Original article

The Postcode Lottery: Gender-affirming Healthcare Provision across New Zealand's District Health Boards

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Abstract

Need for transgender health services has significantly increased in New Zealand, but public health service provision has lagged behind demand. Provision of transgender healthcare is further complicated by a lack of clarity around which gender-affirming healthcare services are provided by each District Health Board, and the process for accessing these services.

Aims

To establish which gender-affirming healthcare services are available in each of New Zealand's 20 districts and what process each District Health Board follows for providing these services.

Methods

Data were gathered using Official Information Act 1982 requests to each of the 20 District Health Boards. Two independent coders coded each response for availability of, and process for accessing, each service. Following this, interpretations of each response were returned to a District Health Board representative for an opportunity to confirm or update their response.

Results

Overall, responses showed notable inconsistency between District Health Boards regarding which services were available and funded. Four District Health Boards reported that they did not provide specific funding for any of the gender-affirming healthcare services listed.

Responses to questions about the process of accessing gender-affirming healthcare produced similarly mixed results.

Conclusions

There is a need for consistency in gender-affirming healthcare provision across District Health Boards, and for the creation of clear health pathways and criteria for care.

The Postcode Lottery: Gender-Affirming Healthcare Provision across New Zealand's District Health Boards

Recent research indicates that the need for transgender health services is increasing significantly in New Zealand (Delahunt et al., 2018), however the Ministry of Health reports that public health service provision¹ has not kept up with demand (Ministry of Health, 2018a). Here, we explore the availability of publicly funded gender-affirming healthcare across New Zealand using results from Official Information Act 1982 (OIA) requests to each of the 20 District Health Boards (DHBs). DHBs are responsible for providing or funding health and disability services in a defined geographical area.

Here, we use 'transgender' to refer to those whose gender differs from their assigned sex at birth, and 'cisgender' to refer to those whose gender is the same as their assigned sex at birth. While 'gender-affirming healthcare' can refer to any health service that affirms and validates a patient's gender, including counselling and support with social transition, in this article we use this term to refer specifically to medical transition-related services, including hormone therapy, surgeries (mastectomy, hysterectomy, orchidectomy, and breast augmentation), and ancillary services (facial hair removal and voice training).

The Importance of Gender-Affirming Healthcare

A well-established body of research documents high rates of depression, anxiety, suicidality, and other mental health difficulties among transgender community members (Budge et al., 2015; Haas et al., 2010), and shows that exposure to societal stigma increases risk for poor mental health and wellbeing (Bockting et al., 2013; Hughto et al., 2015). For many transgender people, the distress associated with gender dysphoria (dissonance between

¹ Similar to Australia, New Zealand has a mixed public-private system for healthcare delivery. Essential healthcare services are fully funded for all New Zealanders and those in New Zealand on work permits valid for at least two years. Primary care is subsidised, as are many medications. The private healthcare system provides urgent, non-urgent and elective treatments alongside the public system. Specialists commonly work across both systems, and patients often switch between accessing public and private healthcare.

one's gender and body; Gender Minorities Aotearoa, 2017) also contributes to the development of mental health difficulties (Holt et al., 2016; Olson et al., 2015). As such, improving the health and wellbeing of transgender community members requires challenging stigma and discrimination at a societal level, as well as providing access to mental health support and gender-affirming healthcare services for those who need it. Meta-analyses and systematic reviews provide empirical support for the efficacy of gender-affirming healthcare, demonstrating that access to transition-related services decreases gender dysphoria, improves psychological symptoms, and increases quality of life (Dhejne et al., 2015; Hughto and Reisner, 2016; Murad et al., 2010).

