

Transgender Health Needs in Simcoe Muskoka

LITERATURE REVIEW

Acknowledgement

In March of 2016, the Gilbert Centre was awarded a contract by Orillia Soldiers' Memorial Hospital to examine the health needs of transgender people and families in the Simcoe Muskoka region. This project, funded by the North Simcoe Muskoka LHIN, was to:

- explore the experiences of transgender people accessing health in the region through community consultations and an online survey,
- examine accessibility to health and social services for transgender people through an organization environmental scan,
- review current literature on best practices in the provision of healthcare to people who are transgender.

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Trans Health Literature Review

This literature review has been prepared as a part of the Trans Health Project, a unique collaboration between the Gilbert Centre, Laurentian University and Orillia Soldiers' Memorial Hospital. Its purpose is to inform and support the planning and development of health care services for transgender people in North Simcoe/Muskoka. The review of the literatures is done in two parts: first, with a focus on best practices in terms of health services for transgender people and second, a more psychosocial perspective on access and barriers to health services for transgender people.

The researchers examined both domestic, continental, and international sources using the following academic databases: PubMed, Cochrane, Ebsco multidisciplinary databases, ProQuest Nursing & Allied Health, Jstor, and Social Work Abstracts. Credible grey literature was also examined that included information on current and best practise of transgender healthcare. Reference lists of articles and previously published literature reviews were also consulted to find articles of interest and relevance.

Key Terms

'Trans' is used as an umbrella term which covers the spectrum of identities and terms used to identify, transgender, transsexual, and gender non-conforming individuals. The Merriam-Webster dictionary (2015) defines transsexual as a person who strongly identifies with the opposite sex and may seek to live as a member of this sex especially by undergoing surgery and hormone therapy to obtain the necessary physical appearance (as by changing the external sex organs, whereas transgender is defined as, relating to, or being a person (as a transsexual or transvestite) who identifies with or expresses a gender identity that differs from the one which corresponds to the persons sex at birth. In the case of the former, physical changes are hormonally or surgically induced, and in the latter, they may also take place, however not all transgender individuals seek to change their physical body. It is important to note that these definitions and identities are individualized, and should not be used as labels. These identities should not be imposed upon a trans individual, but rather discussed with and identified by the individual themselves. For the purposes of this review the term "trans" and "transgender" will be used interchangeably. When the literature refers more broadly to sexual minority and gender minority groups together, the term LGBTQ+ is used to reflect the dynamic and fluid nature of identities when referring these communities.

Review of the Literatures

In general, LGBTQ+ health care needs and challenges are often tied together as a result of their common experiences of stigma and discrimination as sexual and gender minorities. The experience of LGBTQ+ individuals may be intensified by intersectionality and multi-minority status (Fenway Institute, 2011b; Minnesota Evidence-based Practice Center, 2016; Bowleg, Huang, Brooks, Black, Burkholder, 2003). It is important for primary care physicians to recognize the diversity that exists within the transgender communities as it impacts on access to and quality of health care delivery. The intersectionality of social identities also has the potential to leave clinicians with "incomplete information about the health status and specific health needs of each distinct group" (Davidson, 2015, p.40). Health care providers should therefore avoid the notion of "transgender health" as a narrow concept, but as one with an added level of complexity and a need for education (Feldman & Goldberg, 2006a).

Difficulties in determining ‘best practice’ often stem from the wide scope of individual experiences and the complex health needs of trans individuals, however there are practices which have shown to be beneficial in providing appropriate and culturally appropriate/sensitive care. “Research in transgender health is still in its early days, and there are widely diverging clinical (and consumer) opinions about ‘best’ practice” (Dahl, Feldman, Goldberg, & Jaber, 2006, p. 2). The lived experiences of trans individuals are not universal, and like any community or demographic of people, often involve various differences in social, psychological, physical, and economic attributes which affect both individual health and access to medical care. A growing body of literature, guidelines, and protocols specific to transgender health care have been developed to provide clinical guidance and knowledge for health care professionals to support and maximize the overall health, psychological well-being, and self-fulfillment of trans clients.

The World Professional Association for Transgender Health (WPATH) is recognized as one of the leaders in transgender knowledge and research. WPATH’s *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People (SOC7)* (2011) provides physicians and other health care professionals clinical guidance when providing care to trans individuals. The SOC7 (seventh edition) reflects revisions based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health challenges that can arise for trans people. Many challenges are now identified that go beyond the previously focused on hormone therapy and transformative surgery options (Coleman, 2009a, b, c, d).

Other resources and agencies are also available for clinical guidance: ‘Guidelines and Protocols For Hormone Therapy and Primary Health Care for Trans Clients’ created by Sherbourne Health Centre (Toronto) and Rainbow Health Ontario; materials provided by The Center of Excellence for Transgender Health (University of California, San Francisco) and The Fenway Community Health Model from the Fenway Institute (Boston, MA). As well the TransPULSE project in Ontario, which has produced many articles from data collected within the Ontario transgender population (Bourns, 2015; Deutsch, 2016; Fenway Institute, 2011a,b; TransPULSE, 2010). These agencies and their manuals provide best practice guidelines that can aid practitioners with transgender care. They are readily available to be reviewed, and can assist in providing flexible parameters for care and treatment of trans patients.

Primary medical care needs of transgender individuals

Transgender Primary Medical Care, by Feldman and Goldberg (2006a), details the primary medical needs of transgender individuals, and should be reviewed for detailed medical interventions and information that has not been included in this review.

Physical health.

“As defined by the World Health Organization, primary health care includes a broad range of social, educational, and political interventions beyond the scope of the family physician or nurse practitioner” (Feldman & Goldberg, 2006b, p.3-4). Healthcare for trans individuals is not only specific to hormone replacement and sexual reassignment surgeries, but also covers the full range of primary health care needs that a cisgender individual may also require such as regular check-ups and treatment of general health concerns and ailments. “Primary care providers do not have to be experts in transgender medicine to meet the needs of most transgender patients. With appropriate understanding of basic transgender issues and a little experience, non-expert primary care providers can offer “health maintenance, acute illness and

chronic disease management”, and referrals to specialists” (Feldman & Goldberg, 2006b, p. 1). In a Boston needs assessment, “...participants agreed that quality health care hinged on providers’ willingness to listen, learn, and allocate time to discuss condition and issues unique to transgender/transsexual people” (Sperber, Landers, Lawrence, 2005, p. 83). It is also important to note that although many specialized service organizations such as AIDS service organizations (ASOs) have developed programming to assist in the psychosocial care of transgender and LGBTQ+ individuals, this type of segregation from the mainstream healthcare system can create further barriers for transgender individuals. “Although many of the ideas for treating the LGBTQ+ population will likely come from the well-developed specialty care, using a segregated or supplementary system of care should be a patient-elected decision, not one driven either by stigma or the mainstream systems’ lack of skill” (Minnesota Evidence-based Practice Center, 2016, p. 45).

Current data collection by primary care physicians does not regularly include information on an individual’s sexual orientation or gender identity (SO/GI), resulting in research invisibility and contributing to a lack of understanding of care needs within the LGBTQ+ population (Fenway Institute, 2011; Burkhalter et al., 2016). “This invisibility masks disparities and impedes the provision of important healthcare services for LGBTQ+ individuals, such as appropriate preventative screenings, assessments of risk for sexually transmitted infections and HIV, and effective intervention for behavioural health concerns that may be related to experiences of anti-LGBTQ+ stigma” (Fenway Institute, 2011a, p. 1). Forms should be altered to reflect this data collection, in order to gain a better understanding of clients’ potential barriers to care, as well as determine the best practice for the care required. It is essential for patient-centered care to LGBTQ+ individuals that collection of such information is obtained and entered into a patient’s records, and has also been recommended by both the Institute of Medicine (Fenway Institute, 2011). The Fenway Institute has implemented a program called the National LGBTQ Health Education Center, which has released a document called “Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records: Taking the Next Steps” (National LGBTQ Health Education Centre, 2016) details the importance of this collection, as well as a list of questions, and potential methods for collection. It is also important to note that staff who are collecting this SO/GI information are first trained in effective communication strategies, as well as privacy and confidentiality (National LGBTQ+ Health Education Center, 2016). Training is available from the National LGBTQ Health Education Center at www.LGBTQhealtheducationcenter.org (National LGBTQ Health Education Center, 2016).

Physical examination.

Physical examinations can be uncomfortable and even traumatizing for transgender individuals. This may also be exacerbated in patients who are experiencing gender dysphoria or a general disconnection with their physical bodies (Wesp, 2016). It is important to discuss any physical exam with the client prior to examination, and use a gender affirming approach while conducting any type of physical examination (Wesp, 2016). “Physical examination should be relevant to the anatomy that is present, regardless of gender presentation, and without assumptions as to anatomy or identity” (Wesp, 2016, para. 1). The Center of Excellence for Transgender Health suggests specific guidelines and best practices when physically examining trans patients. It is important to talk with the patient prior to any examination, as well as during, explaining “each step in a clear [and] direct way throughout... [and] avoid using medical terms for body parts, unless discussed beforehand that these are preferred terms the patient would like

you to use...a positive experience may lead to the patient considering further examinations in the future” (Wesp, 2016, para. 6).

History of feminizing or masculinizing interventions.

In order for primary care physicians to accurately recognize signs and symptoms of ailments transgender patients present with, it is important to know their history with feminizing or masculinizing interventions (if any); including hormones use (both prescribed and non-prescription), as well as any physical body alterations including top or bottom surgery, in order to properly interpret lab results from any tests performed (Feldman & Goldberg, 2006a). Not all transgender individuals get, or want, hormonal or surgical alterations to their physical bodies, but rather transition socially without any physical alterations to their bodies (Feldman & Goldberg 2006c). Attaining this accurate health history is not as straightforward as it may appear, as many transgender individuals do not disclose their status to their healthcare practitioner out of fear of being discriminated against or pathologized as such. “Safety concerns can deter disclosure” (Sperber, Landers, & Lawrence, 2005, p. 80).

Endocrine therapy

Although not without risks, the use of hormone therapy can be highly beneficial to transgender clients. Endocrine therapy is beneficial to the patient in more ways than just physical bodily changes; it has the potential to significantly benefit mental health and quality of life by affirming their gender identity and decreasing the level of gender dysphoria experienced (Feldman & Goldberg, 2006c). It is important to note that hormone therapy is an individual choice, and not all transgender individuals feel the need to introduce hormones to confirm their identity or felt gender. “Given the spectrum of gender identity and the variation in each person’s expression of this identity, it follows that there is no single pathway for a trans person to follow in order to actualize the expression of their authentic self” (Bourns, 2015, p. 4). “The health care provider’s role in assessing a client’s eligibility and readiness for hormone therapy can create an unfortunate dynamic with the provider positioned as the ‘gatekeeper’ to treatment. In response to this, a number of community health centres in the US have implemented what has become known as the ‘informed consent model’ for hormone provision” (Bourns, 2015, p. 4). Currently WPATH, along with Rainbow Health Ontario, Fenway Health, and the Center of Excellence for Transgender Health all recommend the informed consent model for the introduction of endocrine therapy.

WPATH’s criteria for hormone therapy include: “1. Persistent, well-documented gender dysphoria; 2. Capacity to make fully informed decision and to consent for treatment; 3. Age of majority in a given country (if younger, follow the SOC outlined in section VI); and 4. If significant medical or mental health concerns are present, they must be reasonably well-controlled” (Coleman et. al. 2001, p. 23). Risks associated with endocrine therapy are dependent upon several factors including if the hormonal therapy is feminizing or masculinizing, the medical history of the patient, current medications, and the dosage prescribed, the type of hormone prescribed, as well as behavioural factors such as smoking or substance use (Coleman et. al. 2001). The literature describes many, but not necessarily all, risks to monitor or mitigate. The literature is clear to suggest that lab tests should be ordered regularly to monitor any and all physical changes to maintain healthy ranges. Rainbow Health Ontario has produced a set of guidelines and protocols for providing hormone therapy to patients entitled *Guidelines and Protocols for Hormone Therapy and Primary Health Care for Trans Clients* which was

developed in collaboration with trans community members (Bourns, 2015). The Center of Excellence for Transgender Health at the University of California, San Francisco provides online primary care protocols for transgender patient care. *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia* by Jamie L. Feldman and Joshua Goldberg (year) offers evidence-based guidelines for many transgender health concerns.

It is worth noting specifically here that CAMH, in an open letter to family physicians, encouraged physicians to conduct their own assessments for hormone therapy. They refer specifically to guidance from the WPATH SOC7 as well as the Sherbourne Guidelines & Protocols for Comprehensive Primary Care for Trans Clients (2005). As noted, several sources note the Informed Consent Model approach to hormone therapy as a best practice (for a comprehensive explanation, see the SOC7).

General Primary Prevention Screening and Health-Risk Management

Substance use.

“The LGBTQ+ community is 50-200% more likely to be addicted to smoking than the general public” (National LGBTQ Tobacco Control Network, 2016, p. 1). The transgender community has generally been grouped under the LGBTQ+ umbrella in many studies, and it is hard to determine the percentage of individuals who use or abuse substances due to this, however Lee and colleagues found “an elevated prevalence of smoking among sexual minorities” (Lim, Brown, & Kim, 2014, p. 28). “High rates of alcohol and substance abuse have been identified as a major concern among transgender people in studies conducted in US. Marijuana, crack cocaine, and alcohol have been found to be the most commonly used drugs...[and] access to treatment services for substance abuse can be very difficult for transgender people who need them” (US Department of Health and Human Services, 2010, p. 7). The use of substances is often self-medication to mediate the negative mental health effects experienced by this population as a result of discrimination, stigma, and experiences of trauma. “Living with social stigma and its effects (discrimination, harassment, and violence) creates emotional and physical stress, and like many gay, lesbian, and bisexual people, many transgender people smoke to reduce that stress” (US Department of Health and Human Services, 2010, p. 7). The use of substances can cause health issues when combined with hormone therapies. “In transgender women who take estrogen, smoking greatly increases the chances for blood clots, similar to the risks faced by non-transgender women who smoke and take oral contraception or hormone replacement therapy (HRT). Transgender men who take testosterone increase their risk of heart disease, and smoking increases that cardiovascular risk. Smoking also likely complicates the treatment of HIV-positive transgender people” (US Department of Health and Human Services, 2010 p. 7). The literatures suggest access to services that provide help using a harm reduction approach and access to smoking cessation program would increase positive health outcomes.

Surgical Intervention

Although recognized as a specialized area of care, gender confirming surgery involves the active and proactive support general care practitioners. The “Recommendations Regarding Access to Gender Confirming Surgeries in Ontario” report prepared by Rainbow Health Ontario and the Sherbourne Health Centre (2015) provide context and practical resources, such as sample consent forms for treatments and trans health care assessment/screening forms.

Sexual health.

