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THE UNIVERSITY OF NEW HAVEN

ADDRESSING BARRIERS TO PREVENTATIVE HEALTH CARE FOR TRANSGENDER
POPULATIONS: A SYSTEMS APPROACH TO IMPROVING ACCESS TO
GYNECOLOGICAL CARE

A THESIS

submitted in partial fulfillment of the requirements for the degree of
MASTER OF ARTS IN COMMUNITY PSYCHOLOGY

BY

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West Haven, Connecticut
May, 2019

ACKNOWLEDGMENTS

I would like to express my sincere gratitude to Dr. Melissa L. Whitson and Dr. Lillie Macias. Their patience and wisdom guided me through every stage of this project. Thank you for the time and energy you have invested in me these last two years.

Special thanks to the University of New Haven Graduate Psychology Department, Psychology Research Lab, and Dr. Diana Perry for their ongoing support.

Lastly, I'd like to thank my parents and sister, Kaitlin, whose love and guidance are with me in whatever I pursue.

ABSTRACT

The current study addresses the lack of research exploring the individual and systemic barriers to accessing gynecological care for transgender populations. An integrated mixed-methods needs assessment was designed to explore the individual and systemic barriers to gynecological health care for transgender and gender diverse populations. Participants of the study included established community providers known to serve the transgender community through advocacy or research efforts, as well as clinical psychologists and medical professionals working in gynecological settings. The study includes a brief quantitative survey, which measured “Perceptions of Inclusivity Importance” among key stakeholders. Following the survey, participants were invited to engage in an individual, semi-structured phone interview. Using a modified grounded theory approach to inform data analysis, this study identified themes to reflect the barriers expressed by medical and research providers regarding access to gynecological care for transgender populations. Results from the 7 individual interviews with key informants indicated that the largest barriers trans patients face when seeking health care include: employment, lack of trained medical professionals, and difficulties working with insurance companies. Specific recommendations from key informants also suggested that medical care providers adopt a collaborative and specialized care approach when working with trans patients.

Keywords: Transgender, needs assessment, health care, gynecological care

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Addressing Barriers to Preventive Health Care for Transgender Populations: A Systems Approach to Improving Access to Gynecological Care

Introduction

Statement of Purpose

Transgender and gender diverse individuals are among the most marginalized and underrepresented populations in medical research. Transgender populations experience stigma, discrimination, and health disparities at alarmingly higher rates than the general population (James & Herman, 2017). Research by Seelman et al. (2017) suggests that 70% of transgender and gender diverse adults have experienced some form of discrimination in health care settings. Discrimination can be in the form of staff refusing to provide needed care, medical staff refusing to touch patients, or staff using excessive precautions when treating a patient. Discrimination can also include staff using harsh or abusive language, staff blaming patients' gender identity as a cause for their health status, and staff being physically rough or abusive.

When considering the possible intersectionality of a transgender person's identity, rates of discrimination and stigma increase even more. Transgender women, specifically trans women of color, experience discrimination, harassment, and homicide at alarmingly higher rates. Research by the Human Rights Campaign and Trans People of Color Coalition (2015) suggests that transgender women are four times more likely to be victims of homicide than the general population of women. A 2014 report on hate violence against LGBTQ+ communities from the National Coalition of Anti-Violence Programs (NCAVP) reported that 67% of hate violence homicides were targeted against transgender women of color. Due to increased prevalence of harassment, violence and general life stressors, transgender populations often present with more physical and mental health complications than the general population, suggesting a greater need for health care services.

Despite this need, transgender populations are more likely to be discriminated against in medical settings and are more likely to have to “educate” their medical providers on their gender identity and general terminology. Furthermore, results from the National Transgender Discrimination Survey (2010) reports that upon seeking care, 22% of transwomen and 19% of trans men have been refused treatment from a medical provider due to their gender identity. Transgender individuals who delayed health care have worse health outcomes compared to trans patients who did not delay care (Seelman, et al., 2017).

The transgender community has a unique set of physical and mental health needs that requires both the attention and advocacy of the research community in an effort to improve access to inclusive and equitable health care. Research specifically focused on improving access to quality preventive health care is extremely limited. Research regarding specific clinical settings (i.e. gynecological and urological care) and reproductive health is essentially nonexistent.

The literature review that follows examines empirical research relevant to gender minority stress and establishing gender-affirming health care settings, both of which are imperative to this study. While research specific to this topic is limited, the following review aims to demonstrate the need for further research, advocacy, and support within the field of community psychology.

Literature Review

Gender Minority Stress

Research on minority stress by Meyer (2003) suggests that sexual minority populations (lesbian, gay, bisexual, and queer individuals) are at an increased risk for physical and mental health disparities than the general population. Health disparities among sexual minority populations can be explained by stressors induced by a hostile or discriminatory culture, which often results in a lifetime of harassment, maltreatment, discrimination, and victimization.

Meyer's model describes the many different ways in which sexual minority populations may experience stress. External or distal factors explain the stress and experiences of discrimination or violence based on an individual's identity. Proximal or internal stressors are those individual stressors one faces due to their sexual identity, such as their fear of victimization, internalized homophobia or negative beliefs regarding their identity, and the stress of hiding their sexual identity with others. The final component of the sexual minority stress model includes factors that may mitigate the negative experiences of minority stress. Mitigating or facilitating factors act to support an individual's mental health. Meyer suggests that when individuals are able to establish positive relationships within their communities and with other sexual minorities, their distal and proximal stressors may reduce. Establishing a shared sense of community with other sexual minorities can also help increase feelings of pride and community support.

Hendricks and Testa (2012) expanded Meyer's sexual minority stress model to also include transgender and gender diverse populations. Testa et al.'s (2015) model expands Meyer's original model, while also including barriers specific to gender minority populations (Figure 1). Similar to the presence of internalized homophobia explained in Meyer's Sexual Minority Stress Model, the Gender Minority Stress model also includes internalized transphobia. Internalized

transphobia occurs when an individual feels discomfort with their own transgender identity due to society's normative gender expectations.

Gender minorities, including transgender and gender diverse populations, can also experience additional forms of discrimination, including nonaffirmation. Nonaffirmation describes the tendency for transgender and gender diverse populations' identities to be ignored or not affirmed by others (Testa et al., 2015). This can include individuals being referred to by the wrong names or pronouns. Research on nonaffirmation also suggests that gender-fluid individuals or those who identify outside of the gender binary may be more likely to experience nonaffirmation compared to those individuals that do identify on the binary system. Additionally, nonaffirmation may occur at lesser or greater frequencies depending on an individual's social context, physical appearance, or gender expression at any given time. Research by Sánchez and Villain (2009) suggests that transgender and gender diverse populations are often cut off from their protective community factors, increasing their tendency to experience internalized homophobia and psychological distress. It is imperative for these populations to establish connections early on in their development or gender transition processes to reduce the instances of psychological distress. For many individuals, these connections are established in safe zone contexts, such as community-based advocacy organizations, support groups, and various community agencies.

Physical and mental health outcomes.

Discrimination against transgender populations occurs across all sectors of society; including: employment, education, health care, and housing. This increased rate of discrimination disproportionality disadvantages trans populations to experience both physical and mental health complications at higher rates than the general population. Discrimination

impacts individuals in all aspects of their life; such that discrimination in employment contexts leaves transgender individuals more likely to be both unemployed and uninsured. Constant discrimination also has detrimental effects on one's mental health. For example, research by Testa et al. (2012) found that transgender and gender diverse populations were four times more likely to attempt suicide. Transgender individuals also have significantly greater odds than the general population of experiencing depression, suicidal ideation, anxiety disorders, and substance abuse disorders (Seelman, et al., 2017). Although trans populations have a significantly higher risk for health and mental health complications, they consistently avoid or delay seeking treatment at much higher rates than cisgender patients.

Trauma-Informed Care

Transgender and gender diverse individuals are more likely to experience increased feelings of discomfort and gender dysphoria in medical settings. Feelings of anxiety and dysphoria increase, even more, when the medical setting or procedure is focused on specific, reproductive anatomy or body parts that are incongruent with one's gender identity (Dutton, Koenig, & Fennie, 2008).

Additionally, results from the 2010 National Transgender Discrimination Survey found that transgender individuals, regardless of gender identity or expression, have a disproportionately higher chance of being victims of sexual violence, sexual assault, and rape. Half of all transgender individuals will be sexually assaulted at some point during their life. This rate is significantly higher than the general population and suggests that transgender patients often visit health facilities with pre-existing sexual traumas.

