Gender and Population Studies (GAPS) in Health

Trans Primary Care – Recent Contributions to the Field: A Literature Review

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Lay Summary

Transgender (trans) people experience significant barriers to accessing healthcare services. Recent scholarship in the field of trans health aims to understand barriers to care and develop best practices around trans healthcare. A literature review was conducted on research in the areas of transgender healthcare and health education that included publications between June 2019 and June 2020 to provide an accessible and recent overview of, and key findings from, the field of trans health. This review may assist researchers and community members in learning more about recent transgender health and health education research.

This paper reviews recent scholarship in the field of trans healthcare and health education. Papers published from June 2019 until June 2020 were included in the search, with a total of fifty-seven papers included in the final review. This paper outlines current barriers to and gaps in trans healthcare; current topics in trans healthcare research including gender dysphoria and pathologization, intersectionality, and how trans healthcare has been framed in recent literature; trans primary care including specific areas of care, nonbinary and gender non-conforming care, education in trans primary care, and recent projects in trans health. Where relevant, the specific terminology used in a paper has been retained (ex., trans, TGNC, LGBT, MSM, etc.) to preserve the multiple ways transness is discussed in health literature. Part of preserving this diversity of language around trans lives and health is done with the intention to celebrate the variety of ways transness can be understood.

Introduction

Health and healthcare disparities, and barriers to accessing primary care, for trans patients has been previously noted, including the prevalence of stigma, discrimination and lack of knowledgeable providers in seeking healthcare (Eisenberg, McMorris, Rider, Gower, & Coleman, 2020; Klotzbaugh & Spencer, 2020; Schwend, 2020; Stewart, Lee, & Damiano, 2020; Vries, Kathard, Müller, 2020; Willging, Kano, Green, Sturm, Sklar, Davies, & Eckstrand, 2020; Ziegler, Valaitis, Risdon, Carter, & Yost, 2020; Ziegler, Valaitis, Carter, Risdon, & Yost, 2020; Allison, Marshall, Archie, Neher, Stewart *et al*., 2019; Anzani, Morris & Galupo, 2019; Chambers, Pastrik, & Manzer, 2019; Du Mont, Kosa, Abavi, Kia, & Macdonald, 2019; Edenfield, Colton, & Holmes, 2019; Howard, Lee, Nathan,

Wenger, Chin, *et al*., 2019; Jann, Penzak, White, & Tatachar, 2019; Kattari, Atteberry-Ash, Kinney, Walls, & Kattari, 2019; Langille, 2019; Morris, Cooper, Ramesh, Tabatabai, Arcury, *et al*., 2019; Shaver, Sharma, & Stephenson, 2019; Shinn, *et al*., 2019; Zeeman *et al*., 2018). Others have noted the prevalence of avoiding medical care in transgender communities, or choosing not to disclose important medical or gender/sexual info (including in emergency and primary care) because of fears of discrimination due to transgender or gender non-conforming (TGNC) status (Allison *et al*., 2019; Anzani et al., 2019; Barnes *et al*., 2019; Chambers, Pastrik, & Manzer, 2019; Du Mont *et al*., 2019; Kattari *et al*., 2019; Langille, 2019; Leland & Stockwell, 2019; Morris *et al*., 2019; Zeeman *et al*., 2018). For Trans People of Colour (TPOC), avoiding healthcare may result from being a minority in both trans-focused clinics, who cater primarily to white trans people, and in clinics serving primarily POC patients, who may mostly be cis-gender, highlighting the importance of an intersectional approach to TGNC healthcare, especially for TGNC POCs (Howard *et al*., 2019).

Recent studies have also noted the lack of provider education and challenges to accessing primary care that gender-diverse individuals face in rural settings, pointing to heightened disparities of care in rural settings (Klotzbaugh & Spencer, 2020; Stewart, Lee, & Damiano, 2020; Willging *et al*., 2020; Langille, 2019; Shaver *et al*., 2019). Rurality has been noted among other vulnerable intersections (i.e., older, refugee, immigrant, disability, poverty, ethnicity) as a significant barrier to care (Zeeman *et al*., 2018). The challenges to accessing primary care for gender-diverse individuals in rural Alberta has also been documented (Langille, 2019).

Canadian data on the prevalence of trans people in the population is lacking. In a Canadian context, TGNC patients were found to be "more likely to experience health inequalities due to heteronormativity or heterosexism, minority stress, experiences of victimization and discrimination, compounded by stigma" (Zeeman, *et al*., 2018). One study noted that historically, the bulk of healthcare research on TGNC populations was related to HIV/AIDs and substance use, and that currently there is a lack of knowledge on in-group health differences (Kattari *et al*., 2019).

Barriers & Gaps in Care

As noted previously, trans people face significant barriers to healthcare, including lack of provider knowledge and psychiatric requirements (i.e., a diagnosis of gender dysphoria) governing access to care. Availability of care that meets trans patients' needs has been identified as a gap (Du Mont *et al*., 2019). There are a lack of practitioners offering care, and patients commonly travel large distances or endure long wait times when seeking access to care (Ziegler *et al*., 2020). There is a lack of understanding of LGBTI patient lives and (medical) needs, and a lack of skill to meet needs (Zeeman *et al*., 2018).

Other commonly noted barriers to care include heteronormativity, the assumption that heterosexuality is the default and 'norm,' and cisnormativity, the assumption that cisgender is the default and 'norm,' (Zeeman *et al*., 2018). Cis- and hetero-normativities can lead to microaggressions, subtle ways day-to-day interactions affect marginalized folks, (ex., misgendering, dead-naming) in healthcare and other settings (Vries *et al*., 2020; Anzani et al., 2019; Barnes *et al*., 2019; Langille, 2019; Morris *et al*., 2019).

