HARVARD MEDICAL SCHOOL

BRIGHAM AND WOMEN'S HOSPITAL

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

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Toward Health Equity for Transgender and Nonbinary People

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NATIONAL LGBT HEALTH EDUCATION CENTER

A PROGRAM OF THE FENWAY INSTITUTE

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Continuing Medical Education Disclosure

- Program Faculty: Sari Reisner, ScD
- Current Position: Assistant Professor of Medicine, Harvard Medical School; Investigator and Director of Transgender Research, Brigham and Women's Hospital
- Disclosure: No relevant financial relationships. Presentation does not include discussion of off-label products.

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Learning Objectives

1. To understand **terminology** and language for transgender and nonbinary health and healthcare
2. To review the **epidemiology** of health conditions and etiology of **health inequities** for the transgender and nonbinary population
3. To characterize **gender affirming** clinical care and research for **health equity**

Overview

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

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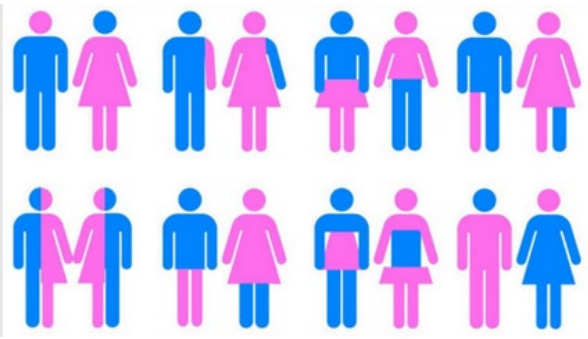
Sex and Gender

- Sex and gender core determinants of health
- Sex – biological differences
  - Anatomy, chromosomes, hormones, genes, etc.
  - Assigned at birth
- Gender – social and cultural distinctions
  - Multidimensional
  - Psychological, social, behavioral
  - Gender identity, gender expression,

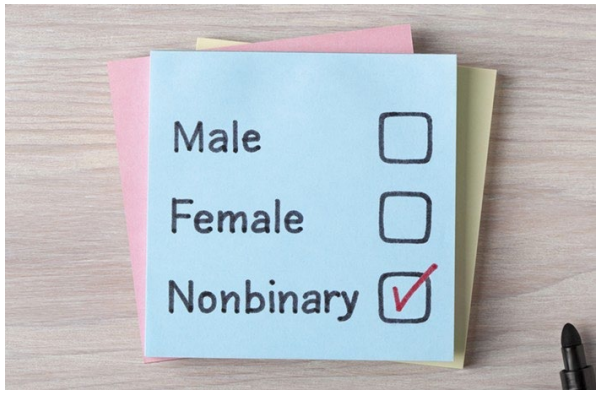


Transgender (Trans)

- Gender identity or expression different than sex assigned 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 or expression not exclusively male or female
- Identify outside traditional male-female gender binary
  - Genderqueer, bigender, genderfluid
  - They/ them/ their
  - Ze/ hir/ hirs
  - Assigned female at birth (AFAB)
  - Assigned male at birth (AMAB)



Nonbinary (NB)

Transgender

Nonbinary

Genderqueer

Genderfluid

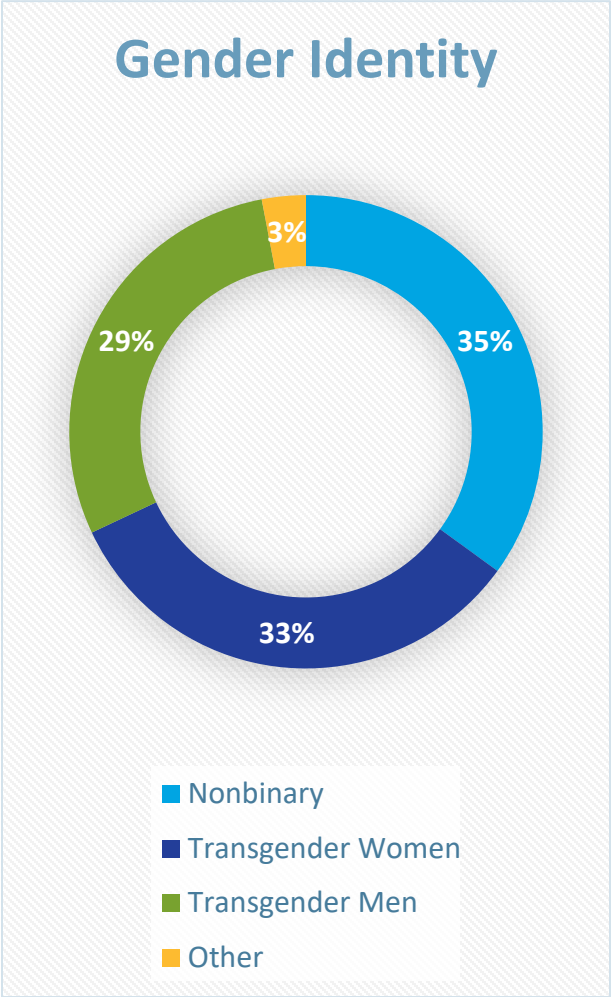
Bigender

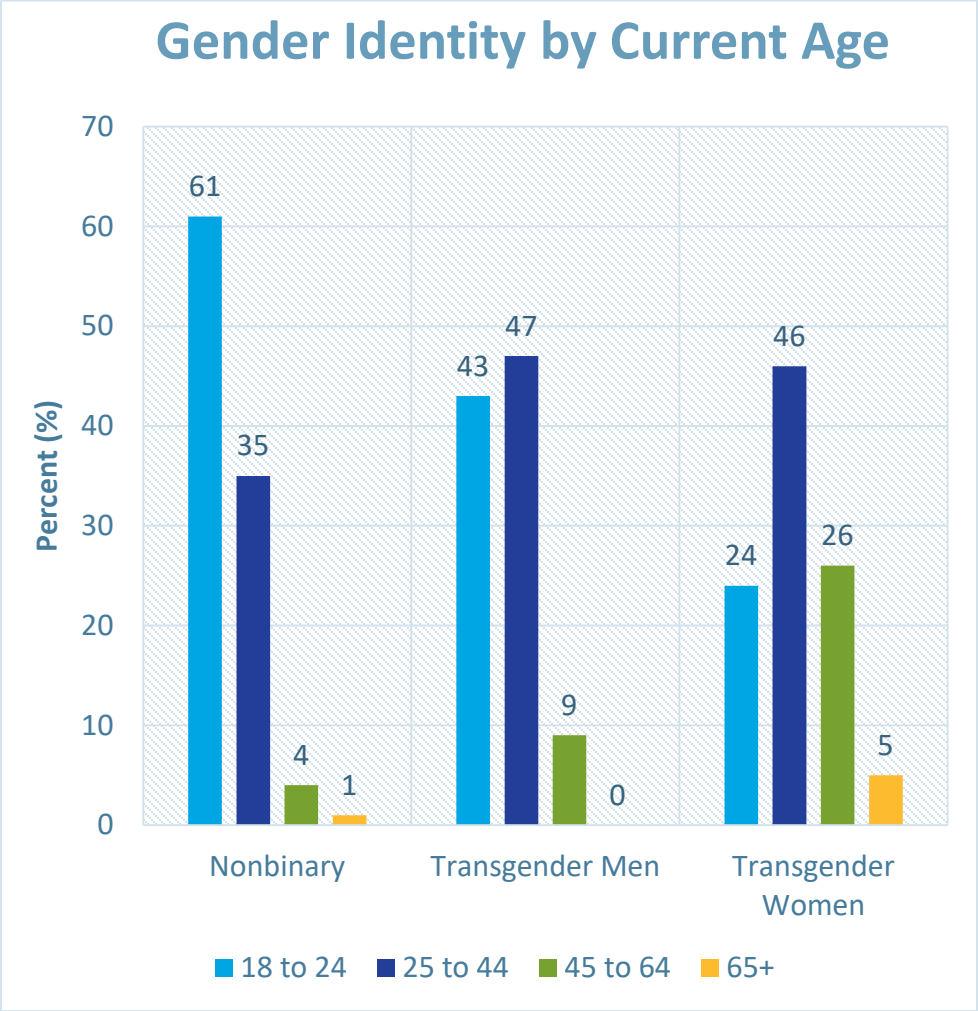
Pangender

Agender

Neutrois

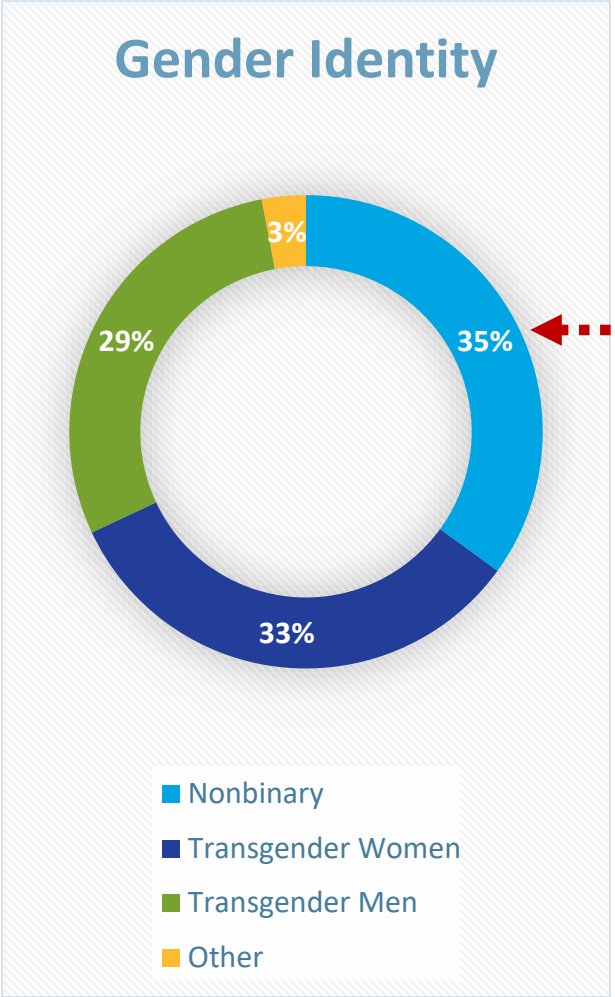
Nonbinary Gender Identity in 2015 U.S. Transgender Survey (>22,000)

