**Transgender health**

**Dr Nate Reid:** My name's Nate. So I'm a GP. I've been working in transgender health probably for the last, only about four years. I kind of stumbled into the area accidentally, in that I think the word got around that there was a transgender doctor, and so then the community came. Which I actually, I quite enjoy. So, I mean, being a GP, I really, really enjoy having that overall caring for people in a range of whatever they're presenting with. And so I find that probably, depending on the week, up to 80 to 90% of the people that I am seeing happen to be transgender, and probably only about a quarter to a third of that time is spent specifically talking about transition issues and that sort of end. And the majority of time is actually talking about their sore foot or something like that. So more broad, general, GP type things.

So I'm very excited to be here today. I think it's very cool that Jean Hailes is putting on this education and that it shows that there's interest and there's enthusiasm around diverse people, I suppose. So in terms of thinking about gender and thinking about trans issues, so in the last five to 10 years there has been this overwhelming kind of explosion of awareness in the general community around transgender people and trans experience. And I quite like the Time cover, which, does anybody know who this lovely lady is? I'm not going to ask you. Does anybody, anyone else? Yeah, so she's from, so Laverne Cox from Orange Is the New Black. And so it was on Time Magazine, and I love the heading, 'The Transgender Tipping Point', and I think she's been an amazing role model for trans communities and has done some really amazing things.

So some terminology, which is both important and not important. So as a general rule, terminology changes, and it's an ever-changing realm, really. But I thought it would be important to talk about some basic terms. So 'gender identity' is basically what people feel as though they are. So everybody has a gender identity, whether that's male, female, other. Regardless of how you identify, everyone has a core understanding or belief of what their gender is. They may never have thought about it, but most people will have a gender identity. So 'cisgender' is a term that is used to describe probably the majority of people. So cisgender means that somebody was born, they said, 'Ah, this is a boy,' and grows up and identifies as a male, as a boy. And similar with, 'This is a girl', female. 'Trans' is basically everybody else. And so trans and transgender is this big umbrella term, and there's lots of different terms that come underneath that category. And this is where I think that language is really important, but it's also not so important. Particularly when you are dealing with people one-on-one, in a one-on-one situation, it actually doesn't matter about all these terms. What matters is what that person who's sitting in front of you identifies as.

So there's this kind of 'transgender versus transsexual'. And so really, speaking, majority of people now use 'transgender' and there's very few people, so 'transsexual' is thought to be a much older term. That being said, there are still definitely members of the community who identify as transsexual, but if referring to groups you're probably better off saying 'transgender', it seems to be a more acceptable term to use. And then under this umbrella we've got a couple of different groups. So there's, actually, hold that thought, I'll get that back to that later. So there's a few terms here which, and I actually had to look up a few of these because I couldn't remember all of them. And so basically the idea of having that picture of that umbrella is literally that there's more terms than you can think of, really. And I get quite excited when I meet a new patient for the first time and they will say, oh, I identify as 'this'. And I go, oh, I don't know what that is. That's exciting.

So actually learning all of these terms is actually not that important. Just being aware that there's quite a lot of terms. In terms of, you might see some acronyms. So MTF means male to female, FTM means female to male. Sometimes that's just an easier term to just explain somebody's identity. So particularly in a medical and healthcare situation, so that you can kind of go, okay, so we are thinking about biology and we're thinking about, so someone who is FTM might have issues with periods and someone who is MTF might have some prostate problems. So as a way of trying to conceptualise it. But as a general rule, people tend not to necessarily use those terms to identify themselves.

So there's also this, so that's one aspect, and then we've got 'gender queer' and 'gender fluidity'. So gender queer is another sub-umbrella underneath the umbrella. And what that means is, it means that people who don't necessarily identify as male or female. So as with everything, there is a big, long grey zone. And so some people might feel as though that they fit somewhere along that grey zone, or some people might feel as though that their gender is completely outside or separate to that. And so there's a term called the 'gender binary', which is thought about like if it's male and female, and then there's people that identify as non-binary, so they're not on that kind of binary level.