“Globally, the chance of acquiring HIV is 49 times higher for transgender women than all adults of reproductive age” (UNAIDS, 2014, p. 3). The TransPULSE project found an HIV prevalence of 0.6 per cent in FTM and 3 per cent in MTF in Canada. The researchers noted that although these numbers are much lower than the international HIV prevalence, they are still higher than the national average” (Davidson, 2015, p. 43). Also, within the TransPULSE study it was noted that 46 per cent of respondents had never been tested for HIV, which could also have an impact on the percentage of trans individuals testing positive (Davidson, 2015). “The high rate of HIV infection may be an indicator of broader difficulties that trans people face in accessing health care” (Sperber, Landers, Lawrence, 2005, p. 77). “The compounding impact of stress in many trans people’s lives can have a cumulative effect on mental health, self-esteem and self-worth. Some struggle with depression and anxiety and may use substances to cope. This in turn can impact trans people’s ability to protect themselves during sexual encounters, heightening their vulnerability to HIV and other sexually transmitted infections” (Bauer, 2007, p. 8).

Education among those in high-risk populations, as well as of medical professionals and community practitioners that work with high risk populations, has a significant impact on removal of barriers to testing and decreasing stigma and discrimination through knowledge transmission. “A literature review of 16 studies exploring the attitudes of nursing students toward people with HIV infection or AIDS found that many students have negative attitudes about these populations, have some degree of homophobia, and harbor a fear of contagion...It stands to reason that a broader education that includes evidence-based knowledge about LGBTQ health issues and instruction in cultural competence could help dispel such attitudes” (Lim, Broun & Kim, 2014, p.25).

The Center for Excellence in Transgender Health in partnership with University of California, San Francisco has created a Capacity Building Assistance Partnership to improve testing and prevention with high-risk HIV-negative individuals (University of California, San Francisco 2016; Deutsh, 2016). The highest risk population is transgender women, specifically trans women of colour (University of California, 2016; Davidson, 2015; US Department of Health and Human Services, 2010; UNAIDS 2014; Sperber, Landers, & Lawrence, 2005). The program entitled Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color is highly recommended (University of California, 2016). Further information on this program can be located here: <http://transhealth.ucsf.edu/trans?page=programs-tetac>.

Mental health.

“Other health burdens that disproportionately affect transgender people include victimization, mental health issues, and suicide, further underscoring the need to develop outreach and community health programs for this largely underserved group” (Lim, Brown, & Kim, 2014, p. 27). Along with being more likely to be unemployed, there are also high rates of physical and sexual violence perpetrated against transgender individuals (US Department of Health and Human Services, 2010). “In 10 studies, 16-60 percent of transgender people were survivors of physical assault or abuse, and 13-66 percent were survivors of sexual assault” (US Department of Health and Human Services, 2010, p. 4). This statistic has ramifications within the healthcare system, as individuals may not seek care for fear of being discriminated against, or

further traumatized within the healthcare setting, which contributes to poorer health outcomes. “Social stigmatization and a distrust of the criminal justice system often result in the under-reporting of acts of violence committed against transgender people” (US Department of Health and Human Services, 2010, p. 5).

Transgender individuals are often subject to high levels stigma, discrimination, and structural violence (for example, public harassment), which has a direct impact on their mental health. “Access to mental health care is very problematic for transgender people. Barriers include: lack of insurance; discrimination-induced poverty; mental health provider insensitivity and hostility; and lack of therapists experienced in working with transgender clients” (US Department of Health and Human Services, 2010, p. 5; Feldman, Goldberg, 2006; MacFarlane, 2015). National studies in the US have found rates of mental illnesses such as anxiety and depression to be disproportionately higher among trans populations than national averages (Davidson, 2015, p. 43). “The majority of transgendered individuals suffer from at least one mental illness, the most common being anxiety and/or perceived stress (52%), depression (43%), and adjustment disorder (26%) with regular alcohol use also being common (65%)” (Davidson, 2015, p. 43). Financial barriers, combined with a lack of qualified and knowledgeable mental health professionals, has created a situation where an entire community of people are generally unable to obtain the care necessary for improved mental health (MacFarlane, 2015). These barriers to mental health care further exacerbate the problems experienced by transgender individuals, and likely contribute to the high rates of suicide ideation and behaviours, as transgender individuals may feel as though they are excluded from access to sensitive informed care (Macfarlane, 2015). Best practices specific to mental health interventions were not researched for this literature review.

Suicide attempts and ideation.

Suicide attempts and suicidal ideation have been discussed at length in previously published reviews (for example, see MacFarlane, 2015). High rates of suicide attempts and ideation have been reported within this population, and are likely underreported (MacFarlane, 2015). “In Canada, the TransPULSE project has estimated that 36% of transgendered Ontarians had suicidal thoughts over the past year, and that 10% had attempted suicide in that time” (Davidson, 2015, p. 43), furthermore it was, “found that across the lifespan that number increased to 77%.”(MacFarlane, 2015, p.8) Barriers to accessing appropriate care have an impact on suicide attempts and ideation; “recent longitudinal studies demonstrate reductions in psychological distress following medical transition” (Bauer, Scheim, Pyne, Travers, & Hammond, 2014, p.2). “From the perspective of service provision, a very important finding of the TransPULSE project was that the people most at risk of past-year suicide attempts were people who were planning but had not yet begun a medical transition, followed by people who were in the process of medically transitioning (MacFarlane, 2015, p. 9). Best practices specific to mental health interventions for suicidal ideation and behaviour were not conducted for this literature review, higher this information speaks to the need for vigilant screening processes and support overall and during the transition process specifically.

Barriers, Risks and the Impacts of Access to Surgical Care

Insurance coverage.

“Transgender people are less likely than lesbians, gay men, bisexuals, and heterosexuals to have [extended] health insurance and that may influence this groups usage of health care services” (Lim, Brown, & Kim, 2014, p. 27). Extended health/private health insurance companies do not always overtly deny coverage because of an individual’s transgender status, and instead create policies that create barriers to necessary care. “Coverage denials can extend to even basic health care services unrelated to sex reassignment. For example, transgender men who have a lifelong need for ongoing gynecological care find their insurance policies will not cover it after they transition to male” (US Department of Health and Human Services, 2010, p.2). Insurance exclusions for trans- related care, including the provision of hormonal therapy, increases the amount of self-medication that occurs, which in turn can create further health issues due to unmonitored dosage and type of hormones utilized (TransPULSE, 2010; US Department of Health and Human Services, 2010).

Medically necessary vs. cosmetic procedures

“WPATH has declared sex reassignment surgeries to be medically necessary and not ‘cosmetic’ or ‘elective’ or ‘experimental,’ ” (US Department of Health and Human Services (2010) p.3). It is the position of several research studies that all surgical and non-surgical interventions that improve gender alignment be considered medically necessary, as they not only improve the mental health and quality of life for the patient, but also may increase the patient’s ability to “pass” in their true gender identity and therefore experience less harassment, discrimination, and potentially less public violence. In the Canadian context, there are significant discrepancies between provinces as to what type of care is provided as publically funded and medically necessary. Information on private insurance coverage in Canada was not researched for this review, but may have an impact on the lives of many trans individuals who do not have the financial capacity to pay for the required care out-of-pocket.

Publicly funded services and the matter of private health insurance.

Across Canada the provision of publically funded care varies from province to province in regards to transgender care and surgeries. The Canadian Professional Association for Transgender Health (CPATH), in partnership with United Food and Commercial Workers Canada (UFCW Canada) conducted research to assess the current landscape of transition-related funding in Canada (United Food and Commercial Workers Canada in collaboration with the Canadian Professional Association for Transgender Health, 2016). They found that no coverage is provided in Canada for facial feminization, tracheal shaving, and laser hair removal, and that only one privately run clinic located in Montreal Quebec offers bottom surgery (United Food and Commercial Workers Canada in collaboration with the Canadian Professional Association for Transgender Health, 2016). Such interventions should be considered necessary as they can facilitate increased congruence between the desired physical presentation and the felt gender, decrease gender dysphoria, and improve outcomes (Feldman & Goldberg, 2006b). A detailed poster which outlines all publically funded transition related care in Canada can be found at http://www.ufcw.ca/templates/ufcwcanada/images/media/posters/Publicly_Funded_Transition_Posters/Publicly-funded-transition-related-medical-care-in-Canada-11x17-EN . The lack of clinics that provide necessary surgeries creates a barrier for trans individuals who do not have the

financial ability to travel such a distance, as well as cover the cost of recuperation and recovery. Several provinces (including Ontario, British Columbia, Saskatchewan, and Newfoundland) offer conditional funding for surgeries provided outside of Canada (United Food and Commercial Workers Canada in collaboration with the Canadian Professional Association for Transgender Health, 2016).

In Ontario, the requirements for transition related surgeries has recently changed as of March 1, 2016 (Ontario Ministry of Health and Long-Term Care, 2016). Previously, approval from The Centre for Addiction and Mental Health (CAMH) was required to receive such procedures, however “Ontario is expanding access to referrals for medically necessary sex reassignment surgery” (Ontario Ministry of Health and Long-Term Care, 2016). Navigating the system of trans related healthcare services can be challenging and confusing for trans clients, who often have to jump through several hoops attaining required documentation and waiting on lengthy waitlists to receive the care they are seeking.

In order for OHIP to provide partial or full coverage for sex reassignment surgeries, prior approval is required from the Ontario Ministry of Health and Long-Term Care (MOHLTC). This MOHLTC approval must be requested by their primary care physician and serves as an example of the gatekeeper function inherent in the healthcare system. Once approval has been obtained, OHIP coverage can include reproductive and external genital surgery, including clitoral release, glansplasty, metoidioplasty, penectomy, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, vaginoplasty, salpingo-oophorectomy, hysterectomy, orchidectomy, mastectomy, and augmentation mammoplasty for the purpose of sex reassignment surgery is also insured for individuals with no breast enlargement following 12 continuous months of hormone therapy (retrieved from Ontario Ministry of Health and Long-Term Care, 2016).

Even more detrimental to access to care is the lack of available options for trans related surgeries. In Canada there is only one clinic—privately run and in Montreal—that offers gender reassignment surgery or ‘bottom surgery’. The prohibitive costs and significant waitlist for such procedures create further barriers to the care and intervention that is required.

Education gaps

“Education must be utilized in order to instruct policy makers, health practitioners, teachers and the general public to help reduce stigma towards transgendered people” (Davidson, 2015, p. 44). Few medical programs have implemented extensive training that cover transgender health. “A recent survey of 132 American and Canadian medical schools found that on average, just seven hours during the entire preclinical and clinical curricula were dedicated to such topics” (Lim, Brown & Kim, 2014, p. 26). The TransPULSE project found that health care providers have very little knowledge about trans health, often resulting in patients having to educate their practitioner, which in turn does not provide quality or informed care to the client (TransPULSE, 2010; Lim, Brown, & Kim, 2014, p. 27) and often results in significant gaps in the continuity of care. “Many studies have recommended the provision of cultural competency trainings for both professional and administrative staff as a means of reducing this barrier to accessing care” (US Department of Health and Human Services 2010, p. 1). Systemic barriers exist that “include institutionalized transphobia where trans people are treated as if they are mentally ill. Service providers in general were ill-informed about trans people and their specific needs, and some even

refused care to trans clients” (Bauer et. al. 2007, p8.). Requiring a minimum level of basic training and education on trans health needs and provision, and providing opportunities for improved training and education, is a best practice noted in almost all of the literatures reviewed.

Stigma & Discrimination as Barriers to Care

Discrimination is a major barrier for trans clients in accessing and receiving quality health care. “Health care providers often held serious misconceptions about trans people, or confused trans and gay identities” (Bauer, Travers, Hammond, Boyce, Anderson, 2007, p.8). The Canadian Psychological Association released a policy and position statement in 2010 which “affirms that all adolescent and adult persons have the right to define their own gender identity regardless of chromosomal sex, genitalia, assigned birth sex, or initial gender role. Moreover, all adolescent and adult persons have the right to free expression of their self-defined gender expression” (Canadian Psychological Association, 2016, para. 10). “Changes are needed at the sociopolitical level to provide the optimal medical interventions” (Davidson, 2015, p 43). Political intervention is beyond the scope of this review, however policy changes at the federal, and provincial level, as well as within education curriculums and institutional policies within hospitals, could be beneficial in improving trans health inequity. Although changes have been made to the diagnostic categories of the DSM—from Gender Identity Disorder (GID) to Gender Dysphoria (GD), which no longer identifies it as a pathological condition— “the classification continues to stigmatize transgender people with a ‘mental disorder’ classification that is dependent on clinically significant distress or impairment” (Davidson, 2015, p. 43). Practitioners who believe that their trans clients are suffering from a mental disorder may treat a condition, rather than a person, which can further stigmatize the patient, creating a distorted and ineffective working alliance between client and practitioner. Discrimination towards trans individuals has been shown to correlate with negative health consequences, both mentally and physically (Shaw & Wang, 2013). Promoting inclusive patient care that provides an accepting and open facility which uses inclusive language and seeks to normalize the disclosure of sexual orientation and gender identity is imperative in order to improve the health care received by trans individuals (Lim, Brown, & Kim, 2014).

Project VOICE was conducted by the Fenway Institute with a primary goal “to better understand the relationship between public accommodations discrimination and health consequences among transgender and gender nonconforming adults in Massachusetts” (Shaw & Wang, 2013, p.1-2). The study found that 24% of respondents had experiences discrimination within a health care setting within the past year. As well trans individuals who had experienced discrimination were 30 per cent more likely to report negative emotional symptoms (Shaw & Wang, 2013). “Public accommodations discrimination was especially detrimental to health outcomes when it occurred in a healthcare setting” (Shaw & Wang, 2013, p.2). Discrimination within the healthcare setting directly affected not only the care received, but also caused delays or avoidance of care altogether by trans individuals (Davidson, 2015; Shaw & Wang, 2013). It is important for care providers to create a space that is respectful and safe, and makes culturally appropriate care a priority, in order for clients to be open and honest about their health care needs (Deutsch, 2016a; Melendez, Pinto, 2009; Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011), which is critical to an effective health care interview and assessment.

Access to care is not only restricted by experiences of stigma and discrimination, but also by a lack of available trained health professionals, making obtaining care difficult for those who

do not live in urban or metropolitan centres. Trans-inclusive providers in Ontario were found to be “generally confined to Toronto and Ottawa, [and] was repeatedly cited as a problem limiting the portability of their lives and uprooting them from the social supports in their home communities” (Bauer et al., 2007, p.8). The expansion of trans-centred service provision is vital for the population of transgender individuals who are unable to travel and live outside of highly populated urban centres. “The current studies and statistics demonstrate that transgender individuals often lack in many determinants of health impairing their physical and mental well-being” (Davidson, 2015, p. 42). Financial stability and income are often factors that determine whether a transgender individual will have the ability to access to seek care that is not provided locally, which contributes to this impairment of physical and mental well-being (TransPULSE, 2010). “Throughout the United States, a transgender person is twice as likely to be unemployed compared to their cisgender counterparts and rates of employment...considerable research has linked low socioeconomic status to poor health outcomes” (Davidson, 2015, p. 42). The social determinants of trans health should be a significant focus of the general and primary health and social services community in order to improve health outcomes.

Overall, the literatures regarding trans health needs and best practices is in an important stage of evolution, and best practices prove to be somewhat of a moving target as the research and practice knowledge makes its way to scholarly publication. What is exciting though is the leadership of Ontario trans health organizations in this regard, allowing for relative ease of access to best practice professionals and practice in our own province.

What follows is an abstract bibliography of reviewed sources for reference purposes.