In the context of gynecological care, natal reproductive organ health can be particularly triggering for transgender survivors of sexual trauma, as this specialty focuses both on the health of body parts closely associated with sexual assault and to organs that may not match their gender identities (Aiken, 2016). These findings suggest the need for deeper consideration and knowledge of trauma among medical professionals when working with transgender and gender diverse populations.

It is imperative for medical settings to increase education on trauma and trauma symptoms. This involves staff working to create an environment where their patients feel comfortable discussing trauma with their providers. Establishing a trauma-informed environment involves educating all staff members on trauma, this includes staff members that may not have direct contact with patients. Trauma-informed care does not require medical care providers to inquire whether their patients have experienced trauma. Rather, trauma-informed environments operate to promote trust, sensitivity, and empathy so that all patients feel comfortable when seeking and accessing care.

In gynecological care, a trauma-informed approach could involve a clinician working closely with a patient to determine the best intake and treatment plan for that patient. For example, patients with a history of sexual assault may avoid or decline medical procedures that trigger traumatic memories, such as gynecological procedures. To reduce the amount of stress during these procedures, medical care providers can offer to take extra time preparing the exam and explaining the procedure before starting. Or, a patient could request that a family member, friend, or another medical staff member be present during the exam to hold their hand and offer emotional support.

Trauma-informed care also involves using inclusive, affirming, and sensitive language during intake processes and in non-clinical office environments. This involves using gender-affirming medical intake forms, decorating an office to be representative of the patients seeking services, and providing gender-neutral restroom options. For many medical care providers, establishing a trauma-informed care approach requires adjustment to their exams and procedures to reflect their patients' comfortability. This involves meeting each patient where they are at and attending to their specific needs rather than providing the same cut-and-dry services for all patients.

Gynecological Care

When considering the complexity of personal transition journeys, the scope of transgender health care research should not solely focus on sex reassignment surgeries. However, research focused on creating gender-affirming gynecological and natal reproductive organ care is extremely scarce. Research by Peitzmeir et al. (2014) on cervical cancer affecting trans men suggests that a majority of trans men have a cervix for most of their adult lives. The presence of natal reproductive organs, regardless of one's gender identity or expression, leaves an individual at risk for cervical cancer and complications specific to various reproductive organs. Individuals with a cervix or natal organs should still follow the same preventative health care and cancer screenings as the general populations. However, Ob/Gyn facilities and clinics are often not welcoming to or educated on transgender issues to effectively serve the needs of their gender diverse patients.

The lack of knowledge among providers can be demonstrated by the significantly higher amount of unsatisfactory Papanicolaou (PAP) tests among trans men (Peitzmeir et al., 2014).

FTM patients are 8.3 times more likely than cisgender patients to have unsatisfactory PAP tests. In gynecological care, unsatisfactory PAP tests typically occur when an exam cannot be accurately measured due to lack of sufficient cells or the presence of blood. Experiencing uncomfortable or unsatisfactory PAP tests induce greater anxiety and are associated with a lower likelihood of returning for preventive screening exams. While research suggests that trans men were just as likely as cisgender women to return for follow-up testing after an unsatisfactory PAP exam, they significantly delayed follow up appointments.

Research from Driák & Samudovsky (2005) suggests that transgender patients that have completed hormone therapy treatments could also be at a higher risk for various cancers. For example, when a trans man has a surplus of testosterone in his body, excess testosterone is converted to estrogen, which can increase the risk of breast cancer. Unsafe binding methods used among trans men can often cause trauma to breast tissue which increases an individual's risk of breast cancer. Ob/Gyn clinics and medical care providers are typically the first to catch these types of cancers during routine examinations in cisgender patients; however, the rate of detection is much lower among trans populations.

To provide gender-affirming gynecological care, providers training should focus extensively on gaining the technical skills to perform cervical exams in a wide array of challenging and diverse circumstances. This training would aid in the reduction of unsatisfactory PAPs among all populations, while also increasing access to gender-affirming care options for transgender populations. Due to the comprehensive care and knowledge that involves receiving gender-affirming hormone treatments, surgeries, and various medical procedures, gynecological care providers often work in groups of teams including multiple specialties.

Purpose of the Study

The purpose of this study was to conduct a mixed-methods needs assessment to gather data from medical providers, researchers, and advocates regarding access to gynecological care for transgender populations. Data included quantitative surveys and follow-up semi-structured phone interviews. This study intended to identify individual and systemic barriers transgender patients face when seeking and accessing gynecological care. By interviewing medical professionals and advocacy stakeholders working with transgender and gender diverse populations, key informant interviews provided direct suggestions on how to improve the current status of gender-affirming gynecological care.

This study aimed to improve access to affirming, equitable health care received by transgender and gender diverse populations by exploring the types of experiences advocacy stakeholders have experienced when providing care. The primary objectives of this study were to: 1) better understand the specific gynecological health needs of transgender populations, and 2) identify specific and direct changes that can be made in gynecological health care settings to better attend to the needs of transgender populations.

Method

Participants

Quantitative surveys.

Participants for the current study included medical professionals, researchers, and transgender advocacy stakeholders across the country. The study adopted an integrative mixed-methods approach such that the short quantitative survey served to inform and enhance individual qualitative interviews (Creswell et al., 2007). The quantitative data of this study was collected from 44 participants. The ages of the participants ranged from 21 to 64 years old ($M =$

34.81, $SD = 10.24$). A large portion of the sample (45%) worked as medical care professionals ($n = 20$), 25% worked in Clinical Psychology settings ($n = 11$), 25% of survey respondents worked in settings dedicated to transgender advocacy research ($n = 11$), and the remaining five percent worked in various other settings. Additionally, most participants held advanced degrees, 39% held a Master's Degree ($n = 17$), and 25% held a Bachelor's Degree ($n = 11$), 20% held Medical Degrees or Doctorates (MD, PhD, PsyD, EdD) ($n = 9$), seven percent held an Associate's Degree ($n = 3$), and the remaining participants were current students who had not obtained a degree ($n = 4$). Additionally, 82% of the participants identified as female ($n = 36$), 14% of the sample identified as male ($n = 6$), and five percent identified as trans men ($n = 2$). A majority of the sample (82%) identified as White ($n = 36$), while nine percent were Black or African American ($n = 4$), seven percent were Hispanic or Latinx ($n = 3$), and seven percent were American Indian or Alaskan Natives ($n = 3$).

Qualitative phone interviews.

Among the 44 participants from the quantitative survey, seven individuals completed a subsequent individual phone interview with the Co-PI. Participants worked directly in gynecological settings, clinical mental health care, or in community advocacy agencies serving transgender and gender diverse populations (Table 1). All participants were women between the ages of 26 and 51 years ($M = 36.43$, $SD = 7.19$). Additionally, 6 of the 7 participants were White (86%) and one participant was Black or African American. All participants held advanced degrees or professional licensure, including: B.A., M.A., LPC, LMSW, MPAS, PA-C, MD, Psy.D, and PhD. Additionally, all participants were employed full-time; length of time in their current positions ranged from 2 to 16 years ($M = 6.14$, $SD = 4.42$). Several of the participants

were also continuing their education through various graduate programs, trainings certificates, or seeking licensure ($n = 3$).

Procedure

Participants were contacted and invited to partake in the online study via email invitation from the Co-PI. The study was administered through the web-based survey tool Qualtrics. Of the 44 total participants, 31 were redirected to the survey via an email link from the researcher. The remaining 13 participants were directed to the survey via the QR code shared by previously-completed participants, suggesting snowball sampling. Data was then transferred into SPSS for analysis. Participants were found via their agency website, which listed that they either: 1) provided trans-inclusive gynecological care; 2) were currently engaged in research or advocacy projects aimed at improving quality of care and access to care for transgender populations; or, 3) served as transgender advocacy groups in their community of origin. After being directed to the online study, participants were required to review and sign a consent form (Appendix A). A preliminary demographics questionnaire was presented (Appendix B). The questionnaire collected information on participants' age, gender identity, education level, and occupation. Following these initial questions, participants were presented with a 16-question Likert-scale survey. The last segment of the survey invited participants to an individual phone interview with the Co-PI. To participate in the subsequent interview, participants were asked to provide a name, phone number or email for future contact. Participants were not given a time restriction to complete the study, however, the average time to complete the study was approximately five minutes. The response rate of those who started the online survey averaged to 86%.