Current Topics in Trans Care

Team delivery of primary care, and collaborative care, for trans patients has been supported in the literature (Nieder *et al*., 2020; Ziegler *et al*., 2020). Yet, a recent study of trans primary care delivery in Ontario noted that practitioners tended to work independently, and in cases where an interdisciplinary team administered care collaboration was limited (Ziegler *et al*., 2020). Although practitioners may feel inexperienced providing primary care to trans patients, trans care is well within the scope of a primary care practice (Ziegler *et al*., 2020). Access to a trans-inclusive primary care provider was one of the strongest indicators for not delaying care due to fear of discrimination and of having had a (gender affirming) medical intervention (Kattari *et al*., 2019).

Gender Dysphoria & Pathologization

Several studies have noted ongoing pathologization in clinical practice and research despite the removal of trans identities from the DSM. "Gender Dysphoria" in the DSM-5 replaced "Gender identity disorder" in the DSM-4 in an effort to be less stigmatizing (Hilário, 2020; Schwend, 2020; Vries, *et al.,* 2020), yet many trans people and their allies and advocates argue that transness continues to be pathologized through this psychological diagnostic which is used to govern access to affirming care. It is worth noting that 'affirming care' in this context is often used to denote hormonal and surgical interventions in trans care.

Psychologists and psychiatrists have been described as "gatekeepers" due to an over-emphasis on diagnosing gender dysphoria as a requirement for accessing gender-affirming care. Decisions on who can access gender-affirming care can thus be stigmatizing (Hilário, 2020; MacKinnon *et al*., 2020; Vries *et al.*, 2020; Brewster *et al*., 2019; Motmans *et al*., 2019). Attaining a diagnosis of dysphoria can be a barrier to affirmative care in part because there are no clear biomarkers or tests of dysphoria, often it falls to the discretion of the provider to judge who is 'authentically' trans. This is problematic because non-binary and other less normative identities may be excluded based on assumptions about who or how a trans person should be or present. Thus, there has been a recent call for dysphoria to be removed from the Diagnostic and Statistical Manual (DSM), and as a requirement for affirming care (Hilário, 2020; Schwend, 2020; Motmans *et al*., 2019). Gender dysphoria thus continues to situate diagnosis & pathologization as fields of power within medicine, highlighting the need for an intersectional approach to trans healthcare that recognizes the complex ways that medicine upholds social inequalities.

Treatment protocols governing access to gender-affirming medical interventions (such as puberty blockers, Hormone Replacement Therapy – HRT, and surgery), namely the requirement of a diagnosis of gender dysphoria, have been under debate (Ducharme; MacKinnon, Ng, Grace, Sicchia, & Ross, 2020), and researchers in a Canadian context have asserted that changes in policy and protocol are needed (Eisenberg *et al*., 2020; Zeeman *et al*., 2018). Research done in a Canadian context describes "mental readiness" assessments and protocols as limiting access to transgender related care, especially for trans people diagnosed with complex mental health issues, and may prevent trans patients from disclosing mental health information or cause patients to engage in psychiatric interventions they wouldn't otherwise in hopes of receiving

gender-affirming care (MacKinnon *et al*., 2020; Schwend, 2020; Allison *et al*., 2019). Trans people have also reportedly "rehearsed" the criteria of dysphoria listed in the DSM-5 to obtain access to treatment (MacKinnon *et al*., 2020).

Delay in receiving gender-affirming care is correlated with negative outcomes for trans people, in the Trans Youth CAN! study, youth who had lower average primary caregiver support were older at first appointment and "had higher gender distress, lower gender positivity, higher psychological distress, higher depression, [and] experienced higher lifetime and past-year discrimination" (Mokashi *et al*., 2020). Access to gender affirming care is associated with better mental health outcomes and quality of life (MacKinnon *et al*., 2020).

Currently there are two primary sources of published clinical guidelines for the medical care of the transgender population (Gamble *et al*., 2019*)*, the "WPATH – Standard of Care Version (SOC) 8" (World Professional Association of Transgender Health) and "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People" (UCSF – Center for Excellence for Transgender Health). The WPATH-SOC is recommended for teaching health professionals how to provide trans care, yet recent research has proposed that it also sets out "minimum readiness indicators that trans people must meet prior to starting hormones or surgeries" (MacKinnon *et al*., 2020). Thus, such tools, although useful for guiding standards of practice, can also cause unintended harm (MacKinnon *et al*., 2020). "Persistent dysphoria" is included among the "readiness criteria" that can lead to unequal access to care. A recent study found that a context of diagnosing gender dysphoria as part of determining "transition readiness" contributed to clinicians' exploration of alternative diagnoses – clinicians tended to defer treatment more frequently when trans people were perceived to have mental health issues, contributing to barriers in accessing medical care for trans people with "complex" mental health issues and conditions, culminating in what has been described as a "medically risky, two-tiered system in which trans people are determined to be either eligible or ineligible for transition-related medicine on the basis of mental health status" (MacKinnon *et al*., 2020).