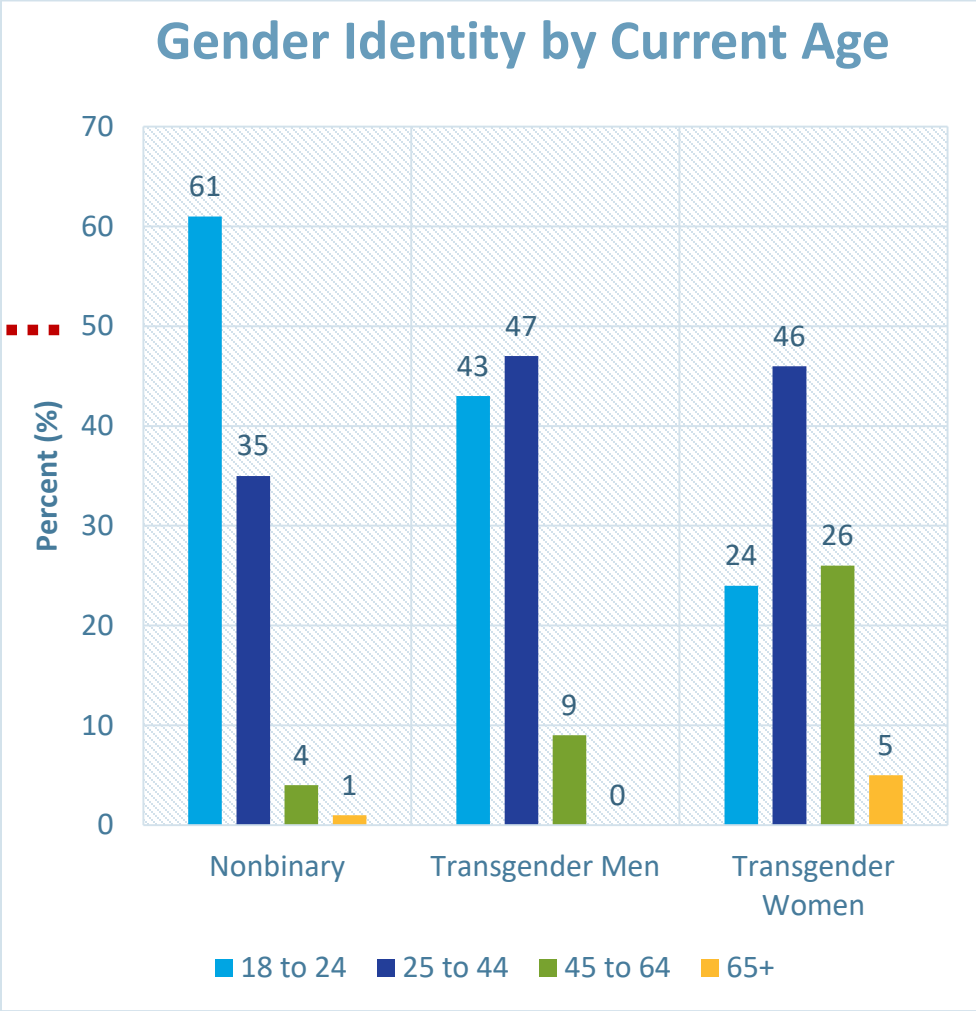




James, Herman, Rankin et al. 2016

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





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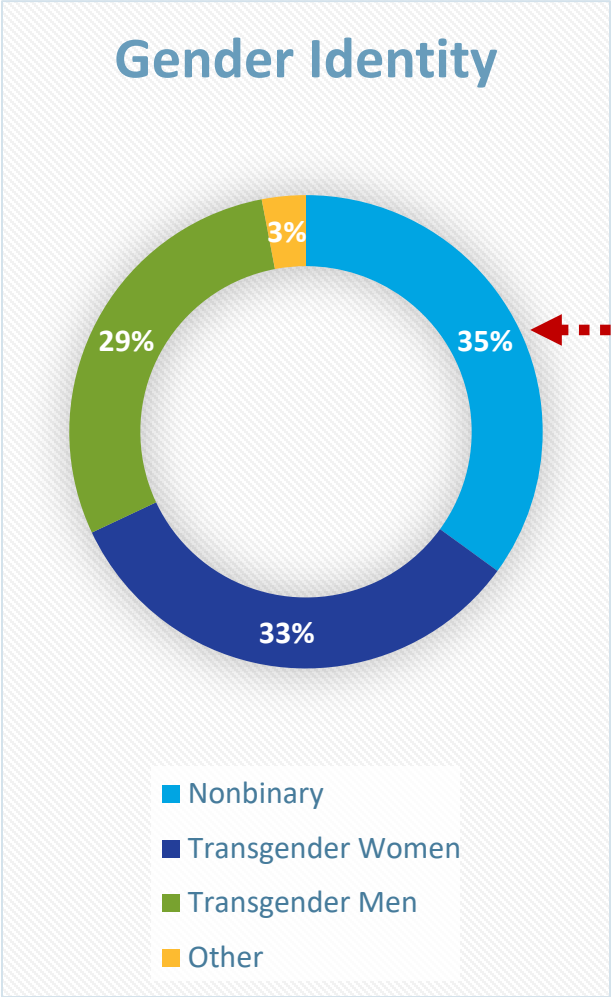
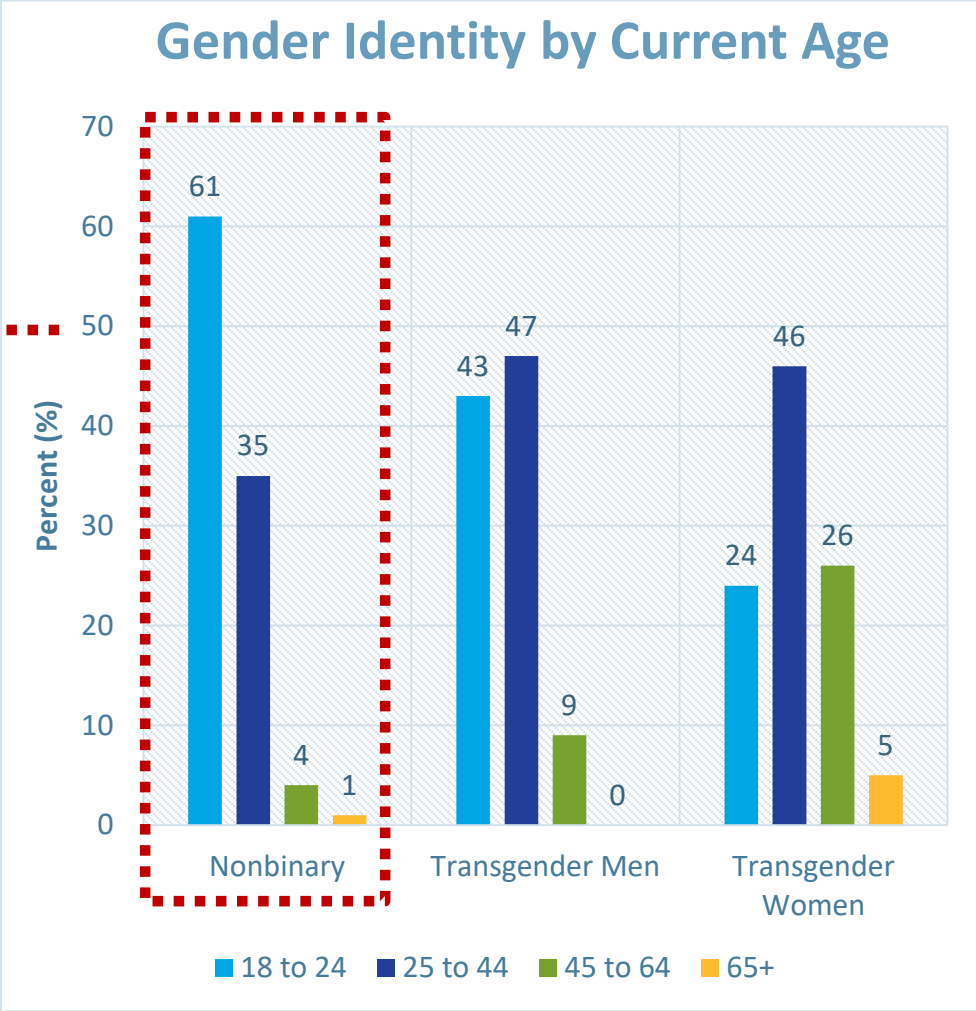
Nonbinary Gender Identity in 2015 U.S. Transgender Survey (>22,000)





James, Herman, Rankin et al. 2016

Population Estimate: People Who Identify as Transgender in the U.S.

Population	Source	Prevalence
Transgender adults, ages 18+ years	Behavioral Risk Factor Surveillance System, 2014	0.58% (0.36%, 0.95%)
Transgender adults, ages 18+ years	Meta-analysis (27 studies)	0.87% (0.52%, 1.22%)
Transgender high school students, grades 9-12	Youth Risk Behavior Survey, 2017	1.8% (1.0%, 3.3%)

Collin, Reisner, Tangpricha, Goodman, J Sex Med, 2016; Flores, Herman, Gates, Brown, Williams Institute, 2016; Johns, Lowry, Andrzejewski, et al. MMWR Morb Mortal Wkly Rep, 2019

Gender Affirmation

Social

Psychological

Medical

Legal

Reisner, Radix, Deutsch, JAIDS, 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., Lancet, 2016

Informed Consent Models

AMA
AMERICAN MEDICAL ASSOCIATION

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AMA Journal of Ethics. November 2016, Volume 18, Number 11: 1147-1155.
doi: 10.1001/journalofethics.2016.18.11.sect1-1611.

SECOND THOUGHTS

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

Timothy Cavanaugh, MD, Ruben Hopwood, MDiv, PhD, and Cei 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 attain 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,

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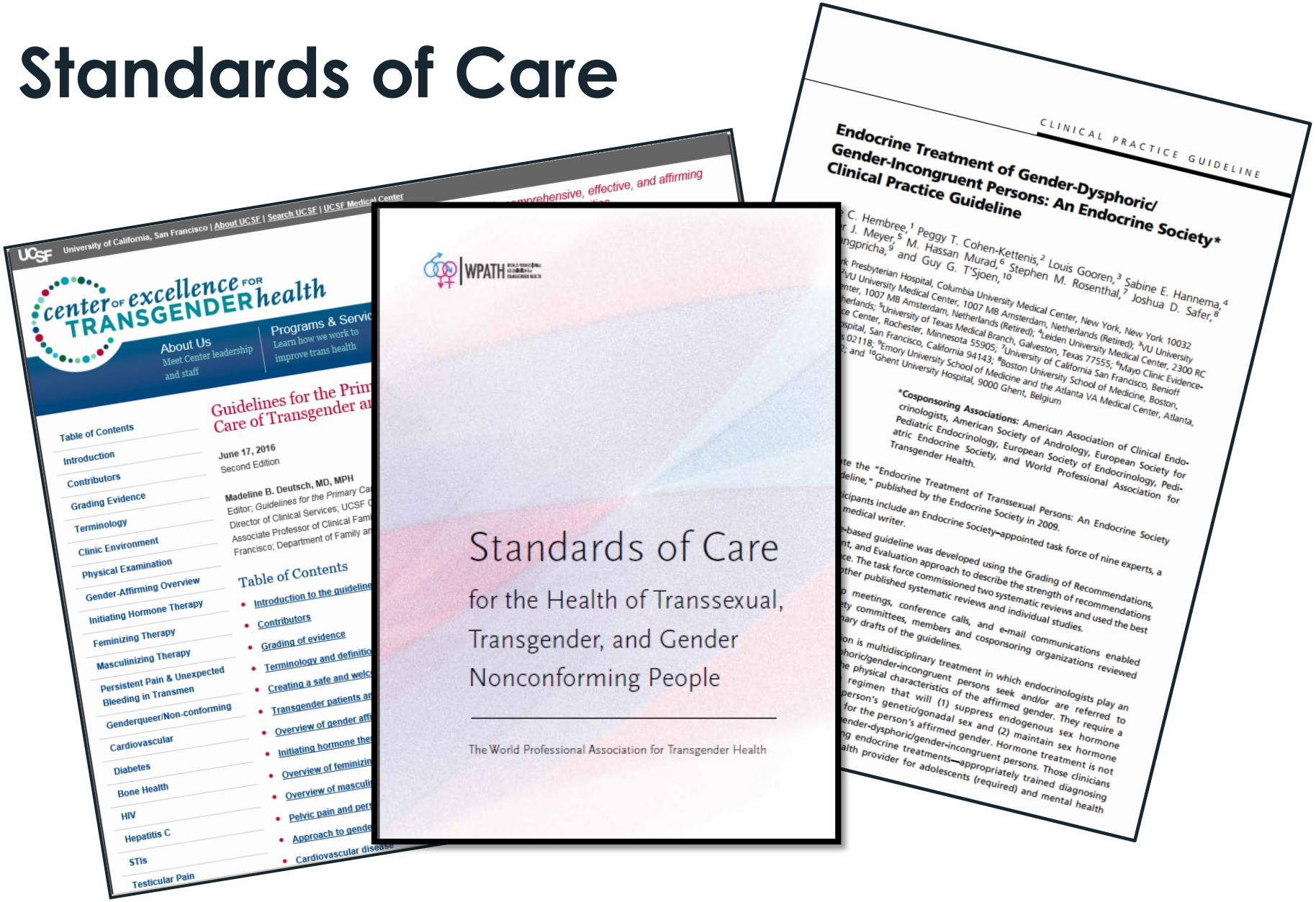
- Discussion of risks and benefits of treatment
- Supportive mental health treatment (not gender-evaluating assessments)
- Patients assess and judge beneficence and consent to receive care

Cavanaugh, Hopwood, Lambert, AMA Journal of Ethics, 2016

Standards of Care



https://www.wpath.org/publications/soc

https://transcare.ucsf.edu/guidelines

Medical Gender Affirmation Improves Mental Health and Quality of Life

1

Clinical Endocrinology (2010) **72**, 214–231 doi: 10.1111/j.1365-2265.2009.03625.x

ORIGINAL ARTICLE

Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes

Mohammad Hassan Murad*,†, Mohamed B. Elamin*, Magaly Zumaeta Garcia*, Rebecca J. Mullan*, Ayman Murad‡, Patricia J. Erwin*,§ and Victor M. Montori*,¶

*Knowledge and Encounter Research Unit, †Division of Preventive Medicine, Mayo Clinic, Rochester, MN, USA, ‡Department of Psychiatry, Centre Hospitalier de Rouffach, France, §Mayo Clinic Libraries and ¶Division of Endocrinology, Diabetes, Metabolism, Nutrition, Mayo Clinic, Rochester, MN, USA

2

Transgender Health
Volume 1.1, 2016
DOI: 10.1089/trgh.2015.0008

Transgender Health
Mary Ann Liebert, Inc. publishers

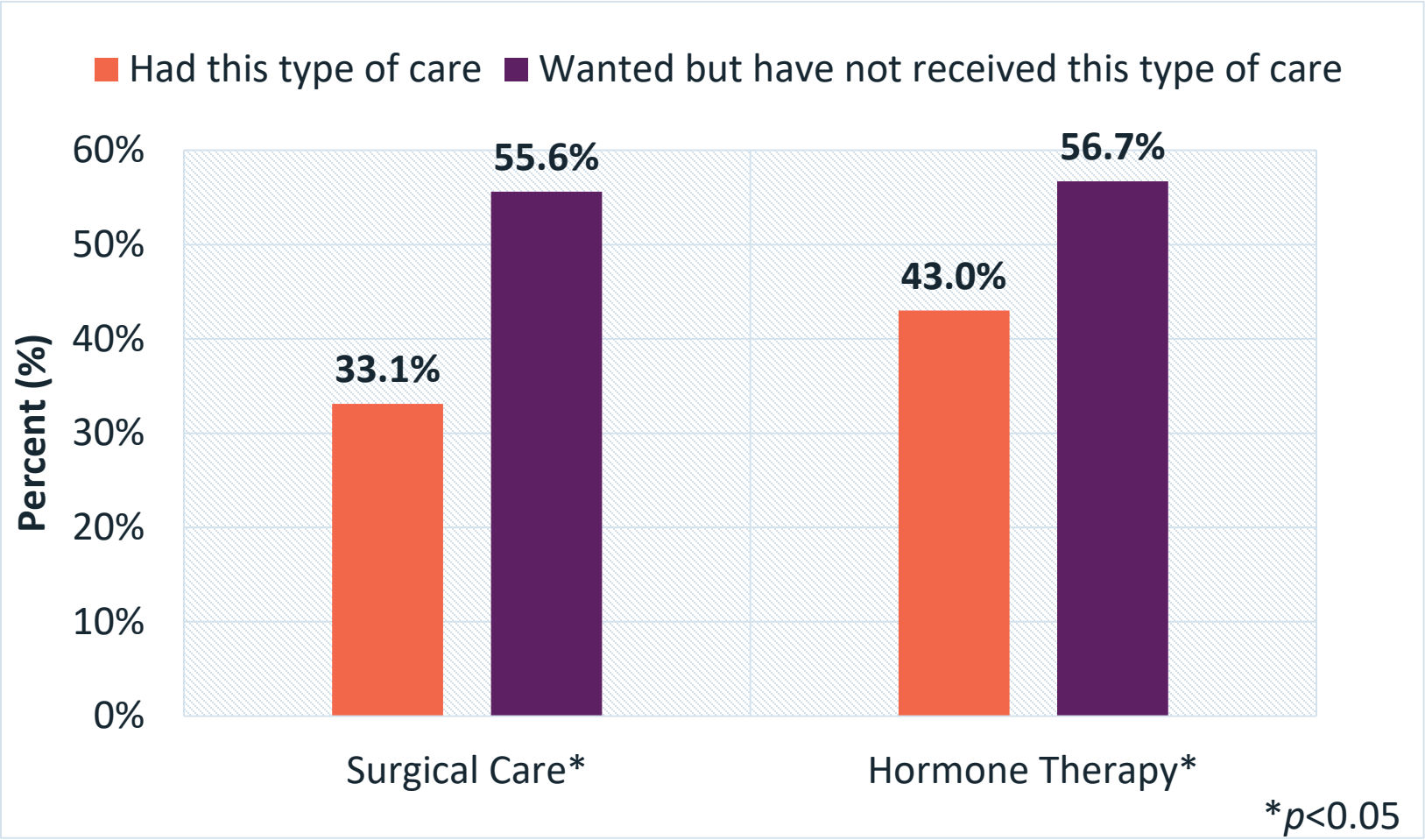
REVIEW ARTICLE Open Access

A Systematic Review of the Effects 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]

Suicidal Ideation in Last 12 Months by Medical Gender Affirmation (n=19,814)

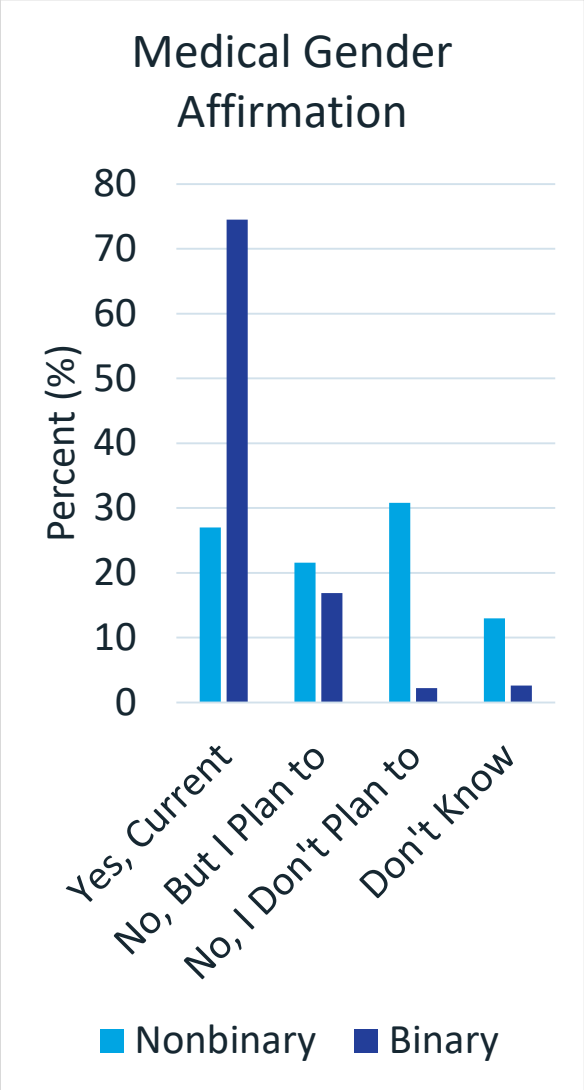
48% Self-Reported Suicidal Ideation in the Last 12 Months



Herman, Conron, Haas, Brown, Liu, Reisner, in prep

Nonbinary vs Binary Gender Minority Adult Health in a State-Wide Non-Probability Sample in Massachusetts (n=452)

- 40.9% nonbinary
- Demographics:
  - Younger age (mean age 28.9 vs 35.1)
  - Trans masculine (77.3% vs 53.2%)
- Gender affirmation:
  - Recognized gender identity at older age (mean age 16.4 vs 12.3)
  - Less likely to have current medical gender affirmation (27.0% vs 74.5%)



Reisner & White Hughto, PLOS One, 2019

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)

	Transgender (n = 73)	Controls (n = 73)	Siblings (n = 49)	P
Depression by gender[b]				.979[c]
Natal boys	49.8 (trans-girls)	48.0	48.9	
Natal girls	50.8 (trans-boys)	48.5	49.9	
Anxiety by gender				.664[c]
Natal boys	53.7	51.1	52.8	
Natal girls	55.3	50.8	51.5	

[a] This is the only value that is significantly above the national average (50), although it is still substantially below the clinical (>63) 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.