Gender-Affirming Healthcare Provision in New Zealand

In New Zealand, funding for genital surgeries is provided by the Ministry of Health's special high cost treatment pool, a fund set aside for one-off treatments not otherwise funded by the public health system (Ministry of Health, 2018b). Those in need are referred by a specialist to a waitlist, either for masculinising or feminising surgery.² Between 2004 (when a cap for the number of funded surgeries was introduced) and 2018 the Ministry of Health approved up to four surgeries every two years; one masculinising surgery and three feminising surgeries (Ministry of Health, 2018c). As of October 2018 there were 79 people waiting for feminising surgery and 26 people waiting for masculinising surgery (Ministry of Health, 2018d). At that rate of provision, the last person on the waiting list would receive surgery more than 50 years from now. In October 2018, the Government decided there would

² Gender-affirming genital surgeries encompass a range of procedures, which fall into two groups. The Ministry of Health has previously used the terms "male to female" and "female to male" as shorthand to differentiate these groups of surgeries, as well as their waitlists (Ministry of Health, 2018d, 2018e). We avoid the use of these terms as they reify myths of medical transition as 'switching' from one gender to another. Instead, we adopt the terms "genital feminising surgery" and "genital masculinising surgery," where "feminising surgery" refers to penectomy, orchidectomy, clitoroplasty, labiaplasty and vaginoplasty, and "masculinising surgery" refers to metoidioplasty and phalloplasty (D St George, 2018, personal communication). The Ministry of Health are also moving toward the use of the terms "feminising surgery" and "masculinising surgery" (D St George, 2018, personal communication). While the terms "feminising" and "masculinising" are an improvement over "male to female" and "female to male" we acknowledge that they are not entirely unproblematic, as they imply that gender is associated with particular kinds of bodies.

no longer be a cap on the number of surgeries performed, while the previous caps would become a minimum number of surgeries every two years (Coughlan, 2018). It remains unclear, however, how many genital surgeries the Ministry of Health will now fund.

Other gender-affirming healthcare services are provided by patients' local DHBs (Ministry of Health, 2018e), however there is a lack of information regarding the current availability of these various services. A 2015 Ministry stocktake of gender-affirming healthcare services showed that only four DHBs provided gender-affirming surgeries, and nine DHBs provided no gender-affirming healthcare services (Ministry of Health, 2018e). Transgender people report widespread knowledge gaps among practitioners regarding transgender healthcare in New Zealand, and many DHBs continue to seem unsure of their role in providing care to transgender patients (Wi-Hongi et al., 2017). At the time of writing only *one* of the 20 DHBs (Auckland) provided specific information about accessing gender-affirming healthcare when the search term 'transgender' was entered on their website.

As well as uncertainty regarding the availability of gender-affirming healthcare services, there is a lack of clarity regarding the process of accessing these services, largely due to the absence of national guidelines for healthcare providers.³ Up until mid-October 2018, the Ministry of Health website stated that real life experience ("living and working full time for at least two years as a woman/man") was required to access hormones and surgery (Ministry of Health, 2018f), although this has not been a requirement in the World Professional Association for Transgender Health's (WPATH; 2012) internationally accepted Standards of Care since 2011. A readiness for treatment assessment by a mental health

³ Oliphant and colleagues (2018) have recently drafted Aotearoa New Zealand Guidelines for Gender Affirming Healthcare. These are not yet available, but have been endorsed by the Australian and New Zealand Professional Association for Transgender Health, the New Zealand Sexual Health Society, and the New Zealand Society of Endocrinology. National standards of care are available in some other countries, such as Australia (Telfer, et al., 2018), while many others follow the World Professional Association for Transgender Health (2012) Standards of Care or the Center of Excellence for Transgender Health (2016) Guidelines for primary and gender-affirming care of transgender people.

professional is routinely required to access gender-affirming healthcare, however there is a lack of consensus on what the assessment should contain, or who is qualified to carry it out (Wi-Hongi et al., 2017). Finally, it is unclear whether hormone therapy can be prescribed by primary health professionals, and whether DHBs will fund patients to travel to other districts in cases where their local DHB does not provide gender-affirming healthcare services. In this context of confusion and inadequate information, there is an urgent need for research that sheds light on gender-affirming healthcare provision in New Zealand.

The Current Study

In this study, we aim to fill these gaps in the transgender health literature by establishing which gender-affirming healthcare services are available in each district, and what process each DHB follows for providing these services.