Beyond creating inequal access to treatment, dysphoria as a diagnostic criteria governing access to transition-related and gender-affirming care has been more broadly called into question, and the role of medical practices surrounding gender dysphoria in the pathologization of trans identity has been noted (Hilário, 2020; MacKinnon *et al*., 2020; Vries *et al.*, 2020). A diagnosis of dysphoria as a requirement for accessing affirming care requires trans people to engage with a mental healthcare system that may be discriminatory in order to receive affirming care (Anzani et al., 2019). There is continued emphasis on gender dysphoria and medical/surgical interventions in the literature, and affirmative care can tend to be viewed as simply a means by which to align the physical body with gender identity, i.e., a way to 'correct' gender incongruence (MacKinnon *et al*., 2020; Nieder, Koehler, Briken, & Eyssel, 2020), an understanding of affirming care that always already excludes non-binary and gender expansive people.

It is worth noting that pathologization of other diverse genders and sexualities also occurs in

healthcare, for example, asexuality is commonly pathologized (Flanagan & Peters, 2020; Brewster, Motulsky, & Glaeser, 2019). The pathologization of multiple diverse sexualities and genders highlights the ways in which normative views about sexuality and gender, and prescriptive beliefs about how gender and sexuality should be experienced or understood, impact the medical care trans and other LGBTQ2S+ people receive.

Some recent literature on trans health has focused on the role a human rights framework plays as a foundation of depathologization perspective in trans healthcare (Schwend, 2020). The International Network of Trans Depathologization is one such trans self-advocacy network that seeks to shift the model of care from a psychiatric assessment process towards an informed decision-making approach (Schwend, 2020). Depathologization places the problem not in the person, but in the transphobic attitudes of society and has been necessarily linked to decolonization (Schwend, 2020). Schwend notes the "colonist character of an exportation of the Western medical model to other cultures" that the ongoing focus on diagnosis gender dysphoria encourages (2020). Challenges to a depathologizing approach that decenters a focus on gender dysphoria have also been noted, pathology is in part tied to state responsibility for care, and the argument of dysphoria as illness also works to justify state-provided treatment – researchers have thus noted that it is a challenge to conceptualize a model of trans health outside of diagnosis, its pathology, and the care that this pathology justifies (Hilário, 2020).

Approaching Intersectionality in Trans Healthcare

The multiple intersections at which the pathologization of trans bodies comes together as a product of cis- and hetero-normativities, and as understanding of transness as dysphoria, a incongruence between body and mind to be 'fixed' through medical intervention, and as something that must necessarily be understood through the lens of ongoing colonization highlights the importance of an intersectional approach to trans healthcare. Intersectionality is a multi-factorial approach to trans healthcare that allows for a constellation of factors and positionalities to be accounted for when seeking to understand the barriers to, and needs for, healthcare in transgender populations. Recently there have been widespread calls for an intersectional approach to trans healthcare (O'Bryan, Scribani, Leon, Tallman, Wolf-Gould, *et al*., 2020; Burgwal *et al*., 2019; Edenfield, Colton, & Holmes, 2019; Howard *et al*., 2019; Kamen *et al*., 2019; Lacombe-Duncan, Newman, Bauer, Logie, Persad, *et al*., 2019; Zeeman *et al*., 2018). There is a need to account for the culminative effects of multiple positionalities and identities (i.e., race, gender, sexuality, class/socio-economic status, etc.) and their intersections when seeking to address health disparities among trans populations (Willging *et al*., 2020; Barnes *et al*., 2019; Motmans *et al*., 2019). Research on inequalities in LGBTI healthcare has noted that different LGBTI identities experience varying degrees of inequality, and in addition inequalities also vary depending on gender, age, income and disability (Zeeman *et al*., 2018).

In a study of Canadian gay and bisexual men who have sex with men (GBMSM) the authors noted the lack of an intersectional approach

with GBMSM often treated as a "homogenous group," asserting the need for more consideration being given to *within* group inequities (Ferlatte *et al*., 2020). Gender non-conforming (GNC) POC experience more negative outcomes based on their GNC status (Burgwal *et al*., 2019), and trans POC (TPOC) describe experiences of discrimination, "negative healthcare experiences," unique from experiences of either racism or transphobia alone (Howard *et al*., 2019). In order to begin a practice of accountable care, the multidimensionality of identity, and how historical, structural, and cultural factors play a role, need to be acknowledged in the ways they culminate in varying healthcare needs among TGNC patients (Vries *et al*., 2020).

These factors have been described as social determinants of health, the social conditions and inequalities resulting from structural factors that contribute to health and healthcare outcomes (Vries *et al*., 2020). To attend to the social determinants of health in a way that takes into account the intersectionality of peoples' lives it is necessary to incorporate social justice into healthcare (Vries *et al*., 2020; Edenfield *et al*., 2019). Part of this social accountability requires including more fulsome TGNC education into curricula for health providers (Vries *et al*., 2020; Edenfield *et al*., 2019). Suess Schwend encourages researchers to position their work, but also themselves in the field, what Schwend (2020) describes as a "self-reflexive research practice" to touch on the author's own perspective on and position in relation to trans health as a field.

Framing Trans Health Research

Trans health researchers frame their research in relation to several models and paradigms. Shifts in the field of transgender health from a disease-based model to an identity-based model which sees gender-related distress not only as something that should be "fixed" through hormonal and surgical intervention, but as potentially also/or rooted in social stigma associated with gender variance, discrimination, and systemic biases that decrease access to care (Vries *et al.*, 2020; Motmans, Nieder, & Bouman, 2019) demand a broader approach to trans healthcare that recognizes the ways in which trans experiences of their bodies, genders, and lives are socially situated.