If participants expressed interest after completing the online survey, they were contacted via email or phone call from the Co-PI to schedule an individual, semi-structured phone interview. Phone interviews lasted about 30-45 minutes each and were scheduled at a time convenient to the participant. A majority of the interviews were conducted during the participants' lunch breaks, and all interviews were conducted during the workweek. Prior to engaging in the interview, the Co-PI read through an informed consent form (Appendix C) and willing participants gave their verbal consent. All interviews were audio-recorded and then transcribed for accuracy in the data analysis process. Interviews followed a semi-structured format where questions were predetermined by the Co-PI beforehand. Participants for the interviews were given the same 10-15 open-ended questions (Appendix D).

Measures

The quantitative survey sought to measure how important participants felt inclusivity was to providing care to transgender populations in gynecological settings. The quantitative questionnaire did not include any pre-existing measures, but rather amended similar themes used in the Human Rights Campaign's Healthcare Equality Index (2017) and those listed in the American Medical Association's (2016) suggestions for Best Practices for Inclusivity. The 16 Likert-scale questions created a "Perception of Inclusivity Importance" scale, which was designed to measure how important the participants believed the following aspects are to creating inclusive health care environments: 1) staff training and education; 2) trans-inclusive language; 3) diversity values of medical staff; 4) office policies regarding discrimination, non-harassment, and diversity-inclusion; 5) providing and displaying trans resources in office spaces; and, 6) trans-inclusive intake and screening forms. Items were measured on a Likert-scale ranging from 1-5, where a score of 1 indicated low importance of inclusivity, and a score of 5

indicated a high importance of inclusivity. Although the current study did not use a pre-existing scale, it yielded a strong internal reliability statistic ($\alpha = .81$). The quantitative survey also served as a screening measure to recruit participants for the qualitative interview portion of the study.

The purpose of the qualitative interviews was to gain specific information regarding the current climate of trans-inclusive health care in gynecological settings, and what specific and direct changes can be made to improve quality of care. Interviews allowed medical professionals, researchers, and advocates to share what they believe were the most pressing changes needed to increase access to inclusive gynecological care for transgender populations. This also allowed key informants to share their own anecdotal experiences of working in gynecological, medical, or community advocacy settings. Questions were generated based on suggestions for best practices for inclusivity from the American Medical Association (2016), and themes used the Human Rights Campaign's Healthcare Equality Index (2017).

Qualitative Data Analysis

Results from the qualitative data were analyzed using an inductive approach consistent with community-based research measures (Bradley, Curry, & Devers, 2007). A modified grounded theory approach was used to guide qualitative data analysis, such that potential themes were developed and identified throughout the data collection process (Charmaz, 2008). Data analysis first began using open coding, where major themes and categories were created from the data. Upon transcribing all of the data and identifying all open codes, a thematic analysis was conducted to identify the main emergent themes among all interviews. Recommendations made by key informants were also identified and are described below.

Results

Quantitative Data

Perceptions of Inclusivity Importance was measured for each participant by averaging their responses on the 16-point Likert scale. The average score for inclusivity importance among all participants was 4.57 ($SD = 0.35$). A one-way ANOVA measuring Perceptions of Inclusivity Importance was conducted to determine if there was a difference in scores among those working in research, medical, or community-based advocacy settings. The ANOVA showed no significant difference, $F(3, 40) = 0.37, p > .05$. There was not a difference in perceptions of inclusivity importance between professions working in medical, advocacy, or research settings.

The quantitative portion of this study served to triangulate the data in efforts to support the qualitative findings (Carter et al., 2014). Additionally, inviting participants for a phone interview upon completion of the online survey served as the best way to recruit for the qualitative portion of the study, thus acting as a preliminary screening measure.

Qualitative Data

Results from the individual phone interviews include both a discussion of the emergent themes among all interviews, and key informant recommendations.

Emergent Themes.

Theme I: Individual barriers to accessing care.

All seven key informants discussed individual barriers that transgender and gender diverse populations face when accessing care. Among those barriers, employment ($n = 6$), lack

of family support ($n = 5$), and tendency to avoid or delay seeking health care ($n = 4$) were discussed.

Employment.

Employment, or lack thereof was the most salient barrier discussed among key informants. Transgender and gender diverse individuals have a significantly higher chance of being unemployed or uninsured compared to the general population (Mizock & Mueser, 2014). This finding coincided with the responses among interview participants. Key informants discussed unemployment as being one of the biggest barriers to accessing health care and other community resources. This key informant shed light on the especially difficult journeys that unemployed transgender and gender diverse folks face:

Employment a big barrier and itself; perhaps one of the biggest barriers for folks. I mean employment in general is difficult for people but especially when you're trans and you don't know where you can go that you will be safe. You don't know whether or not you're not being hired because of who you are or the way you represent.

The above quote demonstrates that while employment is often a barrier among both transgender and cisgender populations, it can be significantly more difficult for unemployed transgender individuals to identify the root cause of their unemployment.

Family support.

Several key informants ($n = 5$) cited lack of family support as being a key barrier for children, adolescents, and young adults accessing care. For many transgender and gender diverse children and young adults, having a supportive family network is imperative to sustaining a healthy physical well-being, and being able to regularly seek and access health care resources. The following quote from a medical case worker demonstrates this barrier while also describing the need for agencies to provide educational support for caregivers and families:

Some of our families that come in have looked at questionable information, so we try to show all sides of the data. Sometimes our families are not so supportive and they want us to kind of help their child not be the way that they are, so we have to work with those families slowly and meet them where they're at. We help them move towards a different space, we can't force them.

While working with caregivers can be extremely difficult, the above example demonstrates the ability for medical care providers to use these opportunities to share resources and help answer questions that caregivers may have regarding their child's gender identity. In addition, family support in the sense of caregiver consent is necessary for children to be cleared for certain medical procedures, hormone therapy, or surgeries. The lack of family and caregiver support can often delay or halt an individual's' physical and medical transition processes.

Tendency to avoid or delay health care.

Patients' tendency to delay and avoid health care settings due to past medical experiences was also a frequently common barrier discussed by key informants ($n = 4$). Patients' avoidance of health care settings was frequently discussed as a result of previously negative experiences in health care settings, or the lack of gender-affirming services within one's community. This key informant working in a gynecological private practice describes the tendency for transgender and gender diverse populations to avoid or delay seeking care after having negative experiences in medical settings:

For a lot of my patients, when they come here it's the first time they've even been inside a medical facility in 10 or 15 years. That tendency usually starts after a bad experience or after they've started their transition journey. It becomes second nature to only seek care if you have a severe emergency. Then you're walking into an ER, which is chaotic and often not affirming. You have to explain your entire health history and background and justify your identity to people you know will never see you again.

The above quotation sheds lights on the difficulty for patients to regularly seek health care services after upon beginning their transition journey or after a previous negative experience in medical settings. The tendency for patients to wait decades for care or delay seeking care until

severe emergencies supports the previous recommendations for trauma-informed care settings and educational trainings among all medical staff to reduce the amount of negative interactions experienced by patients. Additionally, research by MacKichan et al. (2017) suggests that when individuals use emergency care for primary care purposes they are faced with more adverse health outcomes compared to those individuals that regularly see a primary care physician.

Theme II: Community and systemic barriers to accessing care.

Key informants also shared barriers in accessing care that are outside of an individual's control (i.e., community and systemic-related issues). These barriers included: lack of trained professionals ($n = 7$), difficulties working with insurance companies ($n = 6$), long appointment wait times ($n = 4$), and lack of community resources ($n = 4$).

Lack of trained professionals.

Consistent with recommendations from key informants, the most salient community barrier presented among transgender and gender diverse patients seeking gynecological care centers around the lack of trained professionals in one's community. All seven participants spoke on the general lack of knowledgeable providers within a patient's community, and how this may interfere with an individual's ability to discover and access gender-affirming medical care. For many key informants, discovering this missing resource within their community is how they became involved with their specific agencies or advocacy organizations. One key informant shared their experiences as a director of a pediatric gender program, and how the lack of gender-affirming medical professionals paved way for the establishment of their program:

One of our endocrinologists had a patient who came to them and said, "I am trans and I need you to provide treatment for me," and the provider said, "There are centers in New York City and Boston, you should go there because we don't provide those services

here.” And the patient came back about 6 months later and said, “Look you need to figure this out. You’re my doctor and I cannot afford to get to NY or Boston.”

