Perinatal Care for Trans and Non-Binary Birthing People

NHS University Hospitals of Leicester NHS Trust

Trust ref:C62/2024

Contents

1. Introduction and Who Guideline applies to

Maternity services have typically been designed as a cisgender (cis) women-only service, which may not serve the needs of trans and non-binary service users. When providing perinatal care to trans or non-binary people, the Trust and its employees should treat service users according to their self-identified gender, not the sex they were assigned at birth.

This guideline applies to:

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

Responsibilities
Clinical staff:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline
- This guidance is for staff working in University Hospitals of Leicester NHS Trust Perinatal Services. The guidance is not rigid and should be tailored to the individual circumstances of each person. If the guidance is not being followed, documentation of the reasoning and/or justification is essential, with clear documentation of alternative plans and discussions.

Management Team:

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

Related documents:

Transgender and Non Binary Patients Supporting UHL Policy.pdf
Lactation Suppression – UHL Guideline

2. Guideline Standards and Procedures

2.1 Validity and Rights

Transgender (trans) and non-binary people may face personal, social, economic, institutional and structural barriers to accessing appropriate and affirmative care. They are likely to have had negative experiences in healthcare settings previously, and may worry that healthcare professionals will not understand their specific identity, needs and concerns. The Improving Trans and Non-binary Experiences of Maternity Services (ITEMS) survey (LGBT Foundation 2022) found that trans and non-binary people's experiences of perinatal care are consistently worse when compared with cis women, with 30% compared to 2.1% of the general population not accessing perinatal care in pregnancy for this reason.

Transphobia and racism in perinatal care intersect to produce particularly poor outcomes for trans and non-binary birthing parents of colour (LGBT Foundation 2022).

Gender reassignment is a protected characteristic under the Equality Act 2010. This applies whether the person has proposed, is currently undergoing, or has completed any part of their transition process. Medical assistance is not a necessary component of the transition process for this protection in law to apply.

Pregnant people and new parents are entitled to safe and respectful perinatal care regardless of gender identity, or history of medical and/or social transition. Respectful care

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

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

Some staff may voice objections towards treating trans or non-binary service users on the grounds of their religion or beliefs – this would be classed as discrimination. Managers must be prepared to deal with this in the same manner as for any other similar objection (for example on the grounds of sexual orientation).

It is unlawful to disclose a service user's gender history without consent, and professionals should not disclose a service user's gender history unless it is directly relevant to the condition or treatment. In the context of providing perinatal care, the presence of reproductive organs is a pre-requisite to accessing these services. Respecting a person's identity and using correct pronouns and terminology is not a breach of this guidance.

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

2.2 Environment

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

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

2.3 Communication and language

The ability to use appropriate language is an important skill that professionals should develop, particularly in perinatal care settings where feminine pronouns and descriptors often used as default.

Every service user should be asked which pronouns they use as part of booking questions and this should be documented within their handheld notes. For example, when confirming demographic data such as name, professionals can ask:

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

Professionals should always refer to people using the pronouns and language of their choice. For some people, their pronouns may change over time, so professionals should be led by the way in which an individual service user refers to themselves. Misgendering someone (e.g. using "she" instead of "he", using the wrong name, or referring to someone as "mother" when they do not identify that way) may inadvertently cause harm to trans and non-binary people, and intensify gender dysphoria.

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

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

Pronouns are essential information during handover of care, to allow respectful communication from all members of staff. This also applies to names, if someone uses a different name than is currently on their NHS record. When handing over care, it is good practice to add the pronouns for everyone to avoid "othering" someone who is non cisgender.

Service users will make their own choices about how they wish to refer to themselves. Staff should not use terms such as "mother" or "mum" as default for trans and non-binary service users, unless this is their expressed preference, in order to avoid causing harm and intensifying gender dysphoria.