Increasing prevalence of "rights based" approach to trans healthcare (Schwend, 2020; Zeeman *et al*., 2018), acknowledging multifaceted dimensions of discrimination and move towards an intersectional analysis of barriers to trans health that accounts for the ways that social, political, and cultural factors combine to create health inequalities and barriers (Zeeman *et al*., 2018). Among these commonly identified sources of health inequalities were heterosexism, contexts in which heterosexuality is presumed as the norm, minority stress, which posits that prejudice and discrimination lead to heightened stress in marginalized populations, discrimination (individual and/or institutional), and stigma (Zeeman *et al*., 2018).

Minority stress, discrimination and/or stigma experienced socially by those with a minority identity (ex., sexual minority), was mentioned frequently in the literature and connected to worsened health outcomes (Eisenberg *et al*., 2020; Klotzbaugh & Spencer, 2020; Anzani et al., 2019; Vries *et al*., 2020; Willging *et al*., 2020; Brewster, Motulsky, & Glaeser, 2019; Burgwal *et al*., 2019). One researcher proposed that minority stress lead to "group-level coping" and

the development of trans-specific support networks (Vries *et al*., 2020).

It has also been proposed that trans healthcare is geopolitical, in the way that location-based healthcare often excludes trans people. They argue that health-care communication for any marginalized community needs to be considered from a geopolitical and DIY standpoint. "DIY" internet communities enable individuals to form knowledge communities outside of institutional and expert spaces to navigate lack of access. The authors argue this extends beyond the DIY literacies on trans healthcare into the field more broadly – generalizing the experience of gender, sexual, or other cultural minorities must be avoided – attend to geopolitics and intersectionality. Geopolitics allows for a broader range of considerations at each localized stage of trans healthcare (Edenfield, Colton, & Holmes, 2019).

Other frameworks proposed by researchers include Normalization Process Theory (NPT), a conceptual framework to understand how interventions in healthcare lead to the way that elements of everyday life become integrated in social context (ex., asking pronouns in a clinical setting) (Ziegler *et al*., 2020). NPT has been used to explore the implementation and delivery of trans primary care in Ontario (Ziegler *et al*., 2020).

The principle of autonomy and informed-consent model, which allow for the self-definition of gender identification and more self-determination in care (Hilário, 2020; Motmans *et al*., 2019) have been employed to resituate "treatment [as a] cooperative effort between patient and provider where well-informed patients are the primary decision makers about their care" (Vries *et al*., 2020). One study discussed the use of Change Model, a model used to understand systems change, to facilitate improvements in trans patient care (Willging *et al*., 2020), a model also being used by the Edmonton Men's Health Collective (EMHC) in their LGBTQ2+ grassroot health empowerment program "Pivot" (Edmonton Men's Health Collective, 2019).

Trans Primary Care

The health needs of TGNC populations in many aspects resemble that of the general population, but TGNC patients also have unique healthcare needs (Ziegler *et al*., 2020). In TGNC patients there are varying health needs (Kattari *et al*., 2019), and different TGNC patients may have different desired outcomes for gender-affirming care. A recent study of Canadian trans youth found that among other factors contributing to resiliency, "access to mental health supports, and access to affirming care when desired" was listed (Travers, Marchbank, Boulay, Jordan, & Reed, 2020). Recent studies on trans primary care range widely in area of care being researched.

Specific Areas in Trans Primary Care

There is a need for transgender specific and gender-affirming care education and training across a variety of areas of care to meet the specific health needs of TGNC patients. Recent literature has discussed trans care in a variety of settings. Trans patient access to medical lab services (Langille, 2019), in blood donation and transfusion (Butler-Foster, Chin-Yee, Huang, & Jackson, 2020), cancer care (Kamen, Alpert, Margolies, Griggs & Darbes, *et al*., 2019; Kent, Wheldon, Smith, Srinivasan, & Geiger, 2019), TGNC care in laboratory medicine (Ahmad, Lafreniere, & Grynspan, 2019), transgender aging and geriatric care (Almack & King, 2019;

Gamble *et al*., 2019; Higgins, Downes, Sheaf, Bus, & Connell, *et al*., 2019; Kidlington; Pang, Gutman, & de Vries, 2019), trans-specific gynecological care and contraceptive/reproductive health – including trans parenthood and fertility preservation – (Stewart, Lee, & Damiano, 2020; Bonnington, Dianat, Kerns, Hastings, Hawkins *et al*., 2019; Feigerlová, Pascal, Ganne-Devonec, Klein, & Guerci, 2019), cervical cancer screening disparities in trans men (Dhillon, Oliffe, Kelly, & Krist, 2020), knowledge of and barriers to accessing PrEP in trans women (de Carvalho, Mendicino, Cândido, Alecrime & de Pádua, 2019), and mental healthcare and therapy (Ferlatte, Panwala, Rich, Scheim, Blackwell, & Scott *et al*., 2020; Vries *et al*., 2020; She, McCall, Pudwell, Kielly, & Waddington, 2020; Brewster, Motulsky, & Glaeser, 2019).

A recent study has noted the different experiences that TPOC have compared with white transgender people or cisgender racial/ethnic minorities, little is known about TPOC experiences of healthcare, although poorer health outcomes have been noted compared with single minority counterparts (Howard *et al*., 2019).