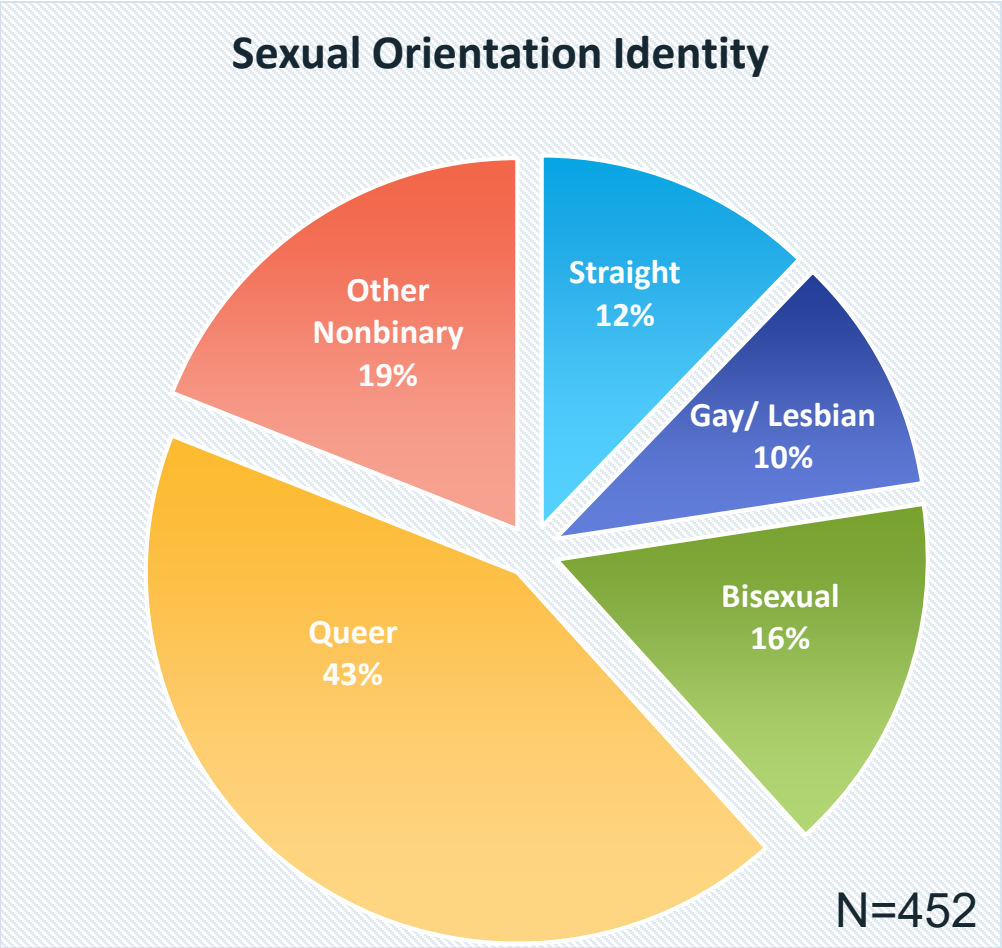
[c] Significance value of interaction between natal sex and group.

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



Katz-Wise, Reisner, White Hughto, Keo-Meier, Archives Sex Behav, 2016

Overview

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

The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (IOM, 2011)

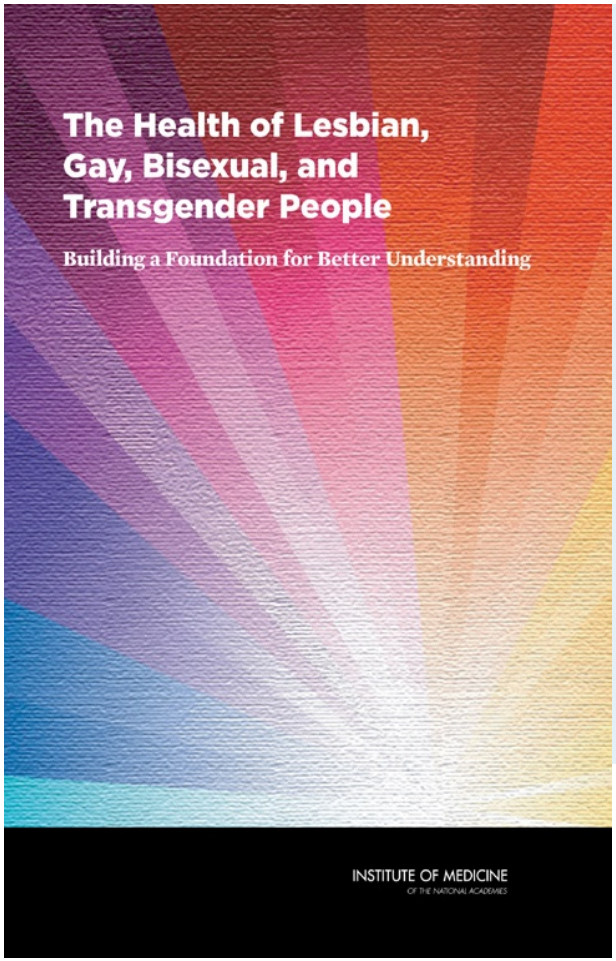
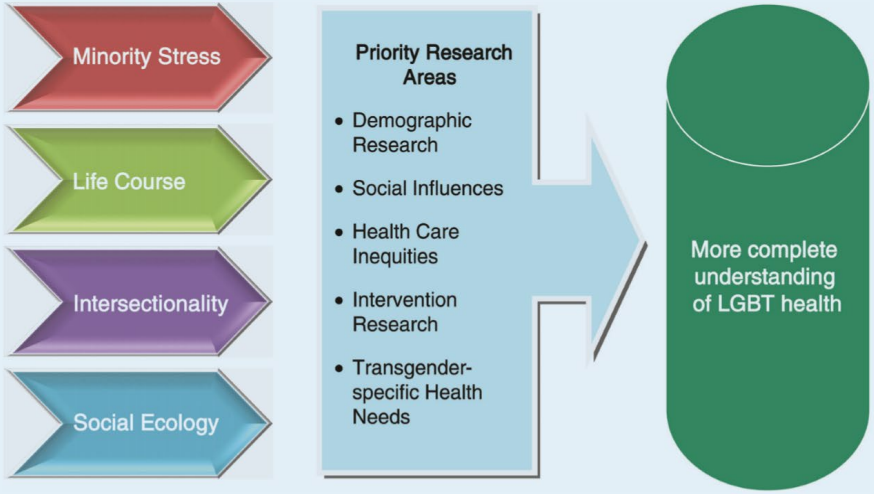


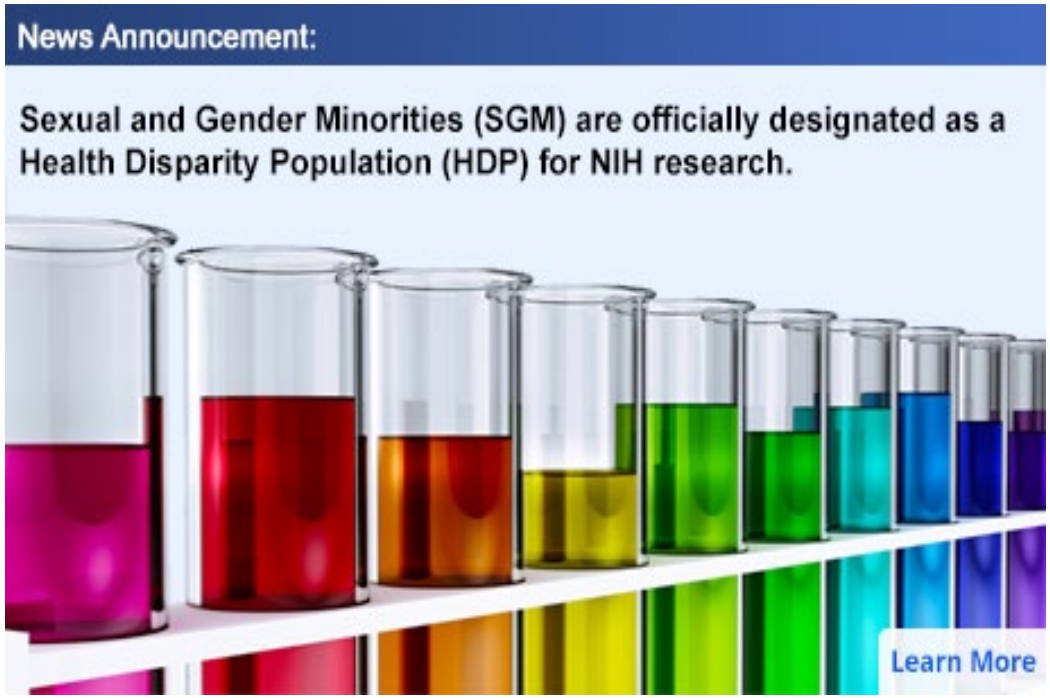
Figure 1: Research Agenda



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.

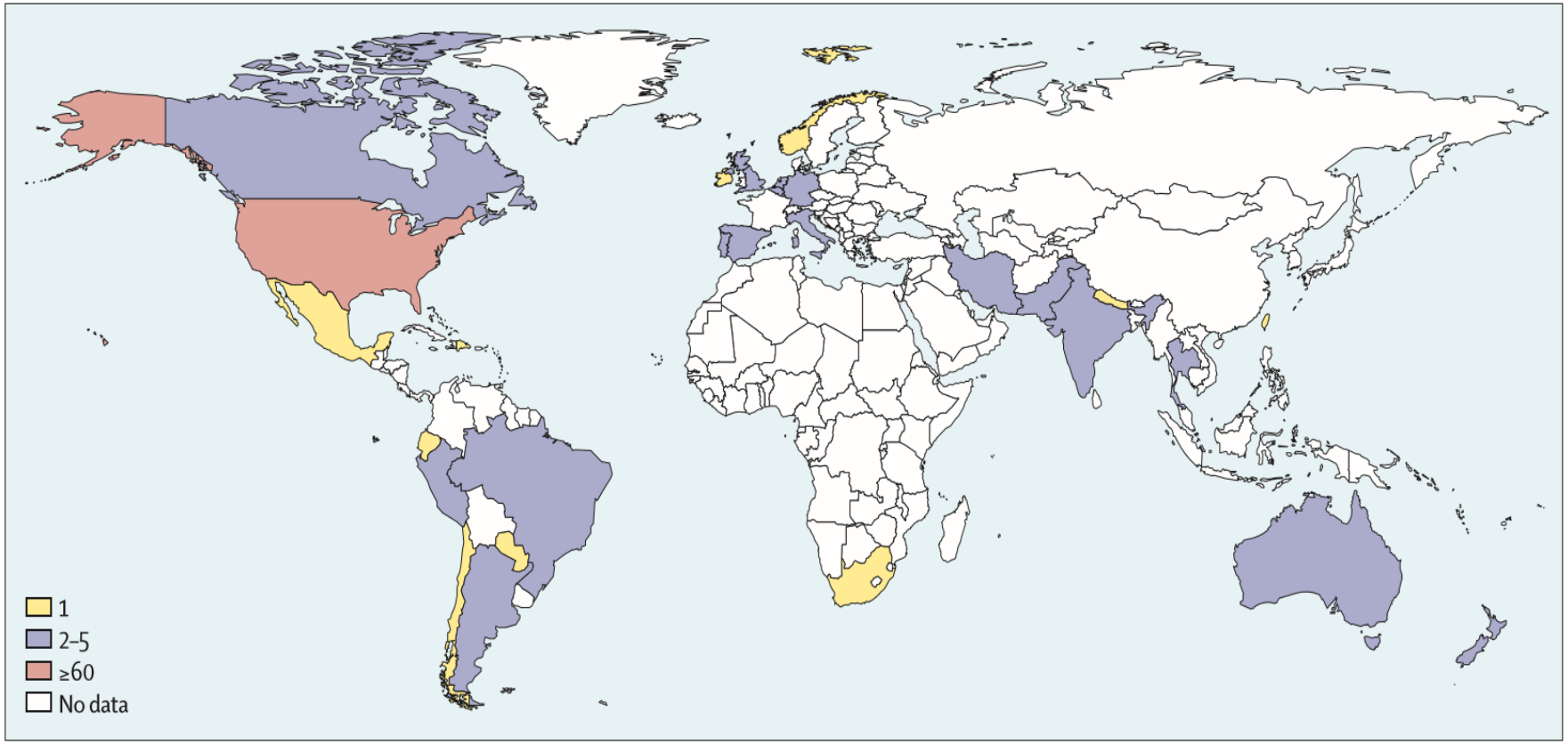
Sexual and Gender Minorities (SGM): A Health Disparity Population

National Institutes of Health (NIH)



2016

Global Health Burden: Studies in Transgender Health, 2008-2014 (n=116)



Reisner, Poteat, Keatley et al., Lancet, 2016

Population Composition of Gender Minority vs Cisgender Adults: U.S. National Probability Sample, 2014-2015