Some service users may have preferred terminology for their own anatomy and these should be respected and used wherever possible. Professionals should refer to the "My Language Preferences" (see Appendix 1). For example, some people may refer to their "chest" and "chest feeding" rather than their "breasts" and "breast feeding". Some people may talk about their "front hole" or "genital opening" rather than "vagina". If a My Language Preferences sheet has not been completed, or the particular clinical scenario has not been covered, ask the service user how they refer to their body parts and activities involving their body (such as infant feeding). For example, "In order to provide you the best healthcare possible, would you be prepared to tell me what language you use to refer to your body parts?" Use of gender

specific anatomical terms can be very triggering and heighten dysphoria, therefore it is important to use the terms specified by the birthing person. The resource in Appendix 2 and 3 can also be used for cis-gender service users as part of trauma informed care.

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

When talking about, or to, groups of people, use gender inclusive, additive, or neutral language. For example, if discussing vaginal birth after Caesarean, say, “The success rate for women and people planning VBAC is 72-75%”, rather than, “The success rate for women planning VBAC is 72-75%”; or say, “Pregnant women and people can choose to birth at hospital or at home”, rather than, “Pregnant women can choose to birth at hospital or at home”. Using gender inclusive language is important, regardless of whether trans or non-binary people are known to be in the space. In this way, we validate and normalise the diverse gender identities of all those who give birth.

2.4 Documentation

Some service users may not have updated their health records to reflect their preferred name, gender identity or title. If the service user has not updated their name on the IT system, their preferred name should still be used in verbal and written communication, in addition to their NHS number, to ensure that the correct medical record is tracked. An exception may apply to laboratory samples, where all service user details must match information recorded on ICE, and people in our care should be warned that due to limitations of the laboratories, perinatal samples will be labelled as female.

Service users can be advised they have the right to change their name, title and gender marker on all health care records.

The Trust’s various IT systems do not yet accept coding perinatal care for sex/gender markers other than female; this should be explained to service users so that they are prepared. Problems encountered with IT systems should be referred to the Digital Lead Midwife and Inpatient Matron for the hospital site booked.

2.5 In-patient Care

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

On shared wards that are typically used for cis women, trans and non-binary service users should be offered the choice between a side room, or shared accommodation on the ward. When a trans or non-binary service user’s preference is for a side room, but one is not currently available, alternative accommodation should be sought. For example, a service

user who has just recently given birth may remain on the Birth Centre/Delivery Suite until a side room on one of the wards is available.

2.6 Pre-conception Care

Trans and non-binary individuals may seek clinical advice before starting a family, especially if they are using hormone therapy. Testosterone is a teratogen, and often suppresses ovulation, but is not an effective form of contraception. Therefore, all service users taking testosterone should be advised to discontinue use prior to conception.

Conception and successful pregnancy can occur even after long-term testosterone usage. Stopping testosterone therapy can result in the return of menstruation and fertility. The potential need for assisted reproductive technologies will depend on the resumption of a normal menstrual cycle, the reproductive capacity of the co-parent, parental preferences and medical advice.

Lower surgeries (gender affirming genital surgery - such as metoidioplasty, scrotoplasty or phalloplasty; without hysterectomy or vaginectomy) do not, by themselves, impair future reproductive options in terms of conception, but would likely necessitate a caesarean birth.

2.7 Booking & Referrals

At the first booking appointment, the community midwife should ask all service users about the name they prefer to go by, and ask for the service user's pronouns. Since gender identity and expression exist on a wide spectrum, assumptions about gender and pronouns should not be made based on the service user's appearance or behaviour.

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

The current clinical consensus is that service users who conceived whilst taking testosterone should be advised to stop taking it if they plan to continue with the pregnancy. Testosterone is considered a teratogen, with potential implications for reproductive development of the fetus. If a pregnant person reports taking testosterone at any point during pregnancy please refer immediately to MINT clinic to receive the appropriate obstetric care and plans for pregnancy, birth and the postnatal periods as testosterone levels are advised to be monitored via blood tests. The consultant will therefore liaise with endocrinologists to ensure appropriate management.