Annotated References List

A

Arnold, L. M. (2001). Promoting culturally competent care for the lesbian, gay, bisexual, and transgender population: Letter to the Editor. *American Journal of Public Health, (91)*11, 1731.

ABSTRACT: The goal of improving post-sexual assault mental health care to transgender women included scientific research findings related to 1) minority stress as it relates to suicidal behaviors and patterns of health care seeking behavior 2) health care provider stigmatization and resultant health care disparity for transgender patients 3) demographics and statistics on mental health and suicide ideation, and 4) Centers for Disease Control, World Health Organization, National Survey for Transgender Persons and Healthy People 2020 guidelines and mandates for health care initiatives for LGBT population. Minority stress is identified as a significant contributing factor in the suicidal behavior of ethnic and sexual minorities who have experienced sexual violence. Although there are cultural differences in the expression of suicidal thoughts and behavior, this is not reflected in the current standard suicide risk assessment. The aim of this project is to educate and train mental health care providers on the use of the cultural assessment of risk for suicide (CARS) tool in order to improve post-assault care for transgender women. Fifteen mental health providers whose clients are transgender trauma survivors participated in pre- and post-teaching intervention surveys that focused on suicide risk assessment. The pre specified 80% improvement in learning was observed which was highly significant ($p < 0.0001$). This underscores the need for continued education and increased awareness of the needs of this marginalized and stigmatized population.

Armstrong, R. A. (2015). Examination of Using a Modified Suicide Risk Assessment and Evaluation of Staff Training in Improving Post-Assault Care of Transgender Women (doctoral dissertation). Retrieved from ProQuest Dissertations and theses.

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, (70)*9, 832-864. <http://dx.doi.org/10.1037/a0039906>

ABSTRACT: Transgender and gender nonconforming¹ (TGNC) people are those who have a gender identity that is not fully aligned with their sex assigned at birth. The existence of TGNC people has been documented in a range of historical cultures (Coleman, Colgan, & Gooren, 1992; Feinberg, 1996; Miller & Nichols, 2012; Schmidt, 2003). Current population estimates of TGNC people have ranged from 0.17 to 1,333 per 100,000 (Meier & Labuski, 2013). The Massachusetts Behavioral Risk Factor Surveillance Survey found 0.5% of the adult population aged 18 to 64 years identified as TGNC between 2009 and 2011 (Conron, Scott, Stowell, & Landers, 2012). However, population estimates likely underreport the true number of TGNC people, given difficulties in collecting comprehensive demographic information about this group (Meier

& Labuski, 2013). Within the last two decades, there has been a significant increase in research about TGNC people. This increase in knowledge, informed by the TGNC community, has resulted in the development of progressively more trans-affirmative practice across the multiple health disciplines involved in the care of TGNC people (Bockting, Knudson, & Goldberg, 2006; Coleman et al., 2012). Research has documented the extensive experiences of stigma and discrimination reported by TGNC people (Grant et al., 2011) and the mental health consequences of these experiences across the life span (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), including increased rates of depression (Fredriksen-Goldsen et al., 2014) and suicidality (Clements-Nolle, Marx, & Katz, 2006). TGNC people's lack of access to trans-affirmative mental and physical health care is a common barrier (Fredriksen-Goldsen et al., 2014; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman & D'Augelli, 2006), with TGNC people sometimes being denied care because of their gender identity (Xavier et al., 2012). In 2009, the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (TFGIGV) survey found that less than 30% of psychologist and graduate student participants reported familiarity with issues that TGNC people experience (APA TFGIGV, 2009). Psychologists and other mental health professionals who have limited training and experience in TGNC-affirmative care may cause harm to TGNC people (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012). The significant level of societal stigma and discrimination that TGNC people face, the associated mental health consequences, and psychologists' lack of familiarity with trans-affirmative care led the APA Task Force to recommend that psychological practice guidelines be developed to help psychologists maximize the effectiveness of services offered and avoid harm when working with TGNC people and their families

B

Bachmann, G., Mussman, B. (2015). The aging population: Imperative to uncouple sex and gender to establish "gender equal" health care. *Maturitas* (80)4, 421-425.

ABSTRACT: Aim: The transgender community has long been marginalized in society. As the world's population ages, gender-unbiased health services for this growing population, with age-related chronic illnesses, will be essential. To optimally eliminate hurdles that trans individuals often confront when requesting services, it appears judicious to eliminate the strict and antiquated definition of what constitutes "normal" female and "normal" male.

Results: Existing statistics indicate that unacceptable bias and discrimination are occurring, making trans patients less likely to seek care. There are emerging initiatives that address the transgender and gender non-conforming population. Ongoing needs include defining what constitutes "gender equal," understanding the continuum of gender identity, and establishing and implementing guidelines for gender equal counselling and care.

Conclusions: With the routine practice of defining sex at birth and equating sex with gender in the health care setting, the transgender patient encounters multiple barriers to accessing and acquiring health care services. These strict gender labels appear to preclude the institution of gender equal care. Care templates on gender equal patient encounters should be implemented to better address transgender health needs in a non-biased manner.

Bauer, G. R., Scheim, A. I., Deutsch, M. B., Massarella, C. (2013). Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: Results from a respondent-driven sampling survey. *Annals of Emergency Medicine*, (63)6, 713-720. <http://dx.doi.org/10.1016/j.annemergmed.2013.09.027>

ABSTRACT: Study objective: Transgender, transsexual, or transitioned (trans) people have reported avoiding medical care because of negative experiences or fear of such experiences. The extent of trans-specific negative emergency department (ED) experiences, and of ED avoidance, has not been documented.

Methods: The Trans PULSE Project conducted a survey of trans people in Ontario, Canada (n=433) in 2009 to 2010, using respondent-driven sampling, a tracked network-based method for studying hidden populations. Weighted frequencies and bootstrapped 95% confidence intervals (CIs) were estimated for the trans population in Ontario and for the subgroup (n=167) reporting ED use in their felt gender.

Results: Four hundred eight participants completed the ED experience items. Trans people were young (34% aged 16 to 24 years and only 10% >55 years); approximately half were female-to-male and half male-to-female. Medically supervised hormones were used by 37% (95% CI 30% to 46%), and 27% (95% CI 20% to 35%) had at least 1 transition-related surgery. Past-year ED need was reported by 33% (95% CI 26% to 40%) of trans Ontarians, though only 71% (95% CI 40% to 91%) of those with self-reported need indicated that they were able to obtain care. An estimated 21% (95% CI 14% to 25%) reported ever avoiding ED care because of a perception that their trans status would negatively affect such an encounter. Trans-specific negative ED experiences were reported by 52% (95% CI 34% to 72%) of users presenting in their felt gender.

Conclusion: This first exploratory analysis of ED avoidance, utilization, and experiences by trans persons documented ED avoidance and possible unmet need for emergency care among trans Ontarians. Additional research, including validation of measures, is needed.

Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 1-15. Doi: 10.1186/s12889-015-1867-2

ABSTRACT: Background: Across Europe, Canada, and the United States, 22–43 % of transgender (trans) people report a history of suicide attempts. We aimed to identify intervenable factors (related to social inclusion, transphobia, or sex/gender transition)

associated with reduced risk of past-year suicide ideation or attempt, and to quantify the potential population health impact.

Methods: The Trans PULSE respondent-driven sampling (RDS) survey collected data from trans people age 16+ in Ontario, Canada, including 380 who reported on suicide outcomes. Descriptive statistics and multivariable logistic regression models were weighted using RDS II methods. Counterfactual risk ratios and population attributable risks were estimated using model-standardized risks.

Results: Among trans Ontarians, 35.1 % (95 % CI: 27.6, 42.5) seriously considered, and 11.2 % (95 % CI: 6.0, 16.4) attempted, suicide in the past year. Social support, reduced transphobia, and having any personal identification documents changed to an appropriate sex designation were associated with large relative and absolute reductions in suicide risk, as was completing a medical transition through hormones and/or surgeries (when needed). Parental support for gender identity was associated with reduced ideation. Lower self-reported transphobia (10th versus 90th percentile) was associated with a 66 % reduction in ideation (RR = 0.34, 95 % CI: 0.17, 0.67), and an additional 76 % reduction in attempts among those with ideation (RR = 0.24; 95 % CI: 0.07, 0.82). This corresponds to potential prevention of 160 ideations per 1000 trans persons, and 200 attempts per 1,000 with ideation, based on a hypothetical reduction of transphobia from current levels to the 10th percentile.

Conclusions: Large effect sizes were observed for this controlled analysis of intervenable factors, suggesting that interventions to increase social inclusion and access to medical transition, and to reduce transphobia, have the potential to contribute to substantial reductions in the extremely high prevalences of suicide ideation and attempts within trans populations. Such interventions at the population level may require policy change.

Bauer, G. R., Travers, Hammond, R., Boyce, M., Anderson, S., for the trans PULSE Project Team. (2007). *Trans PULSE: Report on Phase I & Plans for Phases II and III*. Toronto & London, ON: Trans PULSE Project.

Bauer, G.R., Zong, X, Scheim, A. I., Hammond, R., Thind, A. (2015) Factors impacting transgender patients' discomfort with their family physicians: A respondent-driven sampling survey. *PLoS ONE* 10 (12):e0145046. doi:10.1371/journal.pone.014504

ABSTRACT: Background: Representing approximately 0.5% of the population, transgender (trans) persons in Canada depend on family physicians for both general and transition-related care. However, physicians receive little to no training on this patient population, and trans patients are often profoundly uncomfortable and may avoid health care. This study examined factors associated with patient discomfort discussing trans health issues with a family physician in Ontario, Canada.

Methods: 433 trans people age 16 and over were surveyed using respondent-driven sampling for the Trans PULSE Project; 356 had a family physician. Weighted logistic

regression models were fit to produce prevalence risk ratios (PRRs) via average marginal predictions, for transmasculine (n = 184) and transfeminine (n = 172) trans persons.

Results: Among the 83.1% (95% CI = 77.4, 88.9) of trans Ontarians who had a family physician, approximately half reported discomfort discussing trans health issues. 37.2% of transmasculine and 38.1% of transfeminine persons reported at least one trans-specific negative experience. In unadjusted analysis, sociodemographics did not predict discomfort, but those who planned to medically transition sex, but had not begun, were more likely to report discomfort (transmasculine: PRR = 2.62 (95% CI = 1.44, 4.77); transfeminine: PRR = 1.85 (95% CI = 1.08, 3.15)). Adjusted for other factors, greater perceived physician knowledge about trans issues was associated with reduced likelihood of discomfort, and previous trans-specific negative experiences with a family physician with increased discomfort. Transfeminine persons who reported three or more types of negative experiences were 2.26 times as likely, and transmasculine persons 1.61 times as likely, to report discomfort. In adjusted analyses, sociodemographic associations differed by gender, with being previously married or having higher education associated with increased risk of discomfort among transfeminine persons, but decreased risk among transmasculine persons.

Conclusions: Within this transgender population, discomfort in discussing trans health issues with a family physician was common, presenting a barrier to accessing primary care despite having a regular family physician and “universal” health insurance.

Bowleg, L., Huang, J., Brooks, K., Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies*, 7(4). doi: 10.1300/J155v07n04_06

ABSTRACT: SUMMARY This qualitative study explored the experiences of multiple minority stress and resilience among interviewees at a retreat for Black lesbians. Participants were a predominantly middle-class, highly educated sample of Black women (N= 19) between the ages of 26 and 68. The multicultural model of stress (Slavin, Rainer, McCreary, & Gowda, 1991) and the transactional model of resilience (Kumpfer, 1999) were theoretical frameworks for the study. Most of the participants discussed racism as a mundane and significant stressor, and contextualized their experiences of sexism and heterosexism through the prism of racism. Study findings provide empirical support for the "triple jeopardy" experience of Black lesbians (Greene, 1995), as well as the six predictors of resilience in Kumpfer's (1999) transactional model of resilience.

Bradford, J., Reisner, S, L., Honnold, J. A., Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: Results from the Virginia Transgender Health Initiative Study. *American Journal of Public Health*, (103)10, 1820-1829. doi:10.2105/AJPH.2012.300796

ABSTRACT: Objectives. We examined relationships between social determinants of health and experiences of transgender-related discrimination reported by transgender people in Virginia.

Methods. In 2005 through 2006, 387 self-identified transgender people completed a statewide health needs assessment; 350 who completed eligibility questions were included in this examination of factors associated with experiences of discrimination in health care, employment, or housing. We fit multivariate logistic regression models using generalized estimating equations to adjust for survey modality (online vs paper).

Results. Of participants, 41% (n = 143) reported experiences of transgender-related discrimination. Factors associated with transgender-related discrimination were geographic context, gender (female-to male spectrum vs male-to-female spectrum), low socioeconomic status, being a racial/ethnic minority, not having health insurance, gender transition indicators (younger age at first transgender awareness), health care needed but unable to be obtained (hormone therapy and mental health services), history of violence (sexual and physical), substance use health behaviors (tobacco and alcohol), and interpersonal factors (family support and community connectedness).

Conclusions. Findings suggest that transgender Virginians experience widespread discrimination in health care, employment, and housing. Multilevel interventions are needed for transgender populations, including legal protections and training for health care providers

Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity

University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSF Capacity Building Assistance Partnership: <http://cba.ucsf.edu/>

ABSTRACT: Many family physicians and nurse practitioners (henceforth referred to as primary care providers) will, at some point, be involved in the care of transsexual, transgender and gender non-conforming clients. Recent population based surveys in the United States suggest that the number of self-identified trans people are growing and currently represent approximately 0.1-0.5% of the population^{1,2} with one study showing significantly higher prevalence amongst youth.³ The Trans PULSE Project, which studied trans people in Ontario, showed that although urban centres are often sought out by trans people wishing to access health care, approximately 70% of trans Ontarians live outside the Greater Toronto Area.⁴ It is our hope that as many practitioners as possible become proficient in trans care so that people who wish to transition have the choice to remain in their communities.