Method

Data Collection

Data about the availability of gender-affirming healthcare services were gathered using Official Information Act requests. The OIA allows New Zealanders to request any official information held by government agencies. Unless there is a “conclusive” reason to withhold it (see section 6 of the OIA), government agencies are required by law to provide the information no later than 20 working days after receiving a request.

We sent the same OIA request to each of New Zealand’s 20 District Health Boards. We asked if the following gender-affirming services are publicly available: hormone therapy, mastectomy, hysterectomy, orchidectomy, facial hair removal, breast augmentation, and voice training. We selected these services following a review of the literature on gender-affirming healthcare services (e.g. Deutsch, 2018). We also asked if an assessment by a mental health professional is required in order to access gender-affirming healthcare services, and, if so, which services. We asked if primary health providers can prescribe hormones, and

if any period of real life experience is required to access surgery. Finally, we asked if travel to another DHB was funded in cases where a patient required one of the aforementioned services, but the District Health Board did not provide it. All requests were sent May 22-23, 2018.

Of the 20 DHBs, 12 provided a response within 20 working days. Capital & Coast DHB responded within 20 working days to request an extension, and provided the information 27 working days after the original request. All other DHBs also provided responses within 27 working days of the initial request, with the exception of West Coast DHB and South Canterbury DHB, who responded in 42 and 61 working days respectively. In six cases (Southern, Hawke's Bay, Whanganui, Mid Central, Waikato, and Bay of Plenty) we sent follow up requests either to clarify aspects of the response, or to request information that was missing from the original response. We sent all requests via FYI (fyi.org.nz), a website that allows New Zealanders to publicly lodge their requests online, for others to read.⁴

Data Coding

We expected to receive a “yes” or “no” response to each question in our OIA request, however when our requests were returned it became clear that many DHBs did not provide clear cut answers to our questions. Instead we were often advised that, for example, “gender-affirming services are not *routinely* funded” (emphasis added) or that health services “may on occasion accept referrals on a case-by-case basis.” Due to the equivocal nature of many of the OIA responses, we developed a scheme to code “yes” and “no” responses, as well as those that fell somewhere in between.

The coding scheme for availability of services is shown in Table 1, and the coding scheme for the process of accessing services is shown in Table 2. All requests were coded separately by the first and second author. For a service to be coded as ‘A’ for ‘publicly

⁴ To read all requests and responses, visit fyi.org.nz/user/gloria_fraser.

available' *all* aspects of the service must be publicly funded. As such, hormone therapy was not coded as 'publicly available' if endocrinologist appointments were funded, but the assessment by a mental health professional needed to access hormone therapy was not.

Table 1. Coding scheme for availability of gender-affirming healthcare services

Code	Description
NA	Not available
NR	Not available - Patients are referred to another DHB
NDF	No dedicated funding - service may be provided on a case by case basis, or only for patients in particular age groups
A	Service is publicly available

Table 2. Coding scheme for process of accessing gender-affirming healthcare services

Code	Mental health professionals' assessment	Primary health can prescribe	Real life experience	Funded travel
Y	Yes, assessment by mental health professional required	Yes, primary health providers can prescribe	Yes, real life experience required	Yes, funded travel available
S	Assessment by mental health professional required for some age groups, or in some cases	Primary health providers can prescribe some medications, others need specialist approval	-	-
N	Assessment by mental health professional not required	No, primary health providers cannot prescribe	No, real life experience not required	No, funded travel not available
N/A	Not applicable – gender-affirming healthcare not provided	Not applicable – gender-affirming healthcare not provided	Not applicable – gender-affirming healthcare not provided	-
Unclear	-	-	DHB did not understand meaning of real life experience	DHB did not provide response

An interrater reliability analysis using the Kappa statistic was performed to determine consistency among coders. There was substantial agreement between the two coders' interpretations of availability of the seven gender-affirming services, $\kappa = .74$ (95% CI, .62 - .84), $p < 0.01$. There was moderate agreement for the remaining four questions about the process of accessing care, $\kappa = .50$ (95% CI, .36 - .64), $p < 0.01$. Following the initial independent coding, the first two authors discussed inconsistencies and revised the coding scheme until they reached full agreement.