Another study conducted at UBC sought feedback and recommendations from TGNC individuals on sex and gender related issues in genetic counselling in order to provide trans-inclusive care and develop inclusive pedigree symbols (Barnes *et al*., 2019). Using interpretive description, trans experiences of and thoughts on genetic counselling was assessed using thematic analysis of a small group of participants (Barnes *et al*., 2019). It was determined that there is a need to create a safe environment where the importance of both sex and gender in genetic counselling is emphasized by validating gender identity and using inclusive and well-defined pedigree symbols denoting both sex and gender (Barnes *et al*., 2019). Although this study explored a different scope of practice beyond primary care, the emphasis on centering trans experiences of healthcare in cultivating validating and inclusive environments and ways of referring to trans people in clinical settings is salient.

Another study examined "microaffirmations," client experiences of gender-based affirmations, in therapy (Anzani et al., 2019). The authors noted that there is a focus in current literature on negative and discriminatory experiences in healthcare, and a lack of research on what affirmative care might look like (Anzani et al., 2019). A focus on microaggressions, while informative, are limited in terms of developing more practice-based understandings of how interactions with clients/patients can be made more supportive (Anzani et al., 2019). Shifting the focus to what positive experiences of provider microaffirmations might look like in clinical settings can assist in developing more nuanced understandings around trans-inclusive care. In the context of microaffirmations in therapy four themes were identified: absence of microaggressions; acknowledging cisnormativity; disrupting cisnormativity; and seeing authentic gender (Anzani et al., 2019), themes that hold relevance across varying clinical settings.

Non-binary and Gender Non-Conforming Care

It has been noted that genderqueer and nonbinary people "have remained largely invisible in health research" (Burgwal, Gvianishvili, Hård, Kata, Nieto, *et al*., 2019) and that transgender health research typically fails

to address non-binary people (Jones, Bouman, Haycraft & Arcelus, 2019). Thus, differences between binary and non-binary trans people's healthcare needs remain unclear (Cheung, Leemaqz, Wong, Chew, Ooi *et al*., 2020).

Gender dysphoria as a cornerstone of diagnostic and treatment practice for TGNC people enforces normative ideas about transness and gender binarism, transnormitivies that overlook other ways of being trans, including non-binary identities (Cheung *et al*., 2020; Hilário, 2020). Indeed, it has been reported that gender non-conforming people may present themselves as binary trans to increase their changes of receiving treatment (Burgwal *et al*., 2019). Trans health services need to be created with the needs of non-binary trans people in mind, recognizing that their treatment needs ma be different from those who identify within a binary system of gender (Cheung *et al*., 2020; Jones *et al*., 2019).

Normative ideas around gender, what can be thought of as cis- and trans-normativity, are reflected in differential access to and experiences of (affirming) medical care between binary and non-binary trans people. Trans healthcare needs to be responsive to shifts in how gender is understood in trans populations as language around gender identity continues to evolve in nuanced ways (Motmans *et al*., 2019; Ziegler *et al*., 2020). Other non-binary trans researchers have also pointed to the ways gender identity is not stable over life (Leland & Stockwell, 2019), something that must be considered as we approach trans healthcare. It has also been postulated that as normative ideas of gender continue to be socially questioned and as gender variance becomes more accepted the amount of gender non-conforming patients seeking affirming care will increase (Cheung *et al*., 2020).

Non-binary trans people are less likely to access transgender health services compared to binary transgender people and may have different needs for gender affirming care (Cheung *et al*., 2020; Burgwal *et al*., 2019; Jones *et al*., 2019). Non-binary and genderqueer people face unique stressors and are at risk for worse health outcomes when compared to binary trans people (Brewster, Motulsky, & Glaeser, 2019). Non-binary trans people were reported to access lower rates of gender-affirming interventions, and experience higher prevalence of depression, anxiety, and illicit drug use (Cheung *et al*., 2020).

Despite this, the health needs of non-binary and gender non-conforming trans people and the rate at which this population accesses gender-affirming care are unknown (Cheung *et al*., 2020; Motmans *et al*., 2019). Researchers working in this field of study have cited the need for more research on non-binary trans people in healthcare (Cheung *et al*., 2020; Jones *et al*., 2019).

In a community study in the UK, 526 people (97 non-binary TG, 91 binary TG, and 338 cisgender) were surveyed about gender congruence and body satisfaction, for sex-specific parts of the body non-binary trans people reported significantly higher levels of gender and body satisfaction compared with binary trans people (Jones *et al*., 2019). No difference in congruence and satisfaction with social gender role between the two groups was found (Jones *et al*., 2019), suggesting the relative importance of social constructs around gender in trans lives. Yet some of the findings in non-binary trans health are seemingly contradictory – another study finding that body image concerns are

common with gender-expansive people (Brewster, Motulsky, & Glaeser, 2019), emphasizing the importance of giving within group differences due weight when conducting research on trans lives.

Another community-driven survey conducted in five countries (Georgia, Poland, Serbia, Spain, and Sweden) found gender queer and non-binary people showed significantly worse self-reported health and worse general well-being in comparison to binary trans respondents, where being in need of gender affirming medical interventions contributed significantly to worse self-reported health and being younger contributed to worse general well-being (Burgwal *et al*., 2019). This was worsened by having other marginal identities, reflecting the need for an intersectional analysis in trans health research (Burgwal *et al*., 2019).