Because transsexualism, transgenderism and gender non-conformity are not concepts explored in traditional medical training, the management of trans clients can be confusing

for healthcare providers internationally, there are a number of protocols and guidelines in the care of transsexual, transgender and gender non-conforming people, many of which will be referenced in this document

The best-known example is the “Standards of Care” document from the World Professional Association for Transgender Health (previously known as the Harry Benjamin International Gender Dysphoria Association) 5 The Standards of Care provide an international professional consensus around current knowledge and the role of the clinician in working with trans clients While it is the ‘gold standard’ consensus, it does not provide specifics around hormone provision or direction around aspects of primary care that merit consideration Many clinics have developed protocols for their own practitioners, also available to the public, which are more specific in their details around management Likewise, SHC presents this guideline to summarize the current clinical practice at the Centre

For many trans clients, the focus of the medical encounters will be to bring their physical appearance more in-line with their internal gender identity The medical field can assist with this through the provision of hormones and/or surgeries Since primary care providers usually have familiarity with the individual client, they are in a good position to formulate the diagnosis (i.e. of Gender Dysphoria) and develop a management plan In the large majority of cases, it is within the scope of primary care to provide hormone treatments to trans clients In total, 67% of trans people in Ontario who are on hormone therapy receive this treatment through their primary care provider 6 Finding a primary care provider who will assist with medical transition and provide sensitive, knowledgeable primary care however, remains a frequent challenge 7

Some primary care providers would prefer to seek consultation with an endocrinologist; while this may be an appropriate and helpful referral in the case of a medically complex client, it is typically not needed in relatively straightforward cases Additionally, outside major urban areas, an endocrinologist with experience treating trans clients may not be available; requiring such a consultation may result in an unduly long and stressful wait for the client If consultation is sought, it may be helpful to the provider and client to consider starting an androgen blocker +/- low-dose estrogen (e.g. half the regular dosage) for trans women or low-dose testosterone for trans men, until the consultation can be obtained

There is a great deal of variation amongst providers around comfort level of beginning hormones, and also around titration and maintenance of doses Ideally, this document will provide some guidance with regard to common dosages and monitoring strategies as well as references and resources for further learning and support

Buckey, J. W., Browning, C. N. (2013). Factors affecting the LGBT population when choosing a surrogate decision maker. *Journal of Social Service Research* (39). 233–252. doi: 10.1080/01488376.2012.754205

ABSTRACT: For individuals in the marginalized population of lesbian, gay, bisexual, and trans- gender persons (LGBT), choosing a health care surrogate to make medical decisions is an emotionally challenging task. These decisions become more difficult when compounded by issues of discrimination, lack of legal and social support, varying levels of relationship commitment, and complications of disclosure to family and medical professionals. Limited research exists regarding the social, legal, medical, and familial environments that impact the choice of a surrogate decision maker for an LGBT individual. This systematic review examines 14 articles to identify factors influencing individual surrogate choice and existing gaps in the literature. To remedy current research limitations, future research recommendations address the areas of design, sampling, data collection, and data analysis within diverse subgroups of the LGBT population. This review further identifies related areas of service required by members of the LGBT population relative to diversity, demographics, and social, legal, medical, and familial environments influencing their choice of a surrogate decision maker.

Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work*, (52)3, 243-250. Retrieved from: <http://www.jstor.org/stable/23721115>

ABSTRACT: Gender is a ubiquitous social construct that wields power over every individual in our society. The traditional dichotomous gender paradigm is oppressive, especially for transgendered people whose sense of themselves as gendered people is incongruent with the gender they were assigned at birth. Transgendered individuals are targeted for mistreatment when others attempt to enforce conventional gender boundaries. This article discusses gender-based oppression and the resulting psychosocial difficulties experienced by many transgendered individuals. The discussion advances a critical analysis of the dominant gender paradigm using two alternative theoretical perspectives on gender—queer theory and social constructionism. The article argues that the transgender community is an at-risk population and that empowering practice with this population calls on social workers to target society's traditional gender dichotomy for change. An overview of practice implications and research needs is provided.

Burhalter, J. E., Margolis, L., Sigurdsson, H. O., Walland, J., Radix, A., Rice, D., Buchting, F. O., Sanchez, N. F., Bare, M. G., Boehmer, U., Cahill, S., Griebeling, T., Bruessow, D., Maingi, S. (2016). The National LGBT Cancer Action Plan: A White Paper of the 2014 National Summit on Cancer in the LGBT Communities. *LGBT Health* 3(1). 19-31. doi: 10.1089/lgbt.2015.0118

ABSTRACT: Despite growing social acceptance of lesbians, gay men, bisexuals, and transgender (LGBT) persons and the extension of marriage rights for same-sex couples, LGBT persons experience stigma and discrimination, including within the healthcare system. Each population within the LGBT umbrella term is likely at elevated risk for cancer due to prevalent, significant cancer risk factors, such as tobacco use and human immunodeficiency virus infection; however, cancer incidence and mortality data among LGBT persons are lacking. This absence of cancer incidence data impedes research and

policy development, LGBT communities' awareness and activation, and interventions to address cancer disparities. In this context, in 2014, a 2-day National Summit on Cancer in the LGBT Communities was convened by a planning committee for the purpose of accelerating progress in identifying and addressing the LGBT communities' concerns and needs in the spheres of cancer research, clinical cancer care, healthcare policy, and advocacy for cancer survivorship and LGBT health equity. Summit participants were 56 invited persons from the United States, United Kingdom, and Canada, representatives of diverse identities, experiences, and knowledge about LGBT communities and cancer. Participants shared lessons learned and identified gaps and remedies regarding LGBT cancer concerns across the cancer care continuum from prevention to survivorship. This white paper presents background on each of the Summit themes and 16 recommendations covering the following: sexual orientation and gender identity data collection in national and state health surveys and research on LGBT communities and cancer, the clinical care of LGBT persons, and the education and training of healthcare providers. Key words: cancer, cancer disparities, lesbians, gay men, bisexuals, and transgender (LGBT).

Byne, W., Bradley, S., Coleman, E., Eyler, A. E., Green, R., Menvielle, E. J., Meyer-Bahlburg, H. F. L., Pleak, R. R. Tompkins, D. A. (2012). Report of the APA Task Force on Treatment of Gender Identity Disorder. *Am J Psychiatry*, *169*(8), 1-35.

ABSTRACT: After the announcement of the DSM-5 Work Group membership in May 2008, the American Psychiatric Association (APA) received many inquiries regarding the workgroup named to address the entities included under Gender Identity Disorder (GID) in versions III through IVTR of the Diagnostic and Statistical Manual of Mental Disorders™ (DSM). These inquiries most often dealt with treatment controversies regarding GID, especially in children, rather than issues related specifically to the DSM text and diagnostic criteria. In addition, the APA Committee on Gay, Lesbian, and Bisexual Issues had previously raised concerns about the lack of evidence-based guidelines for GID, and questions about whether such guidelines could and should be developed.

While the diagnosis and treatment of mental disorders are inextricably linked, they are separate issues and the evaluation of treatments is not addressed by the DSM Work Groups. The APA Board of Trustees, therefore, formed a task force on the treatment of GID under the oversight of the Council on Research. Members of the GID Task Force were appointed by the APA President, Dr. Nada Stotland, and charged by the Board of Trustees "to perform a critical review of the literature on the treatment of Gender Identity Disorder at different ages and to present a report to the Board of Trustees." The report "would include an opinion as to whether or not there is sufficient credible literature to take the next step and develop treatment recommendations."

Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity

University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSD Capacity Buiding Assistance Partnership: <http://cba.ucsf.edu/>

Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity

University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSD Capacity Buiding Assistance Partnership: <http://cba.ucsf.edu/>

ABSTRACT: This literature review has been prepared to inform and support the planning and development of health care services for transgender people. It examines four main topics: estimates of the prevalence of trans people; care needs of trans people; suicidal ideation and attempts amongst trans people; and barriers to competent care. The document concludes with recommendations for topics to address in further literature reviews.

Callahan, E. (2015). Opening the door to transgender care. *Journal of Internal Medicine*, 30(6), 706-707. doi: 10.1007/s11606-015-3255-0

Clements-Nolle, K., Marx, R., Guzman, R., Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, (91), 915-921.

ABSTRACT: Objectives. This study described HIV prevalence, risk behaviours, health care use, and mental health status of male-to-female and female-to-male transgender persons and determined factors associated with HIV Methods. We recruited transgender persons through targeted sampling, respondent-driven sampling, and agency referrals; 392 male-to-female and 123 female-to-male transgender persons were interviewed and tested for HIV Results. HIV prevalence among male-to-female transgender persons was 35%. African American race (adjusted odds ratio [OR] = 5.81; 95% confidence interval [CI]=2.82, 11.96). A history of injection drug use (OR=2.69; 95% C!= 1.56, 4.62),

multiple sex partners (adjusted OR=2.64; 95% CI= 1.50, 4.62), and low education (adjusted OR = 2.08; 95% CI = 1.17,3.68) were independently associated with HIV among female-to male transgender persons, HIV prevalence (2%) and risk behaviours were much lower. Most male-to-female (78%) and female-to-male (83%) transgender persons had seen a medical provider in the past 6 months. Sixty-two percent of the male-to-female and 55% of the female to-male transgender persons were depressed; 32% of each population had attempted suicide.

Conclusions, High HIV prevalence suggests an urgent need for risk reduction interventions for male-to-female transgender persons. Recent contact with medical providers was observed, suggesting that medical providers could provide an important link to needed prevention, health, and social services.

Coleman, E. (2009a). Toward version 7 of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11(1), 1-7. doi:10.1080/15532730902799912

ABSTRACT: This article reviews the history of the development of the World Professional Association for Transgender Health's (WPATH) Standards of Care (SOC) (formerly the Harry Benjamin International Gender Dysphoria Association). In considering the next revision of the SOC, a number of articles were commissioned to examine various parts of the current WPATH SOC and review the literature pertaining to those sections. These papers were designed to (a) review the evidence (and provide us with references); (b) point out where research is lacking and needed; and (c) make possible recommendations (significant and cosmetic) to the SOC based upon new evidence. This article reviews the process of developing Version 7 of the SOC and introduces the first set of articles pertaining to epidemiology, cultural considerations, nomenclature, and diagnoses.

Coleman, E. (2009b). Toward version 7 of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11(2), 69-73. doi:10.1080/15532730903008008

ABSTRACT: In the previous issue of the *International Journal of Transgenderism*, I reviewed the history of the development of the Standards of Care (SOC) of the World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association (Coleman, 2009). In considering the next revision of the SOC, a number of articles were commissioned to examine various parts of the current WPATH SOC and to review the literature pertaining to those sections. These papers were designed to (1) review the evidence (and provide us with references), (2) point out where research is lacking and needed, and (3) make possible recommendations (significant and cosmetic) to the SOC based upon new evidence. This article introduces the second set of articles pertaining to psychological assessment and approaches to treatment.

Coleman, E. (2009c). Toward version 7 of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11(3), 1-7. doi:10.1080/15532730903383740

ABSTRACT: *Standards of Care (SOC)—Sixth Version* of the World Professional Association for Transgender Health (WPATH, formerly the Harry Benjamin International Gender Dysphoria Association) is in the process of revision. In considering the next revision of the *SOC*, a number of articles were commissioned to examine various parts of the current WPATH *SOC* and review the literature pertaining to those sections. These papers were designed to (1) review the evidence (and provide us with references); (2) point out where research is lacking and needed; and (3) make possible recommendations (significant and cosmetic) to the *SOC* based upon new evidence. This article introduces the third set of articles pertaining to hormonal and surgical approaches to treatment.

Coleman, E. (2009d). Toward version 7 of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11(4), 1-7. doi:10.1080/15532730903439450

ABSTRACT: The World Professional Association for Transgender Health's (WPATH, formerly the Harry Benjamin International Gender Dysphoria Association) Standards of Care (SOC), Version 6, is in the process of revision. In considering the next revision of the SOC, a number of articles were commissioned to examine various parts of the current WPATH SOC and review the literature pertaining to those sections. These papers were designed to (a) review the evidence (and provide us with references); (b) point out where research is lacking and needed; and (c) to make possible recommendations (significant and cosmetic) to the SOC based upon new evidence. This article introduces the fourth set of articles pertaining to medical and therapeutic approaches to treatment.

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J... & Zucker, K. (2001). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism*, 13, 165-232. doi: 10.1080/15532739.2011.700873

ABSTRACT. The Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People is a publication of the World Professional Association for Transgender Health (WPATH). The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. The SOC are based on the best available science and expert professional consensus. Because most of the research and experience in this field comes from a North American and Western European perspective, adaptations of the SOC to other parts of the world are necessary. The SOC articulate standards of care while acknowledging the role of making informed choices and the value of harm reduction

approaches. In addition, this version of the SOC recognizes that treatment for gender dysphoria i.e., discomfort or distress that is caused by a discrepancy between persons gender identity and that persons sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) has become more individualized. Some individuals who present for care will have made significant self-directed progress towards gender role changes or other resolutions regarding their gender identity or gender dysphoria. Other individuals will require more intensive services. Health professionals can use the SOC to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Committee on Health Care for Underserved Women. (2011). Health Care for Transgender Individuals. *The American College of Obstetricians and Gynecologists: Women's Health Care Physicians*. Retrieved from: <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals>

ABSTRACT: Transgender individuals face harassment, discrimination, and rejection within our society. Lack of awareness, knowledge, and sensitivity in health care communities eventually leads to inadequate access to, underutilization of, and disparities within the health care system for this population. Although the care for these patients is often managed by a specialty team, obstetrician–gynecologists should be prepared to assist or refer transgender individuals with routine treatment and screening as well as hormonal and surgical therapies. The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder.

Coren, J. S., Coren, C. M., Pagliaro, S. N., Weiss, L. B. (2011). Assessing your office for care of lesbian, gay, bisexual, and transgender patients. *The Health Care Manager* (30),. 66-70. doi: 10.1097/HCM.0b013e3182078bcd 66

ABSTRACT: Practitioners act as guide, protector, and confidant to their patients' most vulnerable health care concerns. Arguably, one of the most important times to consider the dynamics of a health care relationship is when treating culturally diverse populations such as lesbian, gay, bisexual, and transgender (LGBT) patients. This article outlines several recommendations for how physicians can begin the process of assessing their office and practice habits for supportive care of LGBT patients, including evaluating your belief systems, understanding risk factors associated with LGBT patients, modifying medical intake forms and interview practices, reviewing staff training and office procedures, and becoming familiar with available tools and resources. With several minor but effective changes, you can offer your LGBT patients a practitioner who is (1) knowledgeable of relevant LGBT health care and basic human sexuality, (2) mindful and sensitive to the needs of diverse sexual and gender identities, and (3) capable of making interpersonal and office-related adjustments for the purpose of providing them with the best possible medical care. Key words: cultural competence, LGBT care, vulnerable populations

Corliss, H., Belzer, M., Forbes, C., Wilson, E. (2008). An evaluation of service utilization among male to female transgender youth: A qualitative study of a clinic-based sample. *Journal of LGBT Health Research* (3)2 49-61. doi:10.1300/J463v03n02_06

ABSTRACT: This qualitative study examined experiences with health and social service institutions and experiences related to education, employment, and other social networks among 18 ethnically diverse, male to female (MTF) transgender youth aged 16 to 24 years. Participants were recruited from a youth health clinic where they were receiving services for their transgender/trans sexual identity. In-depth, semi-structured interviews explored youths' patterns of service utilization, reasons for seeking care, beliefs about the usefulness of services received, experiences with service providers, barriers to care, and suggestions for improving services tailored to them. Similar to other studies with this population, participants described a multitude of health and social risk experiences as well as complex needs related to healthcare, education, employment, housing, personal relationships, and safety. Results suggest a mixed pattern of both positive and negative experiences within the medical, social and mental health services arenas. To improve support for transgender youth and assist in their positive development, it is essential to improve and expand the availability of culturally competent and effective services for this population

Coyle, S. M. (2011). A mixed methods investigation of the needs, experiences, and fulfilments of trans persons accessing Ontario health care services (Masters Thesis). Retrieved from ProQuest Dissertations & Thesis. ISBN: 978-0-494-76970-6

ABSTRACT: This study examined the societal factors and subjective beliefs that are hypothesized to be affecting the lives of trans persons accessing Ontario health care services. The purpose of this study was to uncover information pertaining to trans persons' needs and fulfilments within Ontario's health care system in order to discover what the specific health care needs of trans persons accessing health care services are as well as if they are alienated and/or systemically discriminated against when seeking medical attention. The research questions were addressed through a secure, anonymous, online questionnaire taking approximately 30 to 45 minutes to complete. A small sample of 18 to 26 individuals who identified as trans, living in Ontario and have accessed, or are currently accessing, Ontario health care services were recruited through relevant listserves and website postings. Participants accessed a variety of open-ended and closed questions concerning sociodemographics, sexuality, health care access experiences, and health care needs. Qualitative results showed that access to Ontario health care is complicated by race, class and language for participants in this study. Experiences for trans persons with Ontario health care services varied from individual to individual; some reported no negative experiences at all, some have been refused services by the Center for Addiction and Mental Health's Gender Identity Clinic, and some avoided health care services entirely due to discrimination from medical professionals.