For this participant, the lack of community resources and trained professional to provide gender-affirming medical care for transgender populations sparked the development of a community-wide program aimed at providing care for pediatric and young adult populations. Another medical provider shared a similar experience of working as the only gender-affirming gynecologist within their community:

If you ask our patients they’ll tell you too, we’re the only clinic that provides trans-specific care within 60 miles. If you can’t travel to another provider, this is it. It’s comforting to know we can be that resource for them, but it’s not right. There needs to be more options, more resources, trans patients should be able to choose their providers based on how well they fit, not because they’re the only option within a manageable distance.

The above quote demonstrates the luxury that many cisgender patients have when choosing their medical provider. For many transgender and gender diverse individuals, finding a provider within close proximity of their community is the biggest barrier when seeking gender-affirming medical care.

Insurance.

Key informants also mentioned difficulties working with insurance companies to ensure that gender-affirming procedures and medications are covered ($n = 6$). Participants noted that inability to guarantee insurance coverage often causes barriers for patients when accessing care; this is another reason patients significantly delay or avoid seeking medical care. One key informant shared that while many insurance companies cover top and bottom surgeries and procedures, they do not cover other, less-extensive procedures (i.e., hair removal, tracheal shave procedures):

The other thing is working with insurance to approve gender-affirming surgeries. That's been a huge accomplishment, some folks just face incredible barriers with insurance trying to get their surgeries approved.

Similar to these responses, several key informants shared the tendency for their agencies to work directly with insurance companies or insurance coding to ensure that their patients' procedures are covered and do not act as an undue financial burden.

The following key informant described how staff at their agency work on a case-by-case basis with insurance companies to ensure that their patients' procedures are covered:

We have a billing team that handle these situations, but I know it can come up. For example, a trans guy who changes his sex goes and gets a pap smear, and then his insurance rejects it saying it's not covered because he's a man. So then we have to re-submit documentation that states this patient is transgender.

The above quote demonstrates the difficulties in covering gender-affirming surgeries when a patient's medical procedure might not match with their legally-marked sex. While legally changing one's sex helps affirm their gender-identity and increase gender euphoria for some individuals, it can also cause an undue barrier when seeking insurance coverage. These barriers and obstacles often leave staff members or patients with the task of working extensively with insurance companies in hopes to gain financial coverage for procedures.

Long appointment wait times.

In conjunction with lack of trained medical professionals, long appointment wait times for patients pose a barrier when seeking specialized care. Key informants ($n = 4$) shared that patients are often added to a lengthy waiting list; wait times can consist of anywhere between 6 to 24 months. This private-practice gynecologist spoke on the long wait times at their rurally-located clinic:

Our wait list is pretty long, about 2 years. Maybe 26 months or so. Obviously if the patient is in dire need for treatment we shift things around a bit, refer them to someone else, whatever we have to do we'll do. But we definitely have a long wait time for our incoming patients and that impedes on their ability to get our care.

Two years is a substantial amount of time to wait for quality affirming care. For many patients struggling with physical and mental health issues, this wait time is a matter of life and death. Additionally, as transgender and gender diverse individuals are already prone to delaying health care services, the harsh reality of a two-year wait list after finally seeking services can be devastating news.

Lack of community resources.

A majority of the key informants disclosed that lack of resources within a community can act as a barrier when seeking and accessing gender-affirming care specialties ($n = 4$). Throughout all interviews, key informants shared the importance of social networks, advocacy support, and community spaces for healthy well-being serving as facilitators for transgender populations. Participants also spoke on the impacts on a community when these resources are not available. The following key informant provides insight on the roles that online communities play when community resources are scarce:

People outside of the city do not have a lot of resources. They rely on Facebook support groups. A lot of my patients get their information from Facebook groups, parent groups or young adult Facebook groups because they don't have community centers or advocacy agencies in their area.

Facebook groups and online support networks act as communities and emotional support networks, and are often heavily relied on when advocacy organizations and community resources are absent.

Another key informant shared a memory of their community before a community-based advocacy group was established:

Thankfully we have a great Pride Center who acts as our main community resource for LGBTQ+ community members. But I remember what things were like a few years ago before we had the Pride Center. When people had questions they didn't really have anywhere to go, there wasn't a place in the community where they could quickly get

information. We used to have support groups at night in our town library, but that only drew in parents you know? We didn't have the same resources for kids. I don't know how those folks found resources before the Pride Center.

While online support groups are overwhelmingly supportive and allow for community members to build social circles, community resources such as advocacy organizations and professional centers are also needed. Key informants cited these resources as playing an integral role in assisting individuals to gender-affirming care providers. When a community lacks these resources, patients have a harder time locating and connecting with affirming providers.

Theme III: Establishing a collaborative care approach.

The final emergent theme among all key informants focused on the need for medical care providers to establish a collaborative care approach with their patients. Functioning in a specialized, case-by-case manner is the factor that key informants labeled the most helpful and successful way to provide gender-affirming care. Participants discussed that collaborative care and meeting a patient where they are at made it easier to determine what hormones, medications, or procedures a patient needed, helped gather more in-depth and individual-specific intake data, and allowed the provider to work with a patient to determine community resources, other physicians and practices, and navigate the health care system. Many of the key informants shared how their practice used a collaborative care approach to extend resources and support to their patients outside of just gynecological care. The following key informant discussed how their pediatric gender program combines professionals from varying disciplines to provide holistic, interdisciplinary care to patients:

It's really important to have interdisciplinary care from the start, and throughout treatment. We developed a team where it was endocrinology, psychology, psychiatry, affirmative gynecologists, reproductive endocrinologists to talk about fertility-related

issues, a lawyer, and a medical ethicist.

At this pediatric gender program, patients and caregivers receive specialized care in both physical and mental health services, as well as legal and ethical support. Additionally, key informants shared that their experiences operating in a collaborative approach with a patient can often provide the patient a safe space to engage in dialogue and build trust with their provider. Patients were more comfortable sharing feedback with their provider and engaging in meaningful dialogue regarding their health status when they felt their provider was tending to their specific needs.

The following key informant described how they shift the dialogue with their patients to encourage conversation and allow the patient to share what makes them most comfortable:

Doctors tend to think they know it all and that they're experts because of their training. Yes they know a lot. But our patients know so much...Being affirming is also about shifting our understandings as experts in the field to relinquish some power and say, "Hey I'm going to listen to you now. Tell me what you need. Tell me how you see this."

The above quote demonstrates the ability to engage in open dialogue, which in turn allows for the patient to have more control over their medical procedures and enables the provider to establish a stronger relationship with the patient.

Similar to the dialogue shared by the key previous key informant, this medical case manager describes their collaborative approach with patients by asking a patient to individualize their exams, giving the patient the opportunity to share what terms and language best fit their worldview:

We always ask our patients to individualize their exams. What would you like me to call this body part? Would you like me to explain what's happening during the exam or would you rather I be quiet? I always let them have some quiet time before a procedure and I try to follow up with them after to make sure they're mentally ok. I keep an open dialogue. I allow them to tell me things too, I ask for input and feedback. Is there

something I could've done better?

Whether discussing medical procedures, mental health concerns, or community resources, operating in collaborative holistic approach allows for patients and providers to establish a relationship and exchange resources. While key informants worked in various organizations and locations across the country, they all shared a key characteristic in working with their patients: their approach to care was collaborative and encouraged a patient to engage in dialogue and provide feedback. Lastly, all providers cited that working collaboratively with a patient is helpful to increase comfortability and reduce dysphoria and anxiety during various medical procedures.

Key informant recommendations.

All key informants were asked the question “*What suggestions or recommendations do you have to increase access to gender-affirming care for transgender patients?*”.

Recommendations included: improving intake procedures, suggestions for policy changes, training and education of staff members, adopting a trauma-informed approach to care, and encouraging medical providers and agencies to engage with the community (Table 2).

Intake procedures.

All key informants ($n = 7$) offered specific recommendations to improve intake procedures. Recommendations for intake procedures included working with each patient to establish and document their legal and preferred name, pronouns, and the terms they use when referring to various anatomy. One key informant elaborated on the impacts of gaining this information during intake rather than asking for sensitive information throughout a medical procedure:

In intake we always try and ask the patients what they are comfortable with, what pronouns they use, what name they go by. During intake, we set up the expectation that

as health care providers there might be conversations that are difficult to have. We might be talking about body parts that don't match with your gender identity, but our job to help take care of the body parts that you do have, and if there are names or terminology that you feel more comfortable using we can refer to your autonomy using those terms.

The above quote captures the type of dialogue shared by medical care providers to patients during the intake process. In this instance, the key informant, who works directly in a gynecological clinic, shared the importance of discussing definitions and terms for anatomy with patients during the intake process, rather than upon starting an exam or procedure. Exchanging this meaningful dialogue early on helps open a two-way discussion between patient and provider, and allows the provider to acknowledge the potential anxiety and unease that many transgender and gender diverse patients feel during medical exams.

