Gender Affirmative Health Care: Terminology, Demographics, and Epidemiology

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ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
Continuing Medical Education Disclosure

- **Program Faculty**: Sari Reisner, ScD
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- **Disclosure**: No relevant financial relationships. Presentation does not include discussion of off-label products.

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Overview

- Terminology: Sex, Gender, and Transgender
- Transgender Social and Health Inequities
- Gender Affirming Clinical Care and Research
Overview

- Terminology: Sex, Gender, and Transgender
- Transgender Social and Health Inequities
- Gender Affirming Clinical Care and Research
Sex and Gender

- **Sex** and **gender** core determinants of health
- **Sex** – biological differences
  - Anatomy, chromosomes, hormones, genes, etc.
- **Gender** – social and cultural distinctions
  - Multidimensional
  - Psychological, social, behavioral
  - Gender identity, gender expression, gender roles
Transgender (Trans or Trans*)

- Gender identity or expression different than assigned sex at birth
  - **Trans feminine (TF):** Transgender women, trans women, trans female, transgender girls → Male assigned sex at birth
  - **Trans masculine (TM):** Transgender men, trans men, trans male, transgender boys → Female assigned sex at birth
  - **Cultural variations:** Hijra, travesti, waria, two-spirit
  - **Gender minorities - NIH**

- **Cisgender:** Not transgender
Nonbinary (NB) Gender Identity

- Gender identity or expression not exclusively male or female
  - Identify outside traditional male-female gender binary
  - Identify as more than one gender (pangender)
  - Identify as no gender (agender)
  - Examples: Genderqueer, gender fluid, gender expansive
  - They/ them/ their
  - Ze/ hir/ hirs
Population Estimate: People Who Identify as Transgender in the U.S.

- Transgender adults age 18+ years
  - Behavioral Risk Factor Surveillance System, 2014
  - 0.58% (95% CL = 0.36%, 0.95%)
- Transgender students grades 9-12
  - Youth Risk Behavior Survey, 2017
  - 1.8% (range = 1.0%, 3.3%)
- Gender minority college students
  - Healthy Minds Study, 2015-2017
  - 2.1%

Nonbinary Gender Identity in 2015 U.S. Transgender Survey (>22,000)

Gender Identity by Current Age

- Nonbinary
- Transgender Women
- Transgender Men
- Other

- 18 to 24
- 25 to 44
- 45 to 64
- 65+

James, Herman, Rankin et al. 2016
Nonbinary Gender Identity in 2015 U.S. Transgender Survey (>22,000)

Gender Identity

- Nonbinary: 35%
- Transgender Women: 29%
- Transgender Men: 33%
- Other: 3%

Gender Identity by Current Age

- Nonbinary: 61
- Transgender Women: 43
- Transgender Men: 47
- Transgender Men: 46

Percent (%)

- 18 to 24
- 25 to 44
- 45 to 64
- 65+

James, Herman, Rankin et al. 2016
Nonbinary Gender Identity in 2015 U.S. Transgender Survey (>22,000)

Gender Identity

- 35% Nonbinary
- 29% Transgender Women
- 33% Transgender Men
- 3% Other

Gender Identity by Current Age

- 61 Nonbinary
- 47 Transgender Men
- 46 Transgender Women

Percent (%)

Age Groups:
- 18 to 24
- 25 to 44
- 45 to 64
- 65+

James, Herman, Rankin et al. 2016
Gender Affirmation

Social

Psychological

Medical

Legal

Advancing Excellence in Transgender Health

Reisner, Radix, Deutsch, 2016
Medical Gender Affirmation: Paradigm Shift in Transgender Health

- Disorder → Identity
- Gender Diversity ≠ Pathology
- Implications for Clinical Care

History of Diagnostic and Statistical Manual of Mental Disorders:

- 1973: Homosexuality removed from DSM
- 1980: Transsexualism added DSM-III
- 1994: Gender Identity Disorder DSM-IV
- 2000: Gender Identity Disorder DSM-IV-TR
- 2013: Gender Dysphoria DSM-5

Reisner, Poteat, Keatley et al. 2016
Informed Consent Models

Discussion of risks and benefits of treatment

Supportive mental health treatment (not gender-evaluating assessments)

Patients assess and judge beneficence and consent to receive care

Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients

Timothy Cavanaugh, MD, Ruben Hopwood, MEd, PhD, and Csi Lambert, MFA

Abstract

Informed consent as a model of care has evolved as an alternative to the standard model of care recommended by the World Professional Association for Transgender Health's Standards of Care, version 7, which emphasizes the importance of mental health professionals' role in diagnosing gender dysphoria and in assessing the appropriateness and readiness for gender-affirming medical treatments. By contrast, the informed consent model for gender-affirming treatment seeks to acknowledge and better support the patient's right to, and capability for, personal autonomy in choosing care options without the required involvement of a mental health professional. Clinicians' use of the informed consent model would enable them both to obtain a richer understanding of transgender and gender-nonconforming patients and to deliver better patient care in general.