Some service users may be taking Testosterone through an unconventional route and therefore have never divulged this information to a healthcare professional. As a result, they

may not be having their Testosterone levels monitored and they may feel uneasy about sharing this information due to fear of repercussions. Please reassure the service user of the rationale for asking this question is due to the importance of monitoring levels in pregnancy.

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

General referrals for obstetric input (e.g. medical conditions, previous obstetric history etc.) should also be directed to the clinic appropriate to the medical condition or obstetric history.

Some trans and non-binary service users may express a wish to birth via Caesarean section, due to concerns that physiological birth may trigger gender dysphoria. Referrals should be made to the MINT clinic.

Referral to the MINT clinic or perinatal mental health services should be made as appropriate, with recognition that there are increased levels of mental health challenges among the trans and non-binary population, however, trans or non-binary identity is not of itself a reason for referral to mental health services.

2.8 Community Midwifery Care

Ongoing antenatal care may be offered per universal requirements. Some people may prefer to book appointment slots at the beginning or end of the day, when the waiting room is quieter. Alternatively, the community midwife may be able to provide antenatal appointments at home, or another location, for those preferring greater privacy. The Home Birth Team should be offered as a birthing choice in line with guidance for all service users.

With consent, a service user's history should be shared with other members of the community team who may be sharing antenatal clinics, to avoid expressions of surprise when the birthing person attends clinic. Sharing this with midwives at the intended birth location may also be appropriate.

The pregnant person or their partner may need assistance with:

- Support via telephone/email/text throughout pregnancy and postnatal period
- Support visits at home throughout pregnancy and postnatal period
- Telephoning ahead of other appointments, such as scans, to notify reception and clinical staff, and ensure an awareness of pronouns
- Liaison with other professionals including Health Visitors to ensure information is shared according to the family's wishes
- Assistance in producing a personalised birth plan
- Assistance filling out My Language Preferences sheet
- Producing a personalised infant feeding plan, with potential input from the named Specialist Infant Feeding Midwife.
- Tour of hospital facilities

2.9 Obstetric Considerations

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

The choice to birth at home should be supported in line with trust guidance on birth place choices. Trans or non-binary birthing people who have increased need for obstetric input should be referred to the consultant midwife if they express a wish to birth at home outside guidance.

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

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

2.10 Physical Changes and Emotional Health

Service users may have questions about how their body will change during pregnancy, with respect to their previous medical treatments, and professionals should endeavour to answer these questions as far as their knowledge allows. Professionals can discuss in more detail:

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

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

Gender dysphoria during pregnancy may be separated into two sources, which health care providers should understand. Dysphoria can be rooted in an individual's feelings about their body, and the physical changes that are associated with pregnancy. Dysphoria may also be

triggered by social interactions, both with individual practitioners, and through engaging with a gendered system.

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

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

2.11 Intrapartum Care

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

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

Examples of trauma-informed care include:

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

For people who have not had lower surgery (gender affirming genital surgery), catheter selection and insertion is in line with Bladder Care During and After Labour and Delivery UHL Obstetric Guideline.pdf. People who have had lower surgery may have also had their urethra

relocated and/or lengthened. In these situations, professionals should ask the service user about the location and length of their urethra prior to attempting catheterisation. Potential locations for the urethra include:

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

All health care professionals trained to insert or remove catheters for cis women are also suitably qualified to undertake these procedures for pregnant and birthing people who have had lower surgery. Insertion should be as per the Trust Urinary Devices in Adults UHL Policy.pdf.

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

2.12 Postnatal Care

Postnatal checks should be performed as per Postnatal Care UHL Obstetric Guideline.pdf, taking into account additional communication needs while also ensuring safe and thorough care.

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

Professionals should discuss the potential for postnatal depression with all service users. Those who have previously taken testosterone may be more at risk, or their experience of postnatal depression may be different to cis women.