Craft, E. M., Mulvey, K. P., (2001). Addressing lesbian, gay, bisexual, and transgender issues from the inside: One federal agency's approach. *American Journal of Public Health*, (91)6, 889-891.

ABSTRACT: The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to protect and serve underserved and vulnerable populations. Congress established SAMHSA under Public Law 102-321 on October 1, 1992, to strengthen the nation's health care capacity to provide prevention, diagnosis, and treatment services for substance abuse and mental illnesses. SAMHSA works in partnership with states, communities, and private organizations to address the needs of people with substance abuse and mental illnesses as well as the community risk factors that contribute to these illnesses. As part of its efforts to address the unique needs of special populations, SAMHSA has reached out to the lesbian, gay, bisexual, and transgender (LGBT) community. SAMHSA and its centers (Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and Center for Mental Health Services) have made a concerted effort, through both policy and programs, to develop services responsive to this community

Cruz, T. (2014). Assessing access to care for transgender and gender nonconforming people: A consideration of diversity in combating discrimination. *Social Science & Medicine*, 110, 65-73. doi:10.1016/j.socscimed.2014.03.032

ABSTRACT: Transgender and gender nonconforming people face stigma and discrimination from a wide variety of sources and through numerous social realms. Stigma and discrimination originating from biomedicine and health care provision may impact this group's access to primary care. Such stigma and discrimination may originate not only from direct events and past negative experiences, but also through medicine's role in providing treatments of transitioning, the development of formal diagnoses to provide access to such treatments, and the medical language used to describe this diverse group. This paper examines the postponement of primary curative care among this marginalized group of people by drawing from the National Transgender Discrimination Survey, one of the largest available datasets for this underserved group. This paper also proposes an innovate categorization system to account for differences in self-conceptualization and identity, which has been of considerable concern for transgender and gender nonconforming communities but remains underexplored in social and health research. Results suggest that experience, identity, state of transition, and disclosure of transgender or gender nonconforming status are associated with postponement due to discrimination. Other findings suggest that postponement associated with primary place of seeking care and health insurance has ties to both discrimination and affordability. These findings highlight the importance of combating stigma and discrimination generated from within or experienced at sites of biomedicine or health care provision in improving access to care for this group of people. Improving access to care for all gender variant people requires a critical evaluation of existing research practices and health care

provision to ensure that care is tailored as needed to each person's perspective in relation to larger social processes.

D

Dahl, M., Feldman, J. L., Goldberg, J., Jaber, A. (2006). *Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines*. Vancouver: Vancouver Coastal Health. Retrieved From: http://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2009/05/BC_Trans_Adult_Endocrine_Guidelines_2015-Ver1.2-updated-Jan-11-2016.pdf AND/OR http://transhealth.phsa.ca/wp-content/uploads/sites/15/2014/05/BC_Trans_Adult_Endocrine_Guidelines_2015.Ver1_1.pdf

ABSTRACT: Endocrine therapy is a strongly desired medical intervention for many transgender* individuals. The goal of transgender endocrine therapy is to change secondary sex characteristics to reduce gender dysphoria and/or facilitate gender presentation that is consistent with the felt sense of self. While there are risks associated with taking feminizing/masculinizing medications, when appropriately prescribed they can greatly improve mental health and quality of life for transgender people. In addition to inducing physical changes, the act of using hormones is itself an affirmation of gender identity. In British Columbia, the care of transgender individuals is provided through a decentralized community-based model of care.² Clinicians with varying degrees of transgender training and experience are responsible for this care. This document provides updated protocols for the prescribing clinician relating to physical assessment, prescription planning, initiation of endocrine therapy, and ongoing maintenance. It is intended to assist endocrinologists, family physicians, and nurse practitioners whose patients may ask for feminizing/masculinizing medication. It is written for professionals who are already familiar with basic terms and concepts in transgender care and are seeking more advanced clinical guidance in work with transgender adults. Endocrine treatment of transgender adolescents is not discussed in this document. Family physicians and nurse practitioners with training and experience in behavioural health, gender identity concerns, and sexual issues may choose to have sole responsibility for all aspects of transgender endocrine care, including assessment of eligibility and readiness. Alternatively, the primary psychological assessment may be performed by a mental health clinician, with the prescribing physician providing a briefer corroborating evaluation. As discussed in the World Professional Association for Transgender Health (WPATH) Standards of Care, (Version 7) transgender endocrine therapy is best undertaken in the context of a complete approach to health that includes comprehensive primary care and a coordinated approach to psychosocial issues. While the WPATH Standards of Care, (Version 7,) do not require psychotherapy prior to initiation of endocrine therapy, ideally a trans-experienced therapist will be available as needed to assist the patient in adjusting to the profound physical and psychosocial changes involved in endocrine therapy. Advocacy may also be required to assist with changes to legal name or identification. 6 Page 2 WPATH Standards of Care (Version 7) , are intended as a

flexible framework to guide the treatment of transgender people. Likewise, the recommendations made in this document should not be perceived as a rigid set of guidelines. In any clinical practice it is paramount that protocols be tailored to the specific needs of each patient, and clinicians are encouraged to adapt and modify our suggested protocols to address changing conditions and emerging issues. Research in transgender health is still in its early days, and there are widely diverging clinical (and consumer) opinions about “best” practice. In this document we offer suggestions based on an in-depth review of transgender health research, a review of protocols used in 16 clinics, interviews with expert clinicians, and the authors’ clinical experience. The updates are based in the new WPATH standards of care, guidelines from the European Endocrine Society, and a review of recent research. Ongoing research and collegial meetings are needed to further develop practice protocols.

Davis, S., Berlinger N. (2014). Moral Progress in the Public Safety Net: Access for Transgender and LGB Patients. *Hastings Center Report*. doi: 10.1002/hast.370.

ABSTRACT: As a population, people who self-identify as lesbian, gay, bisexual, or transgender face significant risks to health and difficulty in obtaining medical and behavioral health care, relative to the general public. These issues are especially challenging in safety-net health care institutions, which serve a range of vulnerable populations with limited access, limited options, and significant health disparities. Safety-net hospitals, particularly public hospitals with fewer resources than academic medical centers and other non-profit hospitals that also serve as safety nets, are under immense financial pressures. However, with the introduction in 2011 of standards for LGBT inclusion by The Joint Commission, showing progress on LGBT health care has become a compliance issue for hospitals. And because the health care community itself has contributed to LGBT health disparities through prejudice, disrespect, or inadequate knowledge that have made it difficult for LGB and especially T people to seek care or to obtain the care they need, there is a moral case for allocating scarce resources to this population: we owe them some investment in righting wrongs that the health care system itself has produced. So, where to begin in the typical safety-net hospital or clinic? Beyond staff training, which is essential and for which good models now exist, what does justice demand from a service-utilization perspective? Given the range of health care services that an LGBT person in the safety net may need or want, how should we set priorities? And what can't we promise to do for this member of our community?

Davidson, T. W. (2015). A review of transgender health in Canada. *UOJM*, (5)2, 40-45.

ABSTRACT: Transgendered individuals are defined by having a gender identity different from their birth gender. These individuals form a prevalent distinct group within the Lesbian, Gay, Bisexual and Transsexual (LGBT) community that has specific health needs. The goal of the current work is to identify the health needs affecting transgendered individuals in order to guide potential health interventions to ameliorate their well-being. Transgendered individuals often experience elevated rates of social stigma, discrimination and prejudice, which can alienate them from other members of society

including family members and health care professionals. This can have negative effects on their employment and socioeconomic status and may even render them targets of hate crimes. The combination of these factors can have significant ill effects on the physical and mental health of transgendered individuals. For example, high rates of depression and anxiety are observed within this population with a reported suicide attempt rate of over 30%. Transgendered individuals are also at high risk of being infected with HIV, with those having undergone the transition from male to female (MTF) being most affected. Although Canada is ahead of the curve in equal rights pertaining to the LGBT community compared to many countries worldwide that still have anti-homosexual legislation, there still exists a considerable amount of stigma around the transgendered community. There is a need to educate the population at large to combat social stigma in order to reduce discrimination, increase social support, improve access to health services and ultimately improve the physical and mental wellbeing of transgendered people.

De Santis, J. P., (2009). HIV infection risk factors among male-to-female transgender persons: a review of the literature. *The Journal of Association of Nurses in AIDS care*, (20)5, 362-372. doi: 10.1016/j.jana.2009.06.005

ABSTRACT: Male-to-female (MTF) transgender women experience a host of psychosocial issues such as discrimination, stigmatization, and marginalization. These challenges often limit economic opportunities, affect mental health, and may place members of this population at an increased risk for HIV infection. This report presents a review of the literature that focuses on risk factors for HIV infection specific to the MTF population. Factors including needle sharing and substance abuse, high-risk sexual behaviors, commercial sex work, health care access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues have been identified in the literature as risk factors for the acquisition of HIV infection by members of this population. Implications for care provided to MTF transgender persons are presented, and suggestions for future research are identified.

Deutsch, M. B. (2016, June 17a). Center of Excellence for Transgender Health. Retrieved from Creating a safe and welcoming clinic environment: <http://transhealth.ucsf.edu/trans?page=guidelines-clinic-environment>

Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity

University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSD Capacity Buiding Assistance Partnership: <http://cba.ucsf.edu/>

Deutsch, M., & Buchholz, D. (2015). Electronic health records and transgender patients: Practical recommendations for the collection of gender identity data. *Journal of General Internal Medicine*, 30(6), 843-847.

ABSTRACT: Transgender (Trans, Trans*) persons may have a gender identity and a preferred name that differ from those assigned at birth, and/or those listed on their current legal identification (Gender ID, Birth-assigned Sex, Legal Sex). Transgender people who are referred to in a clinical setting using the wrong pronoun or name may suffer distress, ridicule or even assault by others in the waiting area, and may not return for further care. Furthermore, failure to accurately document (and therefore count) transgender identities has negative implications on quality improvement and research efforts, funding priorities and policy activities. The recent announcement that gender identity data may be included in Meaningful Use Stage 3 has accelerated the need for guidance for both vendors and local implementation teams on how to best record and store these data. A recent study demonstrated wide variation in current practices. This manuscript provides a description of identifiers associated with gender identity, and makes practical and evidence based recommendations for implementation and front-end functionality.

Diffin, K. (2011). *Clinician Competency in Treating Transgender Individuals (Doctoral Dissertation)*. Retrieved from ProQuest Dissertations & Theses.

ABSTRACT: The mental health field has limited research regarding transgender people. An integral part of the transition process for transgender individuals seeking sex reassignment surgery is to work with a mental health provider to determine if they are appropriate candidates for medical intervention. Transgender individuals also seek therapy for other mental health related issues. Yet virtually no research describes best practice for working with transgender clients. Although clinicians currently work with transgender clients, the lack of discussion regarding appropriate training and preparation of clinicians to work with this specialized population is substantial. The goal of this research was to gain an understanding of how master- and doctorate-level clinicians determine their competency to work with transgender clients. The data were gathered through a phenomenological qualitative research study of mental health providers experienced in working with transgender clients. Questions regarding the participant's view of gender, worldview of transgender clients, and previous training were asked. The data were analyzed for emergent themes by the use of Weft QDA, an open source qualitative data analysis program. Seven specific themes emerged from the participants' responses to the questions. The participants noted the importance of knowledge, awareness of one's own gender beliefs, awareness of the client's worldview, and appropriate gender interventions. Discussion of these findings focuses on the similarities of the participants' experiences to those becoming multiculturally competent. Based on these findings, social change will occur as clinicians increase their competency to work with transgender clients and transgender clients receive effective therapy, in turn increasing their quality of life

Dewey, J. M. (2010). Uncovering Medical and Mental Health Professionals' Decision-Making in the Treatment of Trans-Variant Patients (Doctoral Dissertation). Retrieved From ProQuest Dissertations and Theses. UMI Number: 3419828

ABSTRACT: This project is a study of medical and mental health professionals who treat trans variant patients. Using in-depth interviews, I show how providers describe the process by which they make decisions with patients who desire, through formal means, to hormonally and/or surgically transition from one gender to the other. This work uncovers the ways professionals make decisions in the absence or limitation of formal knowledge while simultaneously attempting to ground their work in this same knowledge to obtain respect and legitimacy. Professionals must also acknowledge that they relinquish some power to patients to make decisions which involve high risk for them. Providers attempt to balance these demands all while attempting to be viewed by their trans-patients as 'good' doctors and therapists and not gatekeepers

E

Eriksson, S. (2015). A curriculum content change increased medical students' knowledge and comfort with transgender medicine (Thesis Dissertation). Retrieved from ProQuest Dissertations & Thesis. (Publication number UMI 1591718).

ABSTRACT: Transgender individuals experience distress due to the persistent feeling that their gender identity is incongruent with their assigned sex. This distress is associated with depression, a high suicide rate, and increased mortality. The best solution for transgender patients is cross-sex hormone therapy, a treatment that changes the physical sex of the patient to be more congruent with their gender identity. This treatment has been proven to reduce depression and suicide rates, as well as increase overall quality of life. Unfortunately transgender patients face unacceptable barriers to accessing this treatment, due in most part to the lack of willing and knowledgeable transgender care providers. Many physicians share the misconception that gender identity is malleable, making transgender identity a psychiatric problem, and that cross-sex hormone therapy may not be effective and carries too great a risk. However, the literature supports the notion that gender identity is a ridged biological phenomenon and that cross sex hormone therapy is safe and effective. Studies reporting failed attempts to assign female sex to XY patients with disorders of sexual development provide evidence that gender identity is not malleable. Other studies reporting elevated gender identity disorder rates in XX individuals with excess prenatal androgen suggest that gender identity is a biological phenomenon influenced by hormones during prenatal development. Neuroanatomical studies of transgender cadavers report that some sexually dimorphic areas of the transgender brain are more similar to the opposite sex than the natal sex, suggesting that gender identity is a rigid biological phenomenon originating in the structure of the brain. A review of the side effects and risks associated with cross-sex hormone therapy concluded that treatment is safe provided the physician is familiar with the recommended treatment and monitoring regimens. The lack of transgender care providers is perpetuated by the fact that transgender medicine is not a standard part of the medical school curriculum. Few physicians, therefore, have experience or training in transgender medicine, which is why, to combat this problem, this study has focused on the medical

school education system. Previous studies have demonstrated that the addition of transgender medicine to the medical school curriculum increases student comfort and willingness to provide transgender care. Building upon these findings the present study aims to demonstrate that the addition of transgender medicine to the medical school curriculum is an effective means to increase knowledge and change attitudes towards transgender medicine. Methods: A single lecture on gender identity and transgender medicine was added to the mandatory first-year biochemistry course and the mandatory second-year pathophysiology course at Boston University School of Medicine. An audience response survey was conducted immediately before and after the first-year lecture to assess the change in students' opinions regarding the etiology of gender identity. An elective online survey consisting of two exam-style questions was also sent to the first-year students prior to exposure to the curricular content. The same questions were also added to the first-year biochemistry and second-year pathophysiology exams following exposure to the curricular content. The same questions were also added to the first-year biochemistry and second-year pathophysiology exams following exposure to the content. The exam-style questions were designed to assess student knowledge of the rigidity of gender identity and transgender medicine. Results: Following exposure to the curricular content there was an increase in the number of students who believe that the origin of gender identity is in the neuroanatomical structure of the brain ($p < 0.001$). The relative number of correct responses to the exam-style questions significantly improved between the online survey and the first-year exam ($p < 0.001$). On one of the exam questions there was no significant difference between the relative number of correct responses given first-year students and second-year students. On the other exam question the second-year students performed significantly worse ($p < 0.001$). Conclusion: Here we demonstrate that the addition of transgender medicine to a medical school curriculum can increase students' knowledge and change their attitudes towards transgender medicine. Following the curricular content students were convinced that gender identity is a rigid biological phenomenon and that cross-sex hormone therapy is a medically justified treatment. These findings suggest that a simple curricular content change is an effective means of training knowledgeable physicians who are willing to provide transgender care.

