a caesarean birth¹⁰.

3 Antenatal Care

- 3.1 Booking & Referrals
 - 3.1.1 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 behaviour⁵. Pronoun stickers should be offered to anyone who is trans or non-binary, whichever pronouns they use (see 1.5.3).
 - 3.1.2 Trans and non-binary individuals should be offered the patient information leaflet “Support for trans and non-binary people during pregnancy, birth and the postnatal period”, available on the BSUH Maternity website.

- 3.1.3 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.
- 3.1.4 The current clinical consensus is that 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.¹⁰ If a pregnant person reports taking testosterone at any point during pregnancy please refer immediately to the Gender Inclusion Midwives who will co-ordinate advice and support. Referral to the Gender Inclusion Team's named Consultant Neonatologist ([see Appendix 1](#)) Prescribed Medicines Clinic is recommended in order to discuss potential implications and liaise with obstetric services for additional surveillance if required ([See Appendix 8- Prescribed Medication Referral Form](#))
- 3.1.5 Previous testosterone usage, that was discontinued prior to conception, does not require referral to obstetric or neonatal care.
- 3.1.6 People who have had genital surgeries should be offered referral to the Gender Inclusion Team's named Consultant Obstetrician (see [Appendix 1](#)), to discuss options for mode of birth, and to formulate a birth plan.
- 3.1.7 General referrals for obstetric input (e.g. medical conditions, previous obstetric history etc.) should also be directed to the Gender Inclusion Team's named Consultant Obstetrician ([see Appendix 1](#)).
- 3.1.8 Some trans and non-binary birth parents may express a wish to birth via Caesarean section, due to concerns that physiological birth may trigger gender dysphoria. Referrals should be made to the Gender Inclusion Team's named Consultant Obstetrician ([see Appendix 1](#)), either by the community midwife, or the Gender Inclusion midwife.

3.2 Community Midwifery Care

- 3.2.1 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. Alternatively, the community midwife can provide antenatal appointments at home, or another location, for those preferring greater privacy.

3.3 Gender Inclusion Midwife

- 3.3.1 If the pregnant person, or their partner, discloses trans or non-binary identity, they should be offered referral to the Gender Inclusion Midwives (see [Appendix 6 – Referral to Gender Inclusion Midwife](#)).
- 3.3.2 The Gender Inclusion Midwife may provide ongoing non-clinical support, depending on the individual's needs, including:
- Support via telephone/email/text throughout pregnancy and postnatal period
 - Support visits at home throughout pregnancy and postnatal period
 - Telephoning ahead of other appointments, such as scans, to notify reception and clinical staff, and ensure an awareness of pronouns
 - Attendance and advocacy at appointments, including Antenatal Clinic and ultrasound scans
 - Liaison with other professionals including Health Visitors to ensure information is shared according to the family's wishes
 - 1:1 birth and infant feeding preparation at home (personal antenatal class)
 - Assistance in producing a personalised birth plan
 - Assistance filling out My Language Preferences sheet
 - Producing a personalised infant feeding plan, with potential input from the Gender Inclusion Team's named Specialist Infant Feeding Midwife (see [Appendix 1](#)).
 - Tour of hospital facilities

- 3.3.3 If a pregnant trans or non-binary person does not want additional support from the Gender Inclusion Midwives, they should be supported in this decision. Professionals should let them know they can change their mind, and a referral can be made at any point whilst they are accessing midwifery services. If a referral is declined, please still complete the referral form and forward to the Gender Inclusion Midwives stating they do not wish to access support, for audit purposes (see [-Audit and Service Development](#)).