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

Contraception is recommended for all service users, if they engage in sexual activity that could result in conception. Testosterone is not a contraceptive, so contraception is still advised for people considering resuming testosterone, if they have sexual activity with a partner who produces sperm. Copper intrauterine devices are safe and do not interfere with hormonal treatment. Progestogen-only contraceptive methods are not thought to interact with hormonal treatment and are generally acceptable. The use of combined hormonal contraception is generally not recommended for trans men and non-binary people who are

taking testosterone, because the oestrogen component will counteract the effects of testosterone.

Trans and non-binary people are often omitted from sex-specific screening algorithms if their NHS gender markers have been updated to reflect their gender identity. Therefore service users can be reminded postnatally that they are eligible for routine cervical screening, but may not receive invitations to appointments. Cervical screening can be arranged with their GP surgery or with Sexual Health & Contraceptive Services, including the Haymarket Health Centre in Leicester, and these services can make a request to the NHS Cervical Screening Programme so that invitations are sent correctly.

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

2.13 Infant Feeding

Trans and non-binary service users should be supported in their choices regarding infant feeding. Some may be very motivated to breast/chestfeed, and may have chosen to delay top surgery in order to do so. Others may make an advance decision not to breast/chestfeed, whether they have had top surgery or not. Finally, some service users may change their mind about how they wish to feed their baby once their baby has been born.

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

Following top surgery there may be less soft tissue available for the baby to latch on to, however some service users have reported success with using their fingers to firmly shape their ‘c’. Supplementary nursing systems could also be discussed if wished.

The literature is not clear regarding testosterone transmission into human milk, or potential impact on milk supply, although some evidence suggests high testosterone levels may impair lactation. Whilst there are possible risks to the infant, there is no clear evidence of harm, however it should be noted that the evidence-base for this conclusion is very limited. The individual service user is best placed to assess the benefits of resuming testosterone in terms of their own emotional, physical, social and mental wellbeing with additional advice and support. Referrals can be made to the obstetric antenatal clinic that can discuss the potential risks, liaise with their endocrinologist, and develop an individualised care plan.

Service users who have not had top surgery may wish to bind or tape their chest during times they are not actively feeding or expressing. Binding or taping may increase the chances of mastitis, so service users should be made aware the signs and management of mastitis, and may wish to wear a larger size binder than they wore previously.

If a service user is certain they do not want to breast/chestfeed or express, prevention of lactation can be offered to help minimise swelling of the chest in the early postnatal period, which may contribute to dysphoria. This option can be offered regardless of whether they have had top surgery or not, as mammary tissue will still be present post-surgery. If prevention of lactation is desired, then treat as per the **Lactation Suppression – UHL Guideline**.

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

Non-gestational parents may wish to participate in feeding their infants using their own bodies. Cis women who have previously breastfed may have the most success in relactating. People who have not been pregnant may also be able to induce lactation to some extent. Methods for inducing lactation include using galactagogues and physical stimulation. Alternatively, some families choose to use supplemental nursing systems with expressed milk or formula.

A referral is recommended to the infant feeding team for a personalised care plan and additional support, this should be made with informed consent.

3. Education and Training

This guideline will require a formal launch to ensure awareness from all staff.

Staff training and local area champions.

Receptionists and administrative staff who are public facing should also be given training, which should include:

- Basic concepts: sex, gender identity, gender expression, sexuality, transition
- Respectful communication and pronoun usage

Where possible when planning shift staffing, each shift should have a midwife trained in gender diversity issues.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
The number of trans or non-binary people who: - are pregnant locally - present for antenatal care - attend for booking by 10, 12+6 and 20 weeks - attend the recommended number of antenatal appointments, in line with national guidance		Specialist midwife		

- experience, or have babies who experience, mortality or significant morbidity				
For each trans or non-binary pregnant person: - the number of appointments they attend - the number of scheduled appointments they do not attend				

5. Supporting References

BSUH Guideline (2020) 'Perinatal Care for Trans and Non-Binary People'

Equality Act. (2010). London: The Stationery Office.