- 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

Gender minority = Transgender and gender nonbinary adults

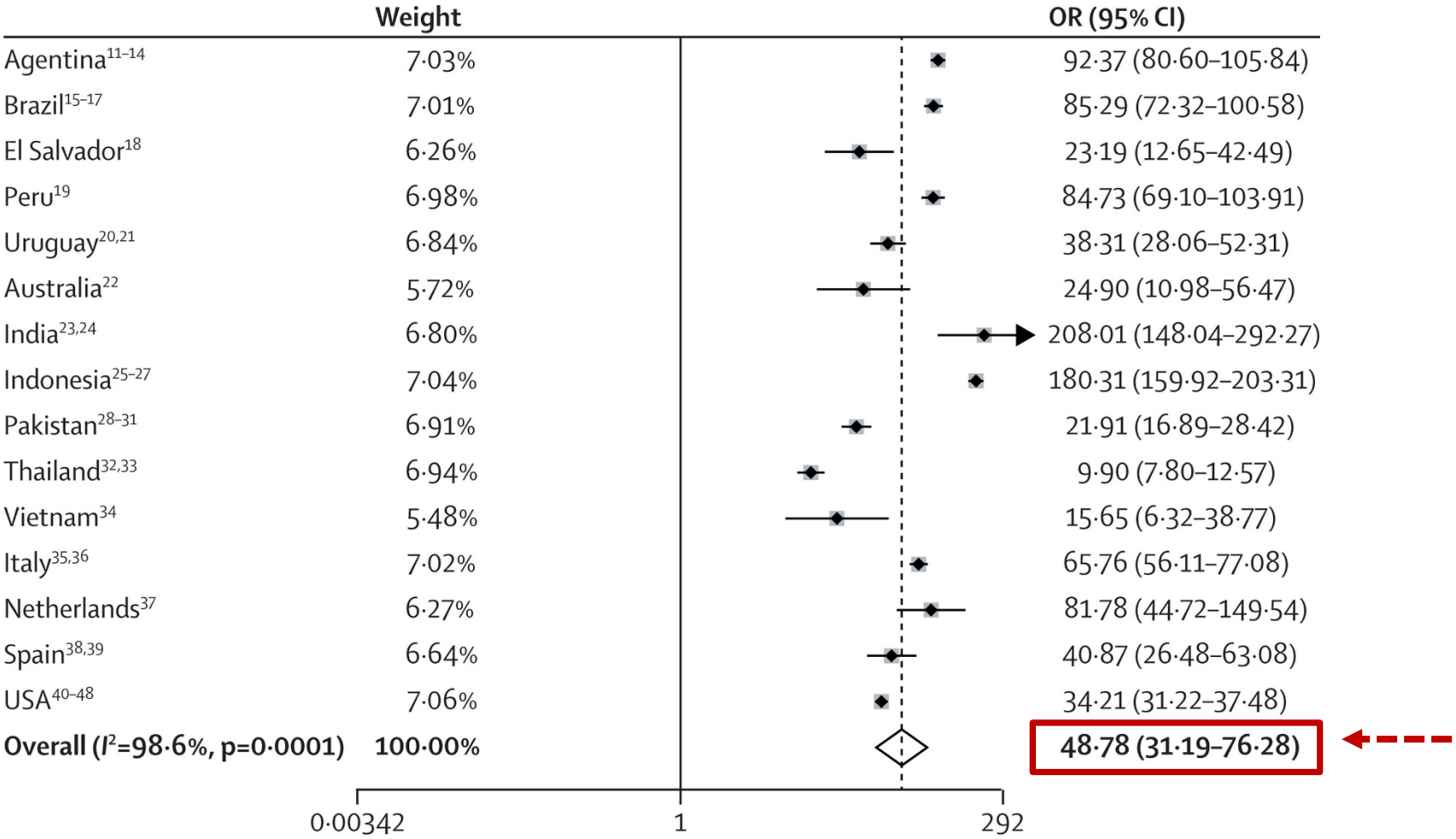
Streed, McCarthy, Haas, JAMA Intern Med, 2017

Transgender Health Inequities

- Poor self-rated general health
- HIV infection and other STIs
- Mental health conditions
- Substance use and abuse
- Eating disorders
- Cancer-related risks
- Violence/ victimization
- Preventive screening
- Lack access to culturally competent care
- Homelessness, incarceration

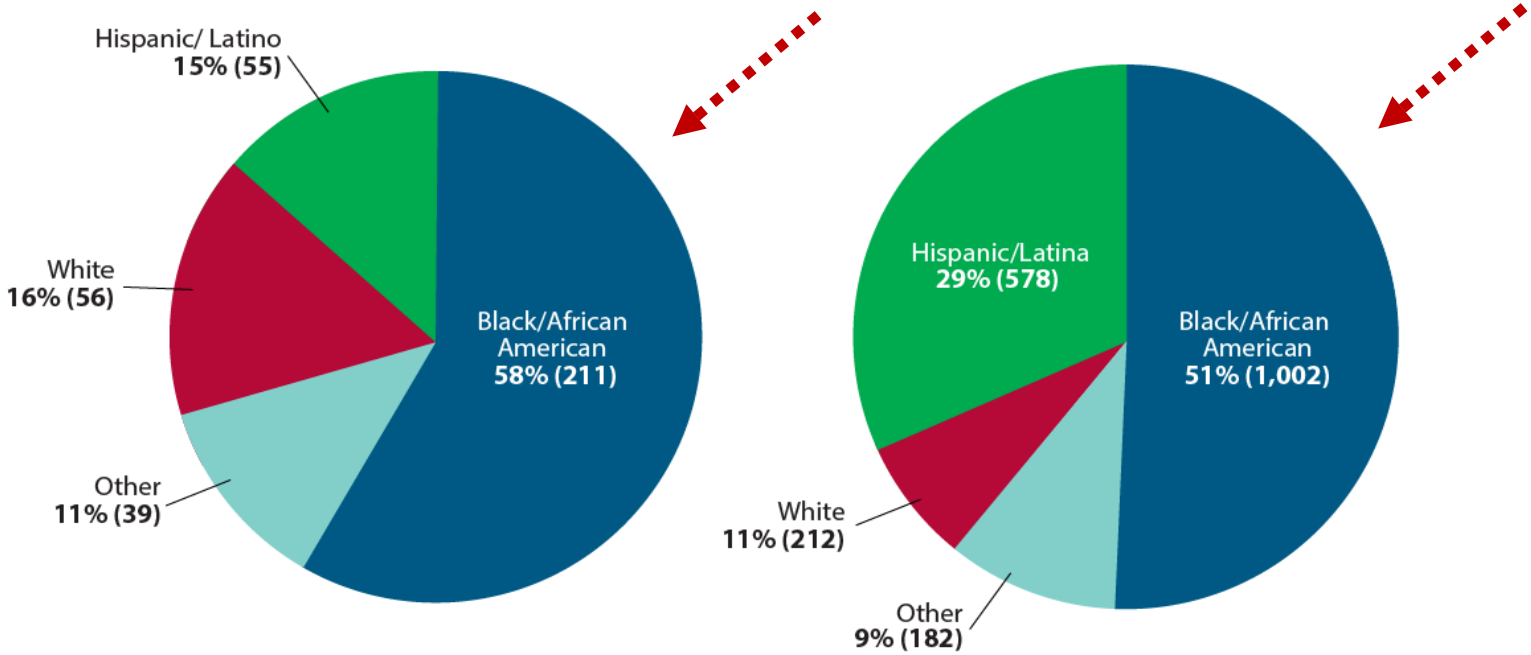
Global Burden of HIV in Transgender Women

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



Baral, Poteat, Stromdahl et al., Lancet Infect Dis, 2013

HIV Diagnoses in Transgender People by Race/ Ethnicity: National HIV Surveillance System 2009-2014

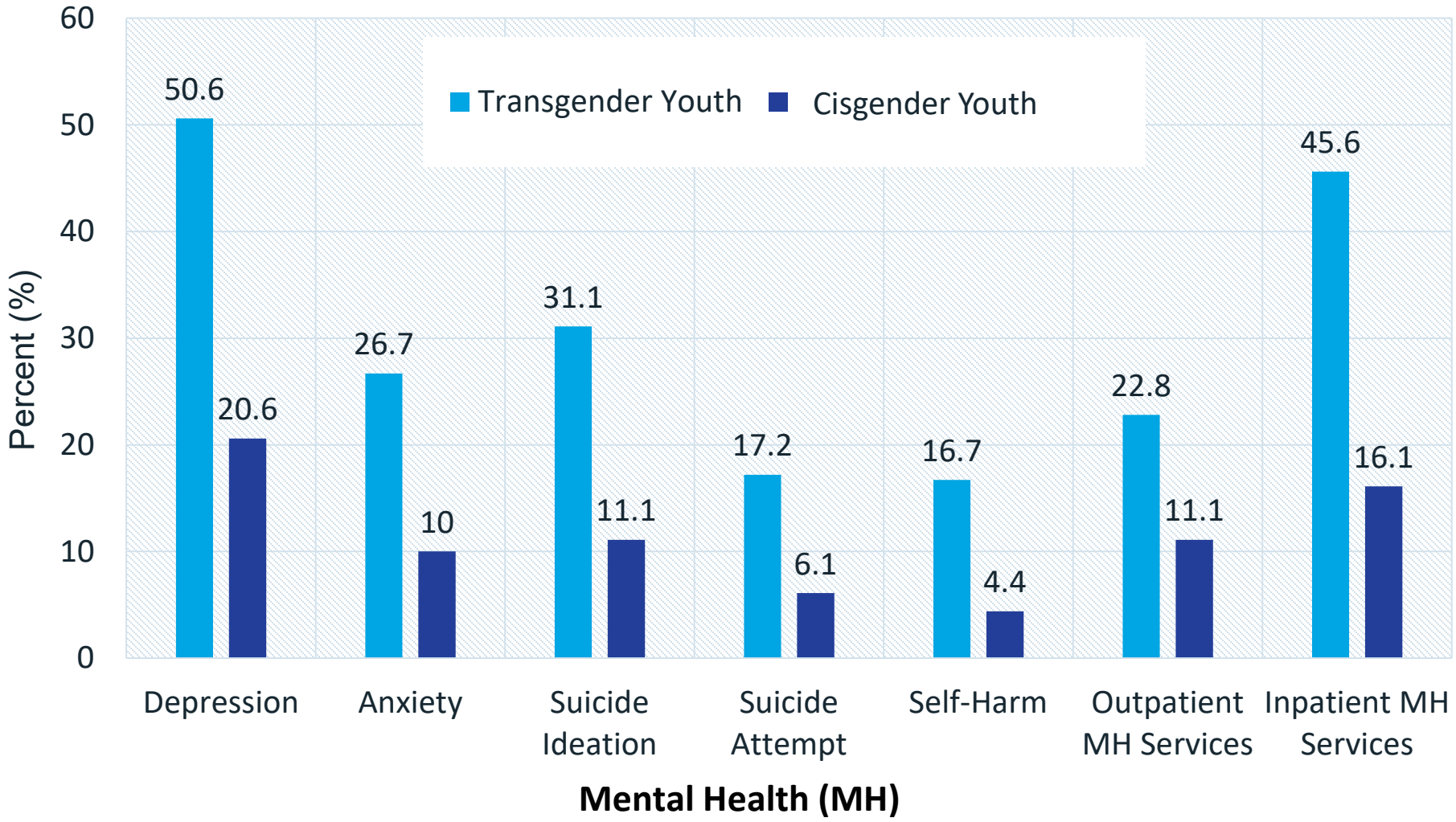


Transgender Men
(N-361)

Transgender Women
(N-1,974)

Clark, Babu, Wiewel, et al. AIDS Behav, 2016

Mental Health of Transgender Youth: A Matched Retrospective Cohort Study (n=360; Mean age=19.6)



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

Reisner, Vetters, Leclerc, et al. J Adolesc Health, 2015

Transgender Disparities: U.S. Behavioral Risk Factor Surveillance System, 2014

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

Transgender vs cisgender:

- More days per month of…
  - Poor mental health (β=1.74; 95% CL=0.28, 3.19)
  - Poor physical health (β =2.43; 95% CL=0.61, 4.24)
- 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)

Meyer, Brown, Herman, Reisner, Bockting, Am J Public Health, 2017

Transgender Subgroups: U.S. Behavioral Risk Factor Surveillance System, 2015

- 22 U.S. states – 764 transgender adults
- Subgroup differences:
  - Transgender men/TM (n=239)
  - Transgender women/TW (n=369)
  - Gender nonbinary/NB (n=156)

Health Outcomes	TM / TW aOR (95% CI)	NB / TW aOR (95% CI)	NB / TM aOR (95% CI)
Frequent Mental Unhealthy Days (≥ 5 days of last 30 days vs 0-4 days)	**1.5 (1.0, 2.2)**	0.9 (0.6, 1.4)	**0.6 (0.4, 0.9)**
	p=0.04	p=0.56	**p=0.03**
Poor Self-Rated General Health (Fair/ Poor vs Excellent/ Very Good/ Good)	**2.3 (1.2, 4.8)**	**2.6 (1.1, 5.9)**	1.1 (0.5, 2.4)
	p=0.02	**p=0.03**	p=0.82

Cicero, Reisner, Merwin, et al., PLOS One, 2020

Sexual Minority Transgender People: U.S. Behavioral Risk Factor Surveillance System, 2015

- Comparing sexual minority (SM) to heterosexual (het) people *within* the transgender population:

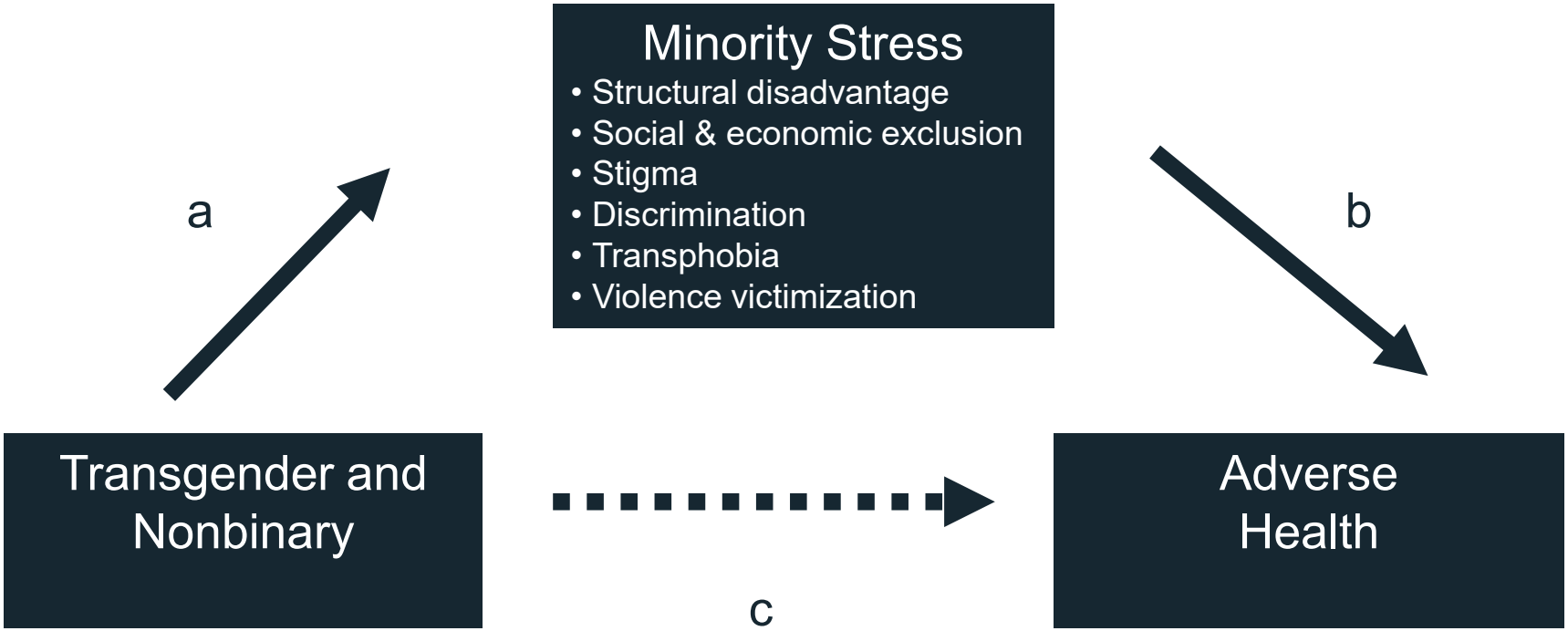
Health Outcomes	SM vs Het aOR (95% CI)	p-value
Frequent Mental Unhealthy Days (≥ 5 days of last 30 days vs 0-4 days)	**1.76 (1.19, 2.61)**	**0.005**
Frequent Physical Unhealthy Days (≥ 5 days of last 30 days vs 0-4 days)	**1.72 (1.18, 2.53)**	**0.005**
Poor Self-Rated General Health (Fair/ Poor vs Excellent/ Very Good/ Good)	**1.69 (1.13, 2.53)**	**0.011**
Co-Morbid Problems or Impairments (≥3 problems or impairments vs 0-2)	**2.72 (1.70, 4.35)**	**0.0001**

Cicero, Reisner, Merwin, et al., PLOS One, 2020

Why Transgender Health Inequities?