And then 'intersex', which is another important thing to be aware of. And so, in terms of thinking about people's gender and people's identity, a lot of the times intersex gets confused within that, and people don't necessarily understand the difference. And people who are intersex can also be trans, but as a general rule, so intersex means that somebody who was born with a chromosomal medical reason, that means that it's not necessarily clear if they're male or female. There's some really good intersex resources around. I don't have as much knowledge as I would like on intersex, but I'm happy to try and answer questions if people have any later on. Just, yeah, I have a couple of patients but not as many. All my intersex patients happen to be trans also, so that probably confuses things.

Anyway, so, this is my favourite picture in the world. This is a great picture, and I like that this is the version 3.3. I was quite fond of the first version, I was fond of the second one. I'm even more fond of this one. And basically this idea of the 'genderbread person'. So what this does is, thinking about a blank canvas, if you will, and then dividing up how people identify, how they express themselves. And I think that it's a really useful way of trying to conceptualise where people's gender might fit.

So if we think about the top, sort of the brain, so thinking about people's gender identity. And you'll notice that, and this is why I particularly like this one, is you'll notice that there's two lines. So it's not one continuous line, there's two lines. The top line is somebody's 'woman-ness' and the bottom line is somebody's 'man-ness'. And what, the idea of having that on two separate lines means that you could actually be a little bit on both, you could be just all on one, or you could be completely off that line and say, 'No, I'm in that circle at the very end where I don't fit on either of those.' So in terms of thinking about somebody's gender identity, so I'll use myself as an example because I like talking about myself, and it makes it easier because then I don't have to make someone up and get confused.

So if I was to think about my gender identity, I would be kind of down on the man-ness, towards the pointy end, maybe not the whole way across, but somewhere around there. So that would be sort of my gender identity. So then we look at the whole genderbread person, so we look at the whole person and look at their expression. So identity in expression can be, they can be exactly the same, so you can go, 'Oh, okay, so someone appears that they're dressing quite masculine, maybe they identify as male or masculine.' But very often the expression and identity don't necessarily match up. And this often is the case, particularly when people might not be 'out' in certain situations, or people might not feel comfortable disclosing that they're trans. They will often not necessarily express themselves in their preferred gender identity.

And so, if we're thinking about, so there's feminine, and then masculine, and then people can fit anywhere on that line. I would like to think that I was sort on the masculine end, down the bottom. Please don't comment if you don't think that's true. So if you were dividing into, that's sort of the people's overall gender expression.

Biological sex. And I find this one quite an interesting one, because if we're thinking about biology, so obviously as healthcare professionals we are thinking about biology. We're thinking, when people are coming, they're coming with a health concern, which means that you actually have to think about their biology. Biological sex, so it can go down as much as if you're going from a chromosome perspective, but then you can also look at things like primary and secondary sexual characteristics. So it can sometimes be good to think about that it's not necessarily one or the other, and not necessarily on one steady line. Because if you were to look at me for example, so in terms of biology, so I would probably fall on the female-ness line because I have an XX chromosome, I have female reproductive organs. But if you were looking at secondary characteristics, I have some facial hair, I have a deeper voice and things like that. So I've used testosterone, which has meant that I've also got, sort of, on that bottom line as well.

And then the bottom two is looking at attraction, so looking at the heart, so looking at what people are sexually attracted to, or how people are romantically attracted to people. And it's important to differentiate these, because a lot of the times people will make assumptions, and it's kind of a fascinating thing around people's sexuality and people's gender. Because if you were to look at myself, so prior to transition I was mostly sexually attracted to women, so I was considered to be a lesbian, I was gay. I then come out and transition, and I am male, and suddenly I'm kind of straight, which is really odd.

So thinking about that actually, that sometimes the labels that we use, and this is why labels I think can be not necessarily important, is that my sexuality technically changed in label, but in practice it actually didn't change at all. In terms of romantic attraction, so that's just basing that it's not all about sex. So there's plenty of people that are sexually attracted to men, but maybe only romantically attracted to women, and things like that. So that's, anyway, it's an important kind of differentiation. And so people can be trans, they can be anywhere on this kind of sexuality list, yeah, people are just [inaudible].

And I probably should have mentioned, if you've got any questions, feel free to put your hands up through it, because, yeah. Any questions at this point? No.

So, thinking about transition. So 'transition', I've put it in little inverted commas, because I think that transition means so many different things to so many different people, and it depends on who you're talking to and it depends on where somebody is in their life. But I've divided it up into social, medical and surgical transition. So if you're thinking about social transition, so this is thinking about people coming out to family, friends, thinking about people changing their name, going through Birth, Deaths and Marriages, things like that. And that's kind of considered a social transition.