LGBT Foundation (2022). 'Trans and Non-binary experiences of maternity service; survey findings'. Retrieved from: Trans Pregnancy Survey (dxfy8lrzbpywr.cloudfront.net)

6. Key Words

Body map, Equality, Gender, Trans, non-binary, perinatal services, Pronouns, Testosterone

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review details	
Guideline Authors Jennie Morris, Midwife Coordinator & Chair of the UHL LGBTQ+ Network Dalvir Kandola, Consultant Midwife, Lead for Inclusivity **This guideline has been reviewed by a working party of trans and non-binary service users, who have also been instrumental in developing the details within.** The guideline has been based on Brighton and Sussex NHS University Hospital's NHS Trust guideline 'Perinatal Care for Trans and Non-Binary People' and with focus groups of trans and non-binary community in Leicester, Leicestershire and Rutland.	**Executive Lead** Chief Nurse

Details of Changes made during review:

Date	Issue Number	Reviewed By	Description Of Changes (If Any)
October 2024	**1**		**New document**

Appendix One: My Language Preferences

Name:

NHS No:

Patient No:

Language preferences

	Name	Pronouns	What your child will call you
Birth parent:			
Co-parent:			
Additional birth partner:			

Please state your preferred alternatives for commonly-used terms around birth, if there are any that you need caregivers to avoid. Please discuss with your caregiver if unsure.

Term to avoid	Preferred term

Supporting references
NMC The Code, 2015: 1 Treat people as individuals and uphold their dignity 1.3 avoid making assumptions and recognise diversity and individual choice 2 Listen to people and respond to their preferences and concerns 2.2 recognise and respect the contribution that people can make to their own health and wellbeing 7 Communicate clearly 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs.
NICE CG190, 2014: Treat all [people] in labour with respect. Ensure that [they] are in control of and involved in what is happening to [them], and recognise that the way in which care is given is key to this. To facilitate this, establish a rapport with the [birthing person], ask [them] about [their] wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used. Use this information to support and guide [them] through [their] labour.