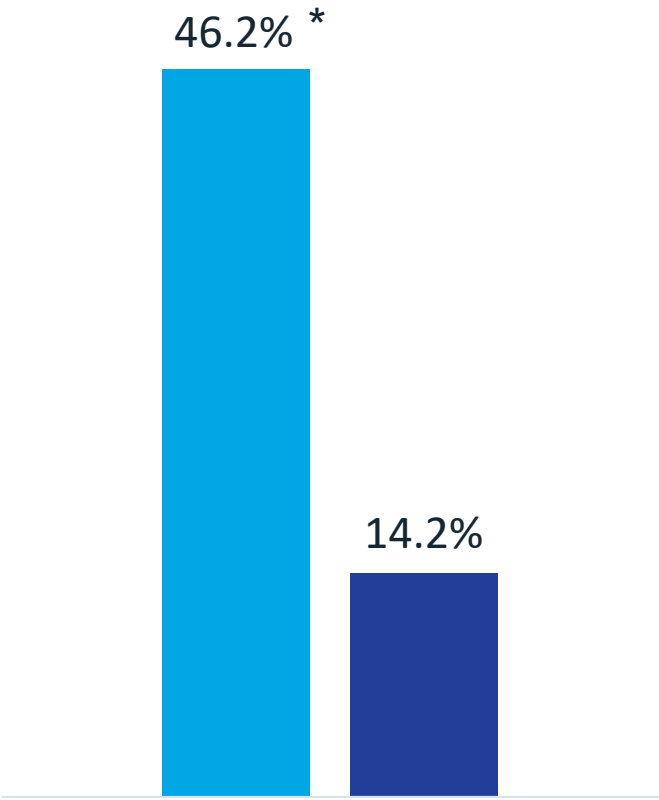
Hendricks & Testa, 2013; Meyer, 1995, 2003; White Hughto, Reisner, Pachankis, 2016

Why Transgender Health Inequities?



Hendricks & Testa, 2013; Meyer, 1995, 2003; White Hughto, Reisner, Pachankis, 2016

Bullying
(weighted proportions)



Often bullied (before age 18)

- Transgender (N = 274)
- Cisgender Straight (n = 1048)

*$p<0.05$

TRANS POP
U.S. TRANSGENDER POPULATION HEALTH SURVEY

NICHD grant R01HD090468 (PI: Meyer)

www.transpop.org

Reasons for Bullying

	Transgender (n=274)		Cisgender Straight (n=1048)	
	Reason	%	Reason	%
1	Physical appearance	63.3	Physical appearance	46.3
2	Gender expression or appearance	46.4	Age	26.3
3	Sexual orientation	28.4	Sex (being female or male)	13.7

Meyer IH, Reisner S, Herman J, Feldman J, Poteat T, Bockting W. Findings from a US transgender population study. USPATH 2019, Washington DC (Sept 2019 Plenary).

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. J Interpers Violence, 2019

Gender Non-Affirmation from Cis Male Partners: Trans MSM

- Transmasculine people who have sex with men (trans MSM)
- N=857 trans MSM sampled online Nov-Dec 2017 in the US
- 65% age<30; 28% nonbinary; 70% white
- 78% gender non-affirmation, last 6 mo
  - Higher psychological distress ($p<0.05$)
  - Higher anxiety ($p<0.05$)
  - Lower odds of HIV testing ($p<0.01$)
  - Higher odds of past 6-month condomless receptive sex ($p<0.01$)

Scale: Gender Non-Affirmation from Cisgender Male Partners:

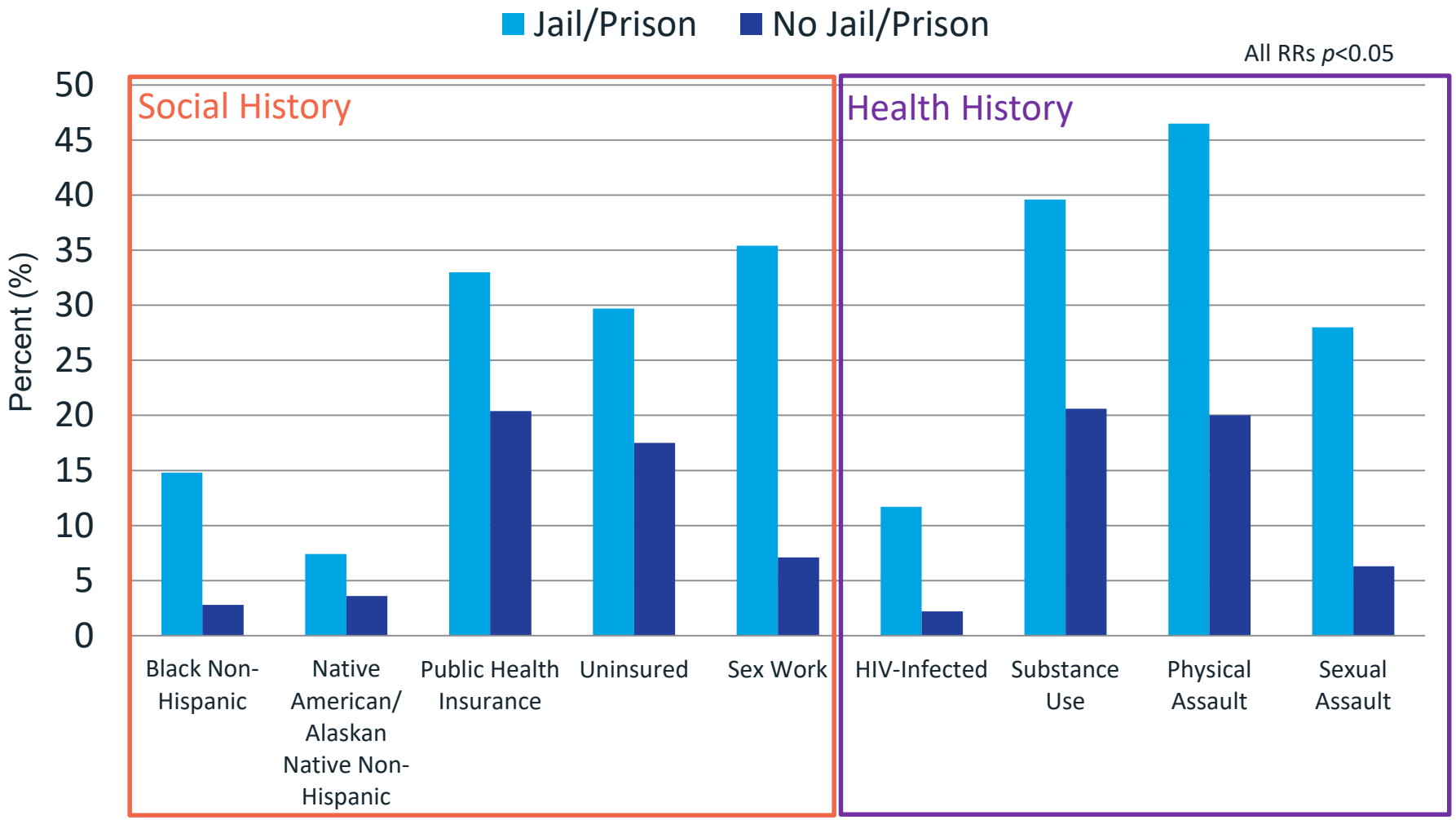
"I have been mis-pronouned/ misgendered during or after sex"

"I have crossed boundaries…to validate my gender identity or expression in the sexual encounter"

Reisner, Moore, Asquith, et al. AIDS Behav, 2020

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

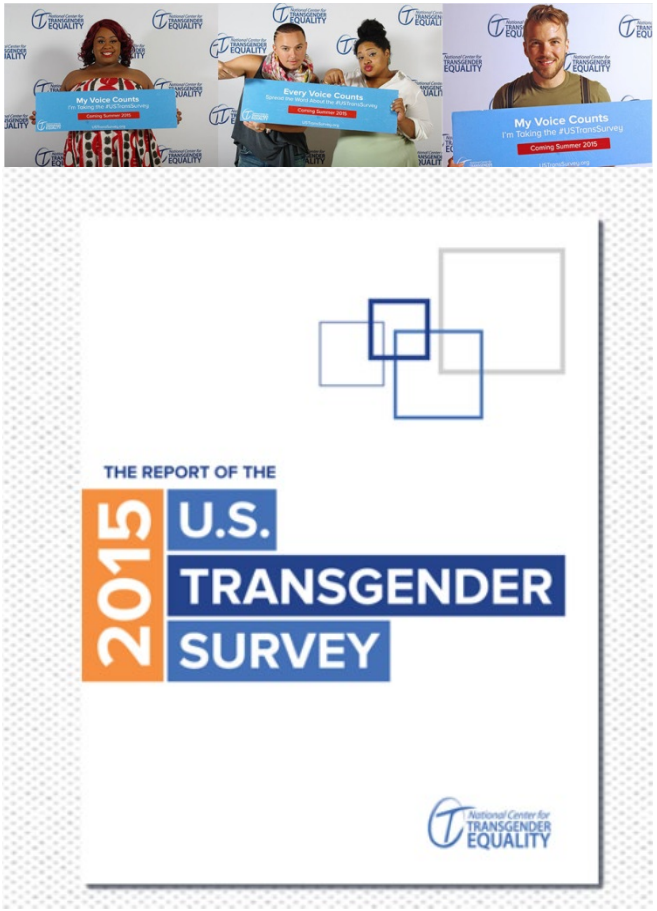
Health Effects of Stigma, Social Exclusion, and Violence

2019

https://www.huffpost.com/entry/at-least-22-transgender-people-were-killed-in-2019-here-are-their-stories_n_5dd40648e4b03b969717f3d7

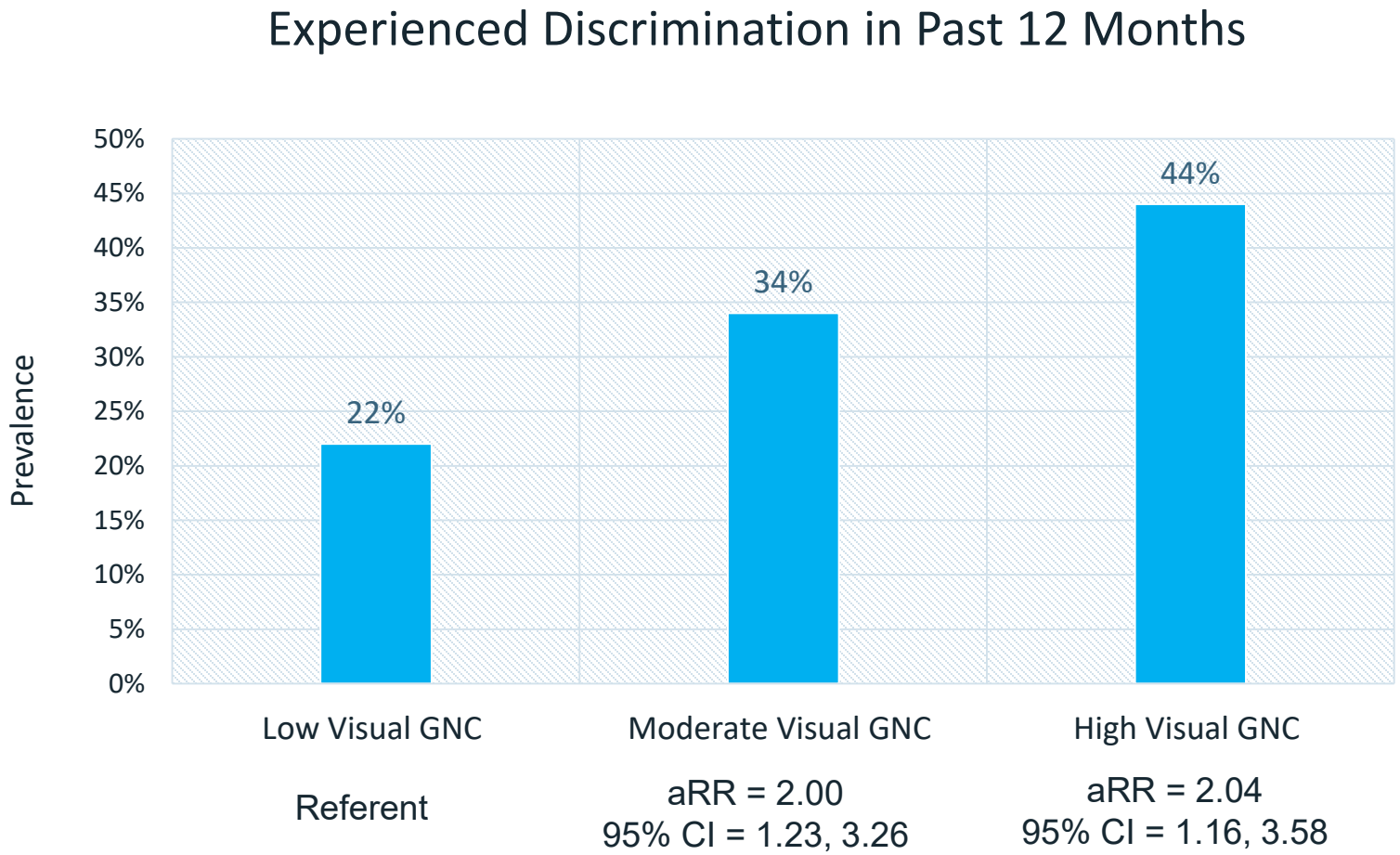
Discrimination and Stigma in Healthcare: 2015 U.S. Transgender Survey (USTS, n>22,000 Adults)

- 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



James, Herman, Rankin et al. 2016

Visual Gender Nonconforming (GNC) Expression (n=452)