3.4 Obstetric Considerations

- 3.4.1 Some trans and non-binary people may request elective Caesarean due to potential gender dysphoria surrounding physiological birth. Gender 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 and theatre.
- 3.4.2 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 Antenatal Clinic, to discuss mode of birth and any additional considerations. Depending on the individual's surgical history, Caesarean birth may be recommended¹⁰, 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.
- 3.4.3 People who conceived while taking testosterone should be offered referral to the Gender Inclusion Team's named Consultant Neonatologist's ([see Appendix 1](#)) Prescribed Medicines Clinic, where potential implications for fetal development will be discussed. This clinic may then refer on to Antenatal Clinic if additional surveillance is required.
- 3.4.4 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.¹³

3.5 Physical Changes

- 3.5.1 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. The Gender Inclusion midwife can discuss in more detail:

- Medical literature reports that many changes induced by testosterone are permanent^{12,14}
- However, some people report partial reversal of some of these changes on cessation of testosterone, and also 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 all⁵

3.6 Emotional Health

- 3.6.1 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.
- 3.6.2 Gender dysphoria during pregnancy may be separated into two sources, which health care providers should understand.⁵ 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.¹⁰
- 3.6.3 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 (see [Appendix 9: Resources](#)).
- 3.6.4 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, as for cisgender women.

4 Intrapartum Care

4.1 General Approach

- 4.1.1 According to NICE guidelines, professionals should, “Treat all [people] in labour with respect. Ensure that the [individual] is in control of and involved in what is happening to [them], and recognise the way in which care is given is key to this. To facilitate this, establish a rapport with the [individual], ask [them] about [their] wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide [them] through [their] labour.”¹⁵

4.2 Communication

- 4.2.1 Professionals should refer to the Birth Plan page and My Language Preferences insert in order to facilitate respectful communication during labour. For example, some people may refer to their “front hole” or “genital opening” rather than “vagina”.
- 4.2.2 If a My Language Preferences sheet has not been completed, or the particular clinical scenario has not been covered, ask the individual how they refer to their body parts. For example, “In order to provide you the best healthcare possible, I wonder, what language do you use to refer to your body parts?”⁸

4.3 Clinical Care

- 4.3.1 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.² A universal approach of trauma-informed care can benefit all service users, including trans and non-binary individuals. Examples of trauma-informed care include:
- Explaining the rationale and procedure of intimate examinations, before asking for informed consent
 - Ask if there is any particular 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, as per [CO38 Chaperone Policy](#)
- 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”)¹⁶

4.4 Catheters

- 4.4.1 For people who have not had lower surgery (gender affirming genital surgery), catheter selection and insertion is in line with protocol [MP040 Bladder Care](#).
- 4.4.2 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 Trust guidance.
- 4.4.3 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

- 4.4.4 Insertion technique is the same for all people who do not have a prostate – i.e. cis women, trans men and non-binary people assigned female at birth. Therefore, all health care professionals trained to insert or remove catheters for cis women are also suitably qualified to undertake these procedures for pregnant and birthing people who have had lower surgery.
- 4.4.5 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.
- 4.4.6 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.

5 Postnatal Care

5.1 Privacy

- 5.1.1 On shared wards that are typically used for cis women, 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. For example, a parent who has just recently given birth may remain on Labour Ward/Central Delivery Suite until a side room on Postnatal Ward is available.

5.2 Clinical Care

- 5.2.1 Postnatal checks should be performed as per [MP071 Provisions and Schedules of Postnatal Care Pathway](#), taking into account additional communication needs (see 5.3) while also ensuring safe and thorough care.
- 5.2.2 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 still remains. Professionals should discuss signs and symptoms of mastitis, particularly if the individual has had their nipples grafted or removed altogether.

5.3 Communication

- 5.3.1 Refer to the My Language Preferences sheet (see [Appendix 7](#)), a copy of which should be transferred over from the Antenatal Care Record. For example, some people may refer to their “chest” and “chestfeeding” rather than their “breasts” and “breastfeeding”. Some people may talk about their “front hole” or “genital opening”, rather than “vagina”.
- 5.3.2 If a My Language Preferences sheet has not been completed, or the particular clinical scenario has not been covered, ask the service user how they refer to their body parts and activities involving their body (such as infant feeding). For example, “In order to provide you the best healthcare possible, I wonder, what language do you use to refer to your body parts?”.⁸

5.4 Emotional Health

- 5.4.1 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 be different to cis women.¹⁰