Introduction

Informed consent is a concept that is familiar to clinicians. On a practical,
Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health
Nonbinary vs Binary Gender Minority Adult Health in a State-Wide Non-Probability Sample in Massachusetts (n=452)

- 40.9% nonbinary

- **Demographics:**
  - Younger ages (mean age 28.9 vs 35.1)
  - Trans masculine (77.3% vs 53.2%)

- **Gender affirmation:**
  - Recognized gender identity at older ages (mean age 16.4 vs 12.3)
  - Less likely to have current medical gender affirmation (27.0% vs 74.5%)

Reisner & White Hughto, 2019
A Systematic Review of theEffects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals

Jaclyn M. White Hughto,1,2,* and Sari L. Reisner,1,3,4

Abstract

Objectives

To review evidence from prospective cohort studies of the relationship between hormone therapy and changes in psychological functioning and quality of life in transgender individuals accessing hormone therapy over time.

Data Sources

MEDLINE, PsycINFO, and PubMed were searched for relevant studies from inception to November 2014. Reference lists of included studies were hand searched.

Results

Three uncontrolled prospective cohort studies, enrolling 247 transgender adults (180 male-to-female [MTF], 67 female-to-male [FTM]) initiating hormone therapy for the treatment of gender identity disorder (prior diagnostic term for gender dysphoria), were identified. The studies measured exposure to hormone therapy and subsequent changes in mental health (e.g., depression, anxiety) and quality of life outcomes at follow-up. Two studies showed a significant improvement in psychological functioning at 3–6 months and 12 months compared with baseline after initiating hormone therapy. The third study showed improvements in quality of life outcomes 12 months after initiating hormone therapy for FTM and MTF participants.
Suicidal Ideation in Last 12 Months by Medical Gender Affirmation (n=19,814)

48% Self-Reported Suicidal Ideation in the Last 12 Months

Herman, Conron, Haas, Brown, Liu, Reisner, in prep
Current Mental Health in a Sample of Socially Transitioned Transgender Children

- Prepubescent trans children who had socially transitioned (mean age 7.7)
- Controls matched by gender identity and age within 4 months (mean age 7.8)
- Siblings closest in age to the trans child (mean age 8.3)

<table>
<thead>
<tr>
<th></th>
<th>Transgender (n = 73)</th>
<th>Controls (n = 73)</th>
<th>Siblings (n = 49)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression by gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natal boys</td>
<td>49.8 (trans-girls)</td>
<td>48.0</td>
<td>48.9</td>
<td>.979c</td>
</tr>
<tr>
<td>Natal girls</td>
<td>50.8 (trans-boys)</td>
<td>48.5</td>
<td>49.9</td>
<td></td>
</tr>
<tr>
<td>Anxiety by gender</td>
<td></td>
<td></td>
<td></td>
<td>.664c</td>
</tr>
<tr>
<td>Natal boys</td>
<td>53.7</td>
<td>51.1</td>
<td>52.8</td>
<td></td>
</tr>
<tr>
<td>Natal girls</td>
<td>55.3</td>
<td>50.8</td>
<td>51.5</td>
<td></td>
</tr>
</tbody>
</table>

a This is the only value that is significantly above the national average (50), although it is still substantially below the clinical (>83) or even preclinical (>60) range.
b Transgender children who are natal boys and live with a female gender presentation are often called transgender girls or trans-girls; transgender children who are natal girls living with a male gender presentation are often called transgender boys or trans-boys.

c Significance value of interaction between natal sex and group.

Olson, Durwood, DeMueles, McLaughlin, Pediatrics, 2016
Gender Identity ≠ Sexual Orientation

Sexual orientation

- How a person identifies their physical, romantic, and emotional attraction to others
- Transgender people can be of any sexual orientation

N=452
Overview

- Terminology: Sex, Gender, and Transgender
- Transgender Social and Health Inequities
- Participatory Population Perspective
The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (IOM, 2011)

Figure 1: Research Agenda

- Minority Stress
- Life Course
- Intersectionality
- Social Ecology

Priority Research Areas
- Demographic Research
- Social Influences
- Health Care Inequities
- Intervention Research
- Transgender-specific Health Needs

More complete understanding of LGBT health

A number of different conceptual perspectives can be applied to priority areas of research in order to further the evidence base for LGBT health issues.
Sexual and Gender Minorities (SGM): A Health Disparity Population

National Institutes of Health (NIH)

2016

- Gender minority+ (n=1,443) vs cisgender (n=314,450):
  - Younger in age
  - People of color (lower % non-Hispanic white)
  - Low income, unemployed, uninsured
  - Never married
  - No minor child in the household
  - Not English-speaking
  - Unmet medical care due to cost in last 12 months
  - Limited in any way

