

# **A Clinical Audit of the Transgender Unit at Grootte Schuur Hospital**

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## **Faculty of Health Sciences Declaration of Originality**

This research report is my original work. Neither the whole work nor any part of it has been, is being, or is to be submitted for another degree to any other university. This work has not been reported or published prior to the registration for the above mentioned degree.

Date of Submission: 14 August 2020

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## **ABSTRACT**

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### **A Clinical Audit of the Transgender Unit at Groote Schuur Hospital**

#### **Background**

The Transgender Clinic at Groote Schuur Hospital (GSH) – a large government funded academic hospital in Cape Town, South Africa - assists with the mental health assessment of transgender individuals and facilitates access to other gender affirming services, such as hormone therapy, plastic and reconstructive surgery, psychosocial, and legal services.

#### **Objectives**

This clinical audit aimed to gain a clearer understanding of the service and areas within the service which could be improved. To this end the general compliance of the clinical services of the multidisciplinary team (MDT) as recommended by the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) was assessed. In addition, an analysis of the demographic and clinical characteristics of individuals attending the clinic and a review of waiting times and distance travelled to attend the clinic, was conducted.

#### **Methods**

The study was a clinical audit without a repeat data collection cycle. Participants included the MDT members working at GSH's Transgender Unit and individuals attending the Transgender Clinic from September 2018 to December 2019 (n = 50). All 11 MDT members were invited to participate in the study and were required to complete a data collection sheet related to their competency and experience. Data collection with respect to services provided, and waiting times for services, was captured from clinician administered standardized history-taking and assessment booklets and patient hospital folder reviews.

#### **Results**

All members of the MDT who participated met the WPATH SOC 7 competency requirements. The mean age of the individuals attending the GSH Transgender Clinic was 28 years. Forty-eight percent were employed, 36% unemployed and 16% full time scholars. The

mean waiting time for an initial appointment with mental health was 75 days, 73 days for endocrinology and 255 days for plastic surgery. Non-attendance at initial appointment was a factor across gender affirming services – 18% mental health service, 20.5% endocrinology and 27% plastic surgery. Forty-two percent of individuals screened positive for a co-occurring mental health condition with a third of these individuals having more than one mental health disorder. Mood and anxiety disorders co-occurred together most frequently. Seventy-five percent of individuals with an untreated or partially treated mental health concern were provided a therapeutic intervention at the time of initial assessment. The introduction of laboratory investigations being performed prior to the initial appointment with endocrinology resulted in a significant improvement in waiting time to the initiation of hormone therapy.

### **Conclusion**

WPATH SOC 7 competency requirements were met by the GSH Transgender clinical team. Inconsistencies were found in the documentation of WPATH SOC 7 recommended clinician tasks within the mental health and endocrinology service. This is secondary to the layout of the standardized history taking and assessment booklet, and documentation of certain tasks being clinician dependent. Limited hospital resources and subsequent understaffing, long waiting times for appointments and gender-affirming surgery and lack of access to other services (e.g. fertility services) result in continued barriers to gender-affirming care.

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## ABBREVIATIONS

ASD	Autism Spectrum Disorder
CANSA	Cancer Association of South Africa
DSM-5	Diagnostic and Statistical Manual of Mental Disorders Fifth Edition
GAD	Generalised Anxiety Disorder
GSH	Groote Schuur Hospital
ICD	International Classification of Diseases and Related Health Problems
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
IPV	Intimate Partner Violence
MDD	Major Depressive Disorder
MDT	Multidisciplinary team
NICE	National Institute for Health and Care Excellence
SAD	Social Anxiety Disorder
StatsSA	Statistics South Africa
WPATH	World Professional Association for Transgender Health
WPATH SOC	World Professional Association for Transgender Health 7 <sup>th</sup> Edition
7	Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People

## **GLOSSARY OF TERMS**

### *Cisgender*

A term used when an individual's gender identity/experienced gender and gender expression are congruent with the sex assigned at birth (Byne et al., 2018).

### *Gender-affirming treatment*

Refers to the treatment procedure for those who want to adapt their bodies to their experienced gender by means of hormones and/or surgery (Hembree et al., 2017)

### *Gender binary*

A gender-categorisation system limited to the two options - male and female (Byne et al., 2018).

### *Gender dysphoria*

Refers to the distress and discomfort experienced by an individual if their gender identity and their sex assigned at birth are not completely congruent (American Psychiatric Association, 2013).

### *Gender expression*

Refers to the expression of one's gender identity, often through external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behaviour, voice or body characteristics (Hembree et al., 2017; Winter et al., 2016).

### *Gender identity/experienced gender*

Refers to a person's fundamental sense of being a man, a woman, or of indeterminate sex – which may or may not correspond to an individual's sex assigned at birth (Coleman et al., 2012; Institute of Medicine, 2011).

### *Gender incongruence*

An umbrella term used when the gender identity/experienced gender and/or gender expression differs from sex assigned at birth. Not all individuals with gender incongruence have gender dysphoria or seek treatment (Hembree et al., 2017).

### *Gender role*

Refers to behaviours, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or society associates with - or considers typical of - the social role of men or women (Hembree et al., 2017).

### *Minority Stress*

Refers to the additional, socially based and unique stress that members of marginalised groups experience because of the prejudice and discrimination that these individuals face (Coleman et al., 2012).

### *Sex*

Refers to attributes that characterise biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics (Hembree et al., 2017).

### *Transgender and gender non-conforming (TGNC)*

An umbrella term used to describe individuals whose gender identity and/or gender expression differs to varying degrees from the sex they were assigned at birth (American Psychological Association, 2015; Coleman et al., 2012; Hembree et al., 2017).

### *Transgender female/transfemale/transgender woman/transwoman/male-to-female*

Refers to individuals assigned male at birth but who identify as women (Hembree et al., 2017).

### *Transgender male/transmale/transgender man/transman/female-to-male*

Refers to individuals assigned female at birth but who identify as men (Hembree et al., 2017).

### *Transition*

Refers to the process through which transgender persons change their physical, social, and/or legal characteristics consistent with their affirmed gender identity (Hembree et al., 2017).

## CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Word count, excluding references: 3950 words

### Background and Significance

Groote Schuur Hospital (GSH) is a large, government-funded academic hospital in Cape Town, Western Cape, South Africa. It officially opened in 1938; and it provides secondary, tertiary and quaternary care for patients in the Western Cape and other areas of South Africa. It is the principal teaching hospital for the University of Cape Town's Faculty of Health Sciences.

Like many countries, South Africa has parallel public and private healthcare systems. The policy of Apartheid resulted in significant inequality in multiple sectors. Roughly 83.6% (49.2 million) of the South African population rely on the government funded public health system (Department Statistics South Africa [StatsSA], 2019a; StatsSA, 2019b). To highlight the disparity, in 2018 the National Budget allocated R205.4 billion rand to public health, while R173.3 billion rand was paid out to beneficiaries of private "medical aid schemes", which only provides cover for 16.4% of the population (Council for Medical Schemes, 2019; National Treasury, 2018).

GSH has provided psychiatric, endocrine and surgical services to transgender individuals since the 1970s. As of 2009, GSH formalised a Transgender Clinic so as to provide a more integrated and multidisciplinary approach to transgender healthcare. The service is coordinated by the Department of Psychiatry and Mental Health at the University of Cape Town, with a mandate to provide a comprehensive package of care for the transgender individual, and to facilitate follow-up support in the local community (Department of Psychiatry and Mental Health, 2020; Marais et al., 2018; Wilson et al., 2014).

The multidisciplinary team (MDT) currently comprises of two psychiatrists, a clinical psychologist, a plastic and reconstructive surgeon and an endocrinologist involved in the provision of clinical services at the Transgender Clinic. The broader multi-disciplinary Transgender Unit comprises other healthcare professional, including a counselling

psychologist, a family physician, a clinical and general social worker, a general practitioner from the private sector. The MDT convenes every two months for multi-disciplinary collaboration, establishment of clear referral pathways, co-ordination of services across platforms, community engagement, complex clinical case discussion and setting of agendas for teaching, training, research and advocacy (Department of Psychiatry and Mental Health, 2020; Marais et al., 2018; Wilson et al., 2014).

The Transgender Clinic assists with the assessment of transgender individuals (>18 years), which includes a comprehensive assessment of gender dysphoria/gender incongruence, and a general mental health assessment. If necessary the mental health practitioner will then facilitate access to other gender affirming services, such as endocrinology, plastic and reconstructive surgery and psychosocial counselling and support services. The Clinic also assists with the application for legally changing gender markers. Gender nonconforming children and adolescents (<18 years) are referred to the Gender Identity Development Service at Red Cross War Memorial Children's Hospital which provides clinical services and psychoeducation to children and adolescents, their families, and their schools (Department of Psychiatry and Mental Health, 2020; Marais et al., 2018; Wilson et al., 2014).

The Transgender Unit aims to follow the internationally accepted practice guidelines, standard management and professional consensus outlined by the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) (Coleman et al., 2012; Department of Psychiatry and Mental Health, 2020; Wilson et al., 2014). Australia, New Zealand and the United Kingdom are examples of other countries that set out to follow WPATH SOC 7 for the provision of adult transgender healthcare (Australian Professional Association for Trans Health, n.d.; National Health Service, 2019; New Zealand Ministry of Health, 2019).

The GSH Transgender Clinic runs two mornings a month. The first clinic is dedicated to seeing new patients (3-4 new patients) and the second clinic is a combination of new patient assessments (2 new patients) and follow up reviews. Referrals are received from Community Health Clinics, District and Regional Hospitals, general practitioners, private psychiatrists/psychologists and civil society organisations (Gender DynamiX and the Triangle Project) in the Western Cape, as well as referrals from other provinces within South Africa. In

2014, Wilson et al. published an article addressing transgender issues in South Africa, with particular reference to the Groote Schuur Hospital Transgender Clinic. The authors highlighted the impact of limited resources in staffing on the provision of timeous gender affirming healthcare. At that time the Transgender Clinic was only running once a month. The waiting list for initial assessment by the mental health professional was 2-3 months, with a further 2-3 month waiting period for endocrinology screening, and a surgical waiting time for genital surgery of 15-20 years based on data captured from January 2009 until December 2017 (Marais et al., 2018). In May 2017 the clinic started running twice a month; and in September 2018, the Transgender Clinic introduced a standardised history-taking and assessment booklet to be used at the initial consultation. The booklet was informed by the WPATH SOC 7 section related to the tasks of mental health professionals working with adults who present with gender dysphoria.

The National Institute of Clinical Excellence defines a clinical audit as:

A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery. (National Institute for Clinical Excellence, 2002, p. 1)

This clinical audit aimed to assess the Transgender Clinic's compliance with the WPATH SOC 7 since the introduction of the new standardised history-taking and assessment booklet. A secondary aim was to consider barriers to compliance (if any), as well as a review of waiting times for assessments and distance travelled to access transgender services. The review of waiting times were compared to the Wilson et al. (2014) study and Marais et al. (2018) review in order to inform the service whether there has been a reduction in waiting times for initial assessment by the Transgender Clinic since the introduction of a second clinic day per month in May 2017. This audit was intended to lead to a clearer understanding of areas within the service where quality of care could be improved. In addition, an analysis of the demographic and clinical characteristics of individuals attending the clinic was done.

## **Methods**

### **Search Strategy**

A review of literature was performed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & PRISMA group, 2009). Terms for transgender individuals (transgender, transsexual, transsexualism, transpeople, gender non-conforming, gender nonconforming, TGNC, genderqueer, non-binary, gender identity disorder, gender dysphoria) were searched using the OR function and were combined with the terms related to healthcare (healthcare, health care, health service, gender-affirming care, trans-affirming care, clinical service) and audit (audit, evaluation, assessment, appraisal, review, standards, best practice, service delivery, guidelines, practice guidelines, models, good practice, service delivery models) using the AND operator. The databases screened for the literature review were Academic Search Premier, Africa-Wide, CINAHL, Health Source Nursing Academic, Medline/PubMed, PsycARTICLES, PsycINFO using the EBSCOhost platform. Articles from the International Journal of Transgenderism (not in PubMed) were also included. The initial search generated 4590 articles. 4015 articles were excluded after the search was refined by applying subject headings as per EBSCOhost platform (transgender, transgender people, gender identity, health service accessibility, transsexualism, mental health, sexual orientation, health disparities, discrimination, gender dysphoria, mental health services, minority groups, sexual minority groups, gender nonconforming, research evaluation, epidemiology, sexual health, stigma, diversity, health promotion, prevention, social discrimination, treatment, needs assessment, cultural sensitivity, humans, minority stress, health education, mental health personnel, professional competence). A review of the abstracts of 575 articles was performed with 489 articles excluded. 86 articles were retained and reviewed as complete texts, with 24 included in the review.

### **Literature Review**

There is currently no accurate prevalence data for transgender individuals worldwide, but estimates suggest a prevalence of 0.3-0.5% (Hughto et al., 2015; Reisner, Poteat, et al., 2016; Winter et al., 2016). With a mid-year population estimate of 58.8 million South Africans, we estimate this would translate to 176 340 to 293 900 transgender South African individuals

(StatsSA, 2019b). Estimates are generally based on the most easily counted subgroup, specifically those that seek gender-affirming care at specialist clinics. However, due to the diversity within the transgender population - some live with their gender incongruence and do not seek gender-affirming care, others do not make their transgender status known, let alone seek care due to stigma - these estimates may underestimate the size of the broader population of transgender people (Winter et al., 2016).

Wanta and Unger (2017) reviewed transgender literature published from January 1950 to June 2016, noting a paucity of published data on the care of transgender patients and outcomes related to this care. Their study also noted a lack of published data addressing the provision and evaluation of gender-affirming healthcare services and the outcomes of care.

The literature repeatedly highlights the stigma (the social process of labelling, stereotyping, and rejecting human difference as a form of social control), discrimination, prejudice and abuse that transgender individuals experience on a daily basis from individuals, groups, organisations and broader society. This may result in transgender individuals experiencing minority stress. This results in social, educational, economic and legal marginalisation and impaired social and emotional well-being (Blondeel et al., 2016; Hughto et al., 2015; Institute of Medicine, 2011; Thomas et al., 2017; Winter et al., 2016; Wylie et al., 2016).

Poor policy and health planning and poor access to health services (gender-affirming and general healthcare) for a multitude of reasons, including, but not restricted to, lack of infrastructure, limited access to gender-affirming services, lack of health insurance, cost of care, lack of health insurance, lack of provider skills in gender-affirming care, discrimination and/or refusal of care of transgender individuals by healthcare providers, further compromise health and well-being (Blondeel et al., 2016; Byne et al., 2018; Hughto et al., 2015; Institute of Medicine, 2011; James et al., 2016; Reed et al., 2016; Reisner, Radix, et al., 2016; Stroumsa, 2014; Winter et al., 2016; World Health Organisation, 2015).

The World Health Organisation's forthcoming eleventh revision of the International Classification of Diseases and Related Health Problems (ICD) is proposing changes to the current ICD-10 classification of Mental and Behavioural Disorders related to gender identity. Categories related to gender identity classified under the Mental and Behavioural Disorders category were initially intended to assist in the identification of people who required mental

health services and in the selection of appropriate treatment. However, as knowledge increases and socio-cultural-political attitudes and pressures transform, there is recognition of the potential stigmatisation that accompanies the classification of transgender identity as a mental disorder. Stigmatisation can contribute towards barriers to appropriate healthcare and human rights violations in this population. A primary mental disorder diagnosis can exacerbate problems in accessing healthcare not considered to be mental health services and contributes to the perception that transgender people must be treated by psychiatric specialists, which further restricts access to services that could be provided at other levels of care. ICD-11 proposes to retain the gender incongruences diagnosis to preserve access to health services, but to include it under Conditions Related to Sexual Health rather than Mental and Behavioural Disorders, and by doing so integrate the medical and psychological perspectives (Reed et al., 2016).

James et al. (2016) published the 2015 U.S. Transgender Survey, which had 27715 respondents, and examined the experiences of transgender people in the United States across a wide range of categories, such as education, employment, family life, health, housing and interactions with the criminal justice system. Respondents reported high levels of mistreatment, harassment, and violence in every aspect of life. Transgender individuals faced barriers to accessing affordable, quality healthcare. These barriers included distance required to travel to see healthcare providers for transgender care, cost of care, mistreatment by healthcare providers, fear of mistreatment, and healthcare provider discomfort or inexperience with treating transgender people. These barriers make it harder for transgender individuals to seek both routine healthcare and transgender related healthcare.

The survey reported that a third of respondents who saw a healthcare provider in the past year recounted at least one negative experience related to being transgender. This included refusal of treatment, verbal harassment, physical and sexual assault, or having to teach the provider about transgender individuals in order to get appropriate care. Transgender men (42%) were more likely to report negative experiences than transgender women (36%) and non-binary respondents (24%). Almost a quarter (23%) of respondents did not go to a healthcare provider when needed in the past year for fear of being mistreated as a transgender individual, and a third of respondents did not go to a healthcare provider when needed because they could not afford it. Only 49% of respondents received hormone therapy, despite 78% of respondents

wanting hormone therapy; and only 58% of respondents received counselling or therapy despite 77% of respondents wanting counselling or therapy (James et al., 2016).

A 2019 research report addressing the realities of violence, mental health and access to healthcare related to sexual orientation and gender identity and expression in South Africa, of which 232 of 832 participants were gender minority individuals (transgender/gender non-conforming/non-binary), also raised awareness of the broad ranging negative consequences of stigma, prejudice, marginalisation and discrimination on the health of gender minority individuals in South Africa. Gender minority participants showed higher levels of co-occurring mental health conditions, experienced higher levels of violence and more barriers when accessing healthcare services (Müller et al., 2019).