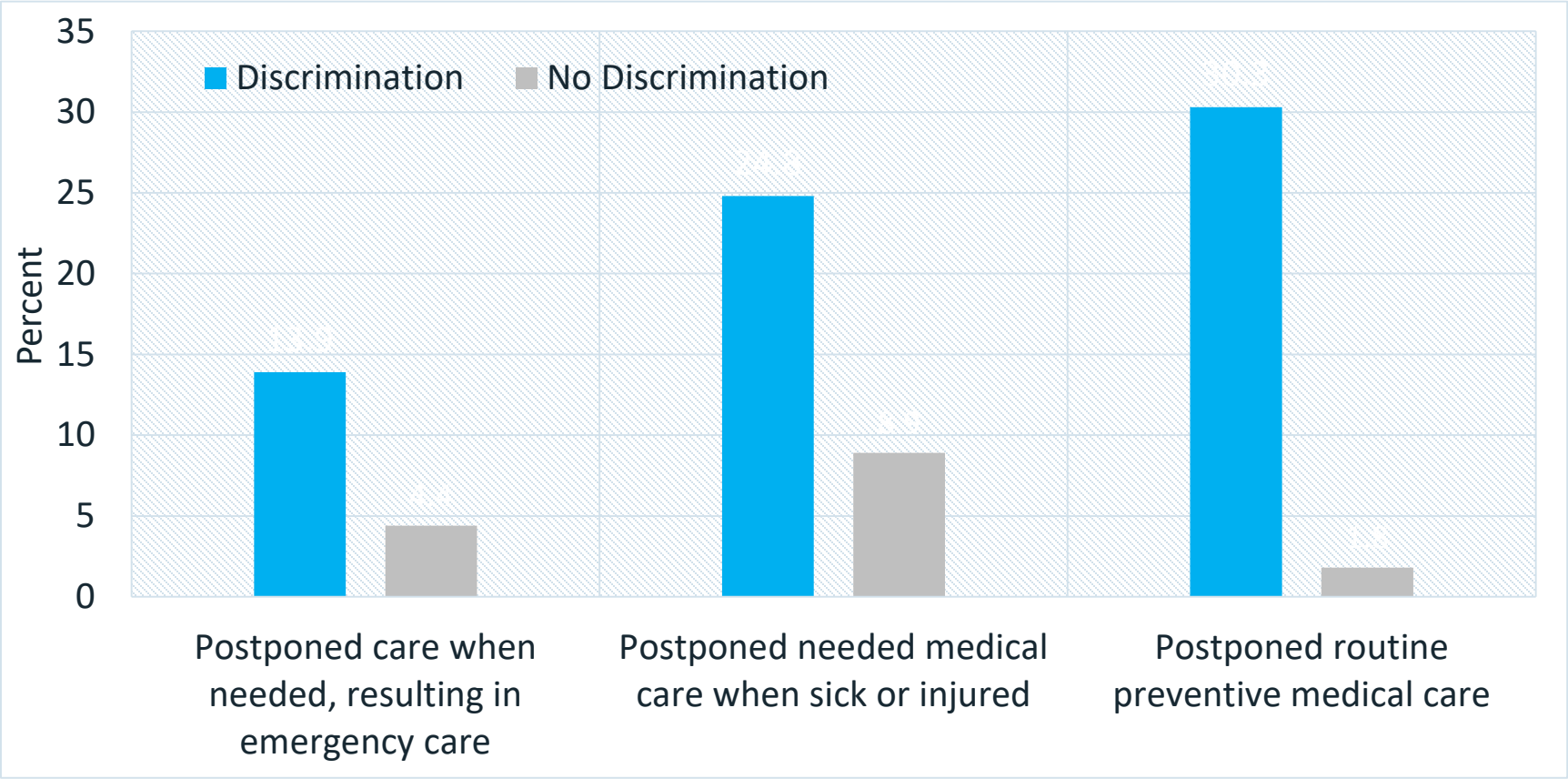


+Multivariable logistic regression model included: age, gender identity, cross-sex hormone use, surgical gender affirmation, visual gender nonconforming expression, race/ethnicity, income, education, employment, health insurance status, and survey modality. aRR = Adjusted Risk Ratio. 95% CI=95% Confidence Interval. GNC= Gender Nonconforming.

Reisner, Hughto, Dunham, et al. Milbank Quart, 2015

Discrimination Shapes Healthcare Utilization (n=452)

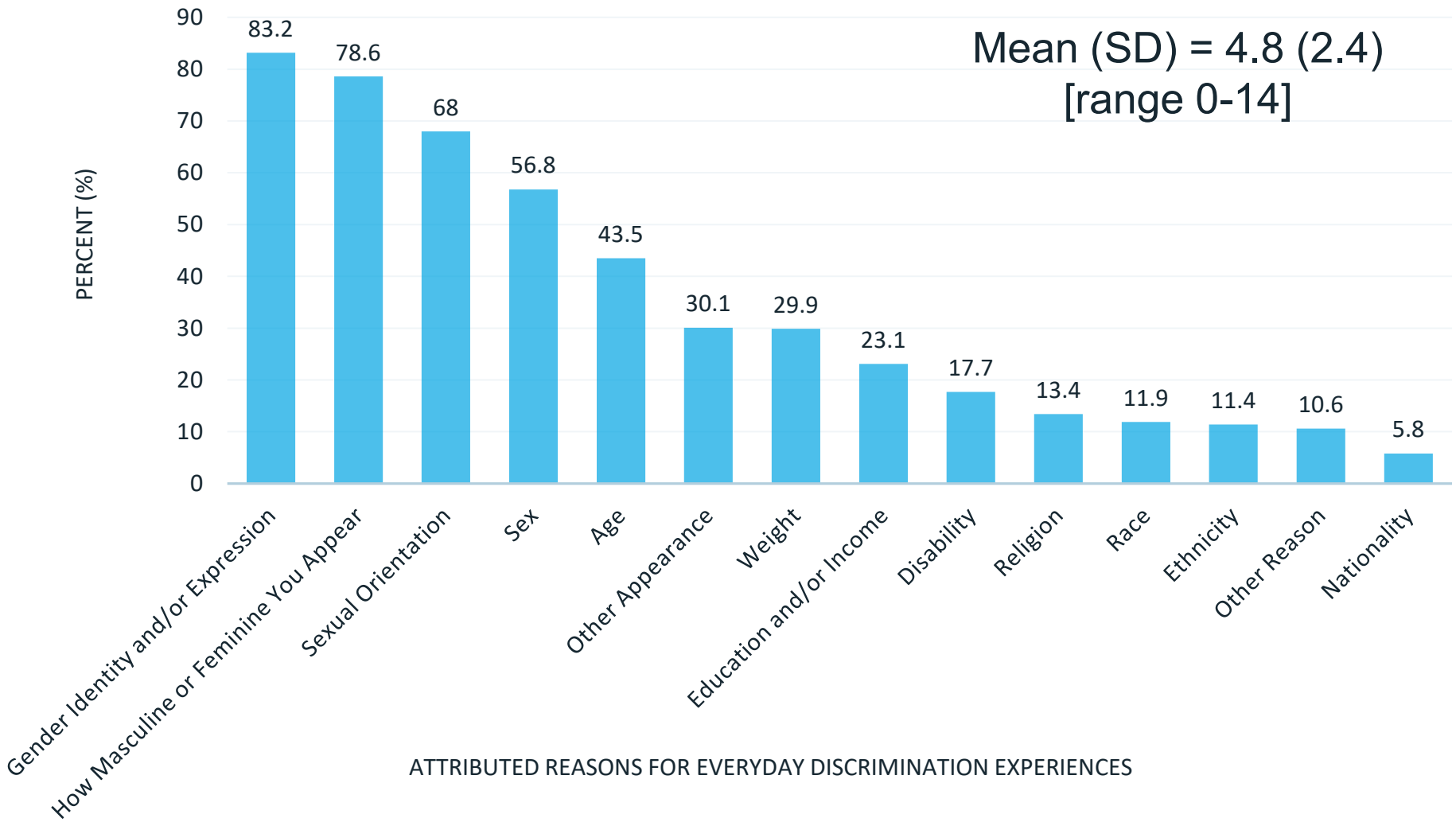
24% prevalence → Discrimination definition: Mistreatment on the basis of transgender or gender nonconforming identity/presentation (included verbal harassment and physical assault).



Adj. RR:	2.38 (1.76, 3.23)	3.14 (2.63, 4.43)	2.43 (1.92, 3.08)

Reisner, Hughto, Dunham, et al. Milbank Quart, 2015

Attributed Reasons for Everyday Discrimination Experienced: A Non-Clinical Sample of Transgender and Nonbinary Adults



Reisner, White Hughto, Gamarel, Keuroghlian, Mizock, Pachankis, J Counseling Psych, 2016

PTSD Symptoms in a Sample of Transgender and Nonbinary Adults (n=412)

- 44.4% probable PTSD

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

Multivariable 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.

Reisner, White Hughto, Gamarel, Keuroghlian, Mizock, Pachankis, J Counseling Psych, 2016

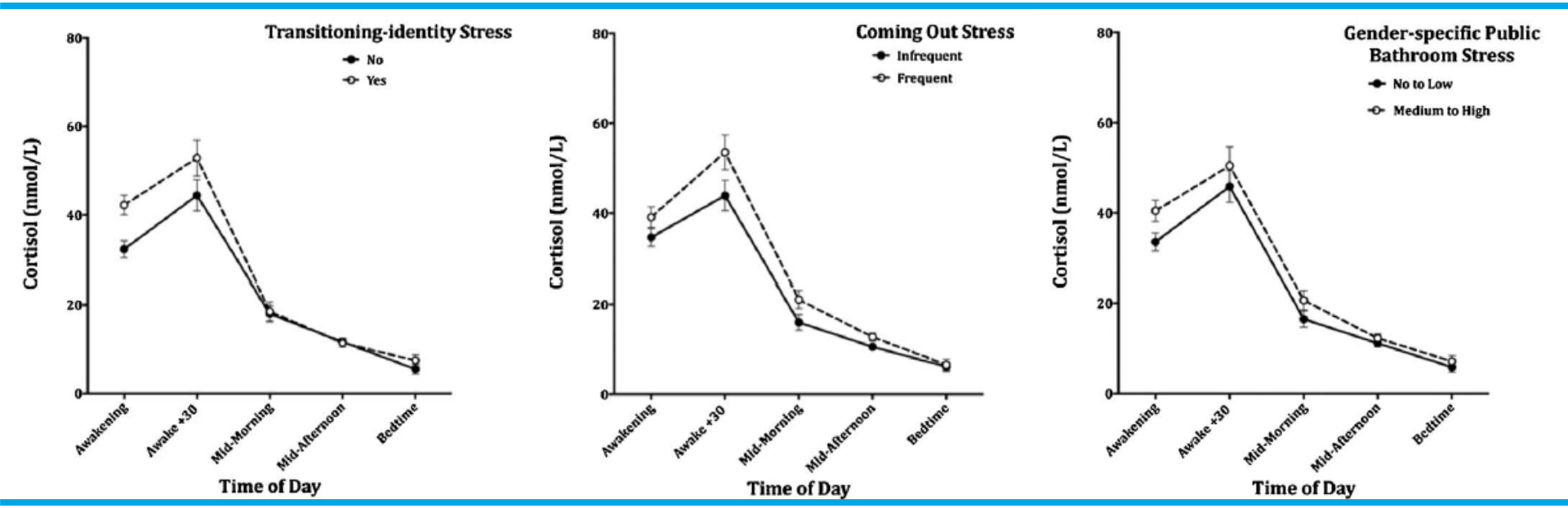
Patient Experiences: Postponing Healthcare

"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)*

Reisner, Randazzo, White Hughto et al. Qual Health Res, 2017

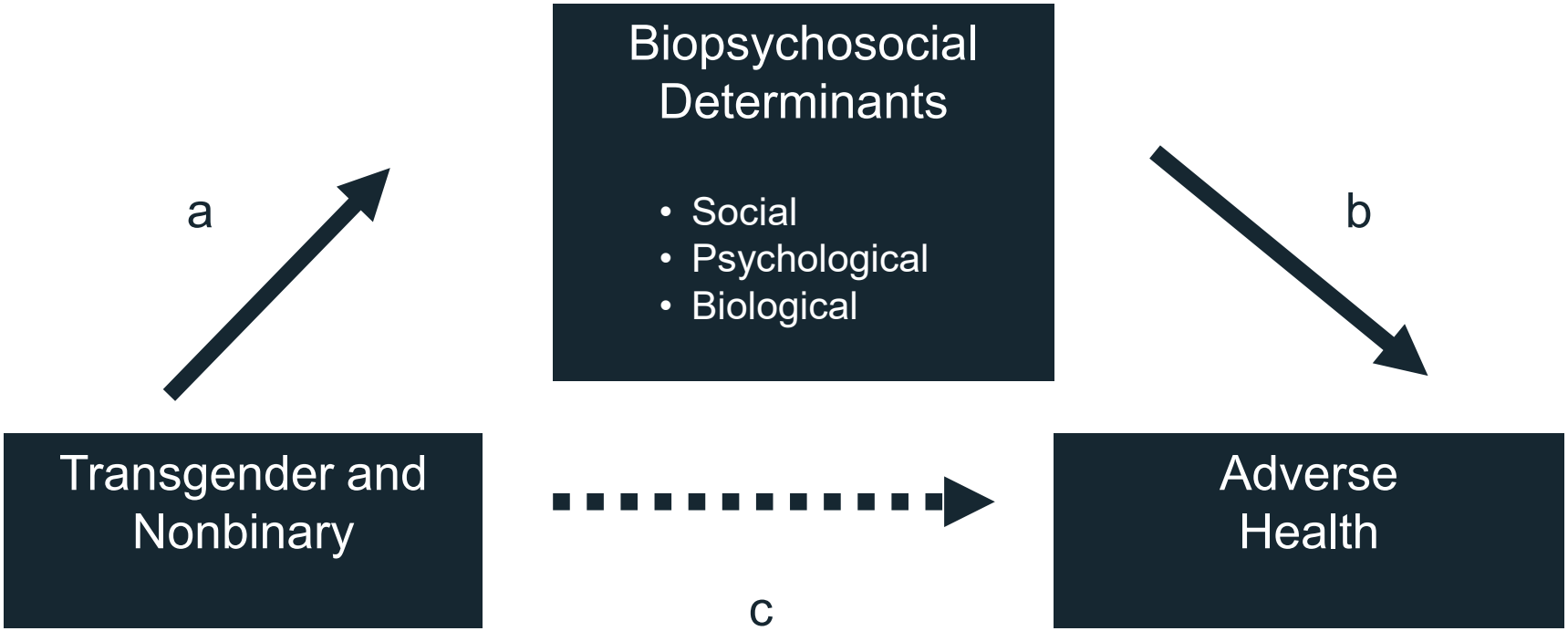
Hypothalamic-Pituitary-Adrenal (HPA) Axis: Diurnal Cortisol Predicted by Transition-Related Stress Variables in Transgender Men (n=65)

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



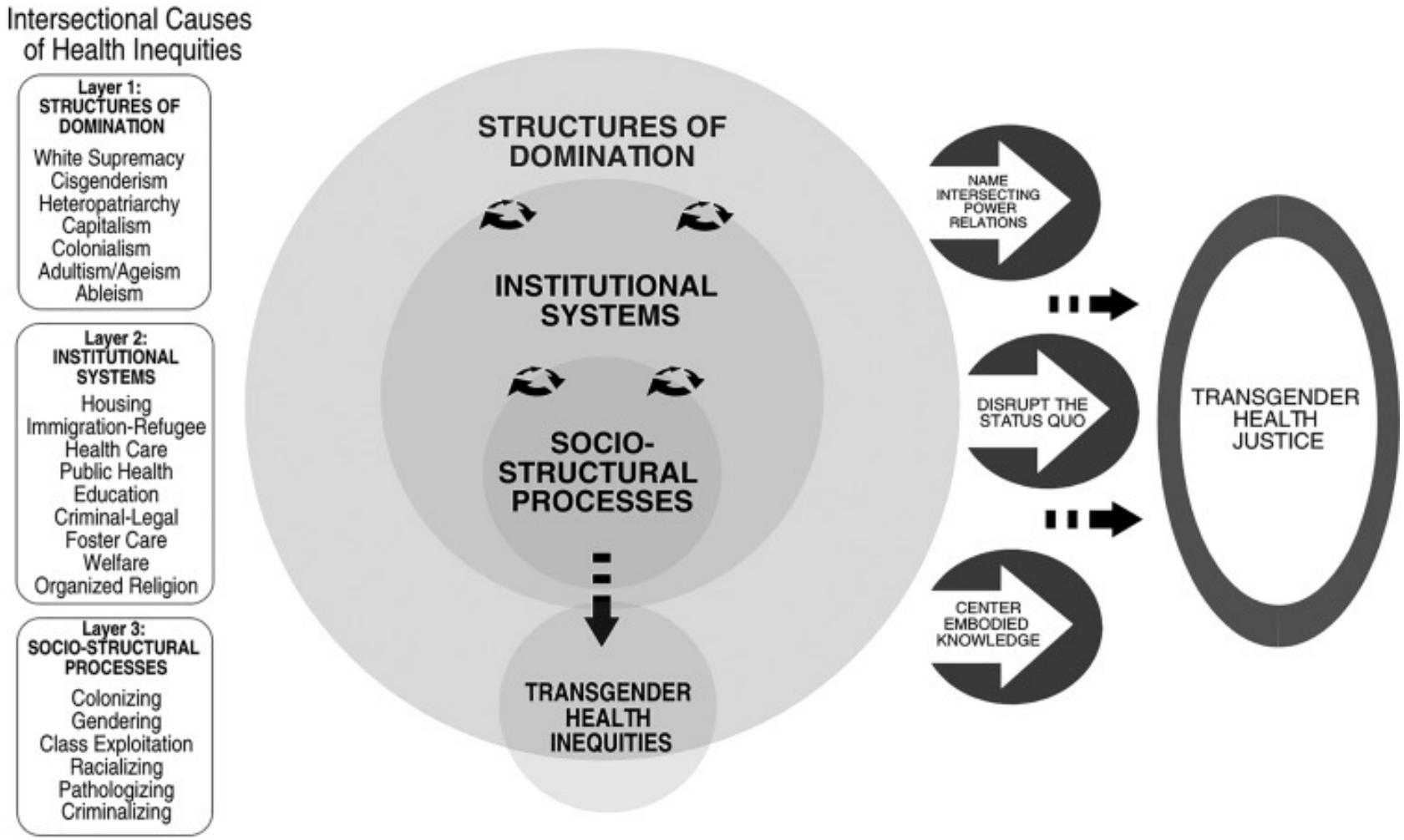
DuBois, Powers, Everett, Juster, Psychoneuroendocrinology, 2017

Why Transgender Health Disparities?