After all responses were coded, we sent each DHB our coding schemes and codes for their DHB, either to the DHB communications email address, or to DHB representatives we had been advised were involved in the provision of transgender healthcare. We invited the DHBs to correct any inaccurate information or misinterpretations on our part. In total, 15 DHBs responded to our request, with 11 DHBs modifying their responses, and four (Canterbury, Capital & Coast, West Coast, and Whanganui) confirming our coding was correct. Of those that corrected our coding, some made a number of small changes to their responses (e.g. Bay of Plenty changed “no dedicated funding” to “not available” for all services except hormone therapy), while others changed several codes drastically (e.g. Taranaki changed the mastectomy, hysterectomy, and orchidectomy codes from “available” to “not available”).

Availability of each gender-affirming healthcare service across the 20 DHBs is summarised in Table 3, as well as in Figures 1-7. In cases where DHBs revised their responses, the revised response is shown in brackets. See Supplementary Material for a table summarising the original codes, based on the OIA responses. The process for accessing gender-affirming healthcare services is summarised in Table 4.

Results

Availability of gender-affirming healthcare services

Overall, responses showed remarkable inconsistency between DHBs regarding which services were available and funded, as well as between the services themselves regarding which were most commonly available. Hawke's Bay and Whanganui DHB reported that they did not provide specific funding for any of the gender-affirming healthcare services listed, and did not report that they referred patients to another DHB. Across all DHBs, hormone therapy was the most widely available healthcare service, with 15 of the 20 DHBs providing specific funding for this service. This was followed by hysterectomy, with eight DHBs provide specific funding for this service, then voice training (seven DHBs providing specific funding for this service). No DHB set aside specific funding for facial hair removal. Overall, services were most often available in major centres (Auckland region DHBs, Capital and Coast DHB, and Canterbury DHB), and in DHBs involved in public sector projects to improve transgender healthcare pathways (e.g. Northern Region Transgender Care Pathways Project).

Process for accessing gender-affirming healthcare services

Responses to questions about the process of accessing gender-affirming healthcare produced similarly mixed results. Assessment by a mental health professional is required to access gender-affirming healthcare in 11 DHBs, and primary healthcare providers are unable to prescribe hormone therapy without specialist approval in five DHBs. Real life experience is required to access healthcare in two DHBs, and just over half (11) provide funding to travel to other areas to access care unavailable in patients' DHB. The majority of DHBs who consider funding travel noted that the patient would also have to meet criteria for the National Travel Assistance (Ministry of Health, 2005) policy in order to access this.

Discussion

We sought to establish which gender-affirming healthcare services are available across New Zealand's DHBs, and to better understand the process of accessing these

services. Results showed notable inconsistencies between DHBs regarding the services they provide and the requirements for accessing these services. There was also inconsistency regarding availability of the services themselves, with hormone therapy available in most districts, surgeries available to varying degrees, and facial hair removal rarely available. The unavailability of facial hair removal is particularly surprising, given that Gender Minorities Aotearoa (2017) describe facial hair removal as the most basic, inexpensive, and urgent of all medical treatments for transgender women.⁵ Only two DHBs reported that they did not allocate funding to transgender health services or arrange referrals to other DHBs for gender-affirming healthcare. This is an improvement compared to the nine DHBs that did not report providing gender-affirming healthcare in October 2015 (Ministry of Health, 2018e), although any number of DHBs that does not provide these services is arguably too high.