The report draws attention to the marked disparities between the under-resourced and over-burdened parallel health systems in South Africa. Roughly 83.6% of the South African population relies on the public health system (StatsSA, 2019a), which likely exacerbates the barriers to healthcare experienced by gender minority participants (Müller et al., 2019). Only 56.5% of gender minority participants had access to hormone therapy and 38.1% had access to surgical procedures. Participants were significantly more likely to report using hormones if they had a private medical aid/health insurance.

Seventy-two point eight percent of gender minority participants reported being treated with less respect by a healthcare provider, with 16.6% reporting that it happens often; 47.8% of gender minority participants reported being called names or insulted in a health facility, with 11.4% reporting that it happens often; and 39.2% of gender minority participants reported being denied healthcare because of their gender identity and expression, with 10.5% reporting that it happened often (Müller et al., 2019).

A study addressing the provision of gender affirming care in South Africa reported that despite the fact that the South African National Health Act 61 (2003) is meant to be one of the legislative measures to facilitate the realisation of the right of everyone to access healthcare services, this unfortunately is not the case, with gender-affirming services being severely limited and unequal, and no national policies or guidelines being currently available (Spencer et al., 2017).

The study also addressed the marked inequality in health between the public and private healthcare system in South Africa, noting that the public health system with 400 hospitals and 4000 primary care facilities services the majority of the population (roughly 49.2 million) (Spencer et al., 2017; StatsSA, 2019a; StatsSA, 2019b).

Six public hospitals provide gender-affirming care to various degrees across South Africa, of note, all of these hospitals are based in urban centres in three of South Africa's nine provinces. Only three hospitals (Chris Hani Baragwaneth Hospital in Soweto, Gauteng; Groote Schuur Hospital in Cape Town, Western Cape; and Steve Biko Academic Hospital in Pretoria, Gauteng) provide endocrinology, psychiatric and surgical services at the same facility (Spencer et al., 2017). Individuals based in rural settings, and in the other six provinces, will often have to travel across the country to access gender-affirming care from these hospitals. Psychosocial support, hormone therapy and gender-affirming surgical procedures are available in the private sector, but are generally not covered by medical aid/health insurance (Spencer et al., 2017).

At present there are no South African national guidelines for gender-affirming care. According to Spencer et al. (2017) the lack of national guidelines for gender-affirming care makes advocating for financial coverage for contextually appropriate and available resources and services difficult and contributes to the provision of gender-affirming care often being discretionary, and dependent on individual interest, effort and networks. This can lead to healthcare providers having to spend considerable time advocating for access to gender-affirming care from other health professionals and health institutions. Without clear guidelines, transgender individuals may be excluded from public health facilities. A lack of guidelines may also create situations where different practitioners have different views on what constitutes gender-affirming care, which can be problematic when a client moves from one practitioner to another.

Lastly, the study considered the challenges to the provision of gender-affirming care in South Africa. Healthcare providers noted a lack of training in gender-affirming care in their respective specialisations, with transgender-health-related topics largely absent from health education curricula. Resource and funding constraints impeded the provision of services in the public health system. Lack of coverage in the private health system for gender-affirming

hormone therapy and surgeries placed additional demands on the public health system (Spencer et al., 2017).

These findings are similar to some of the challenges previously noted by the Transgender Clinic at GSH. In particular it was noted that limited undergraduate and postgraduate training in transgender issues resulted in few healthcare providers being competent in providing gender-affirming care across the specialisations (psychiatry, endocrinology and surgery). Limited availability of clinical time for the provision of transgender care resulted in waiting times of 2-3 months for both mental health and endocrinology review. GSH had surgical waiting times of up to 15-20 years with only two to three gender-affirming surgeries being performed annually as a result of limited surgical theatre time. The centralisation of specialist gender affirming services at GSH resulted in provincial patients being severely disadvantaged in receiving gender-affirming care. The authors also highlighted that a lack of research time limited the development of evidence-based interventions in gender-affirming care in the local context (Marais et al., 2018; Wilson et al., 2014).

A study conducted in KwaZulu-Natal examined the knowledge, attitudes and practices of healthcare workers related to the treatment and care of transgender patients (Luvuno et al., 2017). It noted that there was a lack of knowledge and training with respect to transgender health amongst the healthcare workers and this led to anxiety and avoidance of managing transgender individuals. Due to limited engagement with transgender people the healthcare workers did not feel they were able to develop comfort, experience and expertise in transgender healthcare. In some cases there was hostility when managing transgender patients resulting in victim-blaming, verbal abuse and alienation. There was a lack of data on the number of transgender individuals attending the clinics, which led to lack of review/evaluation of services provided (Luvuno et al., 2017).

A study assessing clinician competencies amongst mental healthcare providers in the United States - with respect to working with transgender individuals - noted that in keeping with other research, many clinicians expressed unfamiliarity and lack of training with transgender issues (Whitman & Han, 2017). This resulted in the perpetuation of psychological distress in transgender individuals caused by lack of adequate and gender-affirming resources. The study highlighted the importance of clinicians demonstrating increased levels of introspection, self-awareness and insight into their own biases, and how these biases may manifest on

therapeutic settings and relationships, so as to avoid perpetuating the discrimination and stigma faced by transgender individuals.

Considering the disparities in healthcare due to multiple factors and the increased vulnerability of the transgender population to co-occurring mental health conditions, it is important to move towards the provision of gender-affirming care.

Reisner, S.L., Radix, A., & Deutsch, M.B. (2016) conceptualise gender affirmation as multidimensional with at least 4 core constructs:

*Social* (choice of name and pronoun, interpersonal and institutional acknowledgement and recognition), *psychological* (internal felt sense of self-actualization, validation of gendered self, internalised transphobia), *medical* (pubertal blockers, hormones, surgery, other body modification), and *legal* (legal name change, legal change of gender marker designation) (p.236)

The GSH Transgender Unit aims to follow the practice guidelines, standard management and professional consensus outlined by the WPATH SOC 7. The WPATH is an international, non-profit, interdisciplinary professional and educational organisation that promotes evidence-based care, education, research, advocacy, public policy, and respect for transgender health. WPATH recognises that health is dependent upon not only good clinical care but also social and political climates, and is promoted through public policies and legal reforms that promote tolerance and equity for gender and sexual diversity. The Standards of Care are flexible, acknowledging that clinical departures may occur as a result of individual patients' needs, cultural context, evolving evidence based treatments and resource availability (Coleman et al., 2012; World Professional Association for Transgender Health, 2019).

The first version of the Standards of Care was published in 1979. The current version, WPATH SOC 7 was published in 2011 it outlines therapeutic approaches available for gender dysphoria, while remaining flexible in order to meet the diverse healthcare needs of transgender individuals. There is recognition that while many individuals may need both hormone and surgical interventions to alleviate their gender dysphoria, there are others who may only need one of these options and some that need neither (Coleman et al., 2012).

WPATH SOC 7 addresses the competencies required of the mental health professionals working with individuals with gender dysphoria. These competencies and responsibilities include the following: recognised qualifications and accreditation; the ability to assess for gender dysphoria; provide psychoeducation regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria; to assess, diagnose and manage any co-occurring mental health concerns; to assess, if applicable, eligibility, and prepare and refer for hormone therapy and/or surgery; to educate and advocate on behalf of their client within their community; provide information and referral for peer support; and support the client in making changes to their identity documents (Coleman et al., 2012).

WPATH SOC 7 addresses the tasks related to psychotherapy, specifically noting that although psychotherapy is not required, it is highly recommended. The general goal of psychotherapy is to find a way to maximise the individual's overall psychological well-being, quality of life, and self-fulfilment. Psychotherapy can be used to assist a transgender individual with clarifying and exploring gender identity and role, addressing the impact of stigma and minority stress on one's mental health, facilitate the coming out process, and facilitate communication with family members and others about their gender identity and treatment decisions (Coleman et al., 2012).

WPATH SOC 7 provides guidelines for gender-affirming hormone therapy: the competencies required, and responsibilities of, hormone-prescribing physicians; the clinical situations and criteria for hormone therapy; the informed consent model; the physical effects of hormone therapy; the risks of hormone therapy; hormone therapy regimens; and clinical monitoring during hormone therapy (Coleman et al., 2012).

WPATH SOC 7 outlines the surgical treatment of patients with gender dysphoria: the competencies required of the surgeons involved; the different techniques and complications; the criteria for breast/chest surgery and genital surgery; and post-operative care and follow-up (Coleman et al., 2012).

WPATH SOC 7 also addresses reproductive health, fertility services, voice and communication therapy, and lifelong preventive and primary care (Coleman et al., 2012).

In South Africa transgender individuals have the same legal rights as cisgendered individuals. The Alteration of Sex Description and Sex Status Act No. 49 of 2003 (2003) makes provision for the amendment of a person's gender in the population registry and consequently updating their identity document and passport. Despite this, transgender individuals face multiple challenges in South Africa and require local, evidence based affirming care. In 2019 a group of interested local clinicians were granted resources by the Southern African HIV Clinicians Society to start collaboration on developing South African Guidelines for Transgender and Gender Non-conforming individuals. A better understanding of the GSH Transgender Service is critical in achieving these objectives.

## **Aims**

The primary aim of this study was to perform an audit of the clinical services provided by the multidisciplinary team at the GSH Transgender Clinic. This audit aimed to assess the care provided against the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) so that quality and effectiveness of care could be enhanced.

## **Objectives**

1. To assess whether the GSH Transgender Clinic complies with WPATH SOC 7 guidelines since the introduction of a standardised history-taking and assessment booklet in September 2018.
2. To identify areas of excellence within the service.
3. To identify areas within the service that require improvement.
4. To assess waiting times for initial assessments by the mental health service since the addition of a second monthly Transgender Clinic from May 2017.
5. To assess waiting times for initial assessments by endocrinology and surgical services.
6. To assess the distance transgender individuals travel to access transgender services.
7. To contribute to the body of knowledge regarding transgender healthcare services within South Africa, which may inform the development of South African guidelines for transgender healthcare services.
8. A description of the demographic and clinical characteristics of attendees.

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## **CHAPTER 2: PUBLICATION READY MANUSCRIPT**

### **Prepared for the International Journal of Transgender Health**

(Taylor & Francis' Layout Guide, Word Template for journal articles and Standard Reference Style Guide in use: Times New Roman, 12-point font, double line spacing, 2.5cm margin, American spelling style and American Psychological Association Seventh Edition referencing style)

### **A Clinical Audit of the Transgender Unit at Groote Schuur**

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The authors declare that they have no conflict of interest.

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The authors have nothing to disclose.

## **A Clinical Audit of the Transgender Unit at Groote Schuur Hospital**

### **Abstract**

**Background:** The Transgender Clinic at Groote Schuur Hospital (GSH) - a large government funded academic hospital in Cape Town, South Africa - assists with the mental health assessment of transgender individuals and facilitates access to gender affirming services, such as hormone therapy, plastic and reconstructive surgery, psychosocial, and legal services.

**Objectives:** This clinical audit aimed to gain a clearer understanding of the service and areas within the service which could be improved. To this end the general compliance of the clinical services of the multidisciplinary team (MDT) as recommended by the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) was assessed. In addition, an analysis of the demographic and clinical characteristics of individuals attending the clinic and a review of waiting times and distance travelled to attend the clinic, was conducted.

**Methods:** The study was a clinical audit without a repeat data collection cycle. Participants included the MDT members working at GSH's Transgender Unit and individuals attending the Transgender Clinic from September 2018 to December 2019 (n = 50). All 11 MDT members were invited to participate in the study and were required to complete a data collection sheet related to their competency and experience. Data collection with respect to services provided, and waiting times for services, was captured from clinician administered standardized history-taking and assessment booklets and patient hospital folder reviews.

**Results:** All members of the MDT who participated met the WPATH SOC 7 competency requirements. The mean age of the individuals attending the GSH Transgender Clinic was 28 years. Forty-eight percent were employed, 36% unemployed and 16% full time scholars. The mean waiting time for an initial appointment with mental health was 75 days, 73 days for endocrinology and 255 days for plastic surgery. Non- attendance at initial appointment was a factor across gender affirming services – 18% mental health service, 20.5% endocrinology and 27% plastic surgery. Forty-two percent of individuals screened positive for a co-occurring mental health condition with a third of these individuals having more than one mental health disorder. Mood and anxiety disorders co-occurred together most frequently. Seventy-five percent of individuals with an untreated or partially treated mental health concern were provided a therapeutic intervention at the time of initial assessment. The introduction of laboratory investigations being performed prior to the initial appointment with endocrinology resulted in a significant improvement in waiting time to the initiation of hormone therapy.

**Conclusion:** WPATH SOC 7 competency requirements were met by the GSH Transgender clinical team. Inconsistencies were found in the documentation of WPATH SOC 7 recommended clinician tasks within the mental health and endocrinology service. This is secondary to the layout of the standardized history taking and assessment booklet, and documentation of certain tasks being clinician dependent. Limited hospital resources and subsequent understaffing, long waiting times for appointments and gender-affirming surgery and lack of access to other services (e.g. fertility services) result in continued barriers to gender-affirming care.

**Keywords:** transgender; clinical audit; South Africa; gender affirming services; mental health; World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7)

## **Introduction:**

Groote Schuur Hospital (GSH) is a large government funded academic hospital in Cape Town, Western Cape, South Africa. Like many countries, South Africa has parallel public and private healthcare systems. The policy of Apartheid resulted in significant inequality in multiple sectors. Roughly 83.6% (49.2 million individuals) of the South African population rely on the government funded public health system (Department Statistics South Africa [StatsSA], 2019a; StatsSA, 2019b). To highlight the disparity, in 2018 the National Budget allocated \$11.7 billion dollars to public health, while \$9.9 billion dollars was paid out to beneficiaries of private “medical aid schemes”, which only provides cover for 16.4% of the population (Council for Medical Schemes, 2019; National Treasury, 2018).

There is currently no accurate prevalence data for transgender individuals worldwide, but estimates suggest a prevalence of 0.3-0.5% (Hughto et al., 2015; Reisner, Poteat, et al., 2016; Winter et al., 2016). With a mid-year population estimate of 58.8 million South Africans, we estimate this would translate to 176,340 to 293,900 transgender South African individuals; and with the Western Cape home to 11.6% of the population we estimate this would translate to 20,532 to 34,221 transgender individuals in the Western Cape (StatsSA, 2019b).

South Africa has put measures in place to protect the rights of transgender individuals. Section 9 of the South African Constitution (1996) acknowledges the right to equality as a fundamental human right and Section 27 states that everyone has the right to have access to healthcare services – including reproductive healthcare. The Promotion of Equality and Prevention of Unfair Discrimination Act (2000) was enacted to give effect to section 9 of the Constitution and offer protection against discrimination based on sex, gender and sexual

orientation. The National Health Act (2003) was enacted to facilitate the right of everyone to access healthcare.

Other Southern African countries – Angola, Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, Zambia and Zimbabwe – guarantee the right to equality and non-discrimination in their constitutions, but the South African Constitution is the only one specifying non-discrimination based on sex, gender and sexual orientation. Only Namibia and South Africa have specific legal provisions to allow for change of gender marker on identity documents – South Africa’s Alteration of Sex Description and Sex Status Act (2003) and Namibia’s Births, Marriages and Deaths Registration Act (1963). In Angola, Botswana, Eswatini, Malawi and Mozambique gender marker change is nominally possible but frequently requirements are unclear or prohibitive (Chiam et al., 2017; Southern Africa Litigation Centre, 2016). South Africa’s Employment Equity Act (1998) and Botswana’s Employment Amendment Act (2010) protects employees from discrimination based on gender identity and sexual orientation in the workplace. Eswatini and Zimbabwe only have legislature protecting individuals from discrimination based on gender identity and not sexual orientation, and Malawi prohibits discrimination based on “sex” or “other status”. Despite there being no law making it illegal to be a transgender individual in any Southern African countries, many individuals face criminal harassment based on laws against consensual sexual activity between same sex couples – Eswatini, Malawi, Namibia, Zambia and Zimbabwe – and public indecency – Botswana, Malawi, Namibia and Zambia (International Lesbian, Gay, Bisexual, Trans and Intersex Association [ILGA], 2019; Mendos, 2019; Southern Africa Litigation Centre, 2016).

GSH has provided psychiatric, endocrine and surgical services to transgender individuals since the 1970s. As of 2009, GSH formalised a Transgender Clinic to provide a more integrated and multidisciplinary approach to transgender healthcare. The Transgender Clinic assists with the assessment of transgender adults (>18 years), which includes a comprehensive assessment of gender dysphoria/gender incongruence, and a general mental health assessment. If necessary the mental health practitioner will then facilitate access to other gender affirming services, such as endocrinology, plastic and reconstructive surgery and psychosocial counselling and support services. The clinic also assists with the application for legally changing gender markers (Department of Psychiatry and Mental Health, 2020; Marais et al., 2018, Wilson et al., 2014).

The multidisciplinary team (MDT) currently involved in the provision of clinical services at the Transgender Clinic comprises of two psychiatrists, a clinical psychologist, a plastic and reconstructive surgeon and an endocrinologist. The initial assessment clinic, run by mental health practitioners, takes place on two mornings a month.