5.5 Infant Feeding

- 5.5.1 Trans and non-binary parents should be supported in their choices regarding infant feeding. Some parents may be very motivated to breast/chestfeed, and may have chosen to delay top surgery in order to do so.⁵ Other parents may make an advanced decision not to breast/chestfeed, whether they have had top surgery or not. Finally, some parents may change their mind about how they wish to feed their baby, once their baby has been born.
- 5.5.2 Breast/chestfeeding or expressing may still be possible after top surgery, as long as 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 advance¹⁰ and full milk supply may not be possible in some cases.⁵ Parents should be especially aware of signs of effective milk transfer, and expected newborn behaviour and output to ensure adequate milk intake.
- 5.5.3 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).¹⁷

- 5.5.4 Parents who have not had top surgery may wish to bind their chest during times they are not actively feeding or expressing.⁵ 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 than they wore previously.
- 5.5.5 If a parent is certain they do not want to breast/chestfeed or express, prevention of lactation can be offered to help minimise swelling of the chest in the early postnatal period, 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 lactation¹⁸, as per [MP073 Pregnancy Loss protocol](#).
- 5.5.6 If breast/chestfeeding is not possible, or desired, discuss other methods of infant feeding and promotion of attachment, including skin-to-skin contact and responsive bottle feeding.
- 5.5.7 Non-gestational parents may wish to participate in feeding their infants using their own bodies. Cis women who have previously breastfed may have the most success in relactating. Trans women and cis women who have not been pregnant may also be able to induce lactation to some extent.^{19,20,21,33} Methods for inducing lactation include using galactagogues and physical stimulation. Alternatively, some families choose to use supplemental nursing systems with expressed milk or formula.

5.6 Resumption of Testosterone

- 5.6.1 Some parents may be keen to initiate, or resume, testosterone therapy soon after they have birthed.
- 5.6.2 Testosterone should not be considered an effective form of contraception.¹⁰ Professionals should still counsel individuals resuming testosterone to consider their contraceptive options, if appropriate to their sexual relationships, especially with regard to the teratogenic effects of testosterone.

5.6.3 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.^{21,22,23,24} Whilst there are possible risks to the infant, there is no clear evidence of harm¹⁰, however it should be noted that the evidence-base for this conclusion is very limited. The individual is best placed to assess the benefits of resuming testosterone in terms of their own emotional, physical, social and mental wellbeing¹⁰ with additional advice and support. Referrals can be made to the Gender Inclusion Team's named Consultant Neonatologist (see [Appendix 1](#)), who can discuss the potential risks, liaise with their endocrinologist, and develop an individualised care plan.

5.7 Birth Registration

5.7.1 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.²⁵ New parents may benefit from being advised of this in advance, as it may cause distress for some.

5.8 Contraception and Screening

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

5.8.2 Testosterone is not a contraceptive, so contraception is still advised for people considering resuming testosterone, if they have sexual activity with a partner who produces sperm.²⁶ 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 generally not recommended for trans men and non-binary people who are taking testosterone, because the oestrogen component will counteract the effects of testosterone.²⁷

5.8.3 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.²⁸ Therefore birthing parents can be reminded postnatally that they are eligible for routine cervical screening, but may not receive invitations to appointments. Cervical screening can be arranged with their GP surgery or with Clinic T (part of Brighton Sexual Health & Contraception Services), and these services can make a request to the NHS Cervical Screening Programme so that invitations are sent correctly.²⁸

6 Audit and Service Development

- 6.1 Trans and non-binary birthing parents can reasonably be considered to be experiencing a complex social factor, as per [CG110](#) 'Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors'.²⁹ This model denotes a number of responsibilities for service organisation and development.
- 6.2 Using NICE CG110 as a model for improving access to perinatal care for vulnerable groups, commissioners should ensure the following are recorded, in order to inform mapping of their local population to guide service provision:
 - The number of trans or non-binary people who:
 - are pregnant locally
 - present for antenatal care
 - attend for booking by 10, 12+6 and 20 weeks
 - attend the recommended number of antenatal appointments, in line with national guidance
 - experience, or have babies who experience, mortality or significant morbidity
 - For each trans or non-binary pregnant person:
 - the number of appointments they attend
 - the number of scheduled appointments they do not attend²⁹
- 6.3 Using this model, commissioners should ensure that trans or non-binary people presenting for antenatal care are asked about their satisfaction with the services provided; and ensure their responses are:
 - recorded and monitored
 - used to guide service development²⁹
- 6.4 Commissioners should involve trans and non-binary people and their families in determining local needs and how these might be met.²⁹
- 6.5 All staff providing clinical perinatal care should be given training on gender inclusive perinatal care, which should include:
 - Basic concepts: sex, gender identity, gender expression, sexuality, transition
 - Respectful communication and pronoun usage
 - Health and social inequalities
 - Barriers to accessing care
 - Spectrum of experiences and needs of trans and non-binary parents