So similar to sort of anything, and any kind of identity, is that, just because somebody is presenting to you and they're saying that they're trans and they're quite proudly sitting before you saying that, that doesn't necessarily mean that they're out in all aspects of their life. I see quite a lot of people who are not out in their workplaces, and it tends to be often the last place people feel comfortable transitioning. And a lot of the times, particularly in my cohort, I have this very interesting cohort of trans women in their sixties, and then all these young teenagers that are trans, I don't necessarily see the middle group. But often the trans people in their sixties, they're almost waiting for retirement so that they feel as though they can come out and transition.

Family and friends, similarly. So there might be certain members of the family that know, there might be certain family members that don't know, and that's quite important. So particularly as a health professional when people are coming to see you. So I have a couple of young people that see me, that their mum knows that they're trans but their dad doesn't. So I know if they're coming in with a cold and their dad brings them in, I should call them by their legal name. But if they're coming in with their mum, I know that I can call them the name that they've chosen. Which is a hard nuance when there is a packed waiting room and you can't exactly remember what the person looks like. But so far, so good. And if it hasn't worked, I can just pretend that I'm calling somebody else. So that's, I suppose, the level of the social transition.

So thinking about medical transition, so thinking about the things that people might do medically, and so often that medical transition is talking about hormones. Depending on the age, so when people are young, so adolescents, there might be discussion about puberty blockers and things like that. As a general rule, because puberty blockers are really expensive, that's handled at the Children's Hospital, they subsidise, or pay for the puberty blockers, because they're quite expensive. So thinking about puberty blockers tends to be the under 18, and do you, you don't see under 18 here, do you? Sometimes. Yeah. So it might be relevant. But as a general rule, if you're under the age of 18 and you are trans and you're accessing medical treatments, you're probably linked in with the Children's Hospital, which is a really, really good service. They're amazing. So Michelle Telfer who runs that is, she's amazing. So that's thinking about puberty blockers. After puberty, obviously we don't block puberty, it's already happened, so we don't necessarily need those later on. So thinking about hormones, so we think about testosterone-based hormones and oestrogen. Yeah?

**Seminar participant:** What sort of age should people start to recognise? Do they always nail it, or is there a range out there?

**Dr Nate Reid:** It's a massive range, I wish I had that graph. So there's a great graph that looks at the Children's Hospital Gender Service, which was started, so if you look at the number of referrals from 2007 to now, and it's kind of just exponentially grown and grown. With more awareness, as with anything, with more awareness, there's more people coming out a lot earlier. A lot of times, which can be hard, particularly for young people, that, I've had a lot of parents who said, 'Oh look, it's just because it's the new thing and it's 'this'.'

I think it's actually just that people are coming out earlier. So if you look at the range, so some people know from an early age, some people discover that maybe when they're 40 and they go, 'Oh, I realised that this is why I felt the way I did.' Personally, on reflection, so I came out when I was 22, 23, and on reflection I was like, 'Oh, I probably always knew, but I didn't have the language.' So I had no idea that it was possible to transition to become male. I'd heard of trans women before, but I didn't think it was possible to do the other. So in terms of, so you might say, so I might say, well, if I had the language, and my mum often complains that I didn't tell her earlier, I didn't know, but if there had been more awareness and things like that, I probably actually would've come out at a lot younger age.

So I think that when people know it's as with anything, but gender identity tends to form at a really young age. So most people will know quite early on, but the level of that knowledge and awareness depends. So another thing that quite often happens is people will quite actively rebel against that, so try to fit in. So I'll often see a young person who's coming in who identifies as male dressed in full makeup, dress, and says, I just wanted to, you know, trying to suppress that desire, and that sort of identity.

In terms of surgical transition, so there's surgeries that are available. So depending on what you are starting out, how you're starting out, and whether you choose to access surgeries. So as a general rule, surgical access in Australia is all in the private system. What that means is that you generally have to have money to be able to access surgeries. That's not always accessible to people. And the Monash Gender Clinic, which I'll talk about a bit later, does have some capacity to be able to help people with some of those costs. But as a general rule, people have to save, and people save, people who are earning nothing manage to save up for these surgeries. It's quite amazing.