The broader multi-disciplinary Transgender Unit comprises other healthcare professionals, including a counselling psychologist, a family physician, a clinical and general social worker, a general practitioner from the private sector and a representative from the public benefit organization 'Gender DynamiX'. This larger MDT convenes every two months for multi-disciplinary collaboration, establishment of clear referral pathways, co-ordination of services across the platforms, community engagement, complex clinical case discussion and setting of agendas for teaching, training, research and advocacy (Department of Psychiatry and Mental Health, 2020; Marais et al., 2018; Wilson et al., 2014).

Wanta and Unger (2017) reviewed transgender literature published from January 1950 to June 2016, noting a paucity of published data on the care of transgender patients and outcomes related care. The study also noted a lack of published data addressing the provision and evaluation of gender-affirming healthcare services and the outcomes of care.

The literature repeatedly highlights the stigma, discrimination, prejudice and abuse that transgender individuals experience on a daily basis from other individuals, groups, organizations and broader society. This may result in transgender individuals experiencing minority stress, as well as social, educational, economic and legal marginalization and impaired social and emotional well-being (Blondeel et al., 2016; Hughto et al., 2015; Institute of Medicine, 2011; James et al., 2016; Thomas et al., 2017; Winter et al., 2016; Wylie et al., 2016).

Poor policy and health planning and poor access to health services (gender-affirming and general healthcare) for a multitude of reasons, including, but not restricted to, distance to travel to see healthcare providers, lack of infrastructure, limited access to gender-affirming services, lack of health insurance, cost of care, lack of provider skills in gender-affirming care, discrimination and/or refusal of care of transgender individuals by healthcare providers, further compromise health and well-being (Blondeel et al., 2016; Byne et al., 2018; Hughto et al., 2015; Institute of Medicine, 2011; James et al., 2016; Reed et al., 2016; Reisner et al., 2016; Stroumsa, 2014; Winter et al., 2016; World Health Organization, 2015).

A 2019 research report addressing the realities of violence, mental health and access to healthcare related to sexual orientation and gender identity and expression in South Africa, of which 232 of 832 participants were gender minority individuals (transgender/gender non-

conforming/non-binary), also raised awareness of the broad ranging negative consequences of stigma, prejudice, marginalization and discrimination on the health of gender minority individuals in South Africa. Gender minority populations showed higher levels of co-occurring mental health conditions, experienced higher levels of violence and more barriers when accessing healthcare services (Müller et al., 2019).

The report draws attention to the marked disparities between the under-resourced and over-burdened parallel health systems in South Africa. As noted, the vast majority of South Africans rely on the public health system, which likely exacerbates the barriers to healthcare experienced by gender minority participants (StatsSA, 2019a; StatsSA, 2019b; Müller et al., 2019). Only 56.5% of gender minority participants had access to hormone therapy and 38.1% had access to surgical procedures. Participants were significantly more likely to report using hormones if they had medical aid/health insurance. The report stated that 72.8% of gender minority participants described being treated with less respect by a healthcare provider, with 16.6% reporting that it happens often; 47.8% of gender minority participants reported being called names or insulted in a health facility, with 11.4% reporting that it happens often; and 39.2% of gender minority participants reported being denied healthcare because of their gender identity and expression, with 10.5% reporting that it happened often (Müller et al., 2019).

A study addressing the provision of gender-affirming care in South Africa reported that despite the fact that the South African National Health Act (2003) is intended to be one of the legislative measures to facilitate the realization of the right of everyone to access healthcare services, this unfortunately is not the case, with gender-affirming services being

severely limited and unequal, and no national policies or guidelines being currently available (Spencer et al., 2017).

Six public hospitals provide gender-affirming care to various degrees across South Africa, of note, all of these hospitals are based in urban centers in three out of South Africa's nine provinces. Only three hospitals (Chris Hani Baragwaneth Hospital in Soweto, Gauteng; Groote Schuur Hospital in Cape Town, Western Cape; and Steve Biko Academic Hospital in Pretoria, Gauteng) provide endocrinology, psychiatric and surgical services at the same facility (Spencer et al., 2017). Individuals based in rural settings, and in the other six provinces of South Africa, often have to travel far to access gender-affirming care from these hospitals. Psychosocial support, hormone therapy and gender-affirming surgical procedures are available in the private sector but are generally not covered by medical aid/health insurance (Spencer et al., 2017).

At present there are no South African national guidelines for gender-affirming care. According to Spencer et al. (2017) the lack of national guidelines makes advocating for financial coverage for contextually appropriate and available resources and services difficult and contributes to the provision of gender-affirming care often being discretionary, and dependent on individual interest, effort and networks. This can lead to healthcare providers having to spend considerable time advocating for access to gender-affirming care from other health professionals and health institutions. Without clear guidelines, transgender individuals may be excluded from public health facilities. A lack of guidelines may also create situations where different practitioners have different views on what constitutes gender-affirming care, which can be problematic when a client moves from one practitioner to another.

Lastly, the study considered challenges to the provision of gender-affirming care in South Africa. Healthcare providers noted a lack of training in gender-affirming care in their respective specializations, with transgender-health-related topics largely absent from health education curricula. Resource and funding constraints impeded the provision of services in the public health system. Lack of coverage in the private health system for gender-affirming hormone therapy and surgeries placed additional demands on the public health system (Spencer et al., 2017).

These findings are similar to some of the challenges previously noted by the Transgender Clinic at GSH. In particular it was noted that limited undergraduate and postgraduate training in transgender issues resulted in few healthcare providers being competent in providing gender-affirming care across the specializations (psychiatry, endocrinology and surgery). Limited availability of clinical time for the provision of transgender care resulted in waiting times of 2-3 months for both mental health and endocrinology review. GSH had surgical waiting times of up to 15-20 years with only two to three gender-affirming surgeries being performed annually as a result of limited surgical theatre time. The centralization of specialist gender-affirming services at GSH resulted in provincial patients being severely disadvantaged in receiving gender-affirming care. The authors also highlighted that a lack of research limited the development of evidence-based interventions in gender-affirming care in the local context (Marais et al., 2018; Wilson et al., 2014).

The GSH Transgender Clinic aims to follow the practice guidelines, standard management and professional consensus outlined by the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual,

Transgender, and Gender Nonconforming People (WPATH SOC 7). The WPATH is an international, non-profit, interdisciplinary professional and educational organization that promotes evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The Standards of Care are flexible, acknowledging that clinical departures may occur as a result of individual patients' needs, cultural context, evolving evidence based treatments and resource availability (Coleman et al., 2012; World Professional Association for Transgender Health, 2019).

The first version of the Standards of Care was published in 1979. The current version, WPATH SOC 7 was published in 2011 and outlines therapeutic approaches available for gender dysphoria, while remaining flexible in order to meet the diverse healthcare needs of transgender individuals. There is recognition that while many individuals may need both hormone and surgical interventions to alleviate their gender dysphoria, there are others who may only need one of these options and some that need neither (Coleman et al., 2012).

WPATH SOC 7 addresses the competencies and responsibilities required of the mental health professionals. These competencies and responsibilities include the following: recognized qualifications and accreditation; the ability to assess for gender dysphoria; provide psychoeducation regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria; to assess, diagnose and manage any co-occurring mental health concerns; to assess, if applicable, eligibility, and prepare and refer for hormone therapy and/or surgery; to educate and advocate on behalf of their client within their community; provide information and referral for peer support; and support the client in making changes to their identity documents (Coleman et al., 2012).

WPATH SOC 7 provides guidelines for gender-affirming hormone therapy: the competencies required, and responsibilities of, hormone-prescribing physicians; the clinical situations and criteria for hormone therapy; the informed consent model; the physical effects of hormone therapy; the risks of hormone therapy; hormone therapy regimens; and clinical monitoring during hormone therapy (Coleman et al., 2012).

WPATH SOC 7 outlines the surgical treatment of patients with gender dysphoria: the competencies required of the surgeons involved; the different techniques and complications; the criteria for breast/chest surgery and genital surgery; and post-operative care and follow-up (Coleman et al., 2012).

In South Africa transgender individuals have the same rights as cisgendered individuals. Despite this, transgender individuals face multiple challenges and require local, evidence based affirming care. In 2019 a group of interested local clinicians were granted resources by the Southern African HIV Clinicians Society to start collaboration on developing South African Guidelines for Transgender and Gender Non-conforming individuals. A better understanding of the GSH Transgender Service, and the barriers to care faced by transgender individuals, is critical in achieving these objectives.

## **Aims**

This clinical audit aimed to gain a clearer understanding of the service and areas within the service which could be improved. To this end the general compliance of the clinical services of the multidisciplinary team (MDT) as recommended by the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) was assessed. In addition,

an analysis of the demographic and clinical characteristics of individuals attending the clinic and a review of waiting times and distance travelled to attend the clinic, was conducted.

## **Methods**

### ***Study Setting***

The Transgender Clinic at GSH is coordinated by the Department of Psychiatry and Mental Health at the University of Cape Town, with a mandate to provide an integrated and comprehensive package of care for the transgender individual based on international evidence-based standards of care, and to facilitate follow-up support in the local community and beyond.

### ***Research Design***

The study was a clinical audit without a repeat data collection cycle. The main stages of the clinical audit process were: selecting a topic and informing the MDT of the purpose of the study, selecting evidence-based standards (WPATH SOC 7), collecting and analyzing data to measure performance against selected standards, presenting results to the MDT, discussing recommendations and implementing changes.

### ***Study Participants***

The MDT members involved in the provision of clinical services at GSH's Transgender Clinic, the broader multi-disciplinary Transgender Unit, and individuals attending the Clinic from September 2018 to December 2019 (50 individuals). This time frame was selected, as the clinic introduced a standardized history-taking and assessment booklet in September 2018. All individuals who attended the clinic during this period for initial mental health assessment were included in the study. All MDT members who consented to being included

in the study and completed the questionnaire were included in the study. MDT members who did not consent to participating were excluded.

### ***Ethics Approval***

This study was performed in accordance with the principals of the 1964 Helsinki declaration and was approved by the University of Cape Town's Human Research Ethics Committee. Approval to conduct the study was also granted by GSH and the University of Cape Town Faculty of Health Sciences.

### ***Data Collection***

Data collection with respect to the MDT members working at GSH's Transgender Clinic was captured from a data collection sheet completed by each team member. All members of the MDT had the purpose of the audit, and their role in it, explained prior to a request for voluntary participation. Informed consent was obtained from members of the MDT participating in the audit. Information captured related to the competency and experience of the individual MDT member as outlined by the WPATH SOC 7 guidelines.

Each MDT member of the Transgender Clinic was asked to document their qualifications and registration with relevant statutory bodies; as well as their years of experience within their discipline and years of experience providing gender-affirming care. All MDT members were also asked to document whether they were engaged in continuing education in the field.

Mental health professionals were asked to subjectively rate their knowledge, on a scale of zero to ten (0 = none, 5 = fair, 10 = excellent), of gender-nonconforming identities and expressions and the assessment and treatment of gender dysphoria, the use of the Diagnostic Statistical Manual of Mental Disorders 5<sup>th</sup> edition (DSM-5) and International Classification of

Diseases (ICD) for diagnostic purposes, the ability to recognize and diagnose gender dysphoria and coexisting mental health concerns, and the provision of psychotherapy or counselling.

Hormone-prescribing physicians/endocrinologists were asked to subjectively rate their knowledge of feminizing/masculinizing medications and their competencies with regards to the initial evaluation of a transgender client, the provision of psychoeducation on expected effects of feminizing/masculinizing medications, and the provision of ongoing medical monitoring on a scale of zero to ten (0 = none, 5 = fair, 10 = excellent).

MDT members of the Transgender Clinic, as well as the larger MDT of the Transgender Unit, were also asked to provide additional comments or recommendations for the improvement of the service.

Data with respect to demographics, clinical characteristics, services and waiting times was captured from clinician administered Mental Health standardized history-taking and assessment booklets and patient hospital folder reviews.

Data collection sheets containing any personal identifiable information of the MDT member was only kept for the length of time required to input the raw data in an anonymized fashion into the password protected electronic database – after which it was destroyed. Data concerning individuals attending the Transgender Clinic was anonymized and hospital folder numbers were replaced with research numbers, therefore maintaining privacy and confidentiality of the individuals that attend the Clinic.

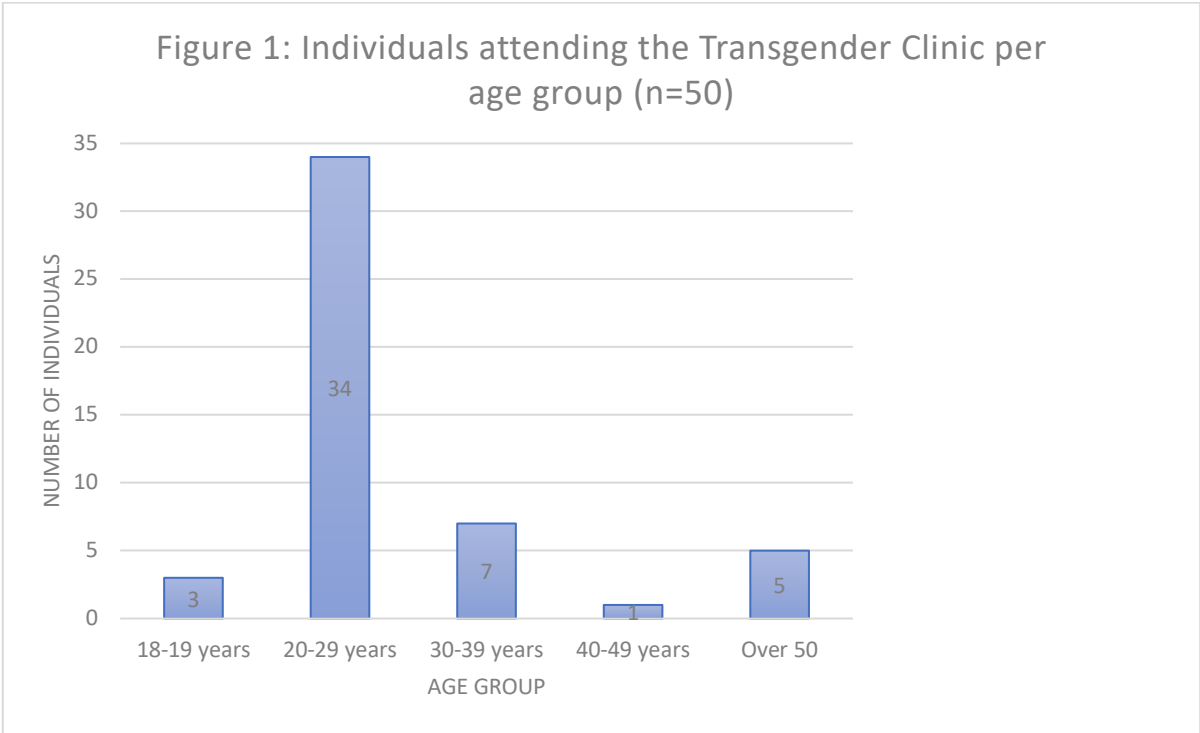
**Data Analysis**

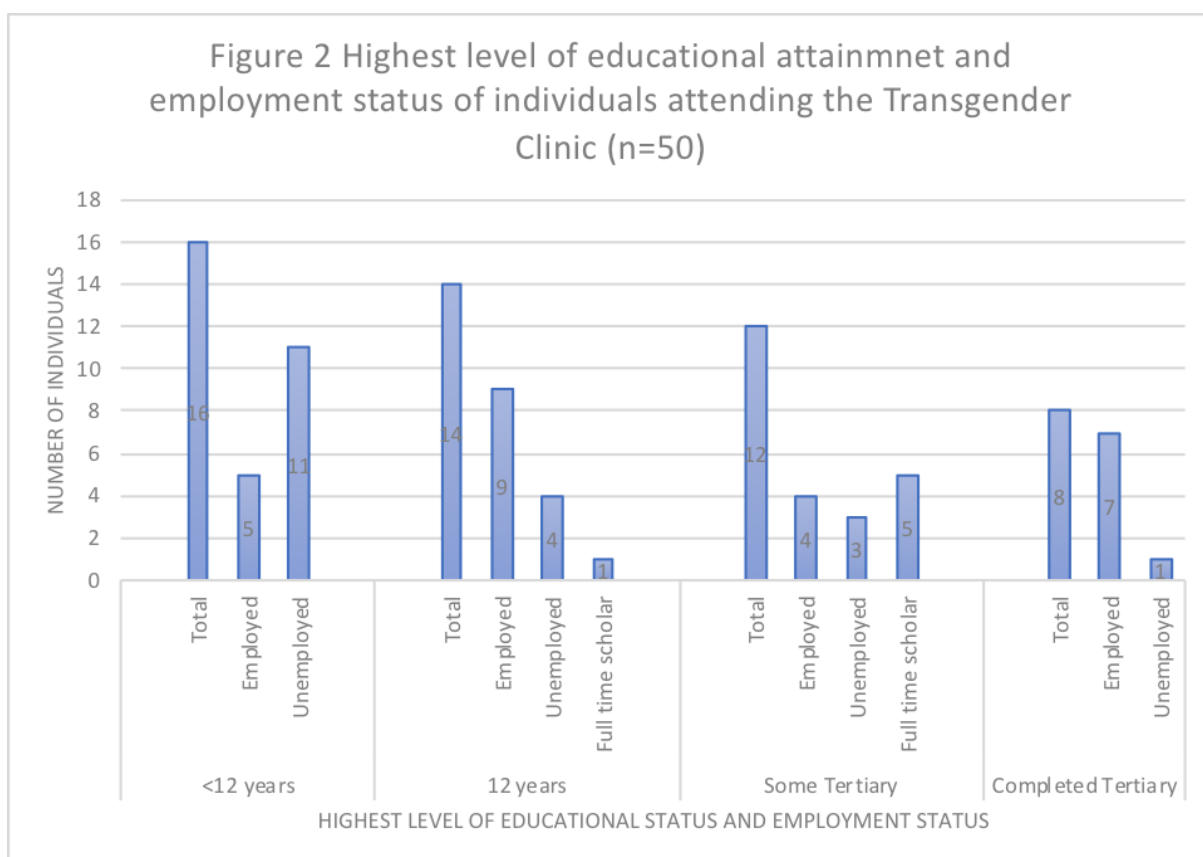
Given the purely descriptive nature of this audit, no inferential statistical analyses were performed. Compliance with clinical audit criteria was calculated using percentages. In order to describe waiting times and distance travelled to attend the Transgender Clinic, descriptive statistics were generated in the form of means and ranges.