- 6.6 Receptionists and administrative staff who are public facing should also be given training, which should include:
- Basic concepts: sex, gender identity, gender expression, sexuality, transition
 - Respectful communication and pronoun usage

7 Appendices

Appendix 1 – Gender Inclusion Team Contact Details

Gender Inclusion Midwives Team

Helen Green

Pronouns: she/they

Role: Service development and networking, hospital midwife

Ash Riddington

Pronouns: he/him

Role: Non-clinical support for families, staff training, community midwife

Team email address: bsuh.genderinclusionmidwives@nhs.net

Consultant Obstetrician

Dr Heather Brown

Pronouns: she/her

Role: Obstetric care for high risk pregnancies where the birth parent is trans or non-binary, requests for elective Caesarean due to gender dysphoria

Email: heather.brown27@nhs.net

Consultant Neonatologist

Dr Neil Aiton

Pronouns: he/him

Role: Medical advice regarding testosterone use during pregnancy or breast/chestfeeding

Email: neil.aiton@nhs.net

Consultant Endocrinologist

Dr Anna Crown

Pronouns: she/her

Role: Advice regarding hormones during pregnancy and breast/chestfeeding

Email: a.crown@nhs.net

Speciality Doctor in Sexual & Reproductive Health

Dr Kate Nambiar

Pronouns: she/her

Role: Pre-conception advice including fertility planning, sexual health, and postnatal contraception

Email: kate.nambiar1@nhs.net

Specialist Infant Feeding Midwife

Carla Mastroianni

Pronouns: she/her

Role: Additional infant feeding support, including creating feeding plans antenatally

Email: carla.mastroianni@nhs.net

Appendix 2 – Definitions

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

AFAB	Shorthand for people who were <u>a</u> ssigned <u>f</u> emale <u>a</u> t <u>b</u> irth. This includes cisgender women, trans men, and non-binary people who were assigned female at birth. Do not use “female bodied”. ⁸
AIAB	Shorthand for people who were <u>a</u> ssigned <u>i</u> ntersex <u>a</u> t <u>b</u> irth.
AMAB	Shorthand for people who were <u>a</u> ssigned <u>m</u> ale <u>a</u> t <u>b</u> irth. This includes cisgender men, trans women, and non-binary people who were assigned male at birth. Do not use “male bodied”. ⁸
Binding	The practice of flattening the chest using compression garments or bandage wrappings. ⁵
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 vaginoplasty. 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”.
Button-hole	A type of top surgery to remove a large proportion of mammary tissue and create masculine chest contour. Two broad incisions below mammary tissue, and repositioning of nipple-areolar complex without severing the pedicle.
Chestfeeding	The act of feeding one’s baby using one’s chest and/or milk. 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.
Direct discrimination	This happens when someone is treated worse than another person in a similar situation because they are trans. ⁴
Double incision	A type of top surgery to remove a large proportion of mammary tissue to create masculine chest contour. This generally involves temporary removal of the nipple-areolar complex, which may be re-sized and re-shaped, before being re-positioned and re-attached by skin graft. Sometimes the nipple-areolar complex is not reattached.
FTM	Someone who has transitioned from <u>f</u> emale <u>t</u> o <u>m</u> ale. This term should only be used by people to refer to themselves, and not to refer to all trans men, as not all people will be comfortable with this terminology.
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 of 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. ⁵
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. ³⁴
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.
Harassment	Harassment is when someone is made to feel humiliated, offended or degraded based in any factor, including because of their gender identity or expression. ⁴
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. ³¹ For trans men and non-binary AFAB people, this consists of testosterone supplementation: <ul style="list-style-type: none"> ○ Various routes: depot intra-muscular injections, topical gel application, or subcutaneous pellets ○ Virilising effects, some of which may be permanent: body and facial hair growth, voice deepening, redistribution of body fat, increased muscle mass, male-pattern baldness, acne, clitoral growth, suppression of ovulation and cessation of menses^{12,14,32}