+ Transgender and gender nonconforming adults

Streed, McCarthy, Haas, 2017
Transgender Health Inequities

- Poor self-rated general health
- HIV infection and other STIs
- Mental health conditions
- Substance use and abuse
- Violence/victimization
- Disordered weight & shape control behaviors/eating disorders
- Preventive screening
- Lack access to culturally competent care
- Homelessness, incarceration
Global Burden of HIV in Transgender Women

Pooled HIV prevalence = 19.1% (95% CI 17.4–20.7) in 11,066 transgender women worldwide

<table>
<thead>
<tr>
<th></th>
<th>Weight</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>7.03%</td>
<td>92.37 (80.60–105.84)</td>
</tr>
<tr>
<td>Brazil</td>
<td>7.01%</td>
<td>85.29 (72.32–100.58)</td>
</tr>
<tr>
<td>El Salvador</td>
<td>6.26%</td>
<td>23.19 (12.65–42.49)</td>
</tr>
<tr>
<td>Peru</td>
<td>6.98%</td>
<td>84.73 (69.10–103.91)</td>
</tr>
<tr>
<td>Uruguay</td>
<td>6.84%</td>
<td>38.31 (28.06–52.31)</td>
</tr>
<tr>
<td>Australia</td>
<td>5.72%</td>
<td>24.90 (10.98–56.47)</td>
</tr>
<tr>
<td>India</td>
<td>6.80%</td>
<td>208.01 (148.04–292.27)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7.04%</td>
<td>180.31 (159.92–203.31)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>6.91%</td>
<td>21.91 (16.89–28.42)</td>
</tr>
<tr>
<td>Thailand</td>
<td>6.94%</td>
<td>9.90 (7.80–12.57)</td>
</tr>
<tr>
<td>Vietnam</td>
<td>5.48%</td>
<td>15.65 (6.32–38.77)</td>
</tr>
<tr>
<td>Italy</td>
<td>7.02%</td>
<td>65.76 (56.11–77.08)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6.27%</td>
<td>81.78 (44.72–149.54)</td>
</tr>
<tr>
<td>Spain</td>
<td>6.64%</td>
<td>40.87 (26.48–63.08)</td>
</tr>
<tr>
<td>USA</td>
<td>7.06%</td>
<td>34.21 (31.22–37.48)</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>100.00%</td>
<td><strong>48.78 (31.19–76.28)</strong></td>
</tr>
</tbody>
</table>

Baral, Poteat, Stromdahl et al., 2013

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH

Transgender Men (N-361)
- Black/African American: 58% (211)
- Hispanic/Latino: 15% (55)
- White: 16% (56)
- Other: 11% (39)

Transgender Women (N-1,974)
- Black/African American: 51% (1,002)
- Hispanic/Latina: 29% (578)
- White: 11% (212)
- Other: 9% (182)

Clark, Babu, Wiewel et al. 2016

19 U.S. states and Guam (n=151,456)

Transgender vs cisgender:

• More days per month of...
  • Poor physical health ($\beta = 2.43$; 95% CI=0.61, 4.24)
  • Poor mental health ($\beta=1.74$; 95% CI=0.28, 3.19)

• Higher prevalence of...
  • Poor general health (OR=1.7; 95% CI=1.2, 2.4)
  • Myocardial infarction (OR=1.7; 95% CI=1.1, 2.5)
  • Lack healthcare coverage (OR=1.8; 95% CI=1.2, 2.7)
  • Lack a healthcare provider (OR=1.5; 95% CI=1.0, 2.1)
  • Not visiting a dentist in the last year (OR=0.7; 95% CI=0.5, 1.0)
Mental Health of Transgender Youth: A Matched Retrospective Cohort Study (n=360; Mean age=19.6)

- Depression: 50.6%
- Anxiety: 26.7%
- Suicide Ideation: 31.1%
- Suicide Attempt: 17.2%
- Self-Harm: 6.1%
- Outpatient MH Services: 22.8%
- Inpatient MH Services: 45.6%

Adjusted Risk Ratios Demonstrating Increased Lifetime MH Burden: 2.36 to 4.30 (all p<0.01)

Reisner, Vetters, Leclerc et al. 2015
Why Transgender Health Inequities?

Transgender and Nonbinary \rightarrow \text{Adverse Health}

Why Transgender Health Inequities?