**Results**

**Demographics**

A total of fifty new patients were seen at the service from September 2018 to December 2019. Individuals attending the Transgender Clinic ranged in age from 18 years to 54 years old (mean age = 28 years). Figure 1 illustrates the age and Figure 2 illustrates their highest level of educational attainment and employment status. Thirty-eight percent of attendees were unemployed. Sixty-four percent of attendees were single, 20% in a relationship, 6% married, 4% separated/divorced and 2% widowed.





### ***Mental Health Referral Process***

Sixty-one individuals were given appointments for an initial assessment from September 2018 to December 2019 – 18% did not attend. The mean waiting time for initial appointment was 75 days (range 2 and 176 days). Figure 3 illustrates the length of time between initial referral to the mental health service and initial appointment with the mental health service, and the length of time between initial referral to the endocrinology service and initial appointment with the endocrinology service. The majority (86%) of attendees were seen within 120 days of referral. Figure 4 illustrates the distance travelled and employment status of attendees. The proportion of individuals who were unemployed increased as the distance to travel to access transgender services increased, with the exception of the over 300km distance category.

Figure 3 Length of time between referral and initial appointment with Mental Health service (n=50) and Endocrinology service (n=38)

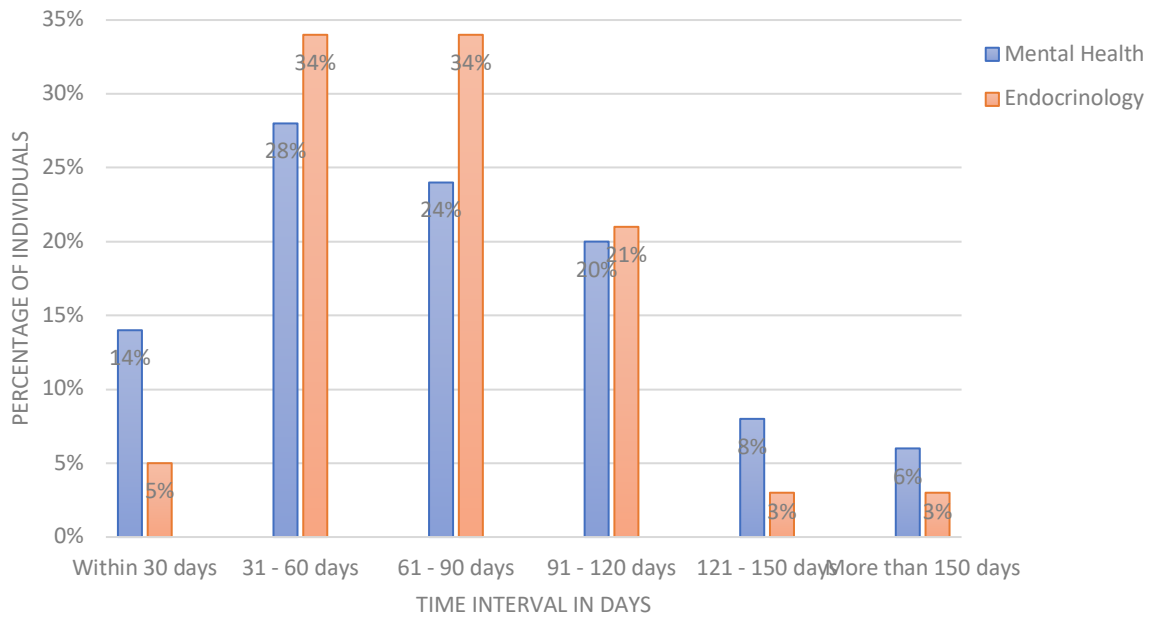
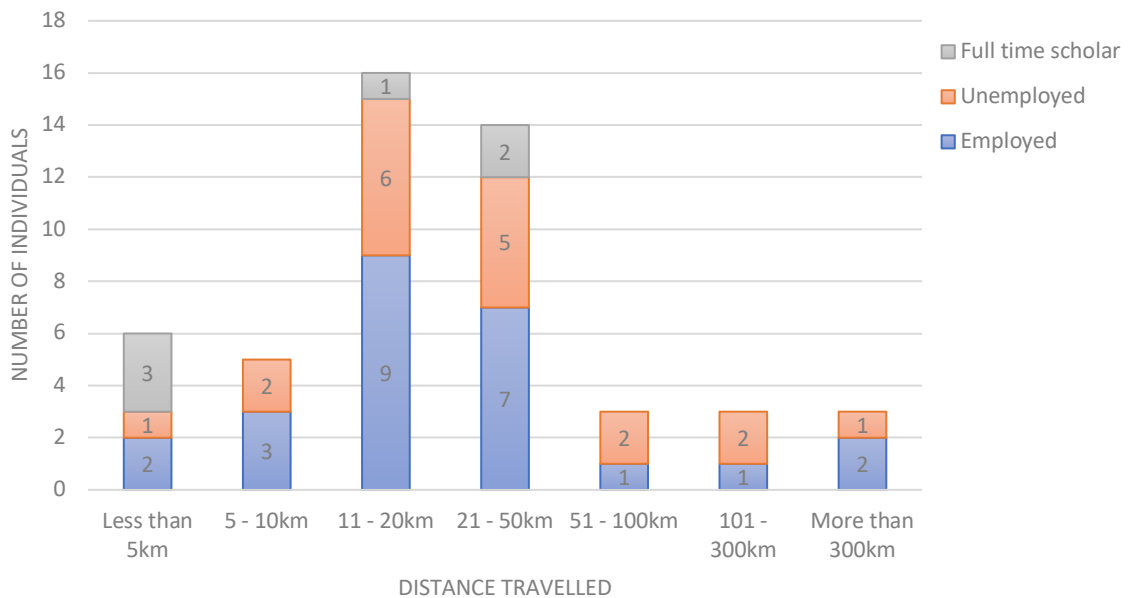


Figure 4 Distance travelled to access transgender services and employment status (n=50)



Regarding the origin of referrals, 58% of attendees were referred by the *Triangle Project* - a Cape Town based LGBTQI+ civil society organization, 26% by public medical facilities, 10% by private mental health practitioners (psychologists, psychiatrists), 4% by private general practitioners, and 2% were self-referred.

### ***Competency of Mental Health Professionals***

The Mental Health team involved in the initial assessment of individuals attending the Transgender Clinic comprises of two psychiatrists and one clinical psychologist. All three have accredited degrees and are registered with the Health Professions Council of South Africa. Two members of the team have been working with transgender individuals at GSH since the clinic's inception in 2009. The third member had less than 5 years of experience with transgender care.

For all three professionals self-rating of competency on a scale from zero to ten (0 = none, 5 = fair, 10 = excellent) with respect to using the DSM 5 for diagnostic purposes ranged between seven and nine; the ability to recognize and diagnose co-occurring mental health concerns and distinguish from gender dysphoria ranged between eight and ten; knowledge about gender nonconforming identities and expressions ranged between eight and ten; and competency with respect to assessment and treatment of gender dysphoria ranged between seven and ten.

All three professionals had received documented supervised training in psychotherapy, and self-rated competency in providing psychotherapy ranged between seven and nine. All three are exposed to continued education in the assessment and treatment of gender dysphoria in the form of attending relevant professional meetings, including the

Transgender Unit MDT meeting held every two months that includes peer consultation and supervision. As well as attendance of workshops, seminars, conferences and participating in research related to gender nonconformity and gender dysphoria.

***Tasks of Mental Health Professionals defined by the WPATH SOC 7: Assess Gender Dysphoria***

Gender identity was screened in 100% of attendees, with 62% identifying as transfemale, 28% identifying as transmale and 10% as non-binary. All 50 attendees were screened for - and met - DSM 5 criteria for gender dysphoria. History and development of gender dysphoria was screened for in 42 attendees. The mean age of onset of gender dysphoria was 10 years (range 3 and 28 years old). The features of gender dysphoria were not secondary to or better accounted for by other diagnoses in any of the individuals.

Forty individuals were screened for stigmatization, discrimination, victimization, negative self-concept, school drop-out and economic marginalization as a result of their gender identity. Table 3 illustrates the proportion of screened individuals (n=40) experiencing stigmatization, discrimination, victimization, negative self-concept, school drop-out and economic marginalization. Stigmatization was highest in transmales (44.4%). Discrimination, negative self-concept and victimization was highest in non-binary individuals (100%; 50%; 75%). School dropout and economic marginalization was highest in transfemales (33.3% and 22.2%).

Table 1 Proportion of screened individuals experiencing stigmatization, discrimination, victimization, negative self-concept, school drop-out and economic marginalization

	<b>Stigmatization</b>	<b>Discrimination</b>	<b>Victimization</b>	<b>Negative Self Concept</b>	<b>School Dropout</b>	<b>Economic Marginalization</b>
<b>Total screened (n=40)</b>	37.5% (n=15)	52.5% (n=21)	52.5% (n=21)	22.5% (n=9)	30% (n=12)	17.5% (n=7)
<b>Transmale screened (n=9)</b>	44.4% (n=4)	33.3% (n=3)	55.6% (n=5)	33.3% (n=3)	22.2% (n=2)	11.1% (n=1)
<b>Transfemale screened (n=27)</b>	37% (n=10)	55.6% (n=15)	51.9% (n=14)	14.8% (n=4)	33.3% (n=9)	22.2% (n=6)
<b>Non-binary screened (n=4)</b>	25% (n=1)	100% (n=4)	75% (n=3)	50% (n=2)	25% (n=1)	0% (n=0)

All attendees were screened for availability of support. Eighty-four percent received support from family, 80% from friends, 50% from LGBTQI+ organizations, 20% from colleagues, 16% from partners/spouses, and 10% from religious organizations. Of the 16% of attendees not receiving any support from their families, four identified as transmale, three identified as transfemale and one identified as non-binary, and seven had co-occurring mental health conditions. Three of these individuals cited their family’s religious views as a factor for lack of support.

***Tasks of Mental Health Professionals defined by the WPATH SOC 7: Assess, Diagnose, and Discuss Treatment Options for Co-Existing Mental Health Concerns***

All attendees were screened for mood (depressive, hypomanic/manic), obsessive compulsive related, trauma and stressor related, generalized anxiety and social anxiety symptoms; as well

as substance use, self-harm and suicidal behaviors. Ninety-eight percent were screened for panic disorder, psychotic symptoms, eating disorder symptoms and sexual health concerns. Ninety-six percent were screened for phobias and body dysmorphic disorder features. Eighty percent of attendees were screened for personality traits and 60% were screened for autistic spectrum features. Table 4 illustrates the proportion of attendees who had co-occurring mental health disorders at the time of initial assessment.

Table 2 Proportion of screened individuals with co-occurring mental health disorders at the time of initial Mental Health assessment.

	Total (n=50)	Transmale (n=14)	Transfemale (n=31)	Non-binary (n=5)
Any co-occurring mental health disorders	42% (n=21)	64.3% (n=9)	25.8% (n=8)	80% (n=4)
Major Depressive Disorder	22% (n=11)	21.4% (n=3)	12.9% (n=4)	80% (n=4)
Bipolar Disorder I and II	6% (n=3)	14.3% (n=2)	3.2% (n=1)	0% (n=0)
Generalized Anxiety Disorder	10% (n=5)	21.4% (n=3)	0% (n=0)	40% (n=2)
Social Anxiety Disorder	10% (n=5)	21.4% (n=3)	3.2% (n=1)	20% (n=1)
Obsessive Compulsive and Related Disorders	4% (n=2)	7.1% (n=1)	0% (n=0)	20% (n=1)

Trauma and Stressor Related Disorders	6% (n=3)	14.3% (n=2)	3.2% (n=1)	0% (n=0)
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Forty-two percent of attendees (n=21) had a co-occurring mental health and a third of these individuals (n=7) had more than one mental health disorder. The most common mental health disorder was depressive disorder (22%; n=11). Depression was highest in non-binary individuals (80%). Mood and anxiety disorders co-occurred together in six of the seven attendees with more than one mental health disorder. Of the eight individuals who were not receiving any form of treatment for their co-occurring mental health disorder, three were started on psychotropic medication and given psychiatric follow up dates with the Transgender Clinic, one was referred for both psychotherapy and psychiatric review for potential initiation of psychotropics, and one of the individuals with autistic spectrum disorder features was referred for further assessment.

All attendees were screened for self-harm and suicidal behaviour at initial assessment; 10% reported a history of self-harming behaviour, 14% suicidal behaviour, and 20% reported a history of both self-harming and suicidal behaviour.

All attendees were screened for substance use and 75% of attendees (n=37) reported current substance use. The most frequently used substance was alcohol (64%, n=32), however tobacco was the most frequently daily used substance (34%; n=17). Figure 5 and 6 illustrates self-reported substance use and the self-reported frequency of use.

Figure 5 Self-reported substance use (n=50)

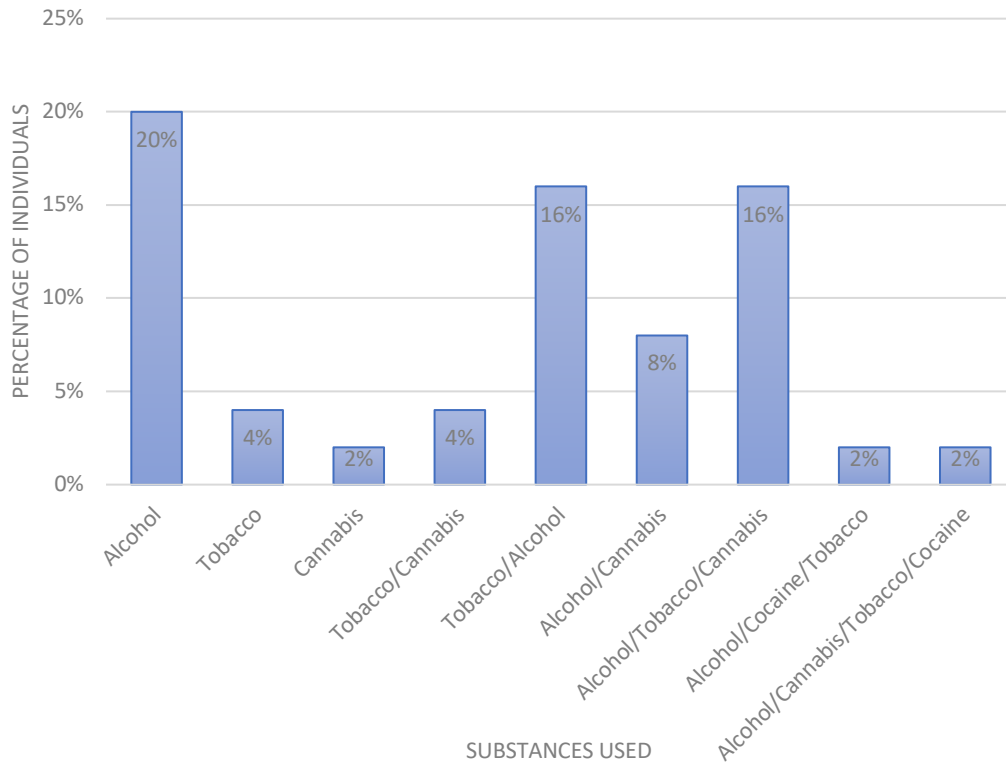
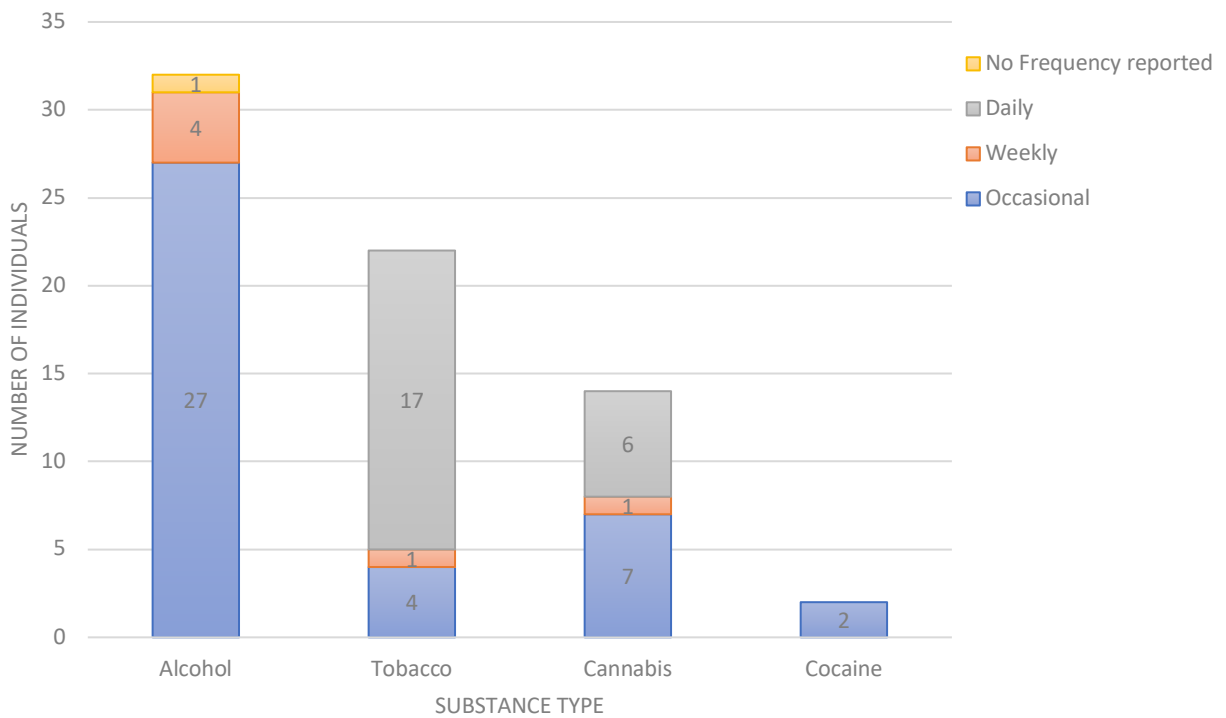


Figure 6 Self-reported frequency of substance use (n=37)



Of the attendees screened for sexual abuse or trauma, 38% reported having a history of being sexually abused or experiencing sexual trauma. Only the 66% of attendees were screened for intimate partner violence, however 18.2% of those screened reported a history of experiencing intimate partner violence.