A lot of people do go internationally as well. So there's local surgeons, but there's also some of the best surgeons in this area in Thailand. And so a lot of trans women will go to Thailand because it's actually quite a lot cheaper to go there to access their treatment. There can be really big problems with that, particularly if there's complications. I've had quite a few, not quite a few, but a number of trans women who have come back from Thailand, and they've had surgeries, and then there's been complications, and then finding a surgeon here who is happy to look at them is really hard because they say, 'Oh, well I didn't do this surgery, I don't—'. That can be a potential issue around that.

So in terms of, if you were thinking, so there's breast augmentation, you can also get a mastectomy. There's SRS, sexual reassignment surgery, it's not a great term. Kind of finding a good term, is the issue. But thinking about creation of the vagina, basically. Facial feminisation, so that's if you're thinking about the transfeminine people. And then the surgical transition for males, there's mastectomy. Phalloplasty is the creation of penis, there Is now one surgeon in Australia who does that. In terms of, so to get an idea of cost, so breast augmentation and mastectomy are around, people are looking at around $10,000. SRS in Australia is upwards of $20,000, phalloplasty is upwards of $100,000, and it's all in the private system. So people have to, that's sort of an issue I suppose, in terms of costs [inaudible].

And I suppose the important part about that is not everybody who is trans chooses to have surgery. It's not just because of cost. A lot of people are quite happy to not use surgical, similar to puberty, to hormones. So not everybody needs access to hormones, because not everyone feels that that's what they need to do. There may be medical reason's why we don't use hormones, so it's, people choose what they feel comfortable with, and what they are able to do.

So thinking about hormones, and I'm conscious that I'm talking to Jean Hailes professionals about hormones, and that makes me feel a little bit nervous, but I used all of your resources for my exams for HIV. So I'm feeling a bit, but I'll give you a rundown. So I find it quite, I know a lot about trans hormones, which is the same hormones that you guys are using, but as soon as I get a menopausal woman coming in to see me, I get so, like, 'Oh I don't what I'm into here.' I mean, it's bit overwhelming. But, so, thinking about transfeminine people, so these are people who are accessing oestrogen-based, generally oestrogen-based hormones. So we use, majority of people, we use oral oestrogen. We use really high doses. So we use two to eight milligrams a day, broken over. Most people probably fit between, they're probably using four to eight milligrams a day. If people were to have any surgery, so removal of testes, we often can actually halve or third that dose, but basically testosterone is pretty powerful, so we need to [inaudible] doses. We do use patches, so we can use 75 to 100 microgram patches. Tend to use those more so in older populations, so people who come in and they've had strokes, they're smoker, they're 65 and they want oestrogen, oh they probably have migraine with aura as well. And so we use patches. And so I suppose that it's an interesting kind of, that I have completely different conversations around hormones with people who are accessing hormones for transition versus people who are accessing hormones for, say, contraception.

So I've got a young person who gets really bad migraine with aura. So she's 24, she identifies as female, we talked about starting oestrogen. She wanted to start with the oral because she gets really bad dermatitis, she gets contact stuff, and she probably has one to two migraine with aura a month. And so we started on a baby dose of PRONOVA and her migraine with aura increased, so we had to switch patches, and that hasn't increased that. But I suppose in terms of thinking about that, had that discussion with her about risks and said, look, you're getting this, there's a really big risk of you having a stroke, but the risk of not treating her with hormones is increased risk of suicide, increased risk of inability to function, there's so many more potentially negative risks of not giving her hormones than there is the risk giving her hormones. So often we actually have these, we're weighing up risks, and I have quite a lot of people over the age of 65 who smoke a lot and who have had strokes and things like that that we still oestrogen to, because the alternative is probably likely that they won't be able to live life.

There's also oestrogen implants. So they're generally compounded. I don't personally do them because I've never done them, but there's a few GPs around Melbourne who do put implants in. They're generally, they last for six to nine months. We tend to go to that when the oral and the patches aren't working.