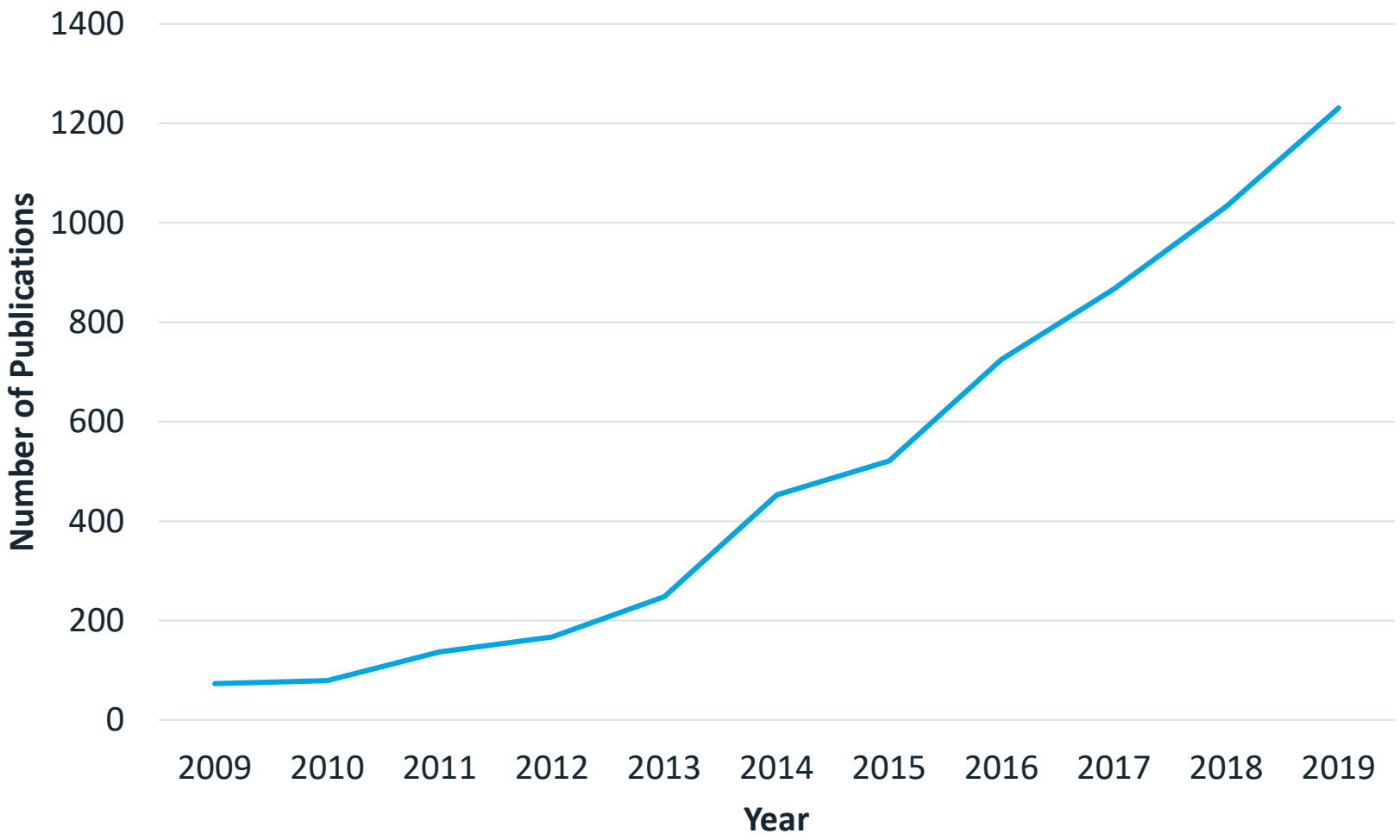
Reisner. In Preparation.

Intersectionality Research for Transgender Health Justice (IRTHJ) Framework



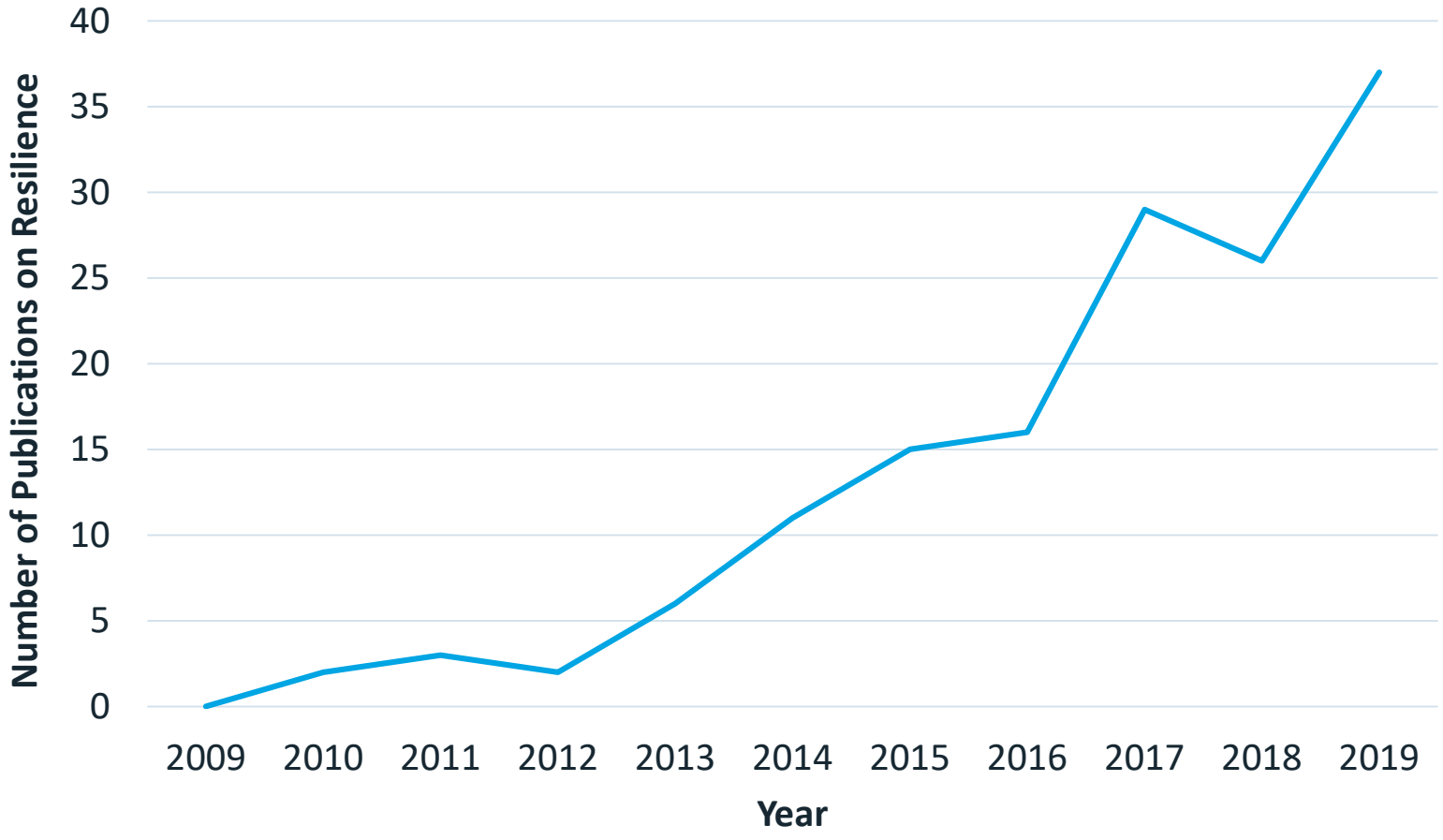
Wesp, Malcoe, Elliott, Poteat, Transgender Health, 2019

10 Years of Transgender Health Research: Number of Peer-Review Publications, 2009-2019



Search performed 10/31/19

10 Years of Transgender Health Research: Number of Peer-Review Publications on Resilience, 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)

	Depression, 7 Days	Anxiety, 7 Days	Non-Suicidal Self-Injury, 12 Months
Prevalence (%)	25.7%	31.1%	15.0%
Multivariable Models	AOR (95% CI)	AOR (95% CI)	AOR (95% CI)
Everyday Discrimination, Last 12 Months	1.08 (1.03, 1.13)*	1.09 (1.03, 1.15)*	1.06 (1.01, 1.13)*
Resilience Score, Current	0.81 (0.71, 0.93)*	0.77 (0.66, 0.90)*	0.78 (0.66, 0.91) *

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, BMC Psychiatry, 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 Epidemiology 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

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
JULY 14, 2016

Beyond Bathrooms — Meeting the Health Needs of Transgender People

Mark A. Schuster, M.D., Ph.D., Sari L. Reisner, Sc.D., and Sarah E. Onorato, B.A.

One might have to go back to the era of racial desegregation of U.S. bathrooms to find a time when toilets received so much attention. Recently, several states have debated or passed legislation requiring people to use the public bathroom corresponding to their sex as "identified at birth" or "stated on a person's birth certificate."[1,2] Some supporters of these laws have focused on the fear that male stalkers will claim to be transgender women in order to victimize girls and women in restrooms. Others have expressed vitriol and revulsion toward transgender people, describing them as "sexual predators," "voyeurs," and "pedophiles." Although transgender people have been characterized as dangerous, it is transgender people who have generally been the victims of verbal harassment and physical assaults when trying to use public bathrooms.

Opposition to the recent legislation has been strong in some sectors, with businesses, performers, and states voicing objections and canceling planned expansions, concerts, and government-sponsored travel. At the federal level, the Obama administration filed a lawsuit against North Carolina, asserting that the state's Public Facilities Privacy and Security Act violates federal law. It also issued a letter outlining the legal obligation of public schools to allow transgender students to use bathrooms that correspond to their gender identity. Eleven states have sued the administration over this directive.

Although these issues may ultimately be decided under civil rights law, bathrooms matter for health. Transgender people who are barred from using bathrooms where they feel safe might feel they have no choice but to suppress basic bodily needs. Delayed bathroom use can cause health problems including urinary tract or kidney infections, stool impaction, and hemorrhoids. Some transgender people even abstain from drinking during the day to avoid the need to urinate.

When transgender people are physically assaulted in public bathrooms, they may suffer bruises, broken bones, or worse. In addition, the ongoing fear of harassment and violence when using public bathrooms can take a toll on mental health. More broadly, laws like North Carolina's send a message that transgender people are not welcome in workplaces or schools, reinforcing the stigma, bias, and fear that fuel discrimination against transgender people.

Transgender people have a gen-

Gender Affirming Clinical and Public Health Model

Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol. 92, No. 3
doi:10.1007/s11524-015-9947-2

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 Todisco,
Timothy Cavanaugh, Rodney VanDerwarker, Chris Grasso,
Shayne Zaslow, 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*

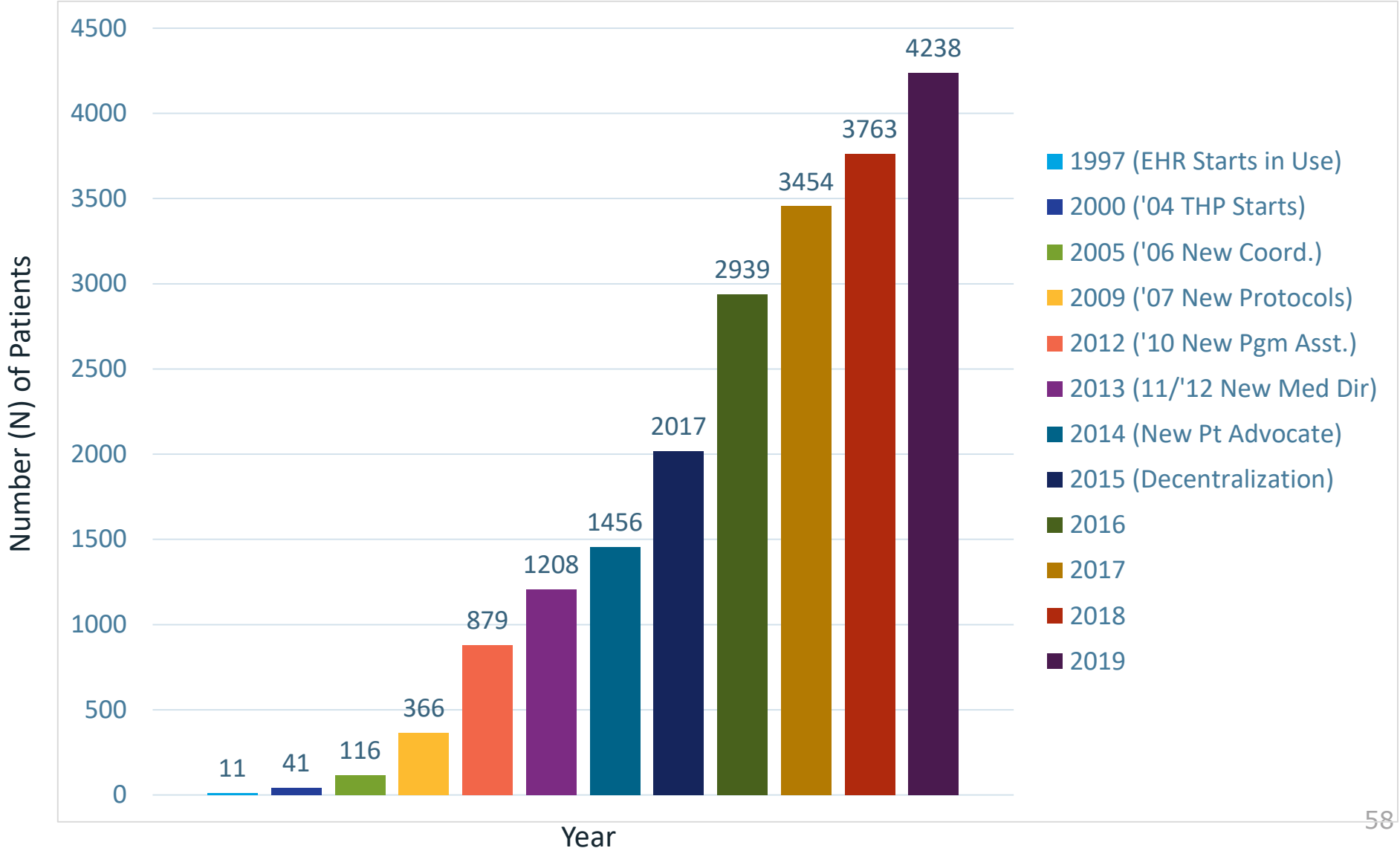
INTRODUCTION

Transgender people have an assigned sex at birth that differs from their current gender identity or expression.[1] 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 changes 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.