There was a near-even split between those DHBs who required assessment by a mental health professional to access gender-affirming healthcare, and those that either did not require this or only required an assessment in some cases. The role of the mental health professional in accessing gender-affirming care has been hotly debated in transgender health literature and practice. Some claim that assessment by a mental health professional is an important safeguard for establishing whether patients are ready for treatment, while others contend that mental health professionals should not act as gatekeepers for services; other professionals can establish informed consent (that is, they can ascertain whether a patient is capable of making decisions around their healthcare; Cavanaugh et al., 2016; Lev, 2009). It is outside the scope of this study to reflect on the role of the mental health professional in accessing gender-affirming healthcare, however the currently variability in process is

⁵ It must be noted that in some districts facial hair removal is not only unavailable as a gender-affirming service, but for any reason. Mid Central DHB, for example, noted that all patients, including women with hirsutism, are required to self-fund facial hair removal. Wi-Hongi and colleagues (2017) point out, however, that in some districts facial hair removal is funded for cisgender women with hirsutism, but is not funded for transgender women as a gender-affirming health service.

problematic; in those districts where assessment by a mental health professional is required for treatment, patients may face financial barriers and waiting times that those in other districts do not.

It is concerning that, as recently as October 2018, Ministry of Health guidelines (which Canterbury DHB and West Coast DHB were following at the time of our request) required living and working for a set period of time in the “preferred” gender role (Bockting, 2008) to access gender-affirming healthcare. Wi-Hongi and colleagues (2017: 156) point out that “attempting to be read as the correct gender without appropriate medical support can have negative consequences”. These include exposure to physical and sexual violence, high social anxiety due to hypervigilance, and physical problems such as back pain and compressed ribs from binding one’s chest too tightly, or bladder infections as a result of avoiding public bathrooms. Due to these potential negative consequences, real life experience was removed from the WPATH Standards of Care for these reasons in 2011, and the Ministry of Health presumably updated their website to remove the real life experience guidelines for the same reason. Following this website update, however, there is little information available to guide practitioners in providing gender-affirming healthcare. As such, we encourage the Ministry of Health to endorse and distribute Oliphant and colleagues’ (2018) recently drafted Aotearoa New Zealand Guidelines for Gender Affirming Healthcare, which are accessible, detailed, and use Te Whare Tapa Whā (an indigenous Māori model) as a holistic health framework for the guidelines.

Implications

Our findings reflect previous literature that describes New Zealand’s gender-affirming healthcare provision as widely variable and, with the exception of hormone therapy, largely unavailable (particularly outside of major centres; McDonald and Byrne, 2015; Wi-Hongi et al., 2017). For example, the Human Rights Commission’s Report of the Inquiry into

Discrimination Experienced by Transgender People noted, in 2007, that “the provision of public health services is patchy and inconsistent” (Human Rights Commission, 2007: 50).

The current study suggests that this is still the case, and highlights the need for an increase in the availability of gender-affirming healthcare services, as well as consistency across DHBs regarding availability and accessibility of services; the services that patients can access should not be a lottery by postcode.

Our results support the need for clear treatment and referral pathways, as well as the development of specialist services for gender diverse people in New Zealand’s tertiary centres. Delahunt and colleagues (2016) propose that practitioners experienced in transgender healthcare could work in ‘centres of excellence’, providing guidance and support to practitioners in local and adjacent DHBs. Given that many DHBs advised that they often access specific services and tertiary care from larger centres, ‘centres of excellence’ could help to ensure that all DHBs are equally equipped to provide gender-affirming healthcare.

Strengths, Caveats, and Future Directions

These results are a helpful starting point for understanding the current availability of gender-affirming healthcare in New Zealand. To our knowledge, this study represents the only comprehensive, publicly available record of the availability of gender-affirming healthcare across New Zealand’s DHBs since the Ministry of Health’s 2015 stocktake (Ministry of Health, 2018e). Our results provide a baseline from which future researchers can track change in New Zealand’s gender-affirming healthcare provision. These findings should, however, be interpreted with a few key points in mind.

While these OIA responses are, to a certain extent, reflective of New Zealand’s gender-affirming healthcare services, it is likely that they do not describe these services with

perfect accuracy. We identified several errors throughout the responses,⁶ suggesting there may be a lack of internal communication within DHBs regarding their own gender-affirming healthcare provision, as well as a more general lack of knowledge around gender-affirming healthcare provision in New Zealand. As such, our results may be indicative not only of inconsistency in gender-affirming healthcare provision in New Zealand, but of the pitfalls of using the OIA to gather data around healthcare provision. Although we confirmed our responses with DHB representatives involved in transgender healthcare where possible in an effort to avoid reporting incorrect information, five DHBs did not provide confirmation in response to our request, meaning their responses may still contain inaccuracies.