F

Feldman, J., Goldberg, J. (2006a). Transgender primary medical care. *International Journal of Transgenderism*, 9 (2-3), 3-34. doi: 10.1300/J485v09n03_02

ABSTRACT: Transgender medical care involves addressing general medical conditions and those related specifically to transgender issues. This article summarizes existing research in transgender medicine and provides guidance for family physicians and nurses in adapting standard primary care protocols relating to health maintenance, acute illness, and chronic disease management to address trans-specific clinical concerns. Trans-specific issues in physical examination, health history, and interpretation of laboratory tests, vaccination, screening, and treatment are explored, and the role of the primary care provider in caring for patients undergoing hormonal or surgical change is discussed.

Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity

University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSD Capacity Building Assistance Partnership: <http://cba.ucsf.edu/>

Feldman, J. L., Goldberg, J. (2006b). *Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia*. Vancouver: Vancouver Coastal Health. Retrieved From: http://lgbtqpn.ca/wp-content/uploads/woocommerce_uploads/2014/08/Guidelines-primarycare.pdf

ABSTRACT: Scope: The purpose of this guide is to assist the primary medical care provider (family physician or nurse) to give appropriate care to their transgender* patients. Some of the tasks outlined in these guidelines are specific to physicians' scope of practice, but many are also applicable to advanced practice nursing. This document is intended for primary care providers who have already taken transgender sensitivity/awareness training or have experience working with transgender individuals, and are seeking more advanced guidance on how to be clinically effective in providing care. In-depth guidance relating to endocrinologic, surgical, socioeconomic, and psychosocial care is beyond the scope of this document, but is discussed further in other documents in this series (Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines,¹ Care of the Patient Undergoing Sex Reassignment Surgery,² Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians,³ Caring for Transgender Adolescents in BC: Suggested Guidelines,⁴ and Counselling and Mental Health Care of Transgender Adults and Loved Ones⁵).

Transgender medical care involves addressing two categories of concerns: general medical conditions and those related specifically to transgender issues. Primary care providers do not have to be experts in transgender medicine to meet the health needs of most transgender patients. With appropriate understanding of basic transgender issues and a little experience, non-expert primary care providers can offer health maintenance, acute illness and chronic disease management, and referral to specialists. Some transgender patients seek medical assistance to feminize or masculinize their bodies through hormones, § surgery, or removal of hair through laser/electrolysis. While specialists are often involved in this level of care, the primary care provider plays a vital role in coordinating care, providing referrals, co-managing hormone treatment (including monitoring lab work and side effects, avoiding drug interactions, supporting smoking cessation, etc.), and providing post-surgical follow up. Primary care physicians or nurse

practitioners with appropriate training and expertise may choose to have sole responsibility for the provision of feminizing or masculinizing hormone therapy. †

As defined by the World Health Organization, primary health care includes a broad range of social, educational, and political interventions beyond the scope of the family physician or nurse practitioner.⁷ We aim not to offer a complete discussion of transgender health, but rather to outline the range of issues commonly of concern in primary medical practice. Like every population the transgender community is diverse and health needs vary greatly from patient to patient. As with the non-transgender population, active consideration of biopsychosocial, socioeconomic, and spiritual health is encouraged as part of holistic primary care of transgender patients.

The recommendations in this document are based on published literature specific to transgender health wherever possible. More research is needed and for this reason some recommendations are based on current practices where the literature is inconclusive or absent. These guidelines are consistent with the Harry Benjamin International Gender Dysphoria Association (HBI-GDA)'s Standards of Care (SOC).⁸ Like the HBI-GDA SOC, these guidelines are intended to be a flexible framework to guide the treatment of transgender individuals. We support the HBI-GDA recommendation that clinical departures from the guidelines be recognized as such, explained to the patient, and documented to help the transgender medicine field evolve.

Fenway Institute . (2011a). *Collectin Sexual Orientation and Gender Identity Data In Electronic Health Records: Taking the Next Steps*. Retrieved from LGBT Health Education: http://www.lgbthealtheducation.org/wp-content/uploads/COM-2111-Brief_Collecting-SOGI-Data.pdf

ABSTRACT: Lesbian, gay, bisexual and transgender (LGBT) people are often “invisible to their providers. Most clinicians do not discuss sexual orientation or gender identity (SO/GI) with patients routinely, and most health centres have not developed systems to collect structured SO/GI data. This invisibility masks disparities and impedes the provision of important health care services for LGBT individuals, such as appropriate preventative screening, assessments of risk for sexually transmitted infections and HIV, and effective intervention of behavioural health concerns that may be related to experiences of anti-LGBT stigma. Like all patients, LGBT people have behavioural as well as medical concerns and want to discuss issues related to coming out, school, work, relationships, children, aging, and other issues that occur in different stages of life. An opportunity to share information about their sexual orientation and gender identity in a welcoming environment will facilitate important conversations with clinicians who are in a position to be extremely helpful. Collecting SO/GI data in electronic health records (EHRs) is essential to providing high-quality, patient-centred care to LGBT individuals. SO/GI data collection has been recommended by both the Institute of Medicine and the Joint Commission as a way to learn about which populations are being served, and to measure quality of care provided to LGBT people. Gathering this data is therefore an

important part of identifying and addressing LGBT health disparities in health centres and other health care organizations.

Fenway Institute . (2011b). *Improving the Health Care of Lesbian, Gay, Bisexual, and Transgender People: Understanding and Eliminating Health Disparities..* Retrieved from LGBT Health Education: http://www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBHealtharticle_v3_07-09-12.pdf

ABSTRACT: The LGBT community is diverse. While L, G, B, and T are usually tied together as an acronym that suggests homogeneity, each letter represents a wide range of people of different races, ethnicities, ages, socioeconomic status and identities. What binds them together as social and gender minorities are common experiences of stigma and discrimination, the struggle of living at the intersection of many cultural backgrounds and trying to be a part of each, and, specifically with respect to health care, a long history of discrimination and lack of awareness of health needs by health professionals. As a result, LGBT people face a common set of challenges in accessing culturally-competent health services and achieving the highest possible level of health. Here we review LGBT concepts, terminology, and demographics; discuss health disparities affecting LGBT groups; and outline steps clinicians and health care organizations can take to provide access to patient-centred care for their LGBT patients.

Fredriksen-Goldsen, K. (2014). Promoting Health Equity among LGBT Mid-Life and Older Adults. *Journal of the American Society on Aging (38)4*. 86-92. Retrieved from: <http://caringandaging.org/wordpress/wp-content/uploads/2015/08/Promoting-Health-Equity-Among-LGBT-Mid-Life-and-Older-Adults.pdf>

ABSTRACT: This article examines the health disparities of LGBT mid-life and older adults through a health-equity perspective. To address the range of health outcomes in these communities, we will look at strengths and resources, as well as challenges. The analysis will incorporate historical and changing social context. I also will consider steps for better addressing the unique health and aging needs of LGBT mid-life and older adults through innovations in services, policy, and research.

Frankish, C. J., Moulton, G. E., Quantz, D., Carson, A.J., Casebeer, A. L., Eyles, J.D., Labonte, R., Evoy, B.E. (2007). Addressing the non-medical determinants of health: A Survey of Canada's health regions. *Canadian Journal of Public Health / Revue Canadienne de Santé Publique*, 98(1). 41-47. Retrieved from: <http://www.jstor.org/stable/41994872>

ABSTRACT: Background: The Canadian health system is undergoing reform. Over the past decade a prominent trend has been creation of health regions. This structural shift is concurrent with a greater emphasis on population health and the broad determinants of health. In parallel, there is a movement toward more intersectoral collaboration (i.e., collaboration between diverse segments of the health system, and between the health system and other sectors of society). The purpose of this exploratory study is to determine the self-reported level of internal action (within regional health authorities) and

intersectoral collaboration around 10 determinants of health by regional health authorities across Canada.

Methods: From September 2003 to February 2004, we undertook a survey of regional health authorities in Canadian provinces (N=69). Using SPSS 12.0, we generated frequencies for the self-reported level of internal and intersectoral action for each determinant. Other analyses were done to compare rural/suburban and urban regions, and to compare Western, Central and Eastern Canada.

Results: Of the 10 determinants of health surveyed, child development and personal health practices were self-reported by the majority of health regions to receive greatest attention, both internally and through intersectoral activities. Culture, gender and employment/working conditions received least attention in most regions.

Conclusion: The exploratory survey results give us the first Canadian snapshot of health regions' activities in relation to the broad range of non-medical determinants of health. They provide a starting data set for baselining future progress, and for beginning deeper analyses of specific areas of action and intersectoral collaboration.

G

Guidelines for psychological practice with transgender and gender nonconforming people. (2015). *American Psychologist*, (70)9, 832-864.

ABSTRACT: In 2015, the American Psychological Association adopted Guidelines for Psychological Practice with Transgender and Gender Nonconforming Clients in order to describe affirmative psychological practice with transgender and gender nonconforming (TGNC) clients. There are 16 guidelines in this document that guide TGNC-affirmative psychological practice across the lifespan, from TGNC children to older adults. The Guidelines are organized into five clusters: (a) foundational knowledge and awareness; (b) stigma, discrimination, and barriers to care; (c) lifespan development; (d) assessment, therapy, and intervention; and (e) research, education, and training. In addition, the guidelines provide attention to TGNC people across a range of gender and racial/ethnic identities. The psychological practice guidelines also attend to issues of research and how psychologists may address the many social inequities TGNC people experience. (PsycINFO Database Record (c) 2015 APA, all rights reserved)

H

Hale, C. J. (2007). Ethical problems with the mental health evaluation standards of care for Adult gender variant prospective patients. *Perspectives in Biology and Medicine*, (50)4. 491-505. doi: 10.1353/pbm.2007.0047

ABSTRACT: The World Professional Association for Transgender Health's "Standards of Care: The Hormonal and Surgical Sex Reassignment of Gender Dysphoric Persons"(SOC) set forth standards clinicians must meet to ensure ethical care of adequate quality. The SOC also set requirements gender variant prospective patients must meet to

receive medical interventions to change their sexual characteristics to those more typical for the sex to which they were not assigned at birth. One such requirement is that mental health professionals must ascertain that prospective patients have met the SOC's eligibility and readiness criteria. This article raises two objections to this requirement: ethically obligatory considerations of the overall balance of potential harms and benefits tell against it, and it violates the principle of respect for autonomy. This requirement treats gender variant prospective patients who request medical intervention as different in kind, not merely degree, from other patient populations, as it

Hardacker, C. T., Rubinstein, B., Hotton, A., Houlberg, M. (2014). Adding silver to the rainbow: the development of the nurses' health education about LGBT elders (HEALE) cultural competency curriculum. *Journal of Nursing Management*, 22, 257-266. doi: 10.1111/jonm.12125

ABSTRACT: Aim In 2009, the Howard Brown Health Center received funding from the US Department of Health and Human Services, and Health Resources and Services Administration to develop and disseminate a peer-reviewed, six-module curriculum entitled, Health Education about LGBT (lesbian, gay, bisexual and transgender) Elders (HEALE). Background The HEALE curriculum targets nurses and health-care staff and is focused on the treatment of LGBT elders, a population that is largely misunderstood and discriminated against in health-care settings. The HEALE curriculum was presented in hospital academic centres, community-based clinics and nursing homes over a three-year period, and training staff provided education to over 500 nurses and health-care providers. Method A pre-test and post-test was administered to participants, and all data were collected and archived to measure knowledge gained. Participants also completed an evaluation at the conclusion of the training to report change in personal attitude and individual response to the curriculum. Results and conclusions From March 2011 to June 2012, 848 individuals attended HEALE curriculum sessions at 23 locations in Chicago and surrounding areas. Participants were 40% white, 25% black, 9% Hispanic/Latino and 25% Asian race/ethnicity. The majority of participants were female and approximately 25% were under the age of 30 years. There were statistically significant gains in knowledge in each of the six modules both in nursing home/home health-care settings and in hospital/educational settings, although participants in nursing home/home health care settings had lower pre-test scores and smaller knowledge gains in each of the six modules than those in hospital/educational settings. Mean increases ranged from 6.4 points (an 8.7% increase) in module 1–14.6 points (a 26.2% increase) in Module 6 ($P < 0.01$). Implications for nursing management The HEALE curriculum sets a standard for best practices in nursing management and for LGBT cultural competency in geriatric education. As such, implementation of this cultural competency training will go a long way to establish fundamental concepts regarding LGBT elder care and provide long-term strategies for providing culturally sensitive patient care

Henry, R. S. (2016). Even Five Years Ago this would have Been Impossible: Health Care Providers' Perspectives on Trans* Health Care (Masters Thesis). Retrieved from ProQuest Dissertations and theses. ProQuest Number: 10102250

ABSTRACT: Trans* studies and issues have recently increased in coverage by the media and popular press. With recent changes in the DSM-5 (APA, 2000; APA 2013) and insurance law (HHS, 2014), trans* healthcare has been under increasing scrutiny. While a small number of studies (Bradford, Reisener, Honnold, & Xavier, 2013; Grant et al., 2011; Rounds, McGrath, & Walsh, 2013; Tanner et al., 2014) have documented discrimination and lack of cultural competencies from the perspective of trans* patients, little research exists that examines the training, support, and decision-making processes of medical professionals who treat trans* patients (Snelgrove et al., 2012, p. 2). The goal of this research study is to explore the training and cultural competencies of healthcare professionals in treating trans* patients by surveying and interviewing healthcare professionals about their experiences of trainings, familiarity with practices/protocols, and attitudes toward treating trans* patients. A survey of 35 health care professionals and nine interviews were conducted. These health care professionals, while generally accepting of trans* individuals, still had some reservations about working with trans* patients and suggested that there were many barriers and challenges to providing trans* health care. A majority of health care professionals had little or no familiarity with treatment protocols or diagnoses for trans* patients, and very few had received any type of training (formal or informal) before or after starting working in the health care about trans* patients. While there are many areas in which there perceived challenges and barriers to care, several participants did observe that there has been a shift in health care recently that is moving towards being more inclusive and responsive to trans* patients

Hoffman, N., Freeman, K., Swann, S. (2009). Healthcare preferences of lesbian, gay, bisexual, transgender and questioning youth. *Journal of Adolescent Health, 45*, 222-229. doi: <http://dx.doi.org/10.1016/j.jadohealth.2009.01.009>

ABSTRACT: Purpose: Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth appear to be at higher risk for certain adverse health outcomes, and to have several personal, cultural and structural barriers to accessing healthcare. Little is known, however, about the experiences of LGBTQ youth with healthcare providers and healthcare services. Our goal was to recruit a sample of LGBTQ youth and to determine their preferences regarding healthcare providers, healthcare settings and the health issues that they consider important to discuss with a healthcare provider.