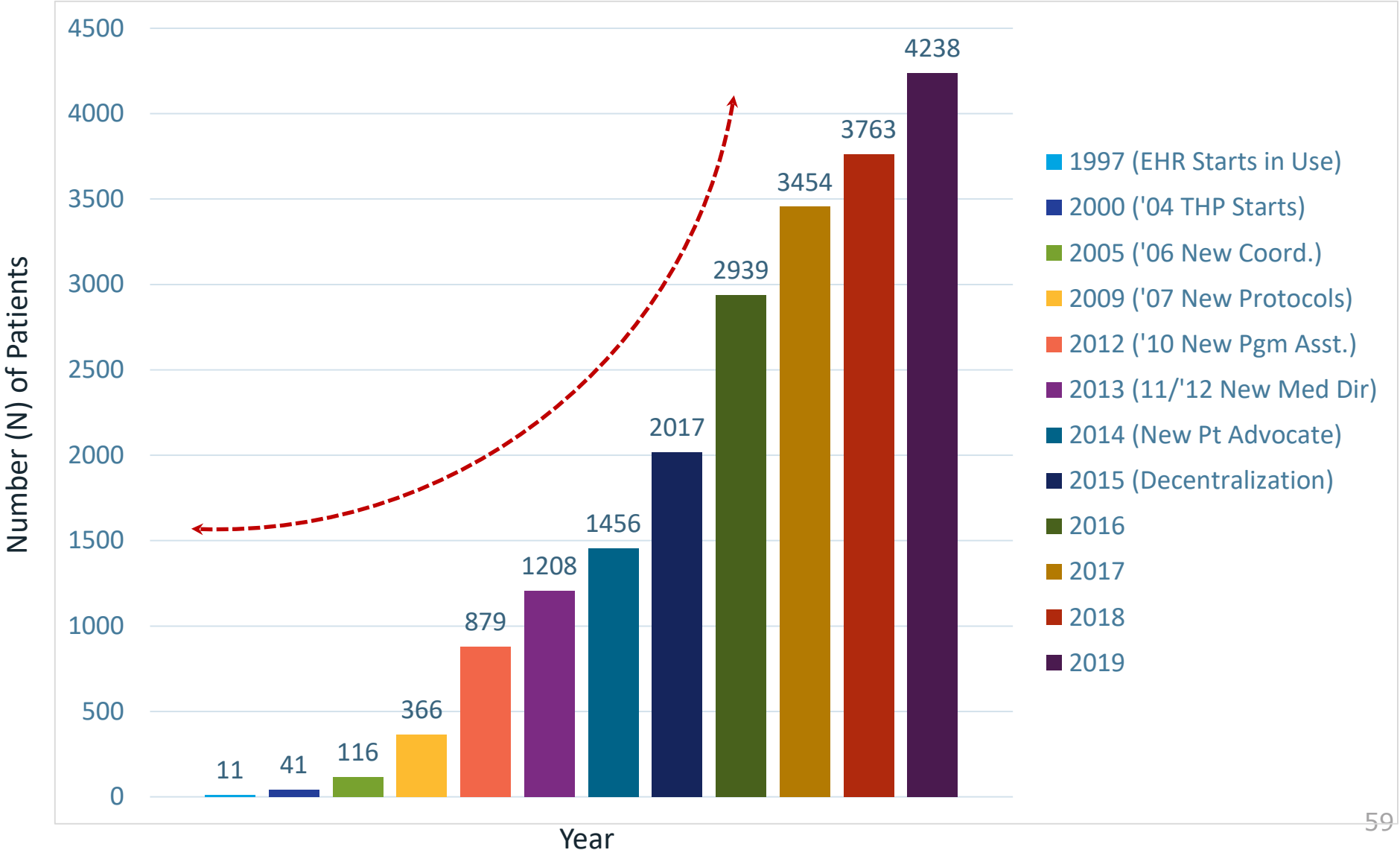
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4456472

http://fenwayhealth.org/the-fenway-institute/

Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2019



Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2019



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

OPEN

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).

Key Words: HIV, transgender, prevention, models of clinical care, health inequities

(*J 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, The Fenway Institute, Fenway Health, Boston, MA; †Callen-Lorde Community Health Center, New York,

OVERVIEW

Despite the disproportionate burden of HIV infection facing transgender communities, particularly for transgender feminine spectrum people worldwide,[1] transgender individuals continue to represent an underserved, highly stigmatized, and under-resourced population in both general clinical care and HIV prevention services. The aim of this article is to describe and present a model of gender-affirmative and integrated clinical care and community research for transgender people to address and intervene on disparities in HIV infection. To do this, we first define terminology pertaining to transgender people, briefly review the epidemiology of HIV infection and risks in transgender communities, describe exemplar models of gender-affirmative clinical care for transgender people in Boston MA, New York, NY, and San Francisco, CA, and offer suggested "best practices" for integrating clinical care and research in trans health. It is our assertion that any holistic HIV prevention intervention for transgender people will need to address clinical issues and integrate primary concerns of transgender people (eg, gender-affirmative care, management of gender transition, and medical gender affirmation) alongside delivery of HIV-related services (biobehavioral prevention, 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.

TERMINOLOGY

Transgender and *gender nonconforming* people (*trans* or *gender minority*) have a gender identity or expression that differs from their assigned sex at birth.[2] Trans people are a diverse group. There is varied terminology used to describe gender minority people in different geographic and cultural contexts and settings; language and terms also continuously

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AMA Journal of Ethics. November 2016, Volume 18, Number 11: 1098-1106.
doi: 10.1001/journalofethics.2016.18.11.stas1-1611.

STATE OF THE ART AND SCIENCE

What's in a Guideline? Developing Collaborative and Sound Research Designs that Substantiate Best Practice Recommendations for Transgender Health Care

Madeline B. Deutsch, MD, MPH, Asa Radix, MD, MPH, and Sari Reisner, ScD

Abstract

Transgender medicine presents a particular challenge for the development of evidence-based guidelines, due to limitations in the available body of evidence as well as the exclusion of gender identity data from most public health surveillance activities. The guidelines that have been published are often based on expert opinion, small studies, and data gathered outside the US. The existence of guidelines, however, helps legitimate the need for gender-affirming medical and surgical interventions. Research conducted on transgender populations should be grounded in gender-affirming methodologies and focus on key areas such as health outcomes after gender-affirming interventions.

Introduction

The past three decades have seen exponential growth in the range and depth of evidence-based guidelines in a broad range of medical disciplines [1]. The term "evidence-based medicine" first appeared in a brief article published in 1992 in the *Journal of the American Medical Association* (*JAMA*) by the Evidence-Based Medicine Working Group [2].

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Participatory Population Perspective

Work "with" not "on" transgender communities

Lesotho: standing up for transgender health and rights

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 at the People's Matrix Association 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.

Photo courtesy of Tampose Mothopeng

Tampose Mothopeng

Tampose Mothopeng is the Director of the People's Matrix Association (Matrix Support Group) in Lesotho, an organisation specialising in civic education, health care, human rights, policy advocacy, research, women's issues, and youth empowerment. During his time at the People's Matrix Association (Matrix Support Group), he has organised strategies to meet the health needs of transgender and non-conforming individuals and responded directly to the health needs of gay and bisexual men through newly developed programmes. Additionally, he has participated in programmes to address LGBT and gender-based violence and develop LGBT youth art and advocacy networks.

South Africa: access to gender-affirming health care

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, institutionalised 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 life 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.

The social context also presents challenges. A Transilience study on violence against transgender women in South Africa showed that 85% of trans women have experienced violence in one way or the other, and the picture is worse for trans women of colour. Another problem for many communities of colour is ritual circumcision. This practice is fraught with gendered implications, since the ritual represents becoming a man, which directly conflicts with the feminine identities of transgender women. However, to reject this tradition often means rejection from families, financial ruin, homelessness, and health risks.

Photo courtesy of L Leigh Ann van der Merwe

L Leigh Ann van der Merwe

L Leigh Ann van der Merwe is the Coordinator and Founder of S.H.E (Social, Health and Empowerment Feminist Collective of Transgender And Intersex Women of Africa). Leigh Ann was born in Ugie, Eastern Cape of South Africa. 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 organisations, and has presented and consulted extensively on transgender women's issues. She was also a fellow in the Open Society/Austrian American Foundation/Transgender Centre of Excellence programme.

Reisner, Keatley, Baral, et al., Lancet, 2016

Barriers and Facilitators to Research Participation

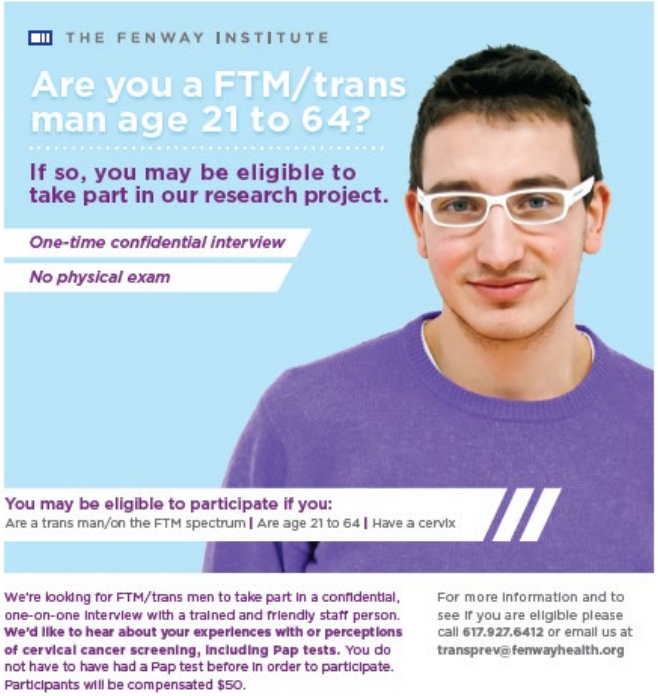
- Social and economic vulnerabilities shape HIV research participation for transgender women
- 5 online focus groups (n=41) from Aug 2017-Jan 2018
  - 4 English, 1 Spanish
  - Atlanta, Baltimore, Miami, New York City, Washington DC

Barriers	Facilitators
• Limited opportunities • Mistrust • Fear of mistreatment • Safety and confidentiality • Competing priorities • HIV stigma	• Peer involvement/ engagement • Monetary incentives • Non-monetary incentives • Flexibility and choices • Multiple modalities/ methods • Transcenteredness

Reisner, Chaudhry, Cooney, et al., BMJ Open, 2020

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, Potter, Am J Prev Med, 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

pcori

Trans Masculine Sexual Health Collaborative

PI: Reisner

- Cavanaugh
- Deutsch
- Potter
- Peitzmeier

http://www.transmaschealth.org

Reisner, Deutsch, Peitzmeier, et al., PLOS One, 2017

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%

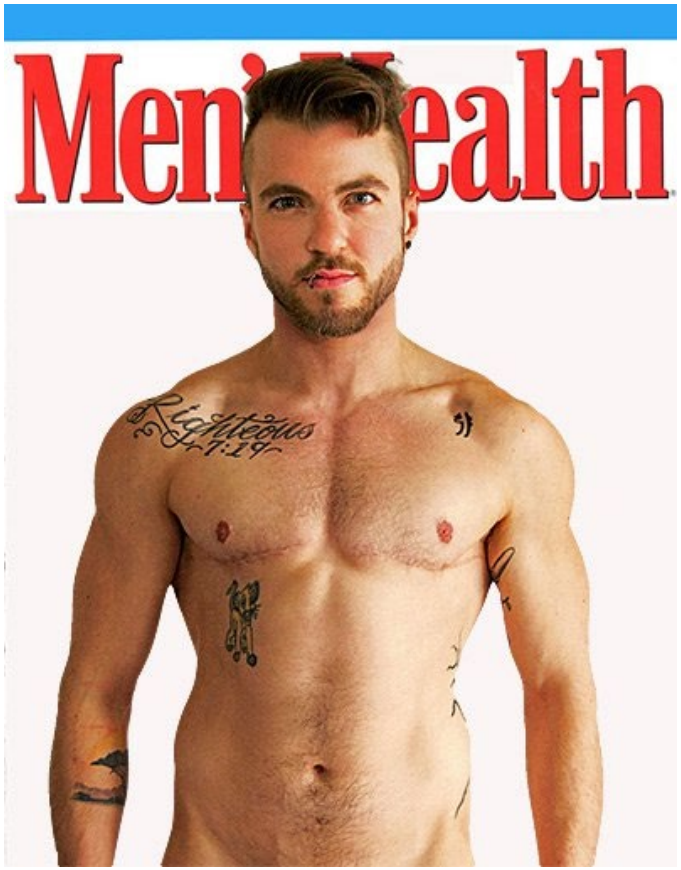
Results: Qualitative Interviews

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."

Take-Home

- Empowerment
- Voice
- Choice
- “With” not “on” communities



Reisner SL, Deutsch MB, Peitzmeier SM, White Hughto JM, Cavanaugh T, Pardee DJ, McLean S, Marrow EJ, Mimiaga MJ, Panther L, Gelman M, Green J, Potter J. Comparing self- and provider-collected swabbing for **HPV** DNA testing in female-to-male transgender adult patients: a mixed-methods biobehavioral study protocol. BMC Infect Dis. 2017 Jun 23;17(1):444. doi: 10.1186/s12879-017-2539-x. PMID: 28645254

Reisner SL, Deutsch MB, Peitzmeier SM, White Hughto JM, Cavanaugh TP, Pardee DJ, McLean SA, Panther LA, Gelman M, Mimiaga MJ, Potter JE. Test performance and acceptability of self- versus provider-collected swabs for high-risk **HPV** DNA testing in female-to-male trans masculine patients. PLoS One. 2018 Mar 14;13(3):e0190172. doi: 10.1371/journal.pone.0190172. eCollection 2018. PMID: 29538411

Summary, Gaps, and Opportunities

- Gender diversity ≠ pathology
- Gender affirmation is a key determinant of health
- Transgender people have worse health than cisgender people for many indicators
- Need data about the health of nonbinary people
- Biopsychosocial factors influence health
- Intersectionality
- Identify risks and resiliencies
- Gender affirming and socially contextualized approaches to healthcare

“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.
Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, Holland CE, Max R, Baral SD. Lancet. 2016; 388(10042):412-436. pii: S0140-6736(16)00684-X. doi: 10.1016/S0140-6736(16)00684-X.

THE LANCET

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

Contact:
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