Education in Trans Primary Care

Recent studies have emphasized the need for more training in dealing with trans health needs for healthcare professionals across a variety of fields (Butler-Foster, Chin-Yee, Huang, & Jackson, 2020; Eisenberg *et al*., 2020; Klotzbaugh & Spencer, 2020; MacKinnon *et al*., 2020; Vries *et al.*, 2020*;* Ziegler *et al*., 2020; Ziegler *et al*., 2020; Allison *et al*., 2019; Feigerlová *et al*., 2019; Kamen *et al*., 2019; Kattari *et al*., 2019; Ng; Kidlington; Ayhan; Zwickl, Wong, Bretherton, Rainier, Chetcuti, *et al*., 2019; Shaver *et al*., 2019; Zeeman *et al*., 2018), with multiple sources noting that only an average of five hours of training on trans specific health is included in medical school (Cheung *et al*., 2020; Willging *et al*., 2020; Ziegler *et al*., 2020; Allison *et al*., 2019; Jann *et al*., 2019). Trans patients do not want to have to educate their healthcare providers, and alongside experiences of discrimination in healthcare settings, lack of provider knowledge is another primary issue preventing TGN patients from accessing health services (Barnes *et al*., 2019).

Within a Canadian context there have been calls for the inclusion of transgender education as part of professional development for primary care providers (Ziegler *et al*., 2020). Education programs are important for increasing knowledge around and comfort working with TGNC patients (Morris *et al*., 2019). There is need for affirming care in all healthcare settings, not just in transition-related care, such widespread adoption of gender-affirming healthcare is part of a depathologization approach to trans healthcare that dis-associates transness with an assumed desire for surgical and medical interventions (Vries *et al*., 2020).

As with recent discussions around trans health that centre an intersectional approach to care, it has been proposed that education programs need to include information on the historical (and I would add ongoing) marginalization, criminalization, and pathologization of trans and other LGBTI people in addition to information on hetero and gender normativity (Zeeman *et al*., 2018). Another normativity that should be addressed, and is increasingly being discussed is *transnormativity,* which assumes a linear progression from dysphoria to resolution by undergoing medical interventions to align outward gender expression with internal gender identity. It is important that transnormativity is addressed in a holistic approach to trans health because of the ways it can be used to gatekeep access to medical interventions, and in the ways it is vital to remember that not all trans people are concerned with “passing” (Brewster, Motulsky, & Glaeser, 2019). One study noted that much like trans identities, asexual

identities are under-represented in health education and training and need to be included (Flanagan & Peters, 2020), raising the issue of how to represent multiple, and often intersecting, marginalized identities in (trans) healthcare education.

Part of broadening the scope of what we understand as vital to trans wellbeing, and thus part of an essential primary care practice, is increasing provider knowledge of "social transition" – non-medical interventions that are essential to transition related care and trans wellbeing more broadly such as shifting pronoun use; communicating with family, friends, coworkers, and other social ties about gender identity; name changes; etc. (Brewster, Motulsky, & Glaeser, 2019). Social transition plays an integral role in the mental health of trans patients (Vries *et al*., 2020), and needs to be considered alongside other gender-affirming care such as hormone therapy.

Lack of training around the social construction of sexuality and gender allows for ongoing cisnormativity and heteronormativity in healthcare spaces to go unchallenged, and the biomedical construction of gender in health sciences leaves little room to explore the social construction of sexuality and gender (Vries *et al*., 2020). There is a need for "students and teachers to identify their discomfort with LGBTQ patients and reflect on how this could have originated in oppressive structures. This can begin to address the root causes of the alienation experienced by TGN persons in health care settings, rather than just treating the symptoms" (Vries *et al*., 2020). A good trans health education program then, needs to recognize that gender is socially and culturally constructed (Barnes *et al*., 2019).

Recent Findings in Trans Health Education

A recent study found short-term (i.e., one-off workshop-based interventions) to show limited improvements in long-term patient care, noting the need to engage in more fulsome discussion about pedagogy and values, rather than simply engaging in education around patient care (Vries *et al*., 2020). With increased training, there has been a call for health professionals to work collaboratively with LGBTI people to address barriers that prevent access to care (Zeeman *et al*., 2018). Among these, it has been noted there is a need for new protocols and practices that are trans-inclusive and gender-affirming – something that requires extensive and ongoing consultation with a wide range of TGN patients from varying intersectional positionalities (Barnes *et al*., 2019). Consultation with a wide range of TGNC patients has been recently noted as a problem with, and limitation to, focus groups: because of the diversity of TGNC patients, findings from smaller focus groups may be highly context specific and not applicable more broadly (Zwickl *et al*., 2019).

The importance of terminology/vocabulary and other markers used in healthcare (ex., health records or genetic nomenclature) used to communicate in providing gender-affirming care (Ahmad, Lafreniere, & Grynspan, 2019; Chambers, Pastrik, & Manzer, 2019; Barnes *et al*., 2019; Bonnington *et al*., 2019; Langille, 2019; Motmans *et al*., 2019; Kamen *et al*., 2019; Restar *et al*., 2019; Butler-Foster) and to recognize the variety of ways people may understand and express their gender. It has been noted that in healthcare it is common to use outdated terminology that upholds transnormativity, ex., MTF/FTM (Brewster,

Motulsky, & Glaeser, 2019). The importance of asking about pronouns in cultivating an affirming and supportive environment in a wide range of healthcare settings has been noted (Barnes *et al*., 2019; Chambers, Pastrik, & Manzer, 2019; Eisenberg *et al*., 2020), in addition to an ongoing commitment to cultivating an environment that uses inclusive terminology and person-centred care. Concrete examples of asking pronouns and orientation involve asking how a patient wants to be addressed, referring to "partners" rather than assuming (ex., "husband"), and using the gender neutral pronoun "they" if unsure about gender identity (Chambers, Pastrik, & Manzer, 2019). A couple studies mentioned the need for LGBTQ2S inclusive posters (Chambers, Pastrik, & Manzer, 2019; Du Mont *et al*., 2019). Another study named pathology reports as part of creating optimal communication with trans individuals (Ahmad, Lafreniere, & Grynspan, 2019), opening up new possibilities for considering how we can cultivate an inclusive healthcare setting through communication in a variety of ways.