A second and related reason we encourage readers to interpret our results with a degree of caution is that our results may indicate that gender-affirming healthcare services are more readily available in some districts and less available in other districts than they truly are. Canterbury, for example, reported that all but one of the services we listed are provided for transgender patients “on a limited basis”. As such, all but one service was coded as “publicly available”. In the experience of the first and second authors, however (who have conducted transgender health research in Canterbury, and provide CDHB with guidance around transgender healthcare provision, respectively), gender-affirming surgeries are rarely funded in Canterbury. In contrast, Auckland noted that there is no dedicated funding for hysterectomies as part of gender-affirming healthcare, so this service was initially coded as “no dedicated funding”. Upon confirming this with the Transgender Health Project Manager, however, we were advised via email that “just because there isn’t dedicated funding for some

⁶ Nelson-Marlborough DHB’s response, for example, claimed that “female to male ‘bottom’ surgery” is not funded in New Zealand, despite the fact that Ministry of Health briefings as recently as May 2018 note that these surgeries are funded to be provided overseas at a rate of one every two years (Ministry of Health, 2018c). Bay of Plenty DHB and Taranaki DHB responded that they either did not understand the meaning of “real life experience” or felt this question was unclear, although at the time of the response the Ministry of Health dedicated a section to real life experience on the “Gender reassignment surgery” page of their website. Finally, Wairarapa DHB noted that they had “not had demand” for the services we listed, although several transgender community members subsequently advised us that they had received transgender healthcare in this district.

things, doesn't mean they aren't widely or readily available. Hysterectomys [sic] is the best example here – there have been 0 cases of people wanting to access them but not being able to” (D Matthews, 2018, personal communication). As such, there may be significant variability even *within* codes in terms of the availability of services, and the line between “publicly available” and “no dedicated funding” is likely a blurry one.

Finally, it is important to note that gender-affirming services are not the only services that have been described as a ‘postcode lottery’ within New Zealand’s public health system; this term has also been used in reference to aged care (New Zealand Labour Party et al., 2017), cancer treatment (Duff, 2017), and hip and knee replacements (Goodwin, 2016). Inconsistencies in care may be an inevitable consequence of the structure of New Zealand’s elective services system. For all medical and surgical services that do not require urgent attention, patients are given a priority score out of 100 based on their level of need for and ability to benefit from care compared to other people (Ministry of Health, 2016). This score determines whether patients’ treatment is funded. Each DHB sets its own threshold for funded treatment (e.g. a priority score of 40 or above results in funded treatment for a specialist service), meaning that the same priority score could result in a patient being denied treatment in one DHB, and approved treatment in another. It is likely, however, that gender-affirming services are disproportionately affected by the ‘postcode lottery’ issue, as it is unclear how practitioners should use current prioritisation tools to make decisions about the level of need for and ability to benefit from gender-affirming healthcare.

Future research in this area should explore the availability of services we did not enquire about, including puberty blockers, vocal surgeries, and facial surgeries (e.g. facial feminisation surgery). In the current study we largely conflated mental health assessments with other services (e.g. a mental health assessment was often considered a part of the process of accessing hormone therapy). Given that mental health assessments are a

significant barrier to accessing gender-affirming healthcare services in general (Wi-Hongi et al., 2017), future studies should consider these assessments as a gender-affirming healthcare service in its own right. Future research could also ascertain not only whether DHBs will fund patients to travel to other districts to access healthcare, but whether they will fund the care, as well as whether DHBs that provide care will accept outside referrals. Given the widespread lack of availability of many gender-affirming healthcare services, it remains unclear whether all DHBs that provide gender-affirming services will extend this care to those residing in other districts. Finally, population-based research is urgently needed to estimate the demand for various gender-affirming healthcare services in New Zealand, in order to inform transgender public health planning.⁷ This requires gender to be assessed in the New Zealand census with an inclusive measure that counts transgender community members, rather than with the current male/female tick box.