Appendix Two: Body Map

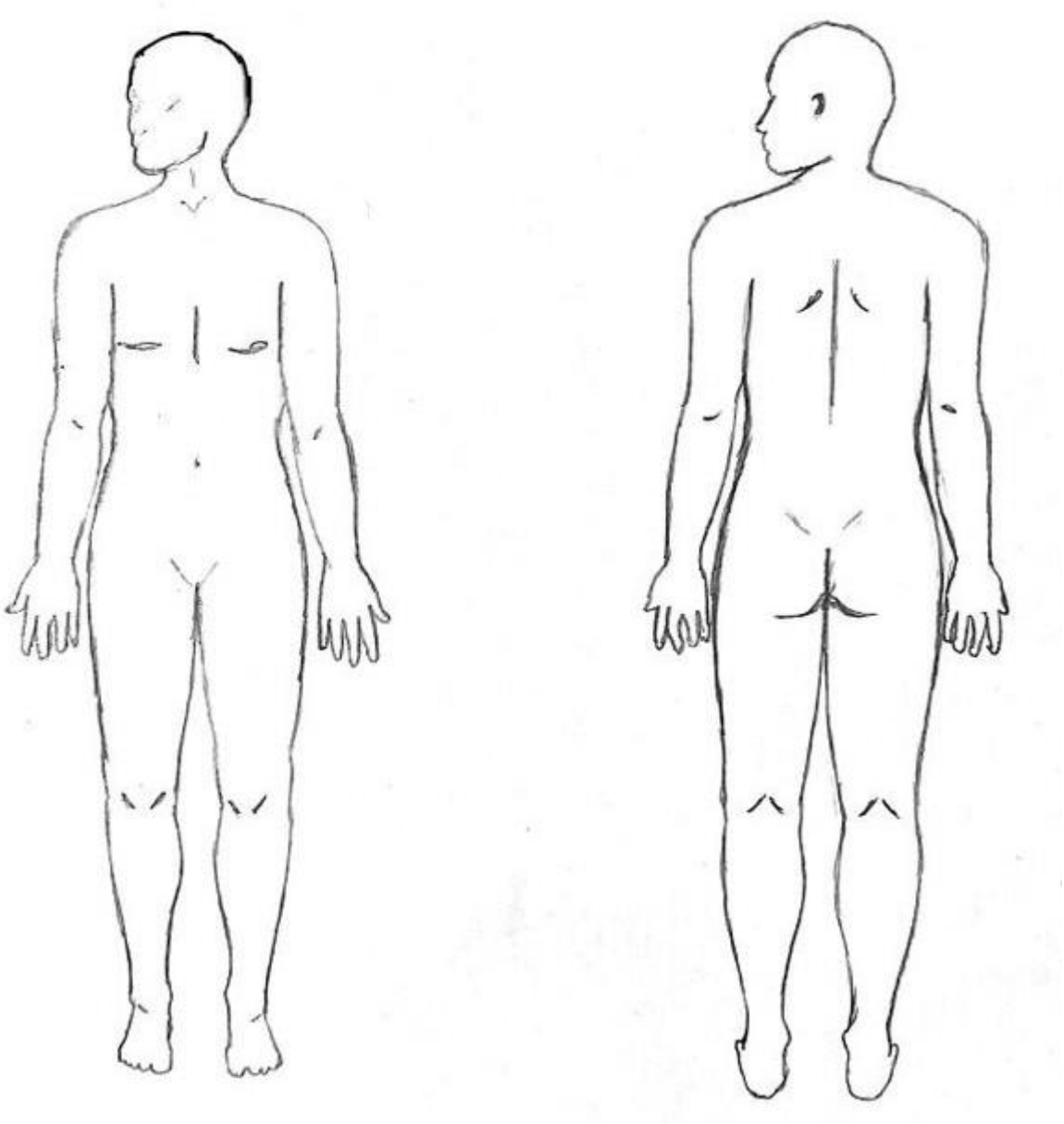
Perinatal body map

Name:

NHS No:

Patient No:

Please use for: highlighting previous surgeries; highlighting alternative phraseology; highlighting areas of trauma.



Please use this space to include any other details or terminology that is important to you. If there is anything you do not wish to include in handheld notes but needs to be passed on to other healthcare providers please let your midwife know.

Appendix Three: Checklist

Name:

NHS No:

Patient No:

Trans and nonbinary Checklist

At booking:

- ☐ Ask **all** service users and partners about gender identity and pronouns, to be recorded on appropriate page in booking notes if consent is given.

- ☐ Complete body map with **all service users** if desired.
- ☐ Complete language preferences with **all service users** if desired.
- ☐ Consider most appropriate location and timing for antenatal clinics.

Remember that trans care is also trauma informed care, and it is important to ask everyone to avoid "othering" the LGBTQ+ community and to avoid anyone being missed. Respect consent – sharing this information is not mandatory.

Referrals – only if clinically indicated (gender difference is not in itself a reason to refer to specialist services):

- ☐ MINT clinic if mental health support is needed or requested.
- ☐ MINT if necessary to discuss mode of birth – this could be due to surgeries, dysphoria, or tocophobia.
- ☐ MINT clinic if necessary due to testosterone usage or requirements postnatally – this will result in appropriate referral and discussions regarding endocrinology review/input

Information for service users:

- ☐ Website link via HealthUnder5's.
- ☐ Inform service users that the legal registration stipulates mother and father; we are unable to change this.
- ☐ Inform the service user that perinatal bloods will be marked as female due to limitations of blood services.

Discuss:

- ☐ Feeding choices – refer to infant feeding team
- ☐ Contraception if sexual activity could result in conception – signpost to GP / Haymarket health centre, or refer to postnatal contraceptive service within hospital setting.