- Cessation of testosterone therapy can result in the return of menses and fertility¹² however some people can conceive while taking testosterone¹⁴

Hormone therapy for trans women and non-binary AMAB people may include suppression of endogenous testosterone and supplementation of oestrogen:

- Testosterone suppression can be achieved pharmacologically with blockers such as decapeptyl, or surgically through removal of the testicles
- Oestrogen supplementation can be given through oral pills or topical gels
- Trans feminine hormone therapy redistributes muscle and body fat and stimulates breast development, with maximal breast development at about 2-3 years³³. Hormone therapy also suppresses sperm production, but not completely for every individual³⁶ so should not be relied on as a form of contraception. Stopping oestrogen can result in the return of spermatogenesis.

**Indirect
discrimination
Intersex**

Indirect discrimination happens when an organisation has a particular policy or way of working that puts trans people at a disadvantage.⁴ Intersex people are born with physical sex characteristics that don't fit medical and social norms for female or male bodies. Intersex traits are natural manifestations of human bodily diversity. Intersex variations are not the same as gender identity (who you are – man, woman, gender non-conforming, non-binary, transgender) or sexual orientation (who you are attracted to – heterosexual, bisexual, lesbian, gay, asexual, pansexual). People born with intersex variations have the same diversity in sexual orientation and gender identity as everyone else. While LGBT activists and Intersex activists may work together, it is important to be clear about the difference and prevent misunderstanding.

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 AFAB people include metoidioplasty and phalloplasty. Options for trans women and non-binary AMAB 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 lower surgery.⁸ Also known as “bottom surgery”.

Metoidioplasty

Often referred to colloquially as “meta”. Genital surgery to create a small sensate penis, using the enlarged clitoris and local tissue. May be combined with testicular implants and surgical refashioning of the labia majora. May be combined with urethral lengthening, or the urethra may be left in its natal position. Vaginectomy, with or without hysterectomy, may be performed at the same time, before, or after.

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.” ⁸
MTF	Someone who has transitioned from <u>m</u> ale to <u>f</u> emale. This term should only be used by people to refer to themselves, and not to refer to all trans men, as not all people will be comfortable with this terminology.
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 <i>transgender</i> 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.
Outed	When a lesbian, gay, bi or trans person’s sexual orientation or gender identity is disclosed to someone else without their consent.
Passing	If someone is regarded, at a glance, to be a cisgender man or cisgender woman. This might include physical gender cues (hair or clothing) and/or behaviour which is historically or culturally associated with a particular gender.
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.
Phalloplasty	Often referred to colloquially as “phallo”. A series of surgeries to create a penis using donor tissue, usually radial forearm flap or antero-lateral thigh. The hormonally-enlarged clitoris is often buried in the base. May involve urethral lengthening, or the urethral exit may remain in its natal position, or between the penis base and the scrotum if scrotoplasty has been performed. Hysterectomy and vaginectomy may be performed at various points in the process, or not at all.
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