The reproductive wishes of all 50 attendees were ascertained, with 54% noting no desire for children, 18% desiring biological children, 12% wishing to adopt and 10% were unsure whether they wanted children or not. Six percent of attendees desired children, but a preference for biological or adopted children was not specified. Of the 9 individuals indicating a desire to have biological children only two were documented as attending the Andrology Clinic at GSH for sperm preservation prior starting hormone therapy.

### ***Competency of Hormone-Prescribing Physicians***

Initial assessment of individuals attending Endocrinology is frequently performed by physicians sub-specializing in the specialty, with all transgender individuals being reviewed by a qualified Endocrinologist. The Consultant Endocrinologist who forms part of the Transgender Clinic MDT has over 20 years of experience in providing transgender related care. Self-rating of competency on a scale from zero to ten (0=none, 5=fair, 10=excellent) with respect to performing an initial evaluation of a transgender client, knowledge regarding the different feminizing/masculinizing medications, counselling a transgender client on the expected effects of feminizing/masculinizing medications, and the provision of ongoing medical monitoring ranged between eight and nine.

### ***WPATH SOC 7: Referral for Hormone Therapy and Responsibilities of Hormone-Prescribing Physicians***

Of the 50 attendees screened for hormone referral, two declined hormone therapy and four chose to pursue hormone therapy in the private healthcare sector. Individuals are referred to GSH Endocrinology by the GSH Mental Health Professional with a New Patient Assessment form. This documents the presenting gender concern, the individual's transition aim/expectation, the evaluation of gender dysphoria and the general psychiatric evaluation. It also notes the eligibility for a referral to Endocrine which includes the following: fulfilment of DSM 5 criteria for gender dysphoria, exclusion of a psychiatric differential diagnosis, confirmation that the individual is mentally stable or that a mental health condition is controlled on therapy; and confirmation that the individual has the capacity to give informed consent.

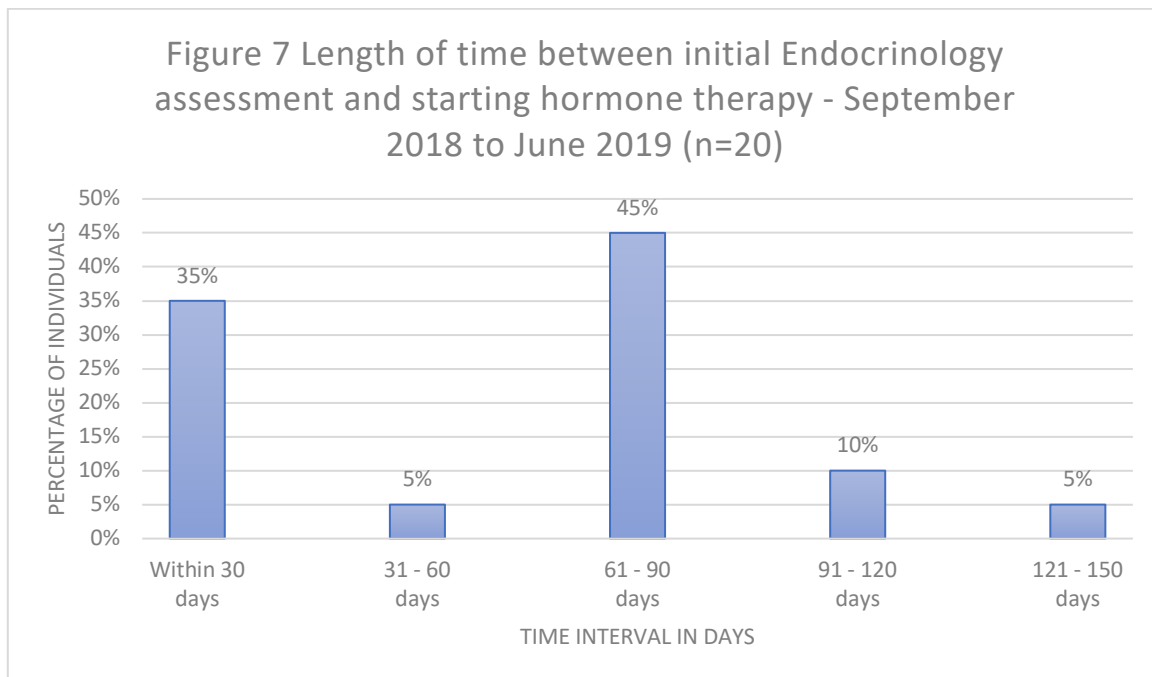
Of the 44 attendees referred to the GSH Endocrinology Outpatient Clinic for assessment, 20.5% did not attend their appointment. Documentation of the date of referral to Endocrinology was not available in all cases. Of individuals whose dates of referral were available for audit purposes (n=38), the mean waiting time for an appointment was 73 days (range 26 to 161 days). Roughly three quarters of attendees were seen by Endocrinology within 3 months of the referral being made by the Mental Health team. Figure 3 illustrates the length of time between referral and initial appointment with Endocrinology service.

Table 3 addresses the tasks, outlined by the WPATH SOC 7 guidelines, that should be performed at initial assessment by the hormone prescribing physician and the completeness of these tasks.

Table 3 Completeness of WPATH SOC 7 recommended hormone prescribing physician tasks (n=32)

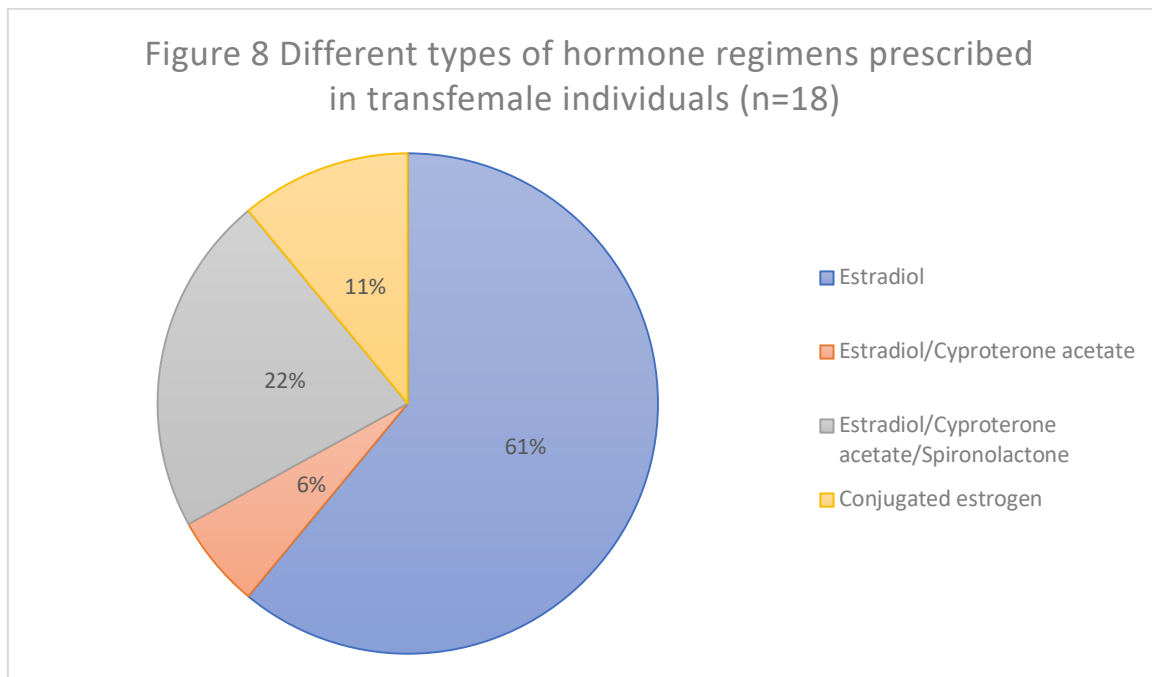
	Documented	Not documented
Physical transition goals discussed	56%	44%
Review of support structures	81%	19%
Health history obtained and physical examination performed	100%	0%
Relevant laboratory investigations performed	100%	0%
Effects of feminizing/masculinizing medications discussed, including adverse effects	81%	18%
Fertility options discussed	84%	16%
Capacity to consent for hormone therapy	100%	0%

Attendees referred from Mental Health to Endocrinology from September 2018 to June 2019 (n=20) had initial laboratory investigations done at the time of or following Endocrinology review. During that time the mean waiting period was 59 days between initial Endocrinology assessment and starting hormone therapy ( longest time 125 days). Figure 7 illustrates the length of time in days between initial Endocrinology assessment and starting hormone therapy (September 2018 to June 2019).



From July 2019 the referral process changed and attendees were sent for laboratory investigations prior to the first consultation with Endocrinology. Of the eight attendees seen by Endocrinology following this change, seven were started on hormone therapy on the day of Endocrinology review, and only one individual started hormone therapy 28 days later.

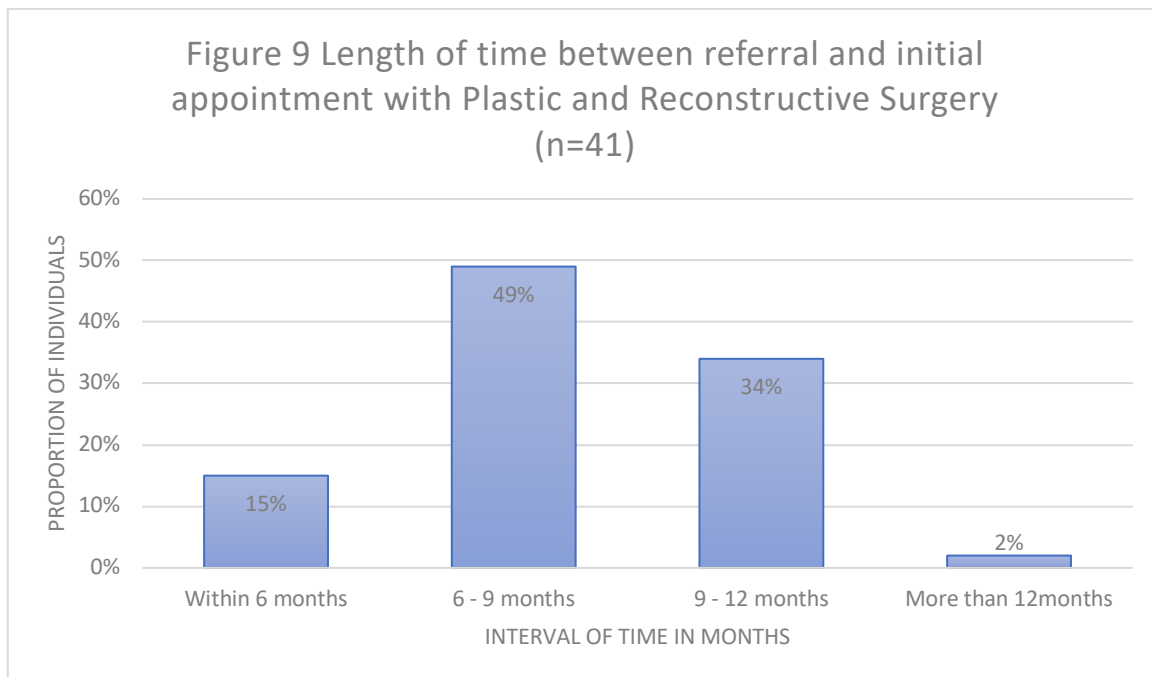
Of the eight transmale individuals seen for initiation of hormone therapy, seven were started on depo testosterone and one on a combination of testosterone and medroxyprogesterone acetate. Figure 8 illustrates the different types of hormone regimens prescribed to the 18 transfemale individuals who were started on treatment. Of the two individuals identifying as non-binary and requesting hormone therapy, one received estradiol and the other testosterone.



Of all the attendees in the study twenty-eight were started on hormone therapy and the mean waiting time between starting hormone therapy and review by endocrinology was 127 days (range 41 to 301 days). One individual had only recently been started on hormone therapy and therefore had not yet received a follow up date.

***WPATH SOC 7: Tasks, Competency and Referral for Surgical Intervention***

Ninety percent of individuals attending the Transgender Clinic requested a referral to the GSH Plastic Surgery Outpatient Clinic for gender affirming surgery assessment. Of the 41 attendees who requested a referral to plastic surgery, and whose referral dates were documented (referral dates were not documented for all referrals), the mean waiting time was 255 days (range 96 to 316 days). Twenty-seven percent of the attendees (n=34), whose plastic surgery assessment dates occurred prior to the end date for data collection, did not attend their appointments. Figure 9 illustrates the length of time between referral and initial appointment with Plastic Surgery.



The WPATH SOC 7 provides a guideline on what tasks should be performed by the surgeon at the preoperative surgical consultation. Due to long surgical waiting list times at GSH the initial assessment by GSH Plastic Surgery is not a preoperative surgical consultation and therefore this audit was unable to assess the completeness of the tasks outlined by WPATH SOC 7 for this domain.

Of the individuals (n=15) who did not attend their Endocrinology or Plastic and Reconstructive Surgery appointments, three did not attend both appointments. The majority (73%) of non-attendees across both disciplines were between 20 and 29 years old. Nine identified as transmale, five as transfemale and one as non-binary. Four lived within 5km of GSH, translating to 73.3% of individuals living outside of a 5km radius of the hospital. Eight of the individuals were employed, five were unemployed and two were full time scholars. The mean distance to travel was 20.6km for the individuals who were unemployed.

## **Discussion**

### ***Assessment of the Provision of Services by the GSH Transgender Clinic Against the WPATH SOC 7 Guidelines***

The literature noted healthcare provider discomfort or inexperience with treating transgender individuals as a barrier to gender-affirming care. This is not the case at the Transgender Clinic, with the Mental Health clinicians having on average ten years experience, and the Endocrinologist having more than 20 years experience, in the provision of gender-affirming care. Subjective competency across a number of domains was above seven for the three Mental Health Clinicians, and above eight for the Consultant Endocrinologist. The requirement of clinicians to self-rate their competencies - and the lack of data pertaining to competency, and years of experience, in the provision of gender-affirming care by endocrinology registrars and the plastic surgeon - were limitations in this study.

Assessment of gender dysphoria and gender identity and the availability of support was documented in all clinic attendees. The proportion of individuals screened for stigmatization, victimization, negative self-concept, school drop-out and economic marginalization was 80%. This may not be an accurate reflection of the Clinic's screening processes but could be attributed to the layout of the standardized history-taking and assessment booklet. The booklet makes provision for one tick box to note if any of the above are present, instead of a yes/no tick box, and so is reliant on the clinician completing the booklet to make a physical note if these risk factors are not present on screening.

A task assigned to mental health professionals by the WPATH SOC 7 is the provision of information regarding the diversity of gender identities and expressions, the various options available to alleviate gender dysphoria and the short- and long-term implications of

any changes in gender role. The standardized history-taking and assessment booklet has no section devoted to this task, which results in under documentation of the performance of these tasks completed by the mental health professionals at initial assessment.

In general, screening for any co-occurring mental health concerns was performed well with most co-occurring mental health concerns being screened in over 95% of individuals. Herman et al. (2009) reported on the lifetime prevalence of mental health disorders in South Africa – the prevalence of major depressive disorder (MDD) was 9.8%, generalized anxiety disorder (GAD) 2.7% and social anxiety disorder (SAD) 2.8%. The proportion of clinic attendees with these conditions was significantly higher, with 22% having a diagnosis of MDD, 10% GAD and 10% SAD. Nine of the 12 attendees with a co-occurring mental health disorder who were not receiving any form of treatment, or continued to have symptoms with treatment, were provided with an intervention plan at initial assessment.