Conclusion

Here we have examined the availability of, and process of accessing, gender-affirming healthcare across New Zealand's DHBs. Results show significant variation between DHBs regarding both service availability and requirements for accessing services, as well as variation in which services tend to be funded. These findings highlight the need for a consistent approach to gender-affirming healthcare provision throughout New Zealand. Clear health pathways and specialist services would greatly improve the quality of gender-affirming healthcare for transgender New Zealanders. Finally, our findings raise numerous questions that should be investigated in future studies.

⁷ Related to this, we look forward to results from Veale and colleagues' Counting Ourselves project, the first large-scale survey about the health of transgender and nonbinary people living in Aotearoa New Zealand.

Table 3. Provision of seven gender-affirming healthcare services across New Zealand’s District Health Boards

DHB	Hormone Therapy	Mastectomy	Hysterectomy	Orchidectomy	Facial hair removal	Breast augmentation	Voice training
Auckland	A	(A)	(A)	NDF	NA	(NDF)	(A)
Bay of Plenty	(A)	(NA)	(NA)	(NA)	(NA)	(NA)	(NA)
Canterbury	A	A	A	A	NA	A	A
Capital & Coast	A	NA	A	A	NA	NA	A
Counties Manukau	A	(A)	(A)	NDF	NA	NDF	A
Hawkes Bay	NDF	NA	NA	NA	NA	NA	NA
Hutt Valley	A	NA	(NR)	(NR)	NA	NA	(NR)
Lakes	A	NDF	NA	NA	NA	NA	NA
Mid Central	NDF	NA	A	NA	NA	NA	NA
Nelson	A	NA	NA	NA	NA	NA	(NA)
Northland	A	A	A	(NDF)	NA	(NDF)	A
South Canterbury	A	NA	NA	NA	NA	NA	NA
Southern	A	NDF	NDF	NDF	NDF	NDF	NDF
Tairāwhiti	A	A	A	A	NA	NA	NA
Taranaki	A	(NA)	(NA)	(NA)	NA	NA	(A)
Waikato	A	NDF	NDF	NA	NA	NA	NA
Wairarapa	NR	NA	NR	NR	NA	NA	NR
Waitemata	A	(A)	(A)	NDF	NA	(NDF)	(A)
West Coast	NR	NR	NR	NR	NA	NR	NR
Whanganui	NA	NA	NA	NA	NA	NA	NA

Table 4. Process for accessing gender-affirming healthcare services across New Zealand’s District Health Boards

DHB	Assessment by mental health professional required	Primary health can prescribe hormones	Real life experience required	Travel to other DHBs funded
Auckland	(N)	(S)	N	Y
Bay of Plenty	Y	N	Unclear	Y
Canterbury	Y	N	Y	N
Capital & Coast	S	S	N	N
Counties Manukau	N	S	N	Y
Hawkes Bay	Y	(S)	N/A	N
Hutt Valley	N	S	N/A	Y
Lakes	Y	Y	N	(Y)
Mid Central	Y	S	N	N
Nelson	Y	(S)	N/A	N
Northland	N	(S)	(N)	Unclear
South Canterbury	Y	N	N/A	Y
Southern	Y	Y	N	Y
Tairāwhiti	Y	Y	N	N
Taranaki	(S)	(Y)	(N)	Y
Waikato	(S)	S	N	N
Wairarapa	Y	N	N/A	Y
Waitemata	N	(Y)	N	Y
West Coast	Y	N	Y	N
Whanganui	N/A	N/A	N/A	Y

Figure 1. Availability of hormone therapy across New Zealand's DHBs

Figure 2. Availability of mastectomy across New Zealand's DHBs

Figure 3. Availability of hysterectomy across New Zealand's DHBs

Figure 4. Availability of orchidectomy across New Zealand's DHBs

Figure 5. Availability of facial hair removal across New Zealand's DHBs

Figure 6. Availability of breast augmentation across New Zealand's DHBs

Figure 7. Availability of voice training across New Zealand's DHBs

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