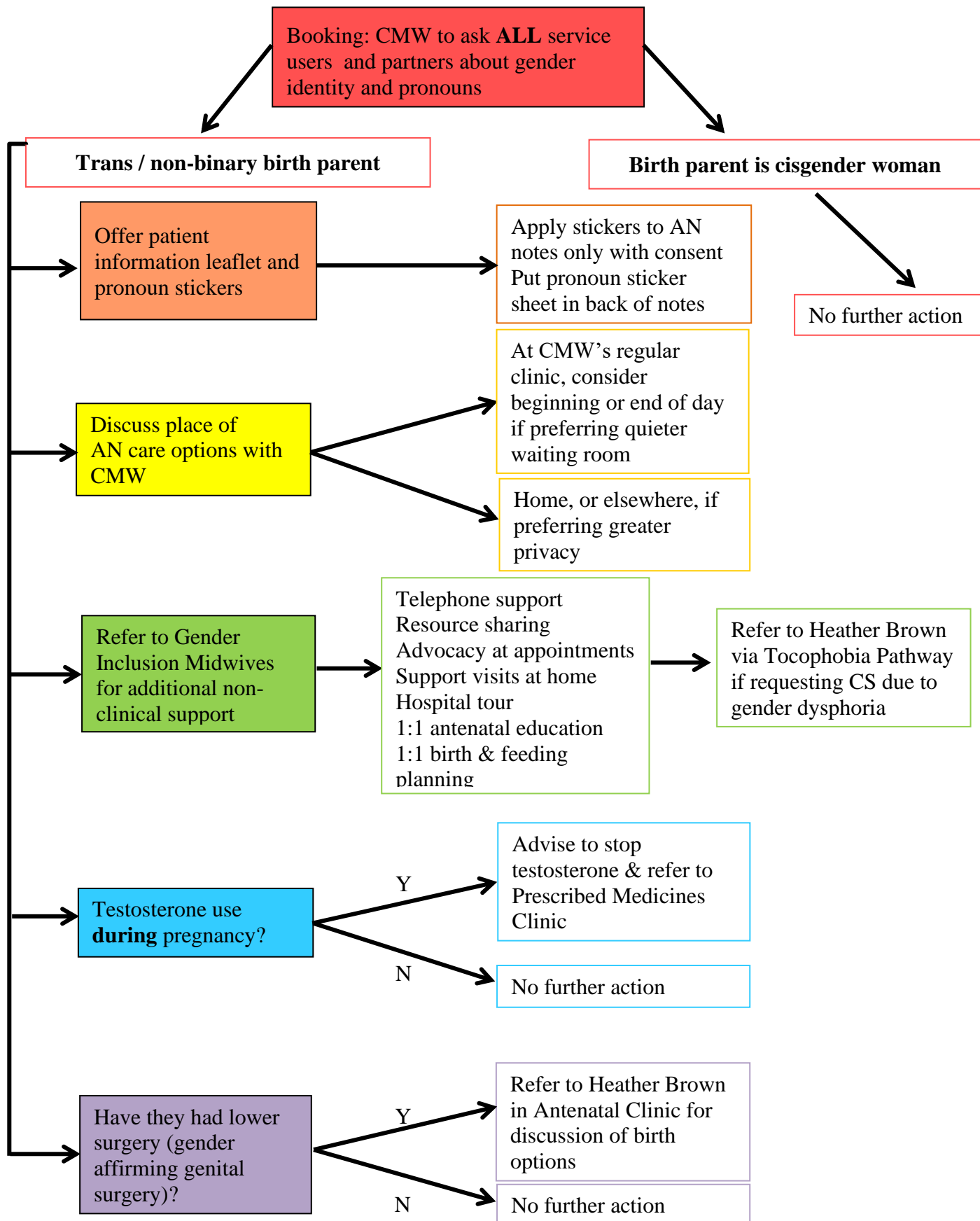
	them in gender neutral language and use pronouns such as they/their and ze/zir.
Sex	A term used to denote male/female/intersex variations, largely based on visible physical differences and attributes. In general, a sex attributed at birth is based on visual indicators. However, sex attributes are often (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. Examples include double incision, button-hole, T-anchor, and peri-areolar techniques. For trans women and non-binary AMAB 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. ⁸
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 each individual. Do not use the term “sex change”. ⁸
Trans man	A person who identifies as a man, but was assigned female at birth. ²
Trans woman	A person who identifies as a woman, but was assigned male at birth. ²
Transphobia	The fear or dislike of someone based on the fact they are trans or non-binary, including the denial/refusal to accept their gender

identity. A hate crime is when transphobia is acted out against someone and it amounts to a criminal offence. Any form of discrimination and hate crime is not tolerated within the Trust, and there is a process for reporting such incidents. It is important that behaviour of this nature is reported, to ensure that the incident/crime is investigated appropriately and the right level of support can be offered to the victim and bystanders. All managers must be aware of how to report hate crimes. If you are unclear of the process contact BSUH.Equality@NHS.net.