Minority Stress
- Structural disadvantage
- Social & economic exclusion
- Stigma
- Discrimination
- Transphobia
- Violence victimization

Transgender and Nonbinary → Minority Stress → Adverse Health

Bullying (weighted proportions)

Often bullied (before age 18)
- Transgender (N = 274) 46.2% *
- Cisgender Straight (n = 1048) 14.2%

* p<0.05

Reasons for Bullying

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physical appearance</td>
<td>63.3</td>
<td>Physical appearance</td>
<td>46.3</td>
</tr>
<tr>
<td>2 Gender expression or appearance</td>
<td>46.4</td>
<td>Age</td>
<td>26.3</td>
</tr>
<tr>
<td>3 Sexual orientation</td>
<td>28.4</td>
<td>Sex (being female or male)</td>
<td>13.7</td>
</tr>
</tbody>
</table>


NICHD grant R01HD090468 (PI: Meyer)

www.transpop.org
Transgender-Related Intimate Partner Violence (T-IPV)

- Unique IPV directed at trans people
- Aug 2015-Sept 2016
- 150 trans masculine adults
  - T-IPV: 38.9% lifetime and 10.1% past-year
  - Associated with two- to three-fold increase in odds of PTSD, depression, and global psychological distress (p<0.05)

T-IPV Scale:
(a) forced to conform to an undesired gender presentation or stop pursuing gender transition;
(b) pressured to remain in a relationship by being told no one would date a trans person;
(c) "outed" as a form of blackmail;
(d) had transition-related hormones, prosthetics, or clothing hidden or destroyed

Peitzmeier, Hughto White, Potter, Deutsch, Reisner, 2019
Structural Disadvantage: Incarceration Experiences Among Transgender Women in the United States (n=3878)

National Transgender Discrimination Survey (NTDS): History of jail/prison 19.3% (n=748)

Single adjusted multivariable regression model included: Age, gender identity, race/ethnicity, health insurance, income, education, hormones, surgery, geographic region, HIV status, sex work, substance use, smoking, physical and sexual assault, suicide attempt, data collection mode.

Reisner, Bailey, Sevelius, Women Health, 2014
Health Effects of Stigma, Social Exclusion, and Violence

2018
In the last 12 months ...

- 25% health insurance coverage denial related to being trans
- 1 in 4 (25%) hormones
- More than half (55%) surgery
- 33% negative experience with a healthcare provider due being trans
  - verbal harassment, refusal of treatment, had to teach provider to receive appropriate care
- 23% did not see a doctor when needed to due to fear of being mistreated

Discrimination and Stigma in Healthcare: 2015 U.S. Transgender Survey (USTS, n>22,000 Adults)

James, Herman, Rankin et al. 2016
Visual Gender Nonconforming (GNC) Expression (n=452)

Experienced Discrimination in Past 12 Months

Prevalence

<table>
<thead>
<tr>
<th>Category</th>
<th>Prevalence</th>
<th>RR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Visual GNC</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Visual GNC</td>
<td>34%</td>
<td>2.00</td>
<td>1.23, 3.26</td>
</tr>
<tr>
<td>High Visual GNC</td>
<td>44%</td>
<td>2.04</td>
<td>1.16, 3.58</td>
</tr>
</tbody>
</table>

+ Multivariable logistic regression model included: age, gender identity, cross-sex hormone use, surgical gender affirmation, visual gender nonconforming expression, race/ethnicity, income, education, employment, health insurance status, and survey modality.

RR = Adjusted Risk Ratio. 95% CI=95% Confidence Interval. GNC= Gender Nonconforming.

Reisner, Hughto, Dunham et al. 2015
Discrimination Shapes Healthcare Utilization (n=452)

24% prevalence → Discrimination definition: Mistreatment on the basis of transgender or gender nonconforming identity/presentation (included verbal harassment and physical assault).

Adj. RR:
- Postponed care when needed, resulting in emergency care: 2.38 (1.76, 3.23)
- Postponed needed medical care when sick or injured: 3.14 (2.63, 4.43)
- Postponed routine preventive medical care: 2.43 (1.92, 3.08)

Reisner, Hughto, Dunham et al. 2015
Attributed Reasons for Everyday Discrimination Experienced: A Non-Clinical Sample of Transgender and Nonbinary Adults

Mean (SD) = 4.8 (2.4) [range 0-14]

Reisner, White Hughto, Gamarel, Keuroghlian, Mizock, Pachankis, 2016
### Multivariable Linear Model, PTSD Symptoms in a Sample of Transgender and Nonbinary Adults*

<table>
<thead>
<tr>
<th></th>
<th>Beta (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyday Discrimination (cont.)</td>
<td>0.25 (0.21, 0.30)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Number Reasons for Discrimination (cont.)</td>
<td>0.05 (0.01, 0.10)</td>
<td>0.015</td>
</tr>
<tr>
<td>Childhood Abuse Age &lt; 15 years</td>
<td>0.29 (0.21, 0.37)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>0.18 (0.10, 0.26)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Depression</td>
<td>0.23 (0.14, 0.32)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Polydrug Use (2+ drugs)</td>
<td>0.13 (0.03, 0.23)</td>
<td>0.009</td>
</tr>
<tr>
<td>Unstably Housed vs Stably Housed</td>
<td>0.24 (0.15, 0.33)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>High Visual Gender Nonconforming Expression</td>
<td>0.17 (0.08, 0.27)</td>
<td>0.0003</td>
</tr>
</tbody>
</table>

*Linear regression model: age, gender spectrum, medical gender affirmation, nonbinary gender identity, race/ethnicity, income, education, sexual orientation, social gender affirmation, survey mode (online vs in-person). All continuous (cont.) variables z-scored.