Methods: We conducted a cross-sectional Internet-based survey. Respondents ages 13-21 years and living in the U.S. or Canada were asked to review three lists of items pertaining to qualities of healthcare providers, qualities of offices or health centers, and concerns or problems to discuss with a healthcare provider, and then to assign for each item a relative importance. Items in each of the three lists were then ranked, and differences among ranks were assessed. Inter-group differences by age, gender, and race/ethnicity were also assessed.

Results: 733 youth met eligibility criteria. Youth indicated as most important competence overall and specifically in issues unique to taking care of youth and LGBTQ persons, as well as being respected and treated by providers the same as other youth. Notably, youth ranked as least important the provider's gender and sexual orientation. Youth ranked accessibility issues higher than specific services provided. As health concerns to discuss with a provider, youth ranked preventive healthcare, nutrition, safe sex, and family as important as common morbidities.

Conclusions: Youth placed as much importance on provider qualities and interpersonal skills as provider knowledge and experience, and placed little importance on a provider's gender and sexual orientation. Youth indicated the importance of providers addressing not only health risks, but also wellness and health promotion, and to do so within the context of home and family. Subgroup analyses underscore the need for greater sensitivity to both cultural and developmental differences among LGBTQ youth. These results provide a foundation for further research about healthcare services and delivery systems for youth, training initiatives for healthcare providers, and the role of utilizing the Internet for health research purposes to access and recruit hard-to-reach youth.

Hussey, W. (2008). Slivers of the journey: The use of photovoice and storytelling to examine female to male transsexuals' experience of health care access. *Journal of Homosexuality*, (51)1, 129-158. doi: 10.1300/J082v51n01_07

ABSTRACT: The purpose of this research project was to examine female to male transsexuals' (FTMs) experiences of accessing health care. This was accomplished by documenting and recording the experiences of five FTMs through the use of photography and interviews. It was hoped that such an inquiry would provide a starting point for future research about the health care needs of the transgender community, and document some of the health care needs of the FTM community that would lead to recommendations for policy changes and educating providers.

I

J

Johnson, M.J. & Amella, E.J. (2014) Isolation of lesbian, gay, bisexual and transgender youth: a dimensional concept analysis. *Journal of Advanced Nursing*, 70(3), 523–532. doi: 10.1111/jan.12212

ABSTRACT: Aim. To present the findings of a dimensional analysis of isolation in the context, and from the perspective, of lesbian, gay, bisexual and transgender youth. Background. Lesbian, gay, bisexual and transgender youth are often at greater risk for negative health outcomes compared with heterosexual youth. Isolation is one risk factor cited throughout the literature; however, the concept is complicated and has many uses and thus warrants clarification. Design. Concept Analysis. Data Sources. Sources comprise 35 English language research articles retrieved from CINAHL and EBSCOHost (1987–2012). Methods. A dimensional concept analysis was undertaken to analyse how the concept, isolation, is socially constructed. Results. This dimensional analysis revealed

five socially constructed dimensions and four sub-dimensions. These findings indicate that there is substantial variability in the concept of isolation. These differences and variations are most notably observed in the 20 articles (57%) that had more than one dimension. Although some of these articles were explicit with the different meanings and use of the concept, most of the papers had wide variability in the use and meaning of the concept. Conclusion. The disproportionately greater physical and mental health disparities between lesbian, gay, bisexual and transgender and heterosexual youth are a signal to conduct more research to clarify the concept of isolation, to develop instrumentation to identify at-risk youth and to explore predictors and consequences of isolation. Nurses and others can lead the way in translating this knowledge into strategies that will improve the health and lives of these young people.

K

Kenagy, G. P. (2005). Transgender health: Findings from two needs assessments studies in Philadelphia. *Health & Social Work, 30*(1), 19-26.

ABSTRACT: HIV/AIDS, suicide, violence, and barriers to health care access among transgender people were explored using two needs assessment surveys conducted in Philadelphia in 1997. A total of 182 people responded to a face-to-face interview or self-administered mail survey: 113 male-to-female individuals and 69 female-to-male individuals. About three-fifths of respondents had engaged in unprotected sexual activity during the past 12 months. The risk for HIV infection from unprotected sex was significantly higher among respondents of color than among white respondents. About one-third (30.1 percent) of respondents had attempted suicide. More than half of respondents had been forced to have sex, 56.3 percent had experienced violence in their homes, and 51.3 percent had been physically abused. Twenty-six percent of respondents had been denied medical care because they were transgender. These findings suggest that prevention services that specifically address HIV/AIDS, suicide, and violence among transgender people are urgently needed.

Kuehn., B. M., (2011). IOM: Data on health of lesbian, gay, bisexual, and transgender persons needed. *Journal of the American Medical Association, 305*(19), 1950-1951.

ABSTRACT: The wide-ranging report (<http://tinyurl.com/6x4wldg>) provides an overview of what is known about the health status of lesbian, gay, bisexual, and transgender populations, gives an overview of their cultural historical roots in the US, and sets forth a series of recommendations aimed at developing comprehensive research agenda addressing the unique health needs of each of these communities.

L

Lim, F. A., Brown, D. V., Jones, H. (2013). Lesbian, gay, bisexual, and transgender health: Fundamentals for nursing education. *Journal of Nursing Education (52)*4, 198-203. doi:10.3928/01484834-20130311-02

ABSTRACT: As the health care needs of the lesbian, gay, bisexual, and transgender (LGBT) population become increasingly important, health care professionals require appropriate academic and clinical training in preparation for the increased demand for culturally competent care. Nurses are of particular interest, as they are the core direct caregivers in many health care settings. This article explores the national climate around LGBT individuals and their related health needs. Educators and administrators who work with future nurses should strive to ensure they foster the development of knowledgeable practitioners who will be able to implement best practices in LGBT patient care. Attention should be paid to providing students with diverse clinical placements, access to LGBT interest groups, and clear expectations for LGBT-sensitive nursing care plans and course outcomes selection that promote cultural competence. Recommendations for nursing education and curricular reform are discussed. [J Nurs Educ. 2013;52(4):198-203.]

- Lim, F. A., Brown, D. V., & Kim, S. M. J. (2014). Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: A review of best practices. *The American Journal of Nursing*, 114(6), 24-34. doi: 10.1097/01.NAJ.0000450423.89759.36
- Lewin, S., Meyer, I. M. (2002). Torture and ill-treatment based on sexual identity: The roles and responsibilities of health professionals and their institutions. *Health and Human Rights*, 6(1), 161-176. Retrieved from: <http://www.jstor.org/stable/4065319>

ABSTRACT: Amnesty International's (AI) recent report "Crimes of Hate, Conspiracy of Silence" examines the torture and ill-treatment of lesbian, gay, bisexual, and transgender (LGBT) people. The report documents widespread human rights abuses, ranging from loss of dignity to assault, rape, and murder. The report also reveals that both the state and society continue to sanction these human rights abuses through formal mechanisms, such as discriminatory laws, and through informal mechanisms, including stigma and prejudice. The disinterest or active hostility of the criminal justice system has allowed many of these abuses to be conducted with impunity this disturbing picture of abuses that goes against human decency should rouse health professionals - as well as citizens everywhere-to action. Health professionals should be particularly alarmed that health-care workers are implicated in these violations not only as passive bystanders but also as active perpetrators of human rights abuses against LGBT people. Health professionals should therefore be prompted by the report to examine their roles and responsibilities regarding the health and human rights of LGBT populations.

- Lombardi, E., (2001). Enhancing transgender health care. *American Journal of Public Health*, 91(6), 869-872.

ABSTRACT: As awareness of transgender men and women grows among health care educators, researchers, policymakers, and clinicians of all types, the need to create more inclusive settings also grows. Greater sensitivity and relevant information and services are required in dealing with transgender men and women. These individuals need their

identities to be recognized as authentic, they need better access to health care resources, and they need education and prevention material appropriate to their experience. In addition, a need exists for activities designed to enhance understanding of transgender health issues and to spur innovation.

M

MacFarlane, D. (2015). The Canadian Association for Transgender Health Literature Review to Support Health Service Planning for Transgender People. Retrieved from: www.cpath.ca

Makadon, H. J., Mayer, K. H., Potter, J., Goldhammer, H. (2008). *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. Philadelphia, Pennsylvania: American College of Physicians.

ABSTRACT: This new 2nd edition of The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health reflects clinical and social changes since the publication of the first edition. Written by leading experts in the field of LGBT health in conjunction with The Fenway Institute at Fenway Health, one of the most trusted and respected community-based research, education, and care centers, this edition continues to present the important issues facing patients and practitioners, including:

- Principles for taking an LGBT-inclusive health history.
- Caring for LGBTQ youth, families, and older adults.
- Behavioral Health Care: coming out, intimate partner violence, drug, alcohol, and tobacco use.
- Understanding health care needs of transgender people.
- Development of gender identity in children and adolescents.
- Sexual health and HIV prevention.
- Policy and legal issues.

Margolies, L. (2014). The psychosocial needs of lesbian, gay, bisexual, or transgender patients with cancer. *Clinical Journal of Oncology Nursing*, 18(4), 462-464. doi: 10.1188/14.CJON.462-46

ABSTRACT: Because of discrimination and secrecy, lesbian, gay, bisexual, and transgender (LGBT) people have poorer health outcomes, which include an increased risk for certain cancers and additional challenges in cancer treatment and survivorship. The oncology nurse also should be aware of issues of LGBT sexuality and the impact that oncology treatment may have on the LGBT patient's immediate and long-term sexual functioning.

McCann, E., Sharek, D., (2014). Survey of lesbian, gay, bisexual, and transgender people's experiences of mental health services in Ireland. *International Journal of Mental Health Nursing*, 23, 118–127. doi: 10.1111/inm.12018

ABSTRACT: Very little is known about the experiences of lesbian, gay, bisexual, and transgender (LGBT) people in relation to mental health services. Therefore, the overall

aim of the current research was to explore LGBT people's experiences of mental health service provision in Ireland. The objectives were to identify barriers and opportunities, to highlight service gaps, and to identify good practice in addressing the mental health and well-being of LGBT people. A mixed methods research design using quantitative and qualitative approaches was deployed. A multipronged sampling strategy was used and 125 respondents responded to the questionnaire. A subset of phase 1 (n= 20) were interviewed in the qualitative phase. Quantitative data was analysed using descriptive statistics. Qualitative data we reanalysed thematically. The sample consisted of LGBT people (n= 125) over 18 years of age living in Ireland. Over three-quarters (77%) had received a psychiatric diagnosis. Findings include that whilst 63% of respondents were able to be 'out' to practitioners, 64% felt that mental health professionals lacked knowledge about LGBT issues and 43% felt practitioners were unresponsive to their needs. Finally, respondent recommendations about how mental health services may be more responsive to LGBT people's needs are presented. **KEY WORDS:** bisexual, gay, lesbian, mental health services, transgender

McWayne, J., Green, J., Miller, B., Porter, M., Poston, C., Sanchez, G., Turner, K., Rivers, J. (2010). Lesbian, gay, bisexual, and transgender health disparities, and President Obama's commitment for change in health care. *Race, Gender & Class*, 17(3-4), 272-287. Retrieved From: <http://www.jstor.org/stable/41674765>

ABSTRACT: Health care services in America are evolving. However, the state of sexual minority health is fraught with individual and institutional health disparities. The Obama Administration and other health organizations are beginning to develop the infrastructure needed to provide quality medical care to all Americans including sexual minorities. In this paper, we review the current state of health for sexual minorities including prevalent health disparities, access to quality care, communication, disclosure, current health issues and disparities. Finally, we will discuss the Obama Administration's role, and how medical and public health professionals can assist through better data collection, health communications, and service delivery for lesbian, gay, bisexual and transgender people. A reduction in health disparities will benefit all Americans

Mereish E.H., & Bradford J.B. (2014). Intersecting identities and substance use problems: sexual orientation, gender, race, and lifetime substance use problems. *J Stud Alcohol Drugs*, 75(1),179-88. PMID: 24411810.

ABSTRACT: Research has documented that sexual minorities are at greater risk for substance use than heterosexuals. However, there are limited studies and mixed findings when investigating these health disparities among racial and ethnic minority samples. We used an intersectionality framework to examine disparities in lifetime substance use problems between heterosexual and sexual minority men and women and within sexual minority groups among a racially diverse sample.

METHOD: A nonprobability sample of heterosexual (n = 1,091) and sexual minority (n = 1,465) patients from an urban community health center ranged in age from 18 to 72

years. Participants completed a brief patient survey and reported demographic information and history of lifetime substance use problems. Logistic regressions analyses were used to examine interactions between and among sexual orientation, gender, and race.

RESULTS: We found a significant three-way interaction among sexual orientation, gender, and race. Sexual minorities had a greater risk of self-reported lifetime substance use problems than heterosexuals, with nuanced gender and racial differences. Of greatest note, sexual minority women of color had greater risks than heterosexual women of color and than White sexual minority women. Sexual minority men of color did not differ in their risk when compared with heterosexual men of color, and they had lower risk than White sexual minority men.

CONCLUSIONS: The results of this study demonstrate that an intersectionality framework is crucial to clearly identify lifetime substance use disparities between racially diverse sexual minority and heterosexual men and women. Future research, treatment, and policy should use intersectionality approaches when addressing substance use disparities.

Meyer, I. H., (2001). Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health*, 9 (16), 856-859.

ABSTRACT: During the past few years public health has begun to address the concerns of lesbian, gay, bisexual, and transgender (LGBT) populations. This special issue of the Journal, the first issue dedicated to this subject in the Journal's 91-year history, is preceded by an American Public Health Association resolution on the need for research on the relationship between disease and gender identity and sexual orientation,' an Institute of Medicine report on lesbian health,^ and the inclusion of gays and lesbians among groups targeted for reducing disparities in health outcomes in the US government's 10-year blueprint for public health,' But do LGBT populations present a viable topic for public health investigation and intervention? What makes their concerns a distinctive health topic? Finally, addressing social issues through a public health prism holds both promise and peril"*—might public health attention to LGBT populations harm LGBT people?