Several key informants ($n = 4$) also described the need for more universal intake forms for public health sectors. Participants suggested that universal intake forms would provide all medical staff with gender-affirming identity information and could help ease the amount of personal information that patients share with office staff and those not directly providing care. One key informant shared how using a universal intake form could help reduce the amount of times a patient has to explain their identity and personal information to staff members that they will not establish close-knit relationships with:

Ideally I'd like there to be a universal intake form for professionals to use, one that allows a patient to explain how they identify themselves instead of them having to constantly retell their story and past procedures or medical history to front office staff or people that aren't actually going to be building a relationship with them like their medical care providers.

This quote demonstrates how adopting a universal intake form could benefit organizations by allowing patients to identify themselves and share their personal health history just once to prevent a patient from having to explain and re-explain themselves to various medical staff.

After a new patient shares this information during intake, their basic demographic information

(i.e., name and pronouns) are then shared with the office staff who also interact with the patient. Doing so would allow a patient to express their identity just once, on paper during intake.

Policy changes.

In all seven key informant interviews, participants gave suggestions on how to improve or implement gender-affirming policies on an organizational, state-wide, and federal-level. A majority of key informants ($n = 5$) suggested that Medicare and Medicaid insurance policies aimed at providing gender-affirming treatments should also include more common procedures such as hair removal, tracheal shave, or voice modifications. The following key informant discussed this need:

The way the Affordable Care Act is written. Any health company, any insurance company that accepts federal dollars, which is all of them, is supposed to provide affirmative trans health care. That includes hormone treatment, top surgery, bottom surgery... We need to include things like facial feminization surgery, but it's not included, which is really unfortunate. For some people, that's more medically necessary than a vaginoplasty.

This key informant shared their experiences working with patients and insurance companies to cover medically necessary procedures that are not currently covered under Medicare and Medicaid protocols. The participant shared that while top and bottom surgeries and hormone treatments are covered through government-funded insurance providers, many of the more pressing procedures to alter physical appearance are not. For many patients, these physically altering procedures and treatments are more important to increase gender euphoria and affirm their identities than other, more extensive procedures.

In addition to insurance policies, several key informants ($n = 6$) suggested greater gender-affirming policy changes within individual organizations and agencies. Participants suggested that all agencies providing care to patients should have established policies against discrimination and harassment, and that agencies should ensure that discrimination claims are

following through with and handled appropriately and kept confidential to protect the identity of the reporter. Medical care agencies should adopt policies to ensure that proper reporting measures for patients, providers, staff, and guests. One key informant shared their experience with discrimination and harassment claims within their organization:

When a patient, guest, or staff member makes a claim with our clinic it needs to be followed through. Far too often we have incidences where people feel violated or discriminated against or something really problematic happens. And obviously our first reaction is to tend to the situation then and there, the best that we can. But we also urge everyone to use the discrimination reporting and confidentiality reporting system. But far too often those claims aren't even listed to by our management, we don't have an HR person who regularly gets updated on those incidents. So yeah, we tell them "make this claim," "report this incident" but no one even follows up on them.

For this key informant, the follow-up and accountability of discrimination and harassment claims are just as important as having the initial policy. Another key informant shared a similar perspective on accountability within individual agencies and organizations:

Then there's the organization function. We need to update and actually adhere to our discrimination policies, currently our policies don't list anything about transgender and gender fluid individuals. We also need our upper-level staff to listen to claims and follow through with them. There needs to be accountability.

While this medical provider shares similar suggestions for accountability among organizational claims of discrimination and harassment, they suggest that a HR department and executive staff take the responsibility of following through with claims.

Similar suggestions advocating for anti-discrimination policies at the federal-level were discussed. Participants also mentioned that while some states have laws protecting transgender and gender diverse populations from discrimination in various settings, federal laws and attitudes of government officials often contradict or undermine these advocacy efforts. A key informant working both in a medical setting and community advocacy organization shared their perspective on this topic:

I think you can do things at a federal level that can show people they are welcome and equal. We can't say we're supportive of gender diverse populations and then have government laws that say otherwise...I would first change the transgender military ban. It's not evidence based and it's cruel.

This suggestion sheds light on the inconsistencies between organizational, state, and federal discrimination policies.

Training and education of staff members.

All seven participants stressed the importance of increasing education and training among staff members to help create a gender-affirming and inclusive environment. The following quote comes from a key informant who stresses the importance of training individuals within all levels of an agency:

You have to have training at every level because it really doesn't matter if the clinician themselves is highly competent or highly inclusive. So training front desk staff, I think is a big thing because they have such an important role they are often the front lines of communication and often the first people our patients are seeing when they come in.

This individual stressed the importance of competency among office staff and how lack of training can impose on a patients' comfortability from the moment they enter an agency. Another key informant suggested that training should include ongoing sessions to stay updated on surfacing definitions or culture changes:

Training should be ongoing. Because definitions, words, culture is always changing and always adapting, we're finding new ways to express things or new words to use. All staff need to have a baseline training too.

In addition, several key informants ($n = 4$) also stressed the importance of increasing education for medical providers while they are in medical school or a similar educational context. This participant cited the lack of transgender and gender diverse educational trainings during medical school:

The average training on providing inclusive care during medical school is around five hours. Five hours, over four years? That's ridiculous. That's nothing. We need to be increasing education.

Another medical care provider discussed the lack of diversity training among medical professionals during school. This participant spoke on their experiences as a medical care professional working in endocrinology settings. Their recommendation for increased training and education for medical care providers also included training in how to engage with diverse populations:

There needs to be more education during actual medical school training. Many of the medical professionals are not trained to handle diverse patients, diverse situations. We're close to the university so we see newly trained students come in and out very often. A lot of them are not trained to deal with the wide array of diversity that our patients bring.

These suggestions not only encompass the importance of greater training and education for medical providers, but also the importance of training for medical students and continuing medical education for those currently working in the field on a vast array of concepts, including diversity-related issues.

Adopting a trauma-informed approach.

A majority of key informants ($n = 4$) recommended that agencies increase education on trauma for all staff members in an attempt to create an environment where staff members are aware of trauma and work together to reduce trauma. This key informant shared their experience working in an organization that has adopted a trauma-informed approach to care:

The first step in creating a trauma-informed atmosphere is being educated. I think that providers can work towards being educated and educating themselves. You need to train the front staff. You need to train the janitorial staff who clean the bathrooms.

The above quote demonstrates the importance of all levels within an organization working in cohesion to provide affirming and trauma-informed care. Many key informants shared examples of what trauma-informed care looks like to them. This provider discussed the types of dialogue they engage with a patient prior to starting an exam or procedure:

Ask everybody's permission before you touch them, ask everyone's permission before you ask them invasive questions. And then I often try to acknowledge that the health care system has failed people. I will say, "you know, we have historically done a really bad job in caring for you and I'm sorry for that." And, "I'm going to ask you some other questions and this may be hard. So can, is it okay if we do it now or do you want to wait until next visit?"

For the above key informant, acknowledging the tendency for transgender patients to have previously negative experiences helps establish a level of understanding and empathy, and allows for the provider to demonstrate that they are aware their patient may be feeling uncomfortable.

Lastly, participants also touched on how gynecological medical settings or those focused on reproductive organs can also induce anxiety, trauma-related symptoms, and gender dysphoria. This key informant discusses how adopting a trauma-informed approach provides staff with the ability to recognize trauma and the ways trauma symptoms can manifest during medical visits:

A lot of staff don't really even have a grasp on trauma. They'll misjudge a patient's traumatic stress symptoms as being insubordinate during medical procedures. When in reality they're struggling with their mental health, their anxiety is heightened, and they're feeling dysphoric.

In this example, the key informant suggests that adopting a trauma-informed approach among all staff members would allow for greater understanding of what a patient might be feeling during exams. This participant suggested that trauma-focused training could also give a new perspective to medical staff and increase empathy among staff members who may not have any previous knowledge on trauma.

Community engagement.

When asked for specific recommendations to providing gender-affirming care, several participants ($n = 4$) discussed the importance for medical care providers and health agencies to be involved in community events. For this key informant working with children and adolescents, hosting events in the community for children was an important way for providers to build a relationship outside of the medical setting:

You need opportunities and events that can increase sense of community. We host fun things for kids just to be kids. A yoga class, or picnic at the park, you know just fun things that aren't focused on them as a patient. Just an opportunity for them to be themselves.