*44.4% probable PTSD

Reisner, White Hughto, Gamarel, Keuroghlian, Mizock, Pachankis, 2016
Patient Experiences: Postponing Healthcare

“I just keep putting it off ... putting it off ... and even when I do finally call and make an appointment, I want to tell people that I'm trans* and need a careful provider, but I don't and the anxiety builds up and I don't go to the appointment or keep rescheduling until I absolutely need to... I think a lot of trans people feel this way, as well as other people that face discrimination in the healthcare setting.” (Trans Masculine, Interview, Boston, MA)
Hypothalamic-Pituitary-Adrenal (HPA) Axis: Diurnal Cortisol Predicted by Transition-Related Stress Variables in Transgender Men (n=65)

- Experiencing transition-related stress
  - Predicted higher cortisol levels at the awakening sample
  - Exhibited steeper slopes

DuBois, Powers, Everett, Juster, 2017
Why Transgender Health Disparities?

Transgender and Nonbinary

Biopsychosocial Determinants
- Social
- Psychological
- Biological

Adverse Health

a  b  c

Reisner. In Preparation.
10 Years of Transgender Health Research: Number of Peer-Review Publications, 2009-2019

Search performed 10/31/19
10 Years of Transgender Health Research on Resilience: Number of Peer-Review Publications, 2009-2019

Resilience = 3.4% of transgender health research published

Search performed 10/31/19
# Trans Masculine Mental Health: Everyday Discrimination Experiences and Resilience (n=150)

<table>
<thead>
<tr>
<th></th>
<th>Depression, 7 Days</th>
<th>Anxiety, 7 Days</th>
<th>Non-Suicidal Self-Injury, 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence (%)</td>
<td>25.7%</td>
<td>31.1%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Multivariable Models</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyday Discrimination,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last 12 Months</td>
<td>1.08 (1.03, 1.13)*</td>
<td>1.09 (1.03, 1.15)*</td>
<td>1.06 (1.01, 1.13)*</td>
</tr>
<tr>
<td>Resilience Score, Current</td>
<td>0.81 (0.71, 0.93)*</td>
<td>0.77 (0.66, 0.90)*</td>
<td>0.78 (0.66, 0.91)*</td>
</tr>
</tbody>
</table>

BSI = Brief Symptom Inventory-18. Multivariable models included any variable with an association <= 0.10 and used backward selection. Depression: Education. Anxiety: Income. NSSI: Age. Resilience score range 10-36; mean = 13.0 (SD=3.3).

*<p><0.05

McDowell, White Hughto, Reisner, 2019
What Protective Factors Have Been Identified in Transgender and Nonbinary Health Research?

- Transgender community connectedness
- Social support (peers, families)
- Gender affirmation
- Transgender pride/identity pride
- Hope/optimism
- Positive coping
- Spiritual beliefs
- Collective self-esteem
- Activism and advocacy
Overview

- Terminology: Sex, Gender, and Transgender
- Transgender Social and Health Inequities
- Gender Affirming Clinical Care and Research
Beyond Bathrooms

- Sensitive, responsive, and gender-affirming clinical care
- Trust and reciprocity between transgender communities and healthcare contexts
- Engage transgender and nonbinary communities
Gender Affirming Clinical and Public Health Model

Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health

Sari L. Reisner, Judith Bradford, Ruben Hopwood,
Alex Gonzalez, Harvey Makadon, David Tidisco,
Timothy Cavanaugh, Rodney VanDerwarker, Chris Grasso,
Shayne Zaslav, Stephen L. Boswell, and Kenneth Mayer

ABSTRACT This report describes the evolution of a Boston community health center’s multidisciplinary model of transgender healthcare, research, education, and dissemination of best practices. This process began with the development of a community-based approach to care that has been refined over almost 20 years where transgender patients have received tailored services through the Transgender Health Program. The program began as a response to unmet clinical needs and has grown through recognition that our local culturally responsive approach that links clinical care with biobehavioral and health services research, education, training, and advocacy promotes social justice and health equity for transgender people. Fenway Health’s holistic public health efforts recognize the key role of gender affirmation in the care and well-being of transgender people worldwide.