Only assessment/screening of personality traits and autistic spectrum disorder (ASD) features, at 80% and 60% respectively, fell short. These two particular mental health concerns are laid out differently in the standardized history-taking and assessment booklet, with the clinician having to clearly document if any of these features are present; whereas other co-occurring mental health concerns are laid out with a section to note if symptoms are present, not present, weren't screened for and a section to provide more detail if required. This design made it difficult to assess whether these concerns had been screened for or not. A 2015 review noted an over-representation of co-occurring Gender Dysphoria and ASD, and highlighted the subsequent challenges that may occur in diagnosis and treatment when these conditions do co-occur (Van Der Miesen et al., 2015). This emphasizes the need for an improved screening process for ASD features.

Considering the medical risks associated with hormone therapy – increased risk of thromboembolic disease, coronary artery disease, cerebrovascular disease, hypertriglyceridemia, hypertension - and the fact that tobacco use is also a separate cardiovascular and cerebrovascular risk factor, it is concerning that 34% of all attendees (n=50) smoke tobacco daily (Chipkin & Kim, 2017; Hembree et al., 2017; Weinand & Safer, 2015).

Only 66% of attendees were screened for intimate partner violence (IPV) versus 100% screened for sexual abuse or trauma. This is attributable to an earlier print of the standardized history-taking and assessment booklet which did not include a specific section for documenting whether IPV had been experienced; and the fact that the later prints only have one tick box documenting the presence of IPV, versus a yes/no tick box that would provide more clarity on whether IPV is being screened for during the initial assessment.

The New Patient Assessment form that mental health professionals use to refer individuals to Endocrinology includes all the information required for referral as outlined by the WPATH SOC 7. The form also has a section for endocrine and surgical care, however these sections were not utilized as Endocrinology and Plastic Surgery were still using their own separate booklets.

With respect to completeness of WPATH SOC 7 recommended hormone-prescribing physician tasks, health history, physical examination, laboratory and assessment of capacity to consent was documented in all cases. Completeness with respect to discussion of physical transition goals, the effects of feminizing/masculinizing medication and fertility options, as

well as the review of support structure, may have been lower than the other tasks as it is clinician dependent on what was documented in the endocrinology notes.

### ***Barriers to the Provision of Timely and Efficient Transgender Care***

The mean waiting time for initial assessment by the Mental Health service was 75 days, 73 days for Endocrinology and 255 days for Plastic and Reconstructive Surgery. This does not show a reduction in waiting time compared to the Marais et al. (2018) review, which noted a two to three month waiting time for initial appointments with Mental Health and Endocrinology services.

Prior to May 2017 the Transgender Clinic was only running one clinic per month, with on average two new patients booked per month. Since the increase in the number of clinic days to two per month, the average number of new patients booked per month has doubled. The lack of a reduction in waiting times for both Mental Health and Endocrinology services could be attributed to the increase in the number of new patients seen per month by the Mental Health service and subsequent increased referrals to the Endocrinology service.

Another barrier to the provision of transgender healthcare is the distance required to travel to access the service and financial constraints. The proportion of attendees who are unemployed has increased to 44% versus 34.5% as noted in the Marais et al. (2018) review. The unemployment rate of the individuals attending the Transgender Clinic is more than double the Western Cape unemployment rate of 20.9% - highlighting the economic hardships faced by many transgender individuals (StatsSA, 2020). Only 12% of individuals lived within a 5-km radius of Groote Schuur Hospital, with only 5% of individuals who were unemployed living within this 5-km radius.

Distance and cost to travel may impact on non-attendance rates - 18% for initial Mental Health assessment, 20.5% for Endocrinology service and 27% Plastic and Reconstructive Surgical service - across the Transgender Clinic disciplines. The majority of non-attendees (73.3%) lived further than 5-km away from GSH, with 45.5% of these individuals reporting unemployment. High non-attendance rates also impact on waiting times.

Stigmatization, discrimination and victimization compromise health and well-being and contribute towards the barriers faced by transgender individuals accessing transgender care. Roughly half of the individuals screened experienced discrimination and victimization, while 37.5% experienced stigmatization. The Transgender Unit's MDT includes a representative from the public benefit organization Gender DynamiX, and works closely with the Triangle Project, to provide support for transgender individuals faced with stigmatization, discrimination and victimization.

The change in when laboratory investigations were performed, from being performed on the day of initial assessment by Endocrinology to prior to the initial appointment, played an important role in reducing the waiting time between being seen by Endocrinology and starting hormone therapy. The mean waiting time prior to this change was 59 days and following the change the majority of individuals were able to start medication on the same day of assessment.

Due to financial constraints within the public health system only mental health, endocrinological and surgical services are currently available at the GSH Transgender Clinic. Despite individuals requesting fertility, voice and communication therapy and psychological

services, these disciplines are not available to all the individuals requesting them, with only two attendees receiving sperm preservation prior to hormone therapy at GSH and two receiving psychological follow up with the Transgender Clinic. Due to the lack of dedicated psychological resources within the Transgender Clinic, individuals are frequently referred back to the Triangle Project for counselling. Surgical resources remain limited with the average waiting time of 255 days for initial assessment and limited theatre time only allowing for 2-3 completed gender affirmation surgeries a year.

### **Recommendations**

Recommendations to improve attendance at Mental Health, Endocrinology and Plastic and Reconstructive Surgery would be to have the Transgender Clinic contact each individual prior to their appointments to remind individuals and to ascertain whether there are financial constraints affecting their ability to attend the Clinic. If financial constraints are a factor, the Transgender Clinic could utilize Health Non-Emergency Transport services – a medical transport service provided by the Western Cape Government.

Recommendations for the improvement of the Transgender Clinic service are based on the findings of the study and the suggestions put forward by the Transgender Unit MDT members. Changes to the layout of the standardized history-taking and assessment booklet would better clarify whether the tasks of the mental health professionals are being performed during initial assessment – changing the single tick box that is in place for certain information (intimate partner violence, stigmatization, victimization, negative self-concept, school drop-out, economic marginalization) to a yes/no tick box. An additional section could be added to the booklet that covers the provision of psychoeducation around options to manage gender dysphoria and the short- and long-term implications of any changes in gender role.

A recommendation would be to modify the sections for personality and autism spectrum disorder features to be more in keeping with the section addressing other co-existing mental health conditions to make the documentation of screening processes clearer. Prior to attending the initial appointment individuals could also complete an Autism Spectrum Quotient, a screening tool recommended by The National Institute for Health and Care Excellence (NICE) (NICE, 2016). Validated screening tools could also be used prior to initial appointment for depressive symptoms and anxiety symptoms considering the increased prevalence of these disorders amongst attendees.

Due to the increased risk of cardiovascular and cerebrovascular events with concurrent hormone therapy and tobacco use, a recommendation would be that health professionals convey this information during the assessment and the clinic could consider the creation of a smoking cessation information pamphlet that could be given to individuals attending the clinic. The Pamphlet could highlight the risks of combined hormone and tobacco use, provide contact information for South African organizations that aid with smoking cessation (Cancer Association of South Africa [CANSAs] free online eKickButt programme, National Council Against Smoking QUIT line), and provide information on nicotine replacement strategies and current non-nicotine pharmacotherapies available to assist with smoking cessation (Livingstone-Banks et al., 2019).

The Transgender Clinic could consider running a combined clinic with multidisciplinary input from Mental Health, Endocrinology and Plastic and Reconstructive Surgery. This would facilitate a more cohesive approach to the provision of gender affirming

care and also reduce the number of appointments, and travel costs, of individuals attending the clinic.

If a combined clinic is not possible, a recommendation would be the creation and utilization of a single Transgender Clinic booklet with sections for each discipline (Mental Health, Endocrinology, Plastic and Reconstructive Surgery), or an electronic health record application available to all the Transgender Clinic clinicians, versus the current system of each discipline having their own separate booklet and methods of documentation. This would better clarify what services have been provided for each individual by the different disciplines, and would streamline the information for all the different clinicians involved in the care of transgender individuals, limit the opportunity for inconsistencies in documentation amongst clinicians with respect to medical notes and allow for a more cohesive multidisciplinary approach. This booklet could be created with the WPATH SOC guidelines for each discipline informing each section; allowing for clear documentation of the evaluation of gender dysphoria and the exclusion of other diagnoses, general psychiatric evaluation and mental health management plan, transition expectations, short- and long-term implications of gender-affirming care, availability of support structures, assessment of medical co-morbidities and medical risk evaluation prior to hormone therapy, capacity to consent, hormone therapy and monitoring regimen, and available surgical options.

Due to limited resources the Transgender Clinic has to refer some individuals to other services for ongoing psychiatric and psychological care (e.g. GSH General Psychiatry Outpatients, Community Health Clinics, District Hospitals, Triangle Project). The provision of additional mental health resources in order to provide psychotherapy and counselling services, as well as ongoing psychiatric care for all attendees with co-existing mental health

conditions within the Transgender Clinic, would enhance continuity of gender-affirming care within the service. A consideration for how to enhance the provision of the additional services within the current mental health framework would be to utilize psychology interns in training. In 2019, an additional specialist psychiatric training post was created at GSH, and part of the requirements of this post is to join the MDT members for new patient assessments during their 6 month rotation through GSH. Following attendance at seminars run by the Transgender Clinic to upskill clinicians in the provision of gender-affirming healthcare, the intern psychologist could also join the MDT members for new patient assessments. The trainees could then assist with the provision of follow up psychiatric and psychological care within the service.

As noted previously, access to other services such as fertility services, voice and communication services, dermatology, urology, occupational therapy, and surgical theatre time within the public sector is often limited due to resource constraints. A recommendation would be for the continued petitioning of GSH for the inclusion of these gender-affirming services within the Transgender Clinic framework. If resources are unavailable, to consider private-public partnerships with respect to services that are under resourced within the public health system. The Transgender Clinic has been involved in advocating for private medical aids to fund gender-affirming care. A major South African open medical aid scheme has piloted a package of care for transgender individuals, unfortunately this package is limited to individuals who have been on the most comprehensive plan for a period of three years.

The WPATH SOC 7 guidelines aim to guide professionals in the provision of transgender care across the board with respect to resource availability. The adoption of South African Standards of Care would allow for specific resource guided guidelines that medical

professionals would be able to follow within the South African public and private health system. The lack of national guidelines contributes to the difficulties experienced by medical practitioners and transgender individuals advocating for the allocation of public hospital resources and financial coverage of private sector gender affirming care (Spencer et al., 2017).

Recommendations to aim to reduce discrimination for attendees would be to address the lack of gender-neutral bathrooms at GSH. The space where the clinic is held does not have a gender-neutral bathroom available. Also, to consider the clear documentation of preferred names and gender on both medical folder and psychiatric confidential folders so that administrative and medical staff are encouraged to use preferred pronouns and names at all times. Once the World Health Organization's eleventh revision of ICD criteria is adopted, the Transgender Clinic plans to change the DSM 5 criteria currently in use in the standardized history taking booklet to ICD 11 criteria. The ICD 11 criteria propose to retain the gender incongruences diagnoses to preserve access to health services, but to include it under Conditions Related to Sexual Health rather than Mental and Behavioral Disorders (Reed et al., 2016). This is a step towards de-psychopathologizing gender nonconformity and reducing stigma, as recommended by the WPATH (Coleman et al., 2012).

## **Conclusion**

WPATH SOC 7 competency requirements were met by the GSH Transgender clinical team. Inconsistencies were found in the documentation of WPATH SOC 7 recommended clinician tasks within the mental health and endocrinology service. This is secondary to the layout of the standardized history taking and assessment booklet, and documentation of certain tasks being clinician dependent. Limited hospital resources and subsequent understaffing, long

waiting times for appointments and gender-affirming surgery and lack of access to other services (e.g. fertility services) result in continued barriers to gender-affirming care.

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The authors declare that they have no conflict of interest.

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## TABLES

Table 1 Proportion of screened individuals experiencing stigmatization, discrimination, victimization, negative self-concept, school drop-out and economic marginalization

	<b>Stigmatization</b>	<b>Discrimination</b>	<b>Victimization</b>	<b>Negative Self Concept</b>	<b>School Dropout</b>	<b>Economic Marginalization</b>
<b>Total screened (n=40)</b>	37.5% (n=15)	52.5% (n=21)	52.5% (n=21)	22.5% (n=9)	30% (n=12)	17.5% (n=7)
<b>Transmale screened (n=9)</b>	44.4% (n=4)	33.3% (n=3)	55.6% (n=5)	33.3% (n=3)	22.2% (n=2)	11.1% (n=1)
<b>Transfemale screened (n=27)</b>	37% (n=10)	55.6% (n=15)	51.9% (n=14)	14.8% (n=4)	33.3% (n=9)	22.2% (n=6)
<b>Non-binary screened (n=4)</b>	25% (n=1)	100% (n=4)	75% (n=3)	50% (n=2)	25% (n=1)	0% (n=0)

Table 2 Proportion of screened individuals with co-occurring mental health disorders at the time of initial Mental Health assessment.

	Total (n=50)	Transmale (n=14)	Transfemale (n=31)	Non-binary (n=5)
Any co-occurring mental health disorder	42% (n=21)	64.3% (n=9)	25.8% (n=8)	80% (n=4)
Major Depressive Disorder	22% (n=11)	21.4% (n=3)	12.9% (n=4)	80% (n=4)
Bipolar Disorder I and II	6% (n=3)	14.3% (n=2)	3.2% (n=1)	0% (n=0)
Generalized Anxiety Disorder	10% (n=5)	21.4% (n=3)	0% (n=0)	40% (n=2)
Social Anxiety Disorder	10% (n=5)	21.4 (n=3)	3.2% (n=1)	20% (n=1)
Obsessive Compulsive and Related Disorders	4% (n=2)	7.1% (n=1)	0% (n=0)	20% (n=1)
Trauma and Stressor Related Disorders	6% (n=3)	14.3% (n=2)	3.2% (n=1)	0% (n=0)

Table 3 Completeness of WPATH SOC 7 recommended hormone prescribing physician tasks  
(n=32)

	Documented	Not documented
Physical transition goals discussed	56%	44%
Review of support structures	81%	19%
Health history obtained and physical examination performed	100%	0%
Relevant laboratory investigations performed	100%	0%
Effects of feminizing/masculinizing medications discussed, including adverse effects	81%	18%
Fertility options discussed	84%	16%
Capacity to consent for hormone therapy	100%	0%

**FIGURES**

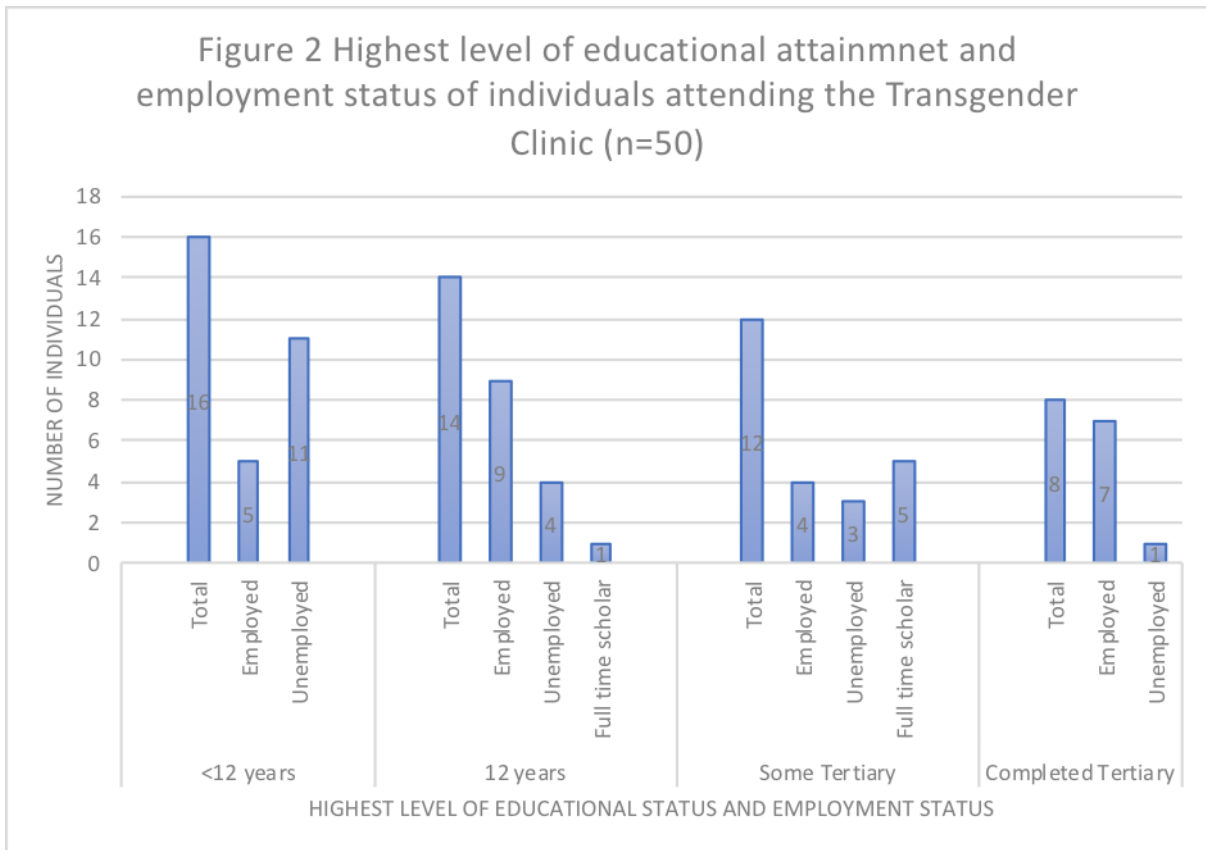
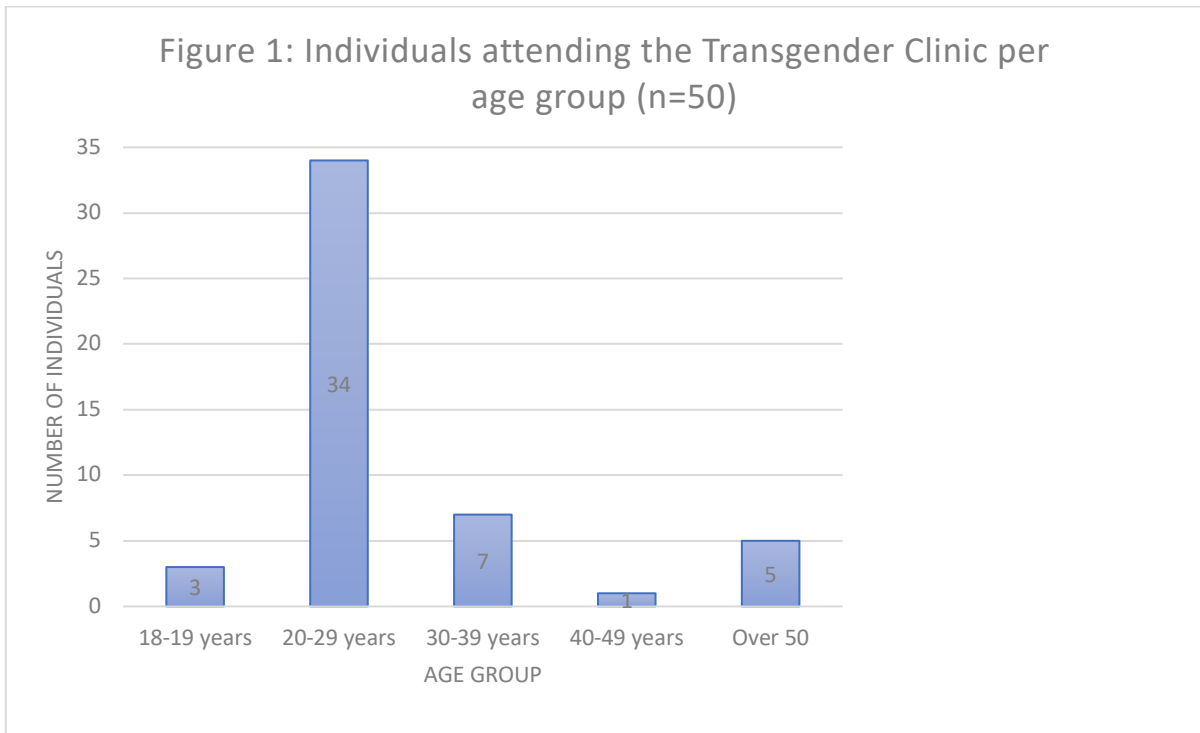