A recent study examined a LGBT health course for Doctor of Pharmacy students (Jann *et al*., 2019). The course was an elective, interprofessional LGBT Queer, Intersex (QI) health forum to supplement the health care curriculum. It was a ten hour course over the weekend which used quizzes, active learning activities, and objective structured clinical examination (OSCE) and student portfolios to determine the students' level of engagement with learning outcomes and was developed using guidelines for LGBT health issues, through faculty members reviewal of publications on LGBT health, and with consultation with LGBT academic organizations (Jann *et al*., 2019). In this study there appears to be a lack of direct engagement with trans and LBGT communities, raising problematic assumptions about who is qualified to speak as an 'expert' on behalf of others. Despite its limitations and assumptions, the concept of using a variety of tools for assessing learning, including a capstone project that requires broader engagement with LGBT communities and organizations, is appealing and something to be considered when conceiving of strategies for using education as a way to cultivate deeper engagement with, and communication between, trans people and communities, and healthcare workers and organizations.

Another study created a tool to self-assess current behaviours of TGNC-affirming practices in the field of applied behavioural analysis, proposed as a shift in the field to be more affirmative overall, not just when someone has self-identified as TGNC (Leland & Stockwell, 2019). The self-assessment is comprised of a twenty-seven Y/N question checklist across three areas: ethics (ex., pronoun use and having a referral network of affirming providers); environmental arrangement (ex., gender inclusive bathrooms); and behavioural arrangement (ex., using gender inclusive language) (Leland & Stockwell, 2019). Although a twenty-seven-item questionnaire is doubtful to enact systemic changes in how TGNC patients are treated, it acts as an accessible starting point for practitioners who might want to begin engaging in conversations around affirming care. Importantly, the authors of the tool self-identify as transgender or gender non-conforming and have extensive experience working closely with TGNC clients (Leland & Stockwell, 2019).

Another study examined the impact of interprofessional workshop development, in

partnership with trans and non-binary individuals on TGNC-affirming care using the Transgender Attitudes and Beliefs Scale (Allison *et al*., 2019). Other research focused on interventions in physician bias in education using experiential learning (Morris *et al*., 2019). Having a network of referrals for trans patients has been mentioned as a desired outcome in a few different studies (Eisenberg *et al*., 2020; Willging *et al*., 2020; Leland & Stockwell, 2019).

Recent Projects in Trans Health

A recent study focused on reducing health disparities among Sexual and Gender Minority (SGM) patients by implementing strategies for primary care clinics in urban and rural New Mexico using the Change Model and an intersectional perspective (Willging *et al*., 2020). The protocol was developed through a series of town halls with SGM patients, before developing statewide SGM health collaborative of SGM patients, healthcare advocates/providers and researchers which created a research agenda for improving SGM healthcare and organizing series of now annual SGM healthcare summits for broader patient and public input into this agenda (Willging *et al*., 2020). The study came up with six recommendations for primary care: "1. Creating inclusive environments (ex., non-discrimination policies and procedures addressing complaints); 2. Standards for clinician-patient communication (ex., use of patient's language); 3. Sensitive documentation of SGM identity/orientation (ex., "documenting SGM identity/orientation and informing patients of what is written"); 4. Special knowledge for SGM awareness (ex., referrals to support groups and health professionals); 5. Staff training (ex., identifying/addressing SGM-negativity); 6. Addressing population health issues (ex., engaging in SGM-targeted health promotion)" (Willging *et al*., 2020).

A recent Canadian study examined steps to providing more inclusive care to trans people who have experienced sexual assault, examining the work of The Victoria Sexual Assault Centre in B.C. Material steps the centre took to better meet the specific healthcare needs of trans clients and to become more inclusive included:

> "hiring a trans inclusion coordinator, changing the center's name to be gender neutral, forming an advisory group of trans community members and allies, introducing a policy of asking a client's preferred pronouns, displaying trans inclusive posters, updating and developing novel training for all personnel and decision makers, updating the language on their website and promotional materials, and meeting with trans-positive service providers to discuss 'best practices'" (Du Mont *et al*., 2019).

The Future of Sex Education (FoSE) provides an interesting perspective on evidence-based, progressive sexual education that centers scientific knowledge while leaving room for uncertainty and ambiguity, and while drawing on the work of late José Esteban Muñoz to imagine queer utopias through and using sexual education (O'Quinn & Fields, 2020), bridging the divide between queer theory and cultural studies and queer health. In doing so FoSE seeks to account for racialized disparities and other injustices by using "queer" as "an analytic to destabilize normative understandings of bodies, health, and sexuality within education." (O'Quinn & Fields, 2020).

In a Canadian context, Trans Youth CAN! Is a prospective cohort study of trans youth (aged <16) referred to gender-affirming care in ten Canadian cities (Mokashi *et al*., 2020). While Trans20 is a prospective longitudinal cohort study based in Australia to assess the long-term outcomes of trans people receiving medical interventions using a biopsychosocial model of health (Tollit *et al*., 2019). Trans Pathways, another study out of Australia, is the largest Australian study of trans and gender diverse youth using an anonymous online cross-sectional survey (Strauss, Cook, Winter, Watson, Wright, *et al*., 2019).