This quote demonstrates the importance for providers and agencies to work outside of their offices. Engaging with the community outside of their medical setting or agency location allows providers to build rapport, increase trust, and establish relationships with community members and patients.

Discussion

The present study acts as a preliminary attempt to understand the barriers and facilitators of seeking and accessing gynecological care for transgender (specifically trans men) and gender diverse populations. This needs assessment researched a severely under looked topic in both Medical and Community Psychology disciplines. Future participatory action research should continue to explore the various perceptions of medical care providers, advocacy stakeholders, and trans-advocacy researchers in an effort to reach full saturation. Furthermore, a larger, mixed-methods study gathering perceptions from transgender participants and those who have experience as a patient in gynecological settings could help add to the current findings and shed light on more patient-specific individual barriers.

Previous research by Meyer (2003) on minority stress and Hendricks and Testa (2012) on

transgender minority stress demonstrates that transgender populations are at a significantly higher risk of both physical and mental health complications compared to the general population. Research on transgender minority stress suggests that health care providers should work to become aware and culturally competent of the stress factors impacting transgender populations (Hendricks & Testa, 2012). Key informants interviewed in this present study also acknowledged these stress factors; their stories and descriptions of agency functioning demonstrate the need for medical providers to adopt a collaborative approach to care where the patient and provider work together to explore holistic and interdisciplinary care options.

While limited with only seven participants, the qualitative portion of this study sought to gather specific information from key informants working with transgender and gender diverse populations. Continuing with a modified grounded theory approach, data collection should continue and expand beyond this preliminary analysis to include more participants in an effort to reach full saturation. Once data collection reaches full saturation, a subsequent needs assessment gathering information from transgender populations, specifically those who frequently seek or should seek gynecological care, should develop. This research should be participatory action-based, where participants can help inform future projects and are able to validate and affirm the results of the study.

Emergent themes among key informant interviews illuminated the many barriers that transgender and gender diverse patients face when seeking gynecological care and health care services in general. Results include both individual and systemic-related barriers (i.e., lack of trained medical providers, unemployment, difficulties working with insurance companies, lack of family support).

The most salient barrier among interviews concerned the lack of training and education among medical care professionals. Key informants stressed the importance of training in multiple contexts: during medical school training, throughout one's profession (continuing medical education), upon entering an agency as a new employee, and regular agency trainings for all employees. On par with agency trainings, a common recommendation included creating trauma-informed medical settings. As previously stated, creating a trauma-informed atmosphere can help alleviate some of the feelings of anxiety and dysphoria that many transgender individuals face when seeking gynecological-specific care. Additionally, increasing education on trauma and trauma symptoms can help medical care providers better attend to their patients' needs.

An additional key barrier identified within this study focused on unemployment rates among transgender and gender diverse populations. Key informants cited this as being one of the most prevalent individual barriers that creates difficulties for patients seeking and accessing medical care. Advocacy efforts to help support transgender populations in seeking, accessing, and securing viable employment opportunities are imperative to increasing employment options. Several key informants suggested that community advocacy organizations should work with transgender populations in helping navigate searching for and securing employment. Hosting workshops where community members can learn to prepare for interviews, create resumes, and network with potential employers could also help fuel this effort.

Lastly, results from the interviews stressed the importance of creating trauma-informed medical environments. Establishing a trauma-informed environment would involve training all staff members on trauma and trauma symptoms, including staff members that may not have direct contact with patients. Trauma-informed education should also include using gender

affirming language and terminology for all patients. Additionally, trauma-informed care would involve providers working with each patient individually during intake, exams, and procedures to provide affirming and collaborative care.

Key informant interviews offered suggestions that other medical care providers and community advocacy organizations can adopt to increase gender-affirming care within their agencies. For example, collaborating with other professionals outside of their discipline to offer holistic, interdisciplinary care to patients. Collaborating with lawyers or medical ethicists to review insurance claims or denials was among one of the many resources that gender-affirming agencies have adopted and use to provide holistic, affirming care.

The study included a few limitations. First, the sample for the qualitative interviews was limited in terms of race and ethnicity diversity. Additionally, both the quantitative and qualitative portions were comprised of mostly women. Although this demographic is consistent with most gynecological offices and community advocacy organizations, it would be helpful to also gather more in depth responses from men working in these settings. Lastly, the lack of a pre-existing quantitative measure required researchers to create a scale themselves. While the scale did indicate strong internal reliability within this study, future research could try to adopt a pre-existing quantitative scale to increase construct validity of the findings.

Moving forward, this study provides a clearer picture on the specific barriers faced by transgender and gender diverse populations when seeking gynecological care. Additional qualitative and quantitative research is needed in order to gather data from transgender and gender diverse populations who have experience seeking care in gynecological settings. It would also be interesting to gather more in-depth qualitative research as to the training materials, courses, and organizational policies that gender-inclusive gynecological clinics are currently

adopting. Establishing a Best Practice for Gender Affirming Care using the trainings, research, and suggestions from both patients and providers could be helpful for other providers and agencies. Creating and disseminating this information to all medical care providers could act as a resource and generate momentum for further advocacy efforts.

Appendix A
Informed Consent Form - Quantitative Survey

UNIVERSITY OF NEW HAVEN
Informed Consent Form

You are invited to participate in an online study being conducted by Meghan Flynn, a University of New Haven graduate student in the Community Psychology department. This study is being completed as part of the student's Master's Thesis. The purpose of this study is to gather information on the specific gynecological health needs of transgender populations. Participation in this study is expected to last no more than 20 minutes.

PARTICIPATION:

Your participation in this survey is voluntary. You may refuse to take part in the research or exit the survey at any time without penalty. You may skip any question you do not wish to answer for any reason. You will be asked to complete a short survey regarding your opinions on trans-inclusive healthcare environments, as well as a short demographic survey.

Upon completion of the online survey, you will be invited to take part in a one-on-one interview. Should you choose to participate in a one-on-one interview, a research assistant will schedule this with you via email or by phone. We will obtain your written consent in a similar manner as today on the day of the individual interview, should you choose to participate in an individual interview. Individual interviews will be audio recorded. When these recordings are transcribed, you will be identified by a number or pseudonym, and not your real name.

BENEFITS & RISKS:

You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about the needs of an underserved population. The risks associated with your participation are minimal and are not in excess of those encountered in normal daily living. Discussing the impact of gynecological care and sex assigned at birth may elicit feelings of anxiety or discomfort. If you experience distress, please feel free to stop at any time during the survey. You do not have to answer questions that make you uncomfortable, and you can leave or stop the survey at any time. Participation is completely voluntary, and there are no penalties for choosing not to participate, not responding to a question, or for ending your participation.

Your anonymity is guaranteed; after you finish the survey, it will not be possible for anyone to know how you responded. If you become uncomfortable during any time during this survey, you may contact the University of New Haven Counseling Center at (203) 932-7332. You may also contact the Trans LifeLine hotline at (877) 565-8860.

CONFIDENTIALITY:

No identifying information (e.g., names) is included in the file that contains your answers. It is important for you to know that your data will be kept completely confidential. After completing the survey, your data file of recorded answers will not be associated with your name. Your consent form is not connected with your answers. This procedure is designed to ensure that your data remain completely anonymous.

Project Expires on

FEB - 1 2020

**University of New Haven
Institutional Review Board**

You should be aware that participation in this study is voluntary. You are free to refuse to participate or withdraw at any time without penalty or loss of benefits to which you are entitled. If you have any questions regarding the procedures, please contact: Dr. Melissa Whitson (Faculty Supervisor) at (203) 479-4589. If you have any questions or concerns regarding this study or your rights as a research participant and would like to talk to someone other than the researcher(s), contact the chair of the University of New Haven's Institutional Review Board, Dr. Alexandria Guzmán at irb@newhaven.edu. By signing below, you indicate your consent to participate in the online survey.

ELECTRONIC CONSENT:

Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates that

- You have read the above information
- You voluntarily agree to participate
- You are 18 years of age or older

✕ Agree

✕ Disagree

Project Expires on

FEB - 1 2020

University of New Haven
Institutional Review Board

Appendix B

Demographics Questionnaire

Please answer the following questions. You can omit any question that you do not feel comfortable answering. Your responses are confidential; your name does not appear anywhere on this document and there is no way for me to link your responses with your identity. Please feel free to answer honestly.