**Seminar participant:** With the patches, is that daily?

**Dr Nate Reid:** Yes. Oh well, no. So it's similar.

**Seminar participant:** So using it similarly?

**Dr Nate Reid:** Using it similar, yeah.

Anti-androgens or testosterone blockers. So the majority of trans women who are wanting to get into a female range of hormones will need to access and get testosterone blockers. Testosterone is just too powerful hormone to be able to be completely suppressed with oestrogen. I do have a couple of patients who managed to completely suppress their testosterone with oestrogen, but as a general rule people will need to be on some form of anti-androgen. We use quite a range. So cyproterone, when I first learned how to do trans hormones, I was told to use 50 to 100 milligrams. What I subsequently found is that then people just add zero testosterone, and that's not good for anybody. And so, in terms of people's libido, people's energy levels and all that sort thing. And so some people still do, some people do definitely need 100 milligrams daily, and I find that younger people tend to need that higher dose. So I've got maybe a handful of people that are on 100, most people are on 50, and then, 50 or 25 milligrams, and then I have a few that are on 12.5. I even have one person that is on 12.5 a couple of times a week, and she describes it, she kind of just licks the tablet. She's slowly being dropping until she finally got a little bit of [inaudible]. So we can also use spiro, yeah it's a very bad typo, 100 to 200 milligrams. So when we're using it for anything else, we slowly up hydrate it, monitor kidney function and potassium and things like that. Spiro tends not to be as good in terms of when you—

**Time keeper:** Ten minutes.

**Dr Nate Reid:** Oh geez, ok, cool.

Spiro tends not to be as good when you're using it for a blocker. So your level doesn't really go down, but it does provide some oestrogen effect. So some people notice that their breast development is a little bit better with that. Generally we monitor oestrogen, testosterone, standard prolactin, so occasionally prolactin can shoot up. So it's always a good idea to do a prolactin first, before starting hormones, because otherwise you'll get a high prolactin and be scared that they have a tumour, but it's probably just that, it's probably too [inaudible]. And remembering about preventative health screening, so as a GP I love preventative health and stuff. People who have breasts that were on estoestrogen definitely need mammograms. So remembering that people might have prostate, or prostate screening, and then bone density. Although there's currently a study going on through the Austin around bone density and hormones, so hopefully that will actually, it's been going for a couple of years, so hopefully there will be some data looking at that.

Transmasculine people, so people who are actively on testosterone. So we tend not to need to use any form of oestrogen blocker when people are on testosterone. We can use injectable or topical versions of testosterone. In terms of injectable, it's either a short-acting or long-acting topical gels which are daily applied. There is a PBS requirement, which drives me nuts, which means that, I mean, it's how you word the PBS, and so it says that to be eligible for PBS, people need to have a testicular disorder, great, so people don't have testicles, so they have a testicular disorder. And it needs to be done in consultation, or with the help of an endocrinologist or a sexual health physician.

What I tend to do, and what a lot of people do, particularly at the clinic I'm at, is that we've got some good relationships with some endos. So I'll write a referral to an endo and I'll give it to the person and I'll say, 'Okay, now you've made an appointment, I'm going to use that endos name for this prescription.' And then they'll see them for a once-off in that first six to 12 months, just so that we can use their name for ongoing prescription. It was really good a couple of years ago, they actually changed the requirements. So it used to be that you had to be male, so we used to have to change people's Medicare details to male, which was easy to do, you just write a letter, but they removed the gender marker of that.

So monitoring testosterone, basically. Occasionally you can get polycythaemia, so we monitor blood counts and lipids and LFTs. And something that I'm particularly passionate about is cervical screening in transmasculine people. So, definitely universally under-screened population, and there's a few reasons for that. So, most of the time it's that people won't ask for it because they might feel really uncomfortable asking for a pap, sorry, cervical screening test. I just like 'pap' better, it's a bit more snappy. So a lot of the times people won't ask for that, and then people won't necessarily feel comfortable within an environment actually saying that they need to have a CST. The other thing is that testosterone de-oestrogenises tissue, and so, often it's actually, it can be really uncomfortable for people to have a pap. So thinking like postmenopausal levels of de-oestrogenisation. And then thinking about with that, that it can be quite uncomfortable, is often I actually get people to use oestrogen like a Vagifem for a couple of weeks beforehand to make it a little bit more comfortable. The really good thing is around the self-collection HPV. So I've had a lot more uptake around HPV testing.