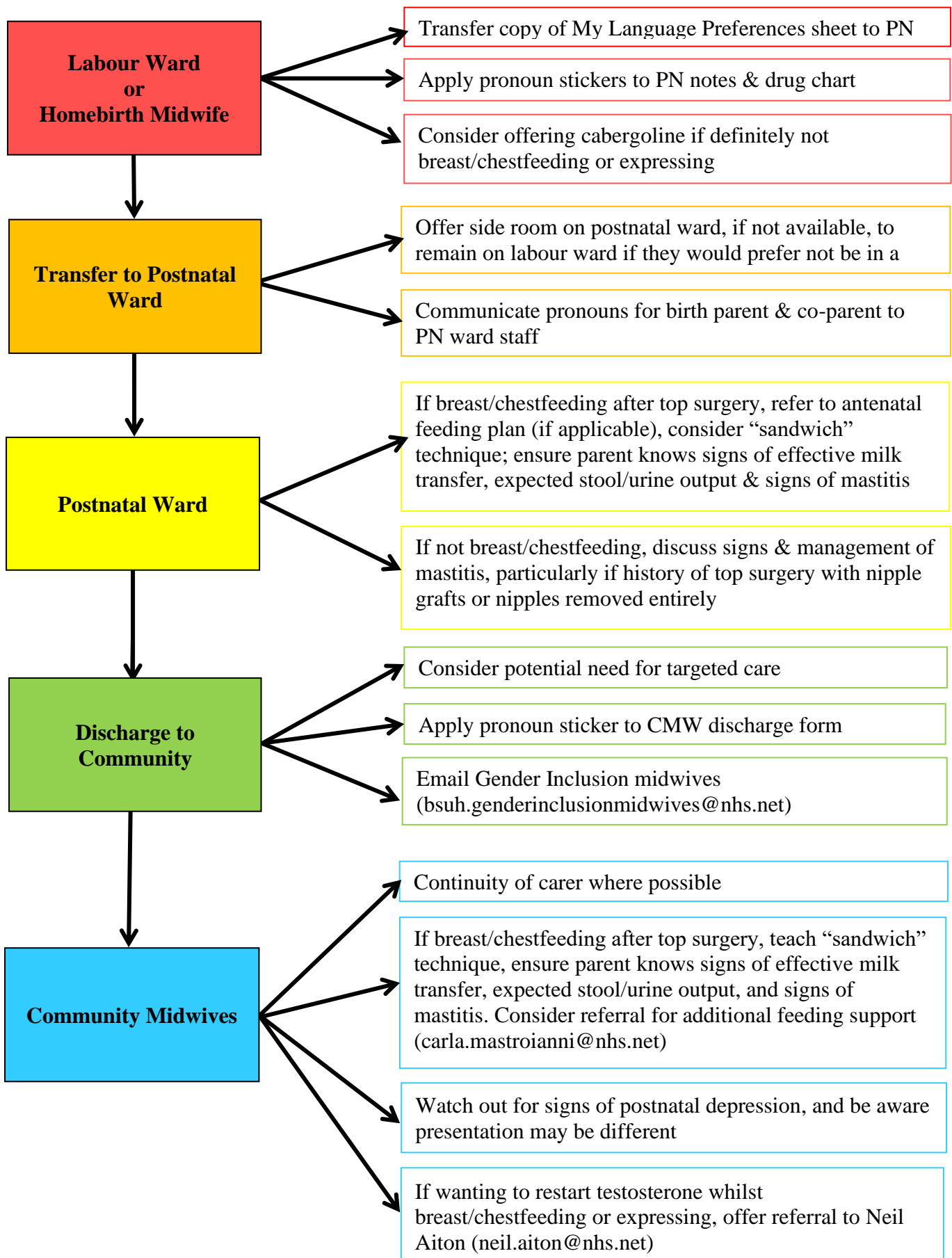
Victimisation

Victimisation is when an individual is treated badly because they have made a complaint of gender reassignment related discrimination under the Equality Act. It can also occur if they are supporting someone who has made a complaint of gender reassignment related discrimination.⁴