KEYWORDS Health equity, Health care, Transgender

INTRODUCTION

Transgender people have an assigned sex at birth that differs from their current gender identity or expression. This report describes the evolution of Fenway Health’s multidisciplinary model of transgender health care, research, education, training, and dissemination of its practice. This includes the development of, and change to, a community-based approach spanning almost two decades. Opportunities for future growth of transgender care and research locally and globally are discussed, with a focus on the linkage of clinical care with health research, education, training, and advocacy to promote social justice and health equity for transgender people across the world.
Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2018
Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2018

Number (N) of Patients

- 1997 (EHR Starts in Use)
- 2000 ('04 THP Starts)
- 2005 ('06 New Coord.)
- 2009 ('07 New Protocols)
- 2012 ('10 New Pgm Asst.)
- 2013 (11/'12 New Med Dir)
- 2014 (New Pt Advocate)
- 2015 (Decentralization)

- N=116
- N=11
- N=41
- N=3454
- N=2939
- N=3763
- N=2017
- N=1456
- N=1208
- N=879
- N=1208
- N=366
- N=1456
- N=1456
- N=1456

Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2018
Gender Affirming Clinical Care

- Be sensitive of language used with all patients
- Ask patients the name and pronouns they use
- Don’t assume a patient wants to medically affirm their gender
- Don’t assume a person’s sexual orientation based on gender identity
- Assess for social stressors
- Provide contextualized healthcare grounded in the lived experiences of transgender and nonbinary patients
Gender Affirming Research

Supplement Article

Integrated and Gender-Affirming Transgender Clinical Care and Research

Sari L. Reisner, ScD,* Asa Radix, MD, MPH, † and Madeline B. Deutsch, MD, MPH, ‡

Abstract: Transgender (trans) communities worldwide, particularly those on the trans feminine spectrum, are disproportionately burdened by HIV infection and at risk for HIV acquisition/transmission. Trans individuals represent an underserved, highly stigmatized, and under-resourced population not only in HIV prevention efforts but also in delivery of general primary medical and clinical care that is gender affirming. We offer a model of gender-affirmative integrated clinical care and community research to address and intervene on disparities in HIV infection for transgender people. We define trans terminology, briefly review the social epidemiology of HIV infection among trans individuals, highlight gender affirmation as a key social determinant of health, describe exemplar models of gender-affirmative clinical care in Boston MA, New York, NY, and San Francisco, CA, and offer suggested “best practices” for how to integrate clinical care and research for the field of HIV prevention. Holistic and culturally responsive HIV prevention interventions must be grounded in the lived realities the trans community faces to reduce disparities in HIV infection. HIV prevention interventions will be most effective if they use a structural approach and integrate primary concerns of transgender people (eg, gender-affirmative care and management of gender transition) alongside delivery of HIV-related services (eg, biobehavioral prevention, HIV testing, linkage to care, and treatment). Integration of gender-affirmative clinical care and research represents a holistic and structural approach to intervene on HIV disparities for transgender people.

KEYWORDS: HIV, transgender, prevention, models of clinical care, health inequities

(© Acquir Immune Defic Syndr 2016;72:S235–S242)

From the General Pediatrics, Harvard Medical School, Boston Children’s Hospital, Boston, MA; Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, MA; Fenway Institute, Fenway Health, Boston, MA; TCalcott-Lorde Community Health Center, New York.
Participatory Population Perspective

Work “with” not “on” transgender communities

Living proudly as a transgender man in the small sub-Saharan country of Lesotho has come at a serious price. My public activism on issues of sexual orientation and gender identity and expression makes me vulnerable to threats to my personal safety. The widespread instances of “corrective” rape against transgender men and lesbian women mean that I must constantly be careful and vigilant in every kind of public space, from entertainment venues to walks home from work. Gender prejudice is a norm in Lesotho, so in addition to these fears and the work I do as Director of the People’s Matrix Association (Matrix Support Group), gaining my family’s acceptance is its own burden. Beyond fears for discrimination and violence in public and even private settings, there are country-wide infrastructure challenges, such as poor internet connection and capacity stressors. Like many such organisations, resources are limited and there are few opportunities for professional development, which makes planning and implementation work extremely challenging. All of which seriously affects my professional and personal life, as I sometimes must sacrifice my personal resources just to keep the organisation running. The late hours this work often requires further endangers my personal safety, not to mention affecting my relationship with partners and friends.

There is hope, however, and that is that I am not alone in this struggle. In the past 6 months, I have gained a mentor guiding me in the organisational development process, and strengthening my self-esteem as I work toward achieving dignity for all transgender people in Lesotho.

**Lesotho: standing up for transgender health and rights**

Tshepo Motsopeng
Tshepo Motsopeng is the Director of the People’s Matrix Association (Matrix Support Group) in Lesotho, an organisation specialising in civil education, health care, human rights, poverty advocacy, women’s issues, and youth empowerment. During his time at the People’s Matrix Association (Matrix Support Group), he has organized strategies to meet the health needs of transgender and non-conforming individuals and organized dialogue to the health needs of gay and bisexual men through newly developed programmes. Additionally, he has participated in programmes to address LGBTI violence and gender-based violence and supports LGBTI arts and advocacy networks.