Figure 3 Length of time between referral and initial appointment with Mental Health service (n=50) and Endocrinology service (n=38)

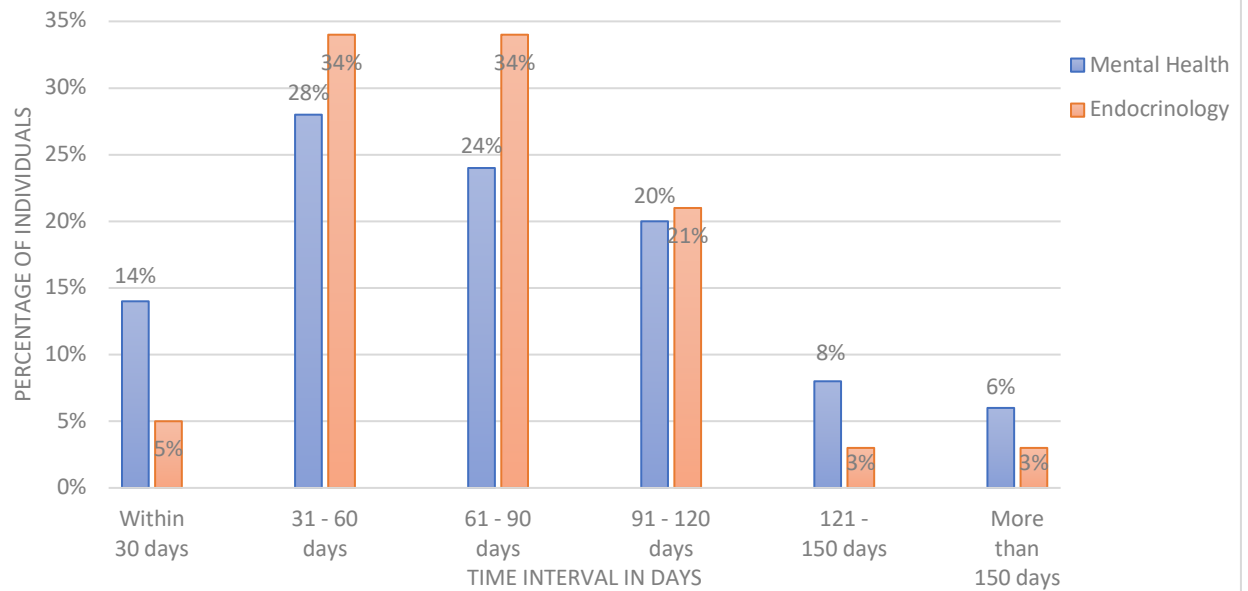


Figure 4 Distance travelled to access transgender services and employment status (n=50)

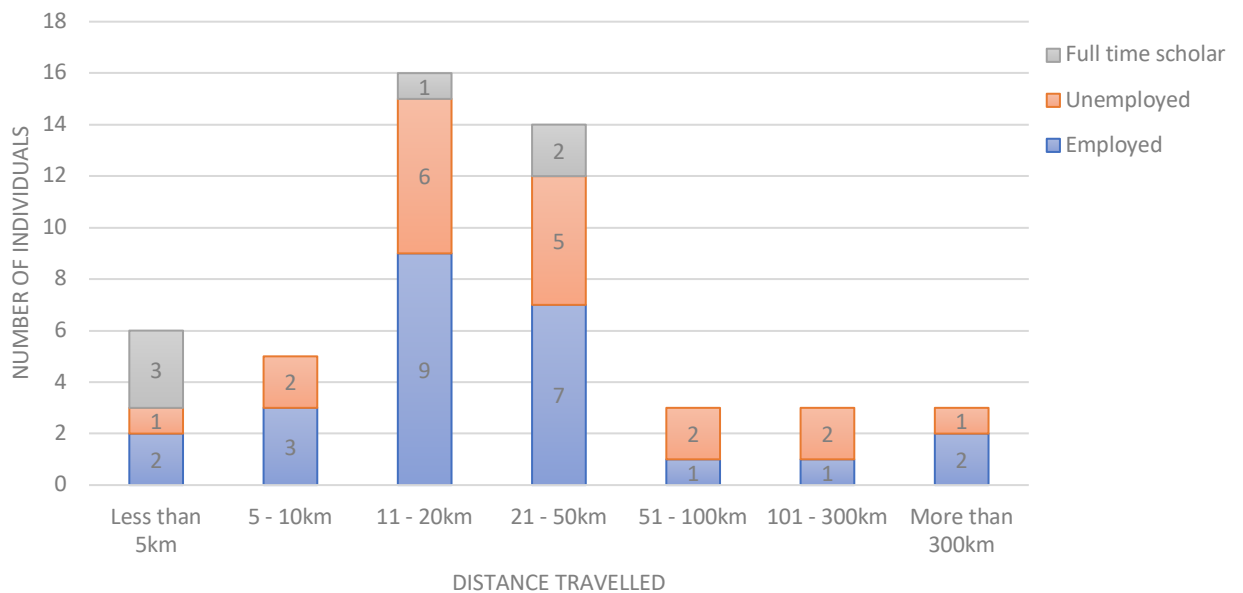


Figure 5 Self-reported substance use (n=50)

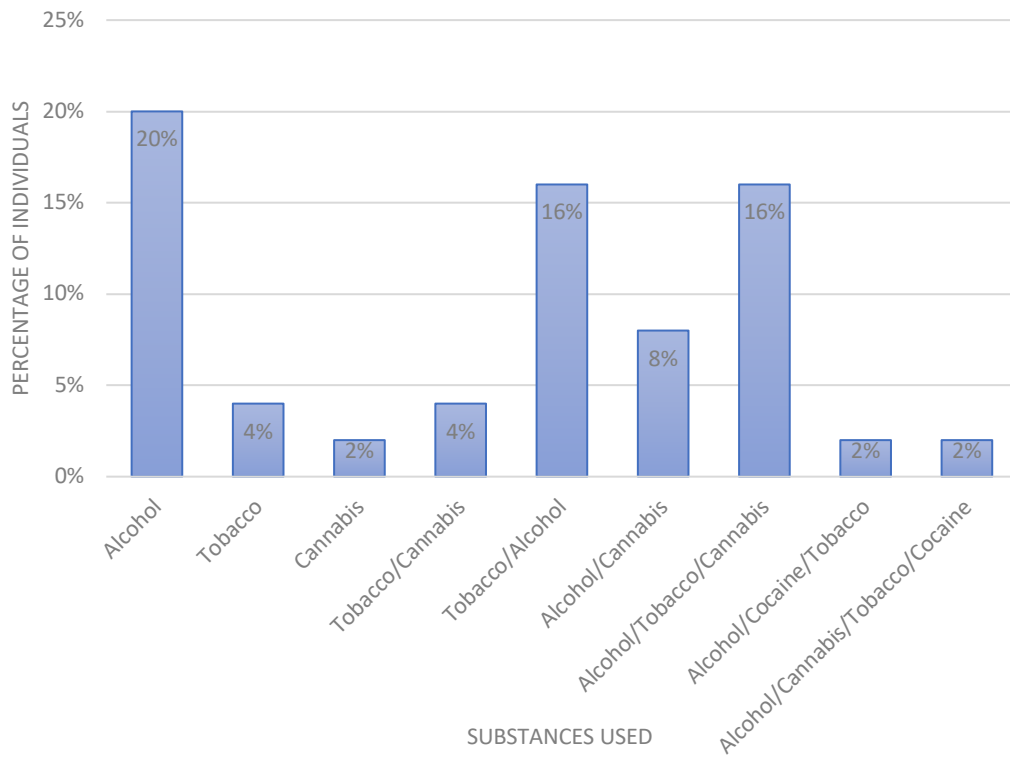


Figure 6 Self-reported frequency of substance use (n=37)

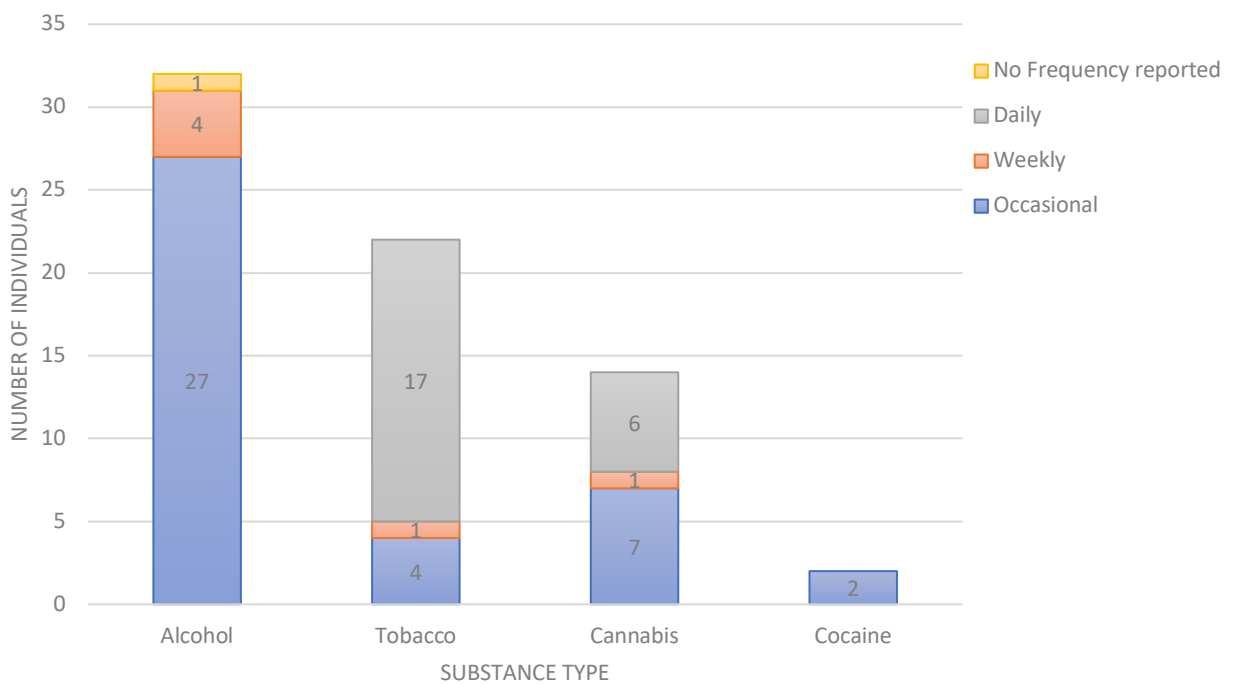


Figure 7 Length of time between initial Endocrinology assessment and starting hormone therapy - September 2018 to June 2019 (n=20)

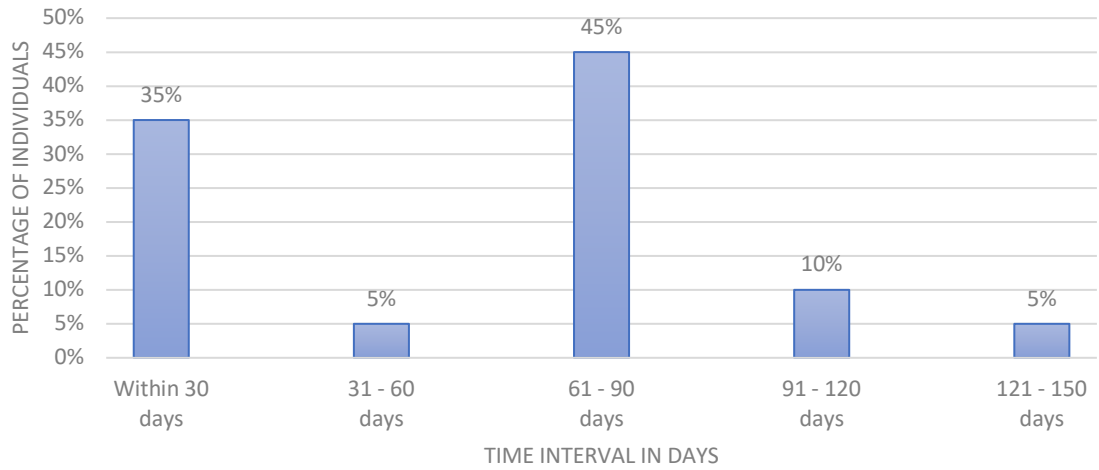


Figure 8 Different types of hormone regimens prescribed in transfemale individuals (n=18)

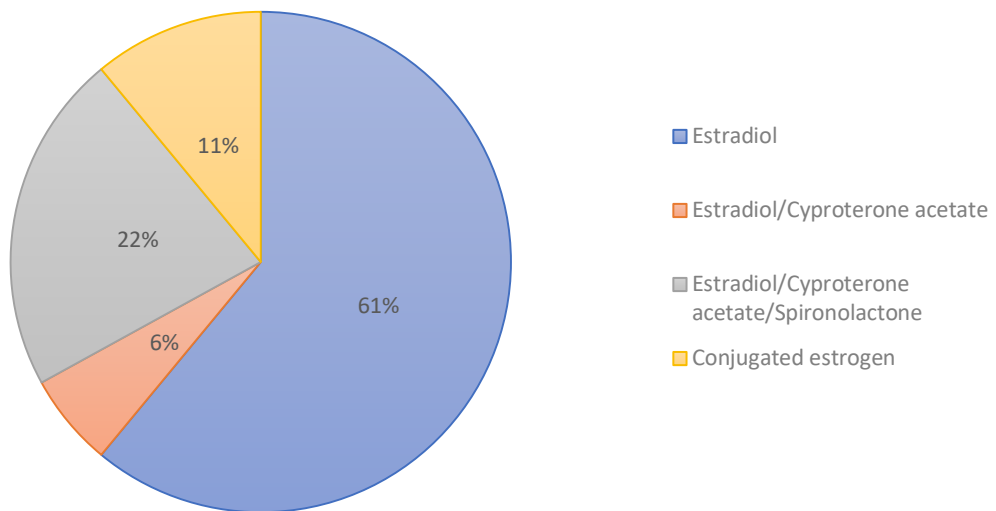
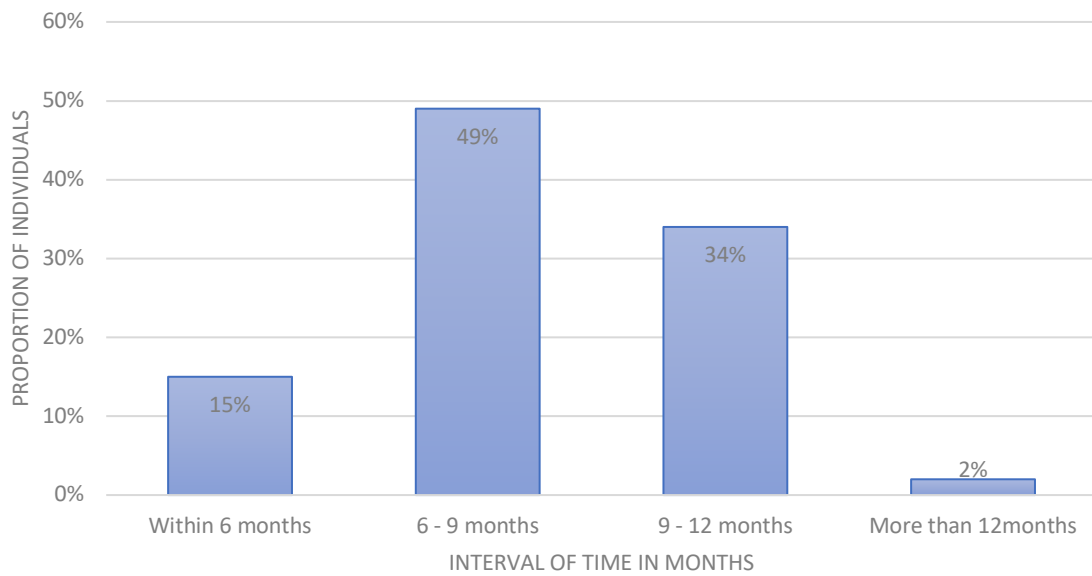