There's some effects of oestrogen and testosterone. It's divided up, so the top section, so the light green is within the first three months, then we look at the three to six month period of time, and then after 12 months, generally, in terms of things that are happening. But that's not particularly relevant. In terms of thinking about health issues and considerations. So cervical screening, cervical screening. Sexual health, so thinking about contraception, and I suppose this might be relevant for why people might be accessing your service. Around Mirenas, so Mirena is a really good option for transmasculine people, because you tend not to, in terms of contraception, particularly if they're having sex that could result in pregnancy. Testosterone is not contraception. So there's, a lot of community members will think that, oh I'm on testosterone, I'm fine. But because there can be changing levels, it's probably a pretty reasonable contraceptive agent, but it's not enough to say if you're on testosterone, you can't get pregnant. So Mirena tends to be a really good option.

Thinking about STI screening, and thinking about fertility. So the impacts of fertility in trans populations is something that I think traditionally has been really, really poorly done. Prior to commencing hormone therapy. So it's really important that people have a conversation about whether they might want to preserve fertility, and that can be an awkward conversation, particularly if you don't necessarily have the language, that you might feel as though you stumble a little bit. What I've found is that using 'sperm', 'eggs', just really kind of basic, standard, across, rather than attaching a gender to that kind of fertility. Really important to have that conversation prior to people having started hormones, because there's no guarantee, basically, of return to fertility if people were to stop taking hormones. It seems to be easier in a transmasculine population that if they were to stop taking testosterone, fertility probably will return somewhat. In transfeminine people on oestrogen, I am yet to have, so I had one patient who stopped taking her hormones because she was thinking about, so she didn't do any sperm preservation prior to starting hormones, but after 12 months she still had zero, she just didn't have fertility after 12 months on non-hormones. And so we decided to restart it.

And then post-hormone therapy, there's fertility, there's a really good clinic in Carlton called Rainbow Fertility, and they actually have really good resources for trans people around access to fertility services. And the people there are really experienced.

**Seminar participant:** Sorry, what was that called?

**Dr Nate Reid:** Rainbow Fertility. It's not exactly an original name. And I suppose that this is just a quick, accessing health service. So thinking about people who might be coming in to your service. And the thing that I'm wanting to point out is this 'gender' down here. Often that's the first barrier to people when they first come in to the service, and they go, 'Oh, what gender do I put down?' I find that on our forms we actually just have a blank space. That seems to work quite well. So people can write what they feel comfortable. But in terms of access to health services, it can sometimes be really full-on, particularly, so from that, thinking about the kind of service that people are accessing.

So, as an overshare, I needed to have a pelvic ultrasound, and I was given a referral to WUMe, so women's ultrasound, and it took me six months to go back to my GP and say, I'm really sorry, I just can't go there, can you— And then she was really lovely and wrote it to someone else and then called and made the appointment for me. So thinking about things which you might not even, and so that was someone who I was like, 'I'll be fine, I'm completely comfortable.' But actually, thinking about where you might be referring people, things that you might not have thought of, the services. Thinking about in terms of accessing health services. So the toilet access, do you have male and female bathrooms, or do you have unisex bathrooms? So unisex bathrooms can sometimes be a really useful way of making services more accessible. As well as language of staff, and having people, having a preferred name on recalls and reminders.

Actually the VCS still puts everyone as 'Ms'. So I have, when they're doing the recall, so people who have clearly have a male name, and will get a reminder or a recall saying, Ms John, please come in for your pap, which can sort of minimise people's uptake and stuff. And then, quickly, finally, some local services. So as a general rule, majority of trans healthcare tends to happen in the private sector. So in general practices. So there's a few around. So there's Northside Clinic where I work, there's Equinox, which is a peer-led service, which is really cool. So it was made with a lot of community consultation, and it's basically a GP. There's counselling there as well, service for people, and it's fully bulk-billed. And there's also Prahran Market Clinic, which does do a lot of trans healthcare as well. Generally speaking, so all of these places you can generally get in touch with the clinic if you have questions, and they'll put you on to someone to answer questions and things like that.

In terms of adult services, there's the Monash Gender Clinic, which is great, but it has a really long wait list. So you're probably looking at a nine to 12 month wait list for people to access that, which is a really long time. So often people access private services. Under eighteens is the Children's. They've got a really good children's practice, like how to care for trans and gender-diverse young people on their website. That's really good. And then if you're just wanting to know, is there an endo around that's friendly, is there a gynaecologist, is there whoever, it's not a particularly up-to-date list, but on ANZPATH, which is the Australian New Zealand Professional Association of Trans Health, they've got a list of providers.

**End of transcript**

**Information about the podcast**

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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