The Transgender Women Engagement and Entry to Care Project (TWEET) consisted of "peer-led, group-based educational sessions called Transgender Leader – Teach Back," and sought to engage trans women of colour with HIV as leaders in trans WOC health and HIV care and as "peer leaders" for other trans WOC with HIV (Hirshfield, Contreras, Luebe, Swartz, Scheinmann, *et al*., 2019). The study found that being a peer leader was associated with improved engagement in HIV care and HIV-related outcomes (Hirshfield, Contreras, Luebe, Swartz, Scheinmann, *et al*., 2019).

Your Voice! Your Health!, was a project "focused on improving shared decision making with LGBT racial/ethnic minority patients" (Howard *et al*., 2019). The study asked participants and focus groups to describe a positive and a negative healthcare experience; focused on the impact of gender identity and race on healthcare experiences; and gathered advice for health providers to develop tools to improve the healthcare experiences of TPOC (Howard *et al*., 2019). After preliminary analysis, results were presented at two separate community forums of LGBT POC for feedback and to "validate" their interpretation of the data gathered (Howard *et al*., 2019).

Conclusion

In approaching an inclusive and affirming paradigm for trans healthcare and health education there is a need for trans people to have the opportunity for active participation in the research process, and in doing so to be recognized as knowledge producers, rather than reduced to a "testimony" role that fails to recognize the theoretical contribution of trans scholarship (Schwend, 2020). Simultaneously, there is a call for health providers to step into an advocate role in trans health (Brewster, Motulsky, & Glaeser, 2019), positioning trans health as a partnership between trans people and their healthcare providers. Providers need to be "knowledgeable on local queer-affirming (especially ones that are sober) spaces, the knowledge that becomes crucial in more conservative locations," and to increase their knowledge on where to order tools to facilitate transitions in ways beyond the usual scope of affirmative care (ex., binders, etc.) (Brewster, Motulsky, & Glaeser, 2019), resources that become all the more vital in rural, conservative spatial locals such as Lethbridge. This, "may not only help [trans people] access products that affirm their gender identity but also communicate that you are making efforts to support them outside of the clinical setting" (Brewster, Motulsky, & Glaeser, 2019), and raises questions about what roles physicians and other primary care providers can play in providing trans affirming care that extends beyond the confines of the clinic.

Currently, trans people continue to face significant barriers in accessing primary care. Dysphoria has been discussed frequently in

recent literature as a form of gatekeeping and pathologization, and calls have been made for policy changes around dysphoria's role in trans care and to "mental readiness" protocols that marginalize and exclude some of the more vulnerable trans patients, especially those with concurrent mental health disorders and non-binary trans people who may not meet mental readiness assessments that are based in more binary understandings of gender. There is a need for more interdisciplinary team care in trans health to bridge gaps in care, and an intersectional approach to trans care is another heavily discussed topic in recent literature. As Lethbridge is (relatively) rurally situated, the impact of rurality must be considered alongside other multiple and compounding intersections (identities and positionalities) that shape access to care. An intersectional approach to trans healthcare also demands recognition of the ways that hetero-, cis-, and transnormativities impact trans lives within a colonial context.

Other models and frameworks for trans care discussed in recent literature include an identity-based model of care that recognizes the social and systemic aspects of gender and health, a rights based approach that accounts for the multifaceted dimensions of discrimination, the principle of autonomy, informed consent model, and the change model. The minority stress model was also widely discussed. One paper proposing a geopolitical view to trans health – both the minority stress model and a geopolitical understanding of trans health were connected to a "DIY" approach to trans health where informal information sharing and support among trans communities is a primary source of care. This necessarily links trans health to disability justice and care webs as community survival tactics, and highlights the importance of bridging informal trans care networks with primary care providers and clinics hoping to provide trans inclusive care.

Non-binary and gender non-conforming people remain under-represented in trans health research. There is a need for more research in this area to explore more fully the ways in which non-binary and GNC people experience the social dimensions of gender differently than binary trans people and what their unique healthcare needs might be.

Recent literature around trans healthcare education points to a need for long-term programs that include conversations about the systemic and social aspects of trans health that go beyond the fundamentals of providing care. Education should be seen as part of cultivating affirming care in a range of healthcare settings, and necessarily plays a role in expanding ideas about affirming care to broader conversations about the social and cultural aspects of gender and how this affects health. Any education program necessitates direct TGNC involvement, preferably trans lead with ongoing and widespread consultation. Paying trans people for their labor and recognizing trans leaders as knowledge producers should be prioritized. With trans community leadership, education programs can discuss historical and ongoing trans experiences of marginalization from a trans perspective and centre issues that are important to regional trans communities, in addition to addressing cis-, hetero-, and trans-normativities. Social transition as an important part of trans lives and affirming care should be centred in an ongoing effort to recognize other ways of trans being outside of dysphoria and medical intervention.

A successful trans health education program would be a collaborative project between trans community members and organizations and health providers and practitioners. Some recent studies have given specific material recommendations and guidelines that clinics and practitioners can take to be more affirming and inclusive. In making a responsive and inclusive trans healthcare education program it is important to recognize the ways in which such an undertaking is never a finished program, but rather constantly being remade and reimagined as ideas about transness, queerness, and gender continue to be redefined and reimagined within LGBTQ2S+ communities. It has been noted in the literature, for example, that terminology used in trans communities is constantly changing, and understanding the fluid and changing ways gender is conceived of and articulated is important to recognize when shifting how we frame affirming care. Engaging in ongoing projects and conversations with local trans communities can bridge this divide between healthcare practitioners and trans community members, and in approaching more collaborative and community driven approaches to healthcare.

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