What is your age? _____

What is your current gender identity (Check all that apply)

- ☐ Male
- ☐ Female
- ☐ Transgender Male / transman / FTM
- ☐ Transgender Female / transwoman / MTF
- ☐ Genderqueer
- ☐ Additional Category (please specify): _____
- ☐ Decline to answer

What sex were you assigned to at birth? (Check one)

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Decline to answer

Do you identify as: (Check all that apply)

- ☐ Straight/Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Asexual
- ☐ Pansexual
- ☐ Other: _____
- ☐ Decline to answer

What is your race/ethnicity? (Please check all that apply.)

- | | |
|----------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Black or African-American | <input type="checkbox"/> Non-Hispanic White |
| <input type="checkbox"/> Asian or Asian-American | <input type="checkbox"/> Hawaiian or Pacific Islander |
| <input type="checkbox"/> Hispanic or Latino(a) | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Other _____ | |

What is the highest level of education you have completed? (If you're currently enrolled in school, please indicate the highest degree you have *received*.)

- ☐ Less than a high school diploma
- ☐ High school degree or equivalent (e.g. GED)
- ☐ Some college, no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, BS)
- ☐ Master's degree (e.g. MA, MS, MEd)
- ☐ Professional degree (e.g. MD, DDS, DVM)
- ☐ Doctorate (e.g. PhD, EdD)

What is your current employment status?

- ☐ Employed full time (40 or more hours per week)
- ☐ Employed part time (up to 39 hours per week)
- ☐ Unemployed and currently looking for work
- ☐ Unemployed and not currently looking for work
- ☐ Student
- ☐ Retired
- ☐ Self-employed
- ☐ Unable to work

What is your total household income?

- ☐ Less than \$10,000
- ☐ \$10,000 to \$24,999
- ☐ \$25,000 to \$34,999
- ☐ \$35,000 to \$49,999
- ☐ \$50,000 to \$74,999
- ☐ \$75,000 to \$99,999
- ☐ \$100,000 to \$149,999
- ☐ \$150,000 to \$199,999
- ☐ \$200,000 or more
- ☐ Prefer not to answer

What company or organization do you currently work for? _____

What is your occupation/job title (or brief description)? _____

Appendix C
Quantitative Survey Questionnaire

Online Survey Questionnaire

Please rate how important you think the following statements are to providing inclusive gynecological care for transgender patients:

The medical staff uses language and terms that reflect trans-inclusivity in an effort to communicate more effectively during assessment, treatment, and other medical practices.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

Ob/Gyn staff understands and respects that some patients may choose not to identify as within the gender binary, and may prefer to use other terms to identify themselves.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

The Ob/Gyn staff works with each patient individually to find languages and terms that work best for them.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

The Ob/Gyn staff understands and respects that some patients may not feel comfortable speaking about their gender identity and expression.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

The Ob/Gyn staff avoids imposing values that may conflict or be inconsistent with those of LGBTQ cultures or groups.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

Members of the Ob/Gyn staff intervene appropriately when they observe others behave or speak insensitively or prejudice against transgender individuals or populations.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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Members of the Ob/Gyn staff are aware of the policies in place at their office regarding discrimination, non-harassment, and diversity-inclusion.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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Members of the Ob/Gyn staff understand that the needs of LGBTQ patients are not always the same as the general population.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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If an Ob/Gyn staff member is presented with a issue regarding a patient's gender-identity or gender-expression, they know where they can go to find help addressing this issue.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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Members of the Ob/Gyn staff understand that many evidence-based approaches require adaptation to be effective for LGBTQ populations.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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Trans-friendly resources and posters are displayed in waiting rooms and exam rooms of Ob/Gyn offices.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
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Intake and screening forms have options for transgender patients to identify themselves and their preferred names/pronouns.

Not Important 1	Slightly Important 2	Moderately Important 3	Important 4	Very Important 5
-----------------------	----------------------------	------------------------------	----------------	------------------------

Non-discrimination and non-harassment policies are in place to protect and welcome transgender patients, and these policies are enforced by office staff and administration.

Not Important	Slightly Important	Moderately Important	Important	Very Important
1	2	3	4	5

Please rate how strongly you agree or disagree with the following statements:

Health is mostly an individual responsibility; it is up to each individual to maintain their health or do what it takes to improve their health.

Strongly Disagree				Strongly Agree
1	2	3	4	5

Health is mostly a collective responsibility; it is up to society to create conditions that help maintain or improve health.

Strongly Disagree				Strongly Agree
1	2	3	4	5

Access to health services is an absolute right; everyone should have the same access to health care.

Strongly Disagree				Strongly Agree
1	2	3	4	5

Appendix D
Consent Form - Individual Phone Interview

UNIVERSITY OF NEW HAVEN
Informed Consent Form

You are invited to participate in a one-on-one interview being conducted by Meghan Flynn, a University of New Haven graduate student in the Community Psychology department. This study is being completed as part of the student's Master's Thesis. The purpose of this individual interview is to gather information on the specific gynecological health needs of transgender populations. Participation in this study is expected to last no more than 60 minutes.

PARTICIPATION:

Your participation in this interview is voluntary. You may refuse to take part in the research or leave the interview at any time without penalty. Individual interviews will be audio recorded. When these recordings are transcribed, you will be identified by a number or pseudonym, and not your real name.

BENEFITS & RISKS:

You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about the needs of an underserved population. The risks associated with your participation are minimal and are not in excess of those encountered in normal daily living. Discussing the impact of gynecological care and sex assigned at birth may elicit feelings of anxiety or discomfort. If you experience distress, please feel free to stop at any time during the session. You don't have to answer questions that make you uncomfortable, and you can leave or stop the interview at any time. Participation is completely voluntary, and there are no penalties for choosing not to participate, not responding to a question, or for ending your participation.

Your anonymity is guaranteed; it will not be possible for anyone to know how you responded. If you become uncomfortable or would like to speak with someone after completion of this interview, you may contact the University of New Haven Counseling Center at (203) 932-7332. You may also contact the Trans LifeLine hotline at (877) 565-8860.

CONFIDENTIALITY:

No identifying information (e.g., names) is included in the file that contains your answers. It is important for you to know that your data will be kept completely confidential. Your name will not be attached to the transcription of the individual interview. Your consent form is not connected with your answers. This procedure is designed to ensure that your data remain completely anonymous.

If you have any questions regarding the procedures, please contact: Dr. Melissa Whitson (Faculty Supervisor) at (203) 479-4589. If you have any questions or concerns regarding this study or your rights as a research participant and would like to talk to someone other than the researcher(s), contact the chair of the University of New Haven's Institutional Review Board, Dr. Alexandria Guzmán at irb@newhaven.edu. By signing below, you indicate your consent to participate in the interview scheduled for today.

Project Expires on

FEB - 1 2020

University of New Haven
Institutional Review Board

CONSENT:

To give your consent to participate in this study, you acknowledge that you understand the following:

- Your participation in this study is entirely voluntary.
- You may drop out of the study at any time without penalty.
- The individual interview will be audio-recorded.
- Your data will be kept in strict confidentiality to the extent allowed by law.

By signing below, you indicate your consent to participate in the interview scheduled for today.

Name (printed): _____ Signature: _____ Date: _____

Project Expires on
FEB - 1 2020
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Appendix E
Open-Ended Interview Questions

Individual-Specific Questions:

1. How long have you been affiliated with your organization? How long have you been in your current role?
2. How does your current position impact your involvement with the trans community?
3. How has your current position impacted your level of involvement in trans advocacy and research within your community?
4. Can you tell me a bit about yourself and what a typical day looks like for you?

Interview Questions:

1. What is your experience working with transgender patients in medical settings?
2. What does it mean for a medical facility to be “inclusive”?
3. How would you describe the current state of transgender health care? Where does your facility/organization fit into this within the community?
4. What aspects are most important when providing a transgender patient medical care?
5. In your opinion, what are the biggest barriers transgender patients face when seeking gynecological health care?
6. How might a transgender patient experience stress differently when seeking gynecological care (compared to cisgender patients)?
7. Medical settings can often evoke trauma-related symptoms from patients: What do you think medical care providers can do to help reduce retraumatization in medical settings?
8. What type of community resources do you think transgender patients need to support access to equitable and inclusive health care?
9. What suggestions or recommendations do you have to increase access to gender-affirming care for transgender patients?
10. On a broader level, what types of policy changes are needed to increase access to care for trans patients? Both in your community and on a federal level?