Figure 9 Length of time between referral and initial appointment with Plastic and Reconstructive Surgery (n=41)



## APPENDICES

### *Appendix 1: Multidisciplinary team member data collection sheet*

Name of clinician:
Role of clinician within the multidisciplinary team:

<b>PLEASE USE MICROSOFT WORD'S HIGHLIGHT FUNCTION TO INDICATE YOUR ANSWER</b>			
Years of experience within your discipline:			
< 5 years	6-10 years	11-15 years	> 16 years
Years of experience in the provision of transgender related care:			
< 5 years	6-10 years	11-15 years	> 16 years
How long have you been part of the multidisciplinary team at the Groote Schuur Hospital Transgender Unit (in years and months):			
Are you aware of the World Professional Association for Transgender Health 7 <sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) guidelines:			
Yes		No	
Qualification of multidisciplinary team member (please highlight each degree if more than one degree):			
Bachelor's degree	MChB	Master's degree	PhD
Registered with the HPCSA:			
Yes	No	Not applicable	

Mental health professional – How would you rate your competence in using the Diagnostic Statistical Manual of Mental Disorders for diagnostic purposes on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental Health professional – How would you rate your competence in using the International Classification of Diseases for diagnostic purposes on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental health professional – How would you rate your ability to recognise and diagnose coexisting mental health concerns and distinguish from gender dysphoria on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental health professional – How would you rate your knowledge about gender-nonconforming identities and expressions on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental health professional – How would you rate your knowledge about the assessment and treatment of gender dysphoria on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental health professional – Did you receive documented supervised training in psychotherapy or counselling:										
Yes					No					
Mental health professional – How would you rate your competence in psychotherapy or counselling on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Mental health professional – Are you exposed to continuing education in the assessment and treatment of gender dysphoria in any of the following ways:										
Attendance of relevant professional meetings					Yes			No		
Attendance of workshops or seminars					Yes			No		

Obtaining supervision from a mental health professional with relevant experience	Yes	No
Participating in research related to gender nonconformity and gender dysphoria	Yes	No

Endocrinologist – How would you rate your ability to perform an initial evaluation of a transgender client (including a discussion of a client’s physical transition goals, obtaining a health history, performing a physical exam, performing a risk assessment and requesting the relevant laboratory tests) on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Endocrinologist – How would you rate your ability to counsel a client on the expected effects of feminising/masculinising medications and the possible adverse effects on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Endocrinologist – How would you rate your ability to provide ongoing medical monitoring, including regular physical and laboratory examination, to monitor hormone effects and side effects on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Endocrinologist – How would you rate your knowledge regarding the different feminising/masculinising medications available on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10
Endocrinologist – How would you rate your ability to confirm whether the client has capacity to understand the risks and benefits of management and are capable of making an informed decision about medical care on a scale of 1-10 (0 = none, 5 = fair, 10 = excellent):										
0	1	2	3	4	5	6	7	8	9	10

Surgeon – How would you rate your competence in genital reconstructive techniques on a scale of 1-10 (0=none, 5 = fair, 10 = excellent)										
					5					



*Appendix 2: Folder review of Mental Health Professionals service*

1. Research number	
2. Date of referral to Transgender Unit	
3. Source of referral to Transgender Unit	
4. Residential area of patient	
5. Date of initial assessment by Mental Health team	
6. Designation of clinician assessing client	
7. Assessment for gender dysphoria performed	
i. Assessment of gender identity	
ii. Assessment of gender dysphoria	
iii. History and development of gender dysphoric feelings	
iv. Excluding the possibility that gender dysphoria is not secondary to or better accounted for by other diagnoses	
v. Assessment of the impact of stigma attached to gender nonconformity	
vi. Assessment of the availability of support from family, friends and peers	
8. Information regarding options for gender identity and expression and possible medical interventions provided	
i. Education of client regarding the diversity of gender identities and expressions	
ii. Education of client regarding management options - changes in gender expression and role, hormone therapy, surgery to change primary and/or secondary	

sex characteristics, psychotherapy, support resources, voice and communication therapy, changes in name and gender marker on identity documents	
iii. Short- and long-term implications (psychological, social, physical, sexual, occupational, financial, and legal) of any changes in gender role and medical interventions discussed with client	
9. Recognition, diagnosis and management of co-existing mental health concerns includes	
i. Assessment for anxiety symptoms	
a. Generalised anxiety disorder	
b. Panic disorder	
c. Social anxiety disorder	
ii. Assessment for mood symptoms	
iii. Assessment for self-harming behaviour	
iv. Assessment for OCD	
v. Assessment for substance abuse	
vi. Assessment for personality disorders	
vii. Assessment for eating disorders	
viii. Assessment for psychotic disorders	
ix. Assessment for autistic spectrum disorders	
x. Assessment for other mental health concerns	
xi. Assessment for a history of abuse	
xii. Assessment for a history of neglect	
10. Assessment, and management if required, of sexual health concerns	

11. Assessment, and management if required, of sexual disorders	
12. Does the client want hormone therapy	
13. If client wants hormone therapy - assessment of eligibility for hormone therapy	
i. Assessment of whether client is making a fully informed decision	
ii. Assessment of whether client has clear and realistic expectations	
iii. Assessment of readiness to receive the intervention in line with overall treatment plan	
iv. Assessment of whether client has included family and community as appropriate	
v. Assessment of whether client has considered psychosocial implications	
vi. Assessment of whether client has any medical contraindications to hormone use	
vii. Assessment of whether reproductive options/fertility preservation have been explored	
14. If client wants hormone therapy - referral for hormone therapy includes	
i. Client's general identifying characteristics	
ii. Results of psychosocial assessment, including any diagnoses	
iii. Duration of referring health professional's relationship with the client	

iv. Psychotherapy received (if applicable)			
v. Criteria for hormone therapy have been met			
a. Persistent, well documented gender dysphoria	Yes	No	N/A
b. Capacity to make a fully informed decision and to consent for treatment	Yes	No	N/A
c. Age of consent to medical treatment (South African Children's Act No.38 of 2005)	Yes	No	N/A
d. Co-occurring medical conditions are well controlled (if applicable)	Yes	No	N/A
e. Co-occurring mental health conditions are well controlled (if applicable)	Yes	No	N/A
vi. Referring health professional is available for coordination of care	Yes	No	N/A
vii. Date of referral to Endocrinology			
viii. Date seen by Endocrinology			
ix. Date hormone therapy initiated			
15. Does the client want breast/chest surgery	Yes	No	N/A
16. Does the client want genital surgery	Yes	No	N/A
17. If client wants surgery - assessment of eligibility for surgery			
i. Assessment of whether client is making a fully informed decision	Yes	No	N/A
ii. Assessment of whether client has clear and realistic expectations	Yes	No	N/A
iii. Assessment of readiness to receive the intervention in line with overall treatment plan	Yes	No	N/A

iv.	Assessment of whether client has included family and community as appropriate	Yes	No	N/A
v.	Assessment of whether client has considered psychosocial implications	Yes	No	N/A
vi.	Assessment of whether client has any medical contraindications to surgery	Yes	No	N/A
vii.	Assessment of whether reproductive options have been explored	Yes	No	N/A
18. If client wants surgery - referral for surgery includes				
i.	Client's general identifying characteristics			
ii.	Results of psychosocial assessment, including any diagnoses			
iii.	Duration of referring health professional's relationship with the client			
iv.	Psychotherapy received (if applicable)			
v. Criteria for breast/chest surgery have been met				
a.	Persistent, well documented gender dysphoria	Yes	No	N/A
b.	Capacity to make a fully informed decision and to consent for treatment	Yes	No	N/A
c.	Age of consent to surgical treatment (South African Children's Act No.38 of 2005)	Yes	No	N/A

d. Co-occurring medical conditions are well controlled (if applicable)	Yes	No	N/A
e. Co-occurring mental health conditions are well controlled (if applicable)	Yes	No	N/A
f. Assessment completed by one qualified mental health professional	Yes	No	N/A
vi. Date of referral to plastic surgery			
vii. Date seen by plastic surgery			
19. Advocating on behalf of the client has occurred (if applicable)			
i. Consultation with representatives from supportive organisations	Yes	No	N/A
ii. Consultation with personnel at work	Yes	No	N/A
20. Assistance with changing client's name and/or gender marker on identity documents (if applicable)	Yes	No	N/A
21. Information and referral for peer support has been provided	Yes	No	N/A
22. Referral for individual therapy (if applicable)	Yes	No	N/A
23. Referral for family therapy (if applicable)	Yes	No	N/A
24. Referral for fertility services (if applicable)	Yes	No	N/A
25. Referral for voice and communication therapy	Yes	No	N/A
26. Any additional interdepartmental referrals	Yes	No	N/A

### *Appendix 3: Introduction to the Study and Consent Form*

Dear team member

Thank you for taking part in this study titled, “A Clinical Audit of the Transgender Unit at Groote Schuur Hospital”.

The primary aim of this study is to perform an audit of the clinical services provided by the multidisciplinary team (MDT) at the Groote Schuur Hospital Transgender Unit. This audit aims to assess the care provided against the World Professional Association for Transgender Health 7<sup>th</sup> Version of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (WPATH SOC 7) so that quality and effectiveness of care can be enhanced.

This study also aims to identify areas of excellence within the service, identify areas within the service that require improvement and to contribute to the body of knowledge regarding transgender services within South Africa.

Participation in this study requires you to complete a data collection sheet in writing.

Information captured from the data collection sheet will relate to the competencies and the experience of each clinician as outlined by the WPATH SOC 7. Information gathered will be anonymised. The data collection sheet will also include a section for additional comments on recommendations for the improvement of the service provided by the Transgender Unit.

Participation in this study is voluntary and you may choose to not participate.

The study will combine the information from the data collection sheets with a retrospective folder review of individuals attending the Transgender Unit from November 2018 to October 2019.

The data will be extracted from the data collection sheets and the folder reviews and be electronically entered into a password protected database. Once the data has been analysed, the study will be complete. The results of the study will be submitted to the University of

Cape Town’s Department of Psychiatry and Mental Health as a part of the requirements of the MMed (psychiatry) degree. The results will also be presented to the Transgender Unit’s multidisciplinary team and management at Groote Schuur Hospital. The results may also be submitted as a journal article for publication.

Consent Form

- 1. I have read the above information and I willingly and voluntarily agree to participate in the study titled, “A Clinical Audit of the Transgender Unit at Groote Schuur Hospital”.
- 2. I understand that participation is voluntary, and I may choose to answer only those questions which I feel comfortable answering.
- 3. I understand that I have a right to ask questions about any aspect of this study, and can withdraw from this study at any time.
- 4. There is no special advantage or disadvantage in participating in this study.
- 5. I have been informed that all information will be treated as confidential, but may be used in a publication in a medical journal. My name will not appear in the publication.
- 6. I understand that I will not receive any financial reimbursement for my participation in the study.

I consent to participate in the above research.

Print name of participant: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Place: \_\_\_\_\_

## *INSTRUCTION TO AUTHORS*

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Should be written with the following elements in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)

### **Style Guidelines**

Please refer to these [quick style guidelines](#) when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

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corresponding author will include a summary statement on the title page that is separate from their manuscript, that reflects a disclosure of any potential conflicts of interest.

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When reporting studies that involve human participants, authors should include a statement that the studies have been approved by the appropriate institutional and/or national research ethics committee and have been performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that the independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study.

### Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. Hence it is important that all participants gave their informed consent in writing prior to inclusion in the study. Identifying details (names, dates of birth, identity numbers and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scientific purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.

### References

Please use American Psychological Association, Seventh Edition referencing style when preparing your paper.

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5. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). [Templates](#) are also available to support authors.
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I am well and hope you to be so.

Thank you for forwarding this email to me.

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Dear Dr. Allannah,

You are welcome to submit the manuscript.

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Durgadevi Dhanasekaran  
International Journal of Transgender Health

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Thank you for your email.  
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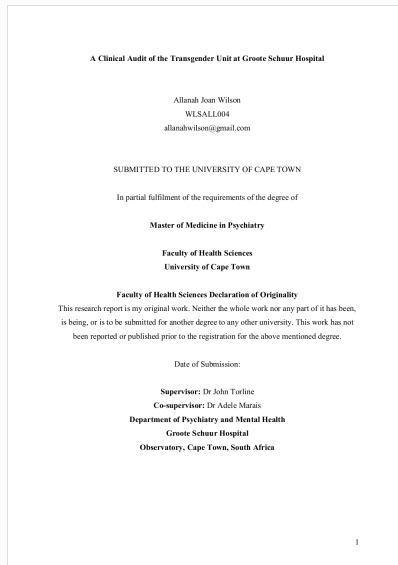


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*J. R. Turline*  
J. R. TURLINE

# ETHICS APPROVAL

## Human Research Ethics Committee



UNIVERSITY OF CAPE TOWN  
Faculty of Health Sciences  
Human Research Ethics Committee



Room G50- Old Main Building  
Groote Schuur Hospital  
Observatory 7925  
Telephone [021] 406 6492  
Email: [hrec-enquiries@uct.ac.za](mailto:hrec-enquiries@uct.ac.za)

Website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms)

28 January 2020

**HREC REF: 021/2020**

**Dr J Torline**

Department of Psychiatry and Mental Health  
2nd Floor, Room H74  
Human Resources and Development Centre  
(aka Drs Bungalows)

Dear Dr Torline

**PROJECT TITLE: A CLINICAL AUDIT OF THE TRANSGENDER UNIT AT GROOTE SCHUUR HOSPITAL (SUB-STUDY - R046/2013) (MMED DEGREE - DR ALLANAH WILSON)**

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 30 January 2021.**

The HREC note that only the database entries will be used with no prospective participation.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms))

***The HREC acknowledge that the student: - Dr Allannah Wilson will also be involved in this study.***

**Please quote the HREC REF in all your correspondence.**

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate Institutional approval, where necessary, before the research may occur.

Yours sincerely

**PROFESSOR M. BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE**

HREC 021/2020sa



Dr John Torline  
**PSYCHIATRY & MENTAL HEALTH**

E-mail: [REDACTED]

Dear Dr Torline,

**RESEARCH PROJECT: A Clinical Audit of The transgender Unit at Groote Schuur Hospital (Sub-Study R046/2013 (MMed Dr Allanah Wilson))**

Your recent letter to the hospital refers.

You are granted permission to proceed with your research, which is valid until **30 January 2021**.

Please note the following:

- a) Your research may not interfere with normal patient care.
- b) Hospital staff may not be asked to assist with the research.
- c) No additional costs to the hospital should be incurred i.e. Lab, consumables or stationary. **If access to TRACK Care/NHLS is required, kindly attach our letter of approval to the application form.**
- d) **No patient folders may be removed from the premises or be inaccessible.**
- e) Please provide the research assistant/field worker with a copy of this letter as verification of approval.
- f) Confidentiality must always be maintained .
- g) **Should you at any time require photographs of your subjects, please obtain the necessary indemnity forms from our Public Relations Office (E45 OMB or ext. 2187/2188).**
- h) Should you require additional research time beyond the stipulated expiry date, please apply for an extension.
- i) Please discuss the study with the HOD before commencing.
- j) Please introduce yourself to the person in charge of an area before commencing.
- k) On completion of your research, please forward any recommendations/findings that can be beneficial to use to take further action that may inform redevelopment of future policy / review guidelines.
- l) Please contact Michelle Riley (Patient Fees) at ext. 2276 to ascertain if there will be charges for conducting the Research and to obtain a quote or to discuss charges
- m) **Kindly submit a copy of the publication or report to this office on completion of the research.**
- n) **At no time should any posters encouraging patients to partake in research, be displayed within a clinical area.**

I would like to wish you every success with the project.

Yours sincerely

**DR BERNADETTE EICK**  
**CHIEF OPERATIONAL OFFICER**  
**Date:** 5<sup>th</sup> May 2020

C.C. Mr. L. Naidoo  
Dr T. Numanoglu  
Professor D. Stein

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