My own reality as a transgender woman of colour from rural South Africa is what brought me to the fight for justice for other transgender women in South Africa and beyond.

In South Africa, the legacy of colonialism, institutionalized inequality, and apartheid shaped the current reality of people of colour, especially for transgender people of colour. All of these intersecting factors lead to a complex array of challenges I can only begin to address:

- The legal context makes the fight for legal rights difficult. South African law allows for transgender people to change names and gender markers, but the law is implemented inconsistently.
- When legal documents do not match the identities of transgender persons, it presents a huge challenge for accessing health and other social services.
- The health context also affects our lives. There are only two facilities in South Africa where gender-affirming surgeries are done, and both have a shocking waiting list of many years. Often when transgender people do not get to be their authentic and true selves, the mental-physical disconnect factors into transgender people not “taking care” of themselves. This manifests in high-risk behaviours like sex work that increase HIV risk.

**South Africa: access to gender-affirming health care**

Leigh Ann van der Merwe
Leigh Ann van der Merwe is the Coordinator and Founder of SHE (Social, Health and Empowerment Trust) of Cape Town, a nonprofit that advocates for transgender and intersex women of colour. Leigh Ann has extensive experience in research pertaining to public health, sexual and reproductive health, and feminism. She holds a certificate in Community Journalism from the University of South Africa and is currently enrolled in the postgraduate programme in Public Health at the University of the Western Cape. Over the past 8 years, Leigh Ann has held positions with several local and international agencies and non-governmental organizations, and has presented and consulted extensively on transgender women’s issues. She was also a fellow in the Open Society/Australian-American Foundation/Transgender Centre of Excellence programme.

**Work “with” not “on” transgender communities**

Reisner, Keatley J, Baral S et al., Lancet 2016
Cervical Cancer Screening: Barriers to Pap Test Uptake for Trans Masculine (TM) People

- Low uptake of provider-administered Pap tests for cervical cancer screening
  - More than 1 in 3 (37%) not up-to-date
- 32 TM qualitative interviews to understand perceived barriers and facilitators
  - Gender dysphoria and discomfort
  - Gendered nature of testing
  - Long-term use of testosterone
  - Difficulty accessing healthcare
- Interest in self-collection methods

“If I could do the HPV swab myself I’d be more inclined to do that on a regular regime ... Simply cause it means I’m not as vulnerable.” (Trans male/genderqueer, 50 years-old)

Peitzmeier, Khullar, Reisner, 2014
Study Aim

- To assess performance characteristics and acceptability of self- vs provider-collection methods for high-risk human papillomavirus (hr-HPV) testing in cervical cancer screening TM adults
Results: Prevalence of hr-HPV in TM (n=131)

- **16.0%** (21/131) tested positive for hr-HPV types via provider-collected cervical sample DNA hybridization assay (gold standard)
- **13.0%** (17/131) positive for hr-HPV types via self-collected frontal/vaginal sample using a DNA hybridization assay
  - hr-HPV prevalence was not statistically significant comparing the collection methods (**p=0.48**)
- **Kappa = 0.75** (SE=0.08); 95% CI = 0.59, 0.92; **p <0.0001**
  - Did not differ by randomization arm (**p=0.66**)
- Sensitivity = **71.4%**
- Specificity = **98.2%**
More than 90% of TM preferred the self-collection method

“[Self-swabbing] still wasn’t easy, but, I mean, I feel comfortable with taking care of my own medical issues. And so the empowerment of being able to -- in a most intimate way, and not have to be objectified or subjected to or be reduced to a subject or, less than that, by -- there’s no judgment when you have to do it yourself. You don’t have to worry about everybody else’s interference in the middle of your own moment where you need privacy.”
Summary, Gaps, and Opportunities

- Gender diversity ≠ pathology
- Gender affirmation is a determinant of health
- Transgender people have worse health than cisgender people for many indicators
- Need data about the health of nonbinary people
- Biopsychosocial factors influencing health
- Intersectionality
- Identify risks and resiliencies
- Gender-affirming and socially contextualized approaches
“Despite substantial gaps in empirical research, there are sufficient actionable data … surrounding health risks and resiliencies for transgender people that need interventions.”

Global health burden and needs of transgender populations: a review.