Closing Questions:

1. Is there anything we didn't cover that you'd like to share with me?
2. Do you have any questions for me?

References

- Aiken, J. (2016). Promoting an integrated approach to ensuring access to gender incongruent health care. *Berkeley J. Gender L. & Just.*, 31, 1.
- American Medical Association. (2016). Creating an LGBTQ-friendly practice. Retrieved from <https://www.ama-assn.org>.
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research*, 42(4), 1758-1772.
- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum*, 41(5), 545–547.
- Charmaz, K. (2008). Constructionism and the grounded theory method. *Handbook of constructionist research*, 1, 397-412.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... & Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International journal of transgenderism*, 13(4), 165-232.
- Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The counseling psychologist*, 35(2), 236-264.
- Driák, D., & Samudovsky, M. (2005). Could a man be affected with carcinoma of cervix?-The first case of cervical carcinoma in trans-sexual person (FtM)-case report. *ACTA MEDICA-HRADEC KRALOVE-*, 48(1), 53.
- Dutton, L., Koenig, K., & Fennie, K. (2008). Gynecologic care of the female-to-male transgender man. *The Journal of Midwifery & Women's Health*, 53(4), 331-337.

- Grant, J. M. M. L., Mottet, L., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). National transgender discrimination survey report on health and health care.
- Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology: Research and Practice*, 43(5), 460.
- Human Rights Campaign. (2017). Healthcare equality index.
- Human Rights Campaign & Trans People of Color Coalition. (2015). Addressing Anti-Transgender Violence: Exploring Realities, Challenges and Solutions for Policymakers and Community Advocates. Retrieved from <http://assets2.hrc.org>.
- James, S. E., & Herman, J. (2017). *The Report of the 2015 US Transgender Survey: Executive Summary*. National Center for Transgender Equality.
- MacKichan, F., Brangan, E., Wye, L., Checkland, K., Lasserson, D., Huntley, A., ... & Purdy, S. (2017). Why do patients seek primary medical care in emergency departments? An ethnographic exploration of access to general practice. *BMJ open*, 7(4), e013816.
- Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674-697. doi:10.1037/0033-2909.129.5.674
- Mizock, L., & Mueser, K. T. (2014). Employment, mental health, internalized stigma, and coping with transphobia among transgender individuals. *Psychology of sexual orientation and gender diversity*, 1(2), 146.
- National Coalition of Anti-Violence Programs (2014). Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2013. Retrieved from <https://avp.org>.
- Peitzmeier, S. M., Reisner, S. L., Harigopal, P., & Potter, J. (2014). Female-to-male patients

- have high prevalence of unsatisfactory Paps compared to non-transgender females: implications for cervical cancer screening. *Journal of general internal medicine*, 29(5), 778-784.
- Sánchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of counseling psychology*, 56(1), 202.
- Seelman, K. L., Colón-Díaz, M. J., LeCroix, R. H., Xavier-Brier, M., & Kattari, L. (2017). Transgender noninclusive healthcare and delaying care because of fear: connections to general health and mental health among transgender adults. *Transgender health*, 2(1), 17-28.
- Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. *Psychology of Sexual Orientation and Gender Diversity*, 2(1), 65.
- Testa, R. J., Sciacca, L. M., Wang, F., Hendricks, M. L., Goldblum, P., Bradford, J., & Bongar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*, 43(5), 452.

Table 1

Phone Interview Demographics

Participant (#)	Job Title	Job Setting	Location (U.S. Region)
1	Administrative Assistant	Community-based Advocacy Organization	South
2	Clinical Mental Health Counselor	Medical Clinic (Geriatric Endocrinology)	Northeast
3	Medical Social Worker	Medical Clinic & Advocacy Organization	Northeast
4	Gynecologist	Private Practice (Ob/Gyn)	South
5	Clinical Psychologist; Director of a Community Gender Program	Medical Clinic (Pediatric Specialty)	Northeast
6	Physician Assistant & Clinical Assistant Professor	Medical Clinic	West
7	Medical Case Manager	Medical Clinic & Advocacy Organization	Northeast

Table 2
Recommendations from Key Informant Interviews

Recommendation	Recommendations Explained
Intake: Intake Procedures (<i>n</i> = 7)	Recommendations for intake procedures included working with each patient to establish and document their legal and preferred name, pronouns, and the terms they use when referring to various anatomy.
Intake: Providing Gender-Affirming Intake Forms (<i>n</i> = 4)	Key informants described the need for more universal intake forms for public health sectors. Participants suggested that universal intake forms would provide all medical staff with gender-affirming identity information and could help ease the amount of personal information that patients share with office staff and those not directly providing care.
Staff Training (<i>n</i> = 7)	All seven participants stressed the importance of increasing education and training among staff members to help create a gender-affirming and inclusive environment.
Policy Changes: Increasing Federal Policy to Cover More Gender-Affirming Procedures (<i>n</i> = 5)	A majority of key informants suggested that Medicare and Medicaid insurance policies aimed at providing gender-affirming treatments should include more common procedures such as hair removal, tracheal shave procedures, or voice modifications.
Policy Changes: Establishing Federal Anti-Discrimination Laws (<i>n</i> = 3)	Suggestions for advocating towards anti-discrimination policies at the federal-level. While some states have laws protecting transgender and gender diverse populations from discrimination in various settings, federal laws and attitudes of government officials often contradict or undermine these advocacy efforts.
Policy Changes: Agency Accountability for Discrimination Incidences (<i>n</i> = 6)	Participants suggested that all agencies providing care to patients should have established policies against discrimination and harassment, and that agencies should ensure that discrimination claims are following through with and handled appropriately and kept confidential to protect the identity of the reporter.

Increased Diversity
Training During
Medical School ($n = 4$)

Lack of diversity training among medical professionals during school. Recommendations for increased training and education for medical care providers also included training in how to engage with diverse populations.

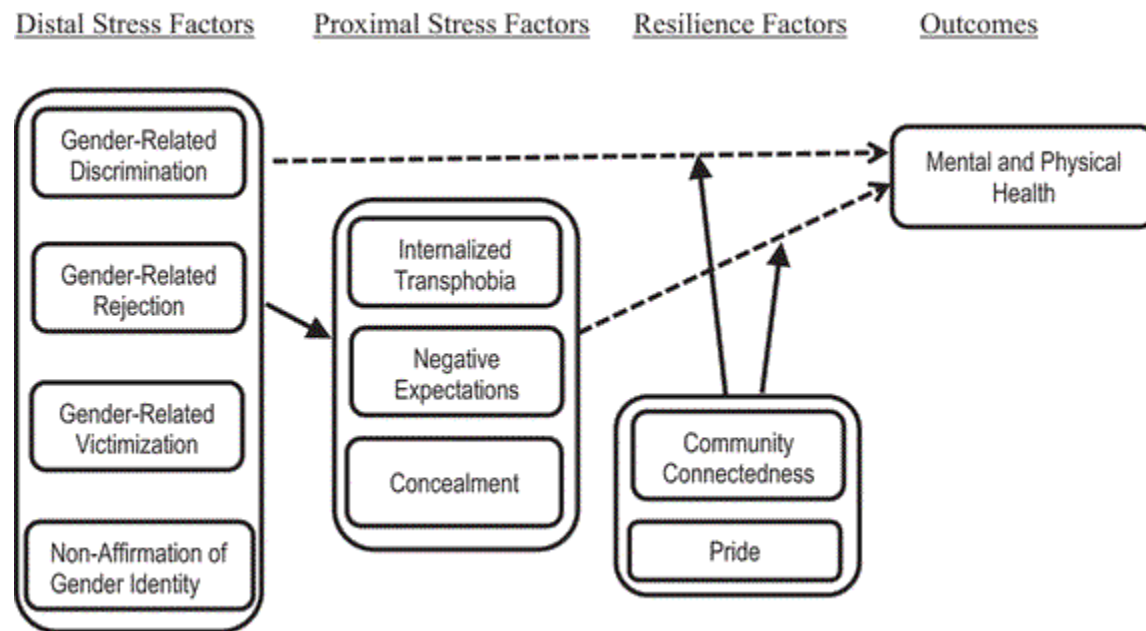
Adopting a Trauma-
Informed Approach
to Care ($n = 4$)

Key informants recommended that agencies increase education on trauma for all staff members in an attempt to create an environment where staff members are aware of trauma and work together to reduce trauma.

Engaging with the
Surrounding Community
($n = 4$)

Participants recommended that providers and health agencies become involved in community events. Key informants suggested this could help providers build relationships with patients and increase trust outside of medical settings.

Figure 1. Testa et al. (2015) Gender Minority Stress and Resilience Model



* Dashed line indicates inverse relationships.

Figure 2. Qualitative Results: Emergent Themes Diagram