Appendix 3 – Trans and Non-Binary Antenatal Care Pathway



Appendix 4 – Trans and Non-Binary Postnatal Care Pathway



[illegible][illegible][illegible]

Referral to Gender Inclusion Midwives

Support from a Gender Inclusion Midwife is available to any birthing parent, or partner, who identifies as trans, non-binary, genderqueer, or any other non-cis identity.

You will continue to see your community midwife for your care, with the Gender Inclusion midwife providing a variety of support services in addition.

We are here to support you on your own unique journey to parenthood.

(Preferred) First Name	Surname
Gender Identity	Pronouns
Address	
Email	Mobile
DOB	NHS / Hospital Number
GP Surgery	Community Midwife / Team
Estimated Due Date	Number of Previous Births
Partner's Name (if applicable)	Partner's Pronouns (if applicable)
<p>What services might you be interested in accessing from the Gender Inclusion Midwife?</p> <p> <input type="checkbox"/> Telephone/email/text support <input type="checkbox"/> Support visits at home <input type="checkbox"/> Company and advocacy at other appointments or scans <input type="checkbox"/> Individual birth, feeding and parenting preparation class at home <input type="checkbox"/> Assistance writing a birth plan, including language preferences <input type="checkbox"/> Tour of hospital facilities <input type="checkbox"/> Other: <input type="checkbox"/> None (referral for audit purposes only – no need to include contact details or partner's details) </p>	
Referring midwife	Date

Send by email to: bsuh.genderinclusionmidwives@nhs.net

MY LANGUAGE PREFERENCES

Birth parent:

Pronouns:

Co-parent/s:

Pronouns:

Additional support person:

Pronouns:

Anatomical Term	Preferred Term	Example
Breast/s		
Breastfeeding		
Breastmilk		
Cervix		
Clitoris		
Labia		
Perineum		
Uterus		
Vagina		
Vaginal examination		
Vulva		

NMC The Code, 2015:

1 Treat people as individuals and uphold their dignity

1.3 avoid making assumptions and recognise diversity and individual choice

2 Listen to people and respond to their preferences and concerns

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

7 Communicate clearly

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

NICE CG190, 2014:

Treat all [people] in labour with respect. Ensure that [they] are in control of and involved in what is happening to [them], and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the [birthing person], ask [them] about [their] wants and expectations for labour, and be aware of the importance of tone and demeanour, and of **the actual words used**. Use this information to support and guide [them] through [their] labour.

Appendix 8 – Prescribed Medication Referral Form

Please ensure all sections of this form are complete before submission – thank you

Name of Referrer			Referring Team														
Contact Number			Postal and/or email Address														
Patient Name																	
ID Hospital/NHS																	
DOB			Date of Referral														
Address																	
Post Code			EDD		Parity												
Contact Number(s)			Patient Pronouns														
Gestation weeks when medication taken – please tick relevant boxes																	
Medication	Pre 5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	On- going
Other Agencies		Name										Contact Number					
GP																	
Please ensure that the patient is made aware that a referral is being made to this clinic – thank you																	
COMMENTS																	

Please email to: jane.battersby@bsuh.nhs.uk (bsuh accounts only) or j.batterby@nhs.net

Or send to: Jane Battersby, Secretary to Dr Neil Aiton, One Stop Clinic, TMBU, L14 Thomas Kemp Tower, Royal Sussex County Hospital, Eastern Road, Brighton BN2 5BE

Appendix 9 – 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>
- Trans Pregnancy research project
<https://transpregnancy.leeds.ac.uk/>
- E-LfH Gender Variance e-learning
<https://www.e-lfh.org.uk/programmes/gender-variance/>
- La Leche League breast/chestfeeding support
<https://www.laleche.org.uk/support-transgender-non-binary-parents/>
- Birth for Every Body
<http://www.birthforeverybody.org/>

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