THE LANCET
http://www.thelancet.com/series/transgender-health

Contact:
Sari.Reisner@childrens.Hhrvard.edu

ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
Gender Affirmation

Gender affirmation is a unique determinant of transgender health and wellbeing globally. It refers to the process of having one's gender affirmed or recognised. There are four key gender affirmation domains:

1. SOCIAL
   - Name
   - Pronoun (e.g., ['HE', 'HIM', 'SHE', 'HER'])
   - Gender presentation (i.e., clothing, mannerisms, expression)

2. PSYCHOLOGICAL
   - Sense of self or authentic identity
   - Access to counselling, trans-competent mental health care

3. MEDICAL
   - Hormone replacement therapy
   - Reproductive options
   - Trans-competent primary and preventative healthcare
   - Gender affirming surgeries and procedures
   - Voice and communication therapies
   - Guidelines for transgender healthcare

4. LEGAL
   - Effective and discrimination legislation
   - Right to autonomy and self-determination
   - Right to be recognised under the law
   - Legal name change
   - Legal change of gender marker/descriptor: M or F

http://www.thelancet.com/series/transgender-health

THE LANCET
ADVANCING EXCELLENCE IN TRANSGENDER HEALTH
Please cite this presentation as follows:

Max, age 13, is agender — neither male nor female. When referring to Max, you don’t use “he” or “she;” you use “they.”

Once strictly a pronoun of the plural variety, “they” is now doing double duty as singular, too — referring to individuals, like Max, who do not see gender as an either/or option. (NPR agreed not to use Max’s last name, because the family feared the sort of online threats that have been made to other transgender families.)

If the whole he/she pronoun thing feels awkward to you, Max is sympathetic — and patient.

“I can’t expect anyone to use the right pronouns for me because it’s not a thing that people know,” Max tells me. “It’s been great being myself, but it’s also been really hard for people to get it, and for even family to get pronouns and stuff.”

“We are seeing more and more kids saying, “You know what? What’s with this either-or business? What’s with this boy-girl thing and you have to fit in one box or the other?” “

Pete Sheras, psychologist, Children’s Gender Clinic, COM宾馆 Children’s Hospital

http://www.npr.org/sections/health-shots/2017/05/02/526067768/a-new-generation-overthrows-gender

List of Facebook Genders

- Agender
- Androgyne
- Androgyrous
- Bigender
- Cis
- Cisgender
- Cis Female
- Cis Male
- Cis Man
- Cis Woman
- Cisgender Female
- Cisgender Male
- Cisgender Man
- Cisgender Woman
- Female to Male
- FTM
- Gender Fluid
- Gender Nonconforming
- Gender Questioning
- Gender Variant
- Genderqueer
- Intersex
- Male to Female
- MTF
- Neither
- Neutrois
- Non-binary
- Other
- Pangender
- Trans
- Trans*
- Trans Female
- Trans* Female
- Trans Male
- Trans* Male
- Trans Man
- Trans* Man
- Trans Person
- Trans* Person
- Transgender
- Transgender Female
- Transgender Male
- Transgender Man
- Transgender Person
- Transmasculine
- Transsexual
- Transsexual Female
- Transsexual Male
- Transsexual Man
- Transsexual Person
- Transsexual Woman
- Two-Spirit
Nonbinary vs Binary Gender Minority Adult Health in a State-Wide Non-Probability Sample in Massachusetts (n=452)

- Healthcare Utilization:
  - Not up-to-date on annual wellness visit
  - Postponed routine preventive care
  - Did not receive mental healthcare in last 12 months

- Mental Health:
  - Clinically significant depressive symptoms in last 7 days
  - Screened AUDIT+ for hazardous alcohol use

- Psychosocial Context:
  - Less family support
  - Less internalized transphobia

Reisner & White Hughto, 2019
The Virginia Transgender Health Initiative Study (THIS)
n=350

Became aware transgender
Forced or unwanted sex
First suicide attempt
Physically attacked
Tobacco problem
Drinking problem
Sought gender transition

Mean Age in Years

11.1
14.3
17.5
19.6
21.9
22.8
29.0

Total Sample

The Virginia Transgender Health Initiative Study (THIS) n=350

Mean Age in Years

Became aware transgender

Forced or unwanted sex

First suicide attempt

Physically attacked

Tobacco problem

Drinking problem

Sought gender transition

Past 12-Month Bullying Victimization in a U.S. National Sample of Transgender Youth, Ages 13-18 Years (n=5542)

<table>
<thead>
<tr>
<th>Method</th>
<th>Transgender (n=442)</th>
<th>Cisgender Female (n=2840)</th>
<th>Cisgender Male (n=2260)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Bullying</td>
<td>3.58 (2.74, 4.68)</td>
<td>2.93 (2.30, 3.72)</td>
<td>1.68 (1.29, 2.19)</td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td>&lt;0.0001</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>In Person</td>
<td>1.98 (1.55, 2.53)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Phone Call</td>
<td>3.02 (2.43, 3.75)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Via Text Message</td>
<td>2.04 (1.62, 2.58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>&lt;0.0001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Other Way</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Models adjusted for age, race/ethnicity, family SES, geographic context.
LITE: Food Security

Responses to Question: How often do you run out of food or money to purchase food at the end of the month?

Food Insecurity Among Cohort Participants

Food Insecurity Among Cross-Sectional Participants

https://www.litestudy.org/

Reisner, Wirtz, The LITE Study Group, in prep.