Minnesota Evidence-based Practice Center (2016). Improving Cultural Competence to Reduce Health Disparities. Retrieved from:
file:///E:/improving%20cultural%20competence%20to%20reduce%20health%20disparities.pdf

N

National LGBT Health Education Centre. (2016, July 16). Publications. Retrieved from National LGBT Health Education Centre: <http://www.lgbthealtheducation.org/wp-content/uploads/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-EHRs-2016.pdf>

National LGBT tobacco control network. (2016). LGBT People and Tobacco Fact Sheet.

Retrieved from National LGBT tobacco control network: <http://www.lgbttobacco.org/>

Newton, H. (2009). A Narrative Exploration of the Lived Experiences of Trans People: Social Exclusion and the Social Determinants of Health (Master's Thesis). Retrieved from ProQuest Dissertations and Theses.

ABSTRACT: Trans people are not achieving optimal health and well-being, especially when compared to the general Canadian population. Further, there is limited research that has explored how the social determinants of health affect trans people across the lifespan. Using a narrative approach, the current study aims to explore and deepen our understanding of how the social determinants of health, and how social exclusion in particular can impact trans women throughout their lives. Five ethno-racially and sexually-diverse trans women were interviewed in two in-depth interviews. The data were used to develop “life stories” and to conduct qualitative analysis of the impacts of these social determinants of health. Findings show that these trans women’s lives have been deeply impacted by the determinants education, gender, employment and health care, and that the positive effects of the social determinants of health have often been mediated by social exclusion in these women’s lives. Intersections of gender and sex and the unique health concerns of trans women are discussed, as are some systems-level strategies to improve the health of trans people.

O

Ontario Ministry of Health and Long-Term Care. (2016). Retrieved from: <http://www.health.gov.on.ca/en/pro/programs/srs/>

P

Poteat, T. (2012). The role of stigma, and discrimination in health care utilization and HIV risk among transgender adults (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses. UMI Number: 3533296

ABSTRACT: Transgender people experience pervasive stigma and discrimination, factors known to be associated with health disparities. Transgender people also bear a disproportionate burden of HIV and have poorer access to health care than the general population. However, little is known about the nature of transgender discrimination and its impact on health. This dissertation aims to: (1) develop a transgender discrimination scale, (2) test associations between transgender discrimination and health, and (3) explore manifestations of stigma in health care encounters.

Methods: Data from 5,949 respondents to the National Transgender Discrimination Survey was used to develop and psychometrically test the Experiences of Transgender Discrimination Scale. This scale was used in bivariate and logistic regression models to analyze the relationship between transgender discrimination and three outcomes: knowledge of HIV status, HIV positivity, and health care utilization. Additionally, in-depth interviews were conducted with a purposive sample of 55 transgender individuals

and 12 health care providers. These interviews were analyzed using Grounded Theory methods.

Results: Factor analysis supported a two-dimensional scale including a 10-item Institutional Discrimination subscale and an 11-item Interpersonal Discrimination subscale. Cronbach's alpha coefficient of 0.81 indicated good internal consistency. Construct validity was supported by significant correlations in hypothesized directions with external items. In bivariate analysis, scores on the Experiences of Transgender Discrimination sub-scales were significantly associated with lack of health care utilization for transgender men and with HIV positivity for transgender women. In multivariable models controlling for race, age, education, income, employment, insurance, history of sex work, and family support, experiences of transgender discrimination remained significantly associated with knowledge of HIV status among transgender women only. Lack of training in transgender health care leaves most medical providers unprepared for these patients. This uncertainty upsets the typical power relationship between provider and patient. Interpersonal stigma functions to reinforce the power and authority of the medical provider.

Conclusions: Addressing the stigma and discrimination faced by marginalized groups is necessary in order to eliminate health disparities. Understanding how stigma functions, being able to measure it, and examining its health effects will facilitate the development and evaluation of effective interventions to improve population health.

Poteat, T., German, D., Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*, 84, 22-29. doi:10.1016/j.socscimed.2013.02.019

ABSTRACT: A growing body of literature supports stigma and discrimination as fundamental causes of health disparities. Stigma and discrimination experienced by transgender people have been associated with increased risk for depression, suicide, and HIV. Transgender stigma and discrimination experienced in health care influence transgender people's health care access and utilization. Thus, understanding how stigma and discrimination manifest and function in health care encounters is critical to addressing health disparities for transgender people. A qualitative, grounded theory approach was taken to this study of stigma in health care interactions. Between January and July 2011, fifty-five transgender people and twelve medical providers participated in one-time in-depth interviews about stigma, discrimination, and health care interactions between providers and transgender patients. Due to the social and institutional stigma against transgender people, their care is excluded from medical training. Therefore, providers approach medical encounters with transgender patients with ambivalence and uncertainty. Transgender people anticipate that providers will not know how to meet their needs. This uncertainty and ambivalence in the medical encounter upsets the normal balance of power in provider-patient relationships. Interpersonal stigma functions to reinforce the power and authority of the medical provider during these interactions. Functional theories of stigma posit that we hold stigmatizing attitudes because they serve

specific psychological functions. However, these theories ignore how hierarchies of power in social relationships serve to maintain and reinforce inequalities. The findings of this study suggest that interpersonal stigma also functions to reinforce medical power and authority in the face of provider uncertainty. Within functional theories of stigma, it is important to acknowledge the role of power and to understand how stigmatizing attitudes function to maintain systems of inequality that contribute to health disparities.

Q

R

Reisner, S. L., Bradford, J., Hopwood, R., Gonzalez, A., Makadon, H., Todisco, D., Cavanaugh, T., VanDerwarker, R., Grasso, C., Zaslou, S., Boswell, S. L., Mayer, K. (2015). Comprehensive transgender healthcare: The gender affirming clinical and public health model of Fenway Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 92(3), 584-592. doi:10.1007/s11524-015-9947-2

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.

Richmond, K. A., Burnes, T., Carroll, K. (2012). Lost in trans-lation: Interpreting systems of trauma for transgender clients. *Traumatology*, 18(1), 45-57. doi: 10.1177/1534765610396726

ABSTRACT: Transgender clients frequently experience multiple types of violence (Mizock & Lewis, 2008), including interpersonal (violence that occurs between, at least, two people), self-directed (violence that is self-inflicted), and collective (violence that is inflicted by larger groups of people/institutions; Krug et al., 2002). Transgender clients who experience any of these types of violence are at a higher risk for developing psychiatric symptoms that may require the attention of a mental health care provider (Mizock & Lewis, 2008). Thus, it is crucial that clinicians understand how transgender clients respond to such violence and how these reactions relate to the clinical needs of transgender clients (Lev, 2004). In this article, we will summarize and cluster the types of violence that have been documented in the transgender literature. We will then highlight PTSD and complex PTSD as conceptual frameworks for working with transgender

clients. Furthermore, we will examine how the binary notion of gender ignores ways in which race, class, and other identities interact with gender and make recommendations for how clinicians can affirm multiple identities as a way to minimize psychological distress following a traumatic event (Roen, 2006). We will also highlight clinical guidelines and provide feminist and multicultural recommendations for working with transgender clients.

Redfern, J., Sinclair, B. (2014). Improving health care encounters and communication with transgender patients. *Journal of Communication in Healthcare*, 7(1), 25-40. doi: 10.1179/1753807614Y.0000000045

ABSTRACT: Background/objectives: Transgender persons represent a generally ill-served or underserved population. This marginalized group continues to experience considerable difficulty in obtaining culturally competent health care despite recommendations by professional organizations and introduction of antidiscrimination legislation. This review examines communication and procedural barriers to transgender health care and suggests practical steps to help ameliorate disparities and unequal treatment. Methods: Publications addressing health disparities and communication and procedural barriers to health care of transgender persons were identified by a structured search of electronic databases. The most pertinent articles are reviewed and consolidated with the authors' collective experiences. Results: To improve their interactions and communication with transgender persons, health care providers can take a variety of practical steps in several key areas: office environment, registration forms, initial interview and assessment, confidentiality, personnel training, awareness of and compliance with applicable antidiscrimination legislation, health insurance-related issues, and outreach and transgender health promotion. Conclusions: Enhancing patient satisfaction through culturally competent health care, quality assurance, and patient feedback is critical to creating open lines of communication between practitioner and patient and fostering a favorable context for transgender patient care.

Roberts, T., Fantz. (2014). Barriers to quality health care for the transgender population. *Clinical Biochemistry*, 47 (10-11), 983-987. doi:10.1016/j.clinbiochem.2014.02.009

ABSTRACT: The transgender community is arguably the most marginalized and underserved population in medicine. A special issue focusing on men's health would be incomplete without mention of this vulnerable population, which includes those transitioning to and from the male gender. Transgender patients face many barriers in their access to healthcare including historical stigmatization, both structural and financial barriers, and even a lack of healthcare provider experience in treating this unique population. Historical stigmatization fosters a reluctance to disclose gender identity, which can have dire consequences for long-term outcomes due to a lack of appropriate medical history including transition-related care. Even if a patient is willing to disclose their gender identity and transition history, structural barriers in current healthcare settings lack the mechanisms necessary to collect and track this information. Moreover, healthcare providers acknowledge that information is lacking regarding the unique needs

and long-term outcomes for transgender patients, which contributes to the inability to provide appropriate care. All of these barriers must be recognized and addressed in order to elevate the quality of healthcare delivered to the transgender community to a level commensurate with the general population. Overcoming these barriers will require redefinition of our current system such that the care a patient receives is not exclusively linked to their sex but also considers gender identity

Roller, C., Sedlak, C., Burke Draucker, C. (2015). Navigating the system: How transgender individuals engage in health care services. *Journal of Nursing Scholarship*, 47(5), 417-424.

ABSTRACT: PURPOSE: Transgender individuals (TIs) experience a number of healthcare disparities that result in compromised access to health care, placing them at high risk for poor health outcomes. Despite their unique health concerns, there is little known about how they engage in health care. The purpose of this grounded theory study was to construct a theoretical framework that depicts the process by which transgender individuals engage in health care.

METHODS: In this grounded theory study, data from interviews with 25 individuals who self-identified as transgender were used to develop a theoretical framework that depicts the process by which TIs engage in health care. Data analysis included open coding, category formation, and theoretical coding. Constant comparative analysis was used to facilitate theory generation.

CONCLUSIONS: The central phenomenon of how TIs engage in health care was the core process of navigating the system. The core process involves four sub processes: needing to move forward, doing due diligence, finding loopholes, and making it work.

CLINICAL RELEVANCE: The theoretical framework of navigating the system can provide healthcare providers with a way to understand how TIs engage in health care as they move through the sub processes of moving forward, doing due diligence, finding loopholes, and making it work in order to get their healthcare needs met. With a better understanding of the healthcare journeys of TIs, healthcare providers can provide better care for this population and advocate for change in policies that contribute to the health disparities TIs experience.

Rosser, B., Oaks, J., Bockting, W., Miner, M. (2007). Capturing the social demographics of hidden sexual minorities: An internet study of the transgender population in the United States. *Sexuality Research & Social Policy*, 4(2), 50-64.

Russell, S., Ryan, C., Toomey, R., Diaz, R., Sanchez, J., (2011). Lesbian, gay, bisexual, and transgender adolescent school victimization: Implications for young adult health and adjustment. *Journal of School Health*, (81)5, 223-230.

ABSTRACT: BACKGROUND: Adolescent school victimization due to lesbian, gay, bisexual, or transgender (LGBT) status is commonplace, and is associated with compromised health and adjustment. Few studies have examined the long-term implications of LGBT school victimization for young adult adjustment. We examine the association between reports of LGBT school victimization and young adult psychosocial health and risk behaviour. **METHODS:** The young adult survey from the Family Acceptance Project included 245 LGBT young adults between the ages of 21 and 25 years, with an equal proportion of Latino and non-Latino White respondents. A 10-item retrospective scale assessed school victimization due to actual or perceived LGBT identity between the ages of 13 and 19 years. Multiple regression was used to test the association between LGBT school victimization and young adult depression, suicidal ideation, life satisfaction, self-esteem, and social integration, while controlling for background characteristics. Logistic regression was used to examine young adult suicide attempts, clinical levels of depression, heavy drinking and substance use problems, sexually transmitted disease (STD) diagnoses, and self-reported HIV risk. **RESULTS:** Lesbian, gay, bisexual, and transgender-related school victimization is strongly linked to young adult mental health and risk for STDs and HIV; there is no strong association with substance use or abuse. Elevated levels of depression and suicidal ideation among males can be explained by their high rates of LGBT school victimization. **CONCLUSIONS:** Reducing LGBT-related school victimization will likely result in significant long-term health gains and will reduce health disparities for LGBT people. Reducing the dramatic disparities for LGBT youth should be educational and public health priorities

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Scott-Dixon, K. (2009). Public health, private parts: A feminist public-health approach to trans issues. *Hypatia*, 24(3), 33-55. Retrieved From: <http://www.jstor.org/stable/20618163>

ABSTRACT: This paper identifies and examines the possible contributions that emerging fields of study, particularly feminist public health, can make to enhancing and expanding trans/feminist theory and practice. A feminist public-health approach that is rooted in a tradition of political economy, social justice and equity studies, and an anti-oppression orientation, provides one of the most comprehensive "toolboxes" of perspectives, theoretical frameworks, methods, practices, processes, and strategies for trans-oriented scholars and activists.

Schultz, S. L. (2012). Gender identity: pending? Identity development and health care experiences of transmasculine/genderqueer identified individuals (Doctoral Dissertation). Retrieved from ProQuest Dissertation and Theses. UMI Number: 3555913

ABSTRACT: The purpose of this study was to explore the identity development process and health care experiences of individuals who identify their gender somewhere along the transmasculine spectrum. Historically, researchers and clinicians have viewed the transgender experience through a lens of medical pathologization and have neglected to

acknowledge the diverse experiences of those who identify as transmasculine. The current standards of care for accessing transition-related health services require transmasculine individuals to express a narrative of distress in order to gain access to services, which further pathologizes those with complex identities that transcend the traditional categories of “male” and “female”.

Using a qualitative grounded theory approach, data were collected through semi-structured interviews with 28 transmasculine identified individuals. Additionally, results from a pilot study with 15 genderqueer identified individuals supplemented these interview data. The interviews focused on the process of transmasculine identity development and experiences in seeking and receiving health care services across a variety of practice settings. Participants also shared how their interactions with individual health and mental health care providers, organizations, and the larger managed care system impacted (both positively and negatively) their experiences of gender identity development.

A number of themes associated with transmasculine identity development were identified. An analysis of these themes revealed that transmasculine identity development is inadequately classified using the DSM model of Gender Identity Disorder. Instead of viewing transmasculine identity as an individual, disordered experience of identity, it is important to incorporate the personal, social, and cultural factors that influence transmasculine identity development. Shifting the focus from viewing transmasculinity solely as an individual problem or disorder may move us closer to the goal of replacing the pathology model with an identity-affirming model of transmasculinity.

The results of this research also indicate that various components of health care provision may impact transmasculine identity development. Access to trans-friendly health care organizations and providers, an informed consent model of health care provision, trans-friendly organizational policies, insurance coverage for transgender health needs, and relationship-centered communication with health providers all lend themselves to a positive, affirming experience of identity.

Shaw, M., Magaldi, J. A. (2010). Analysing the politics of health care: Let's buy ourselves some civilization. *Journal of Business Ethics*, 92(1), 33-47. Retrieved From: <http://www.jstor.org/stable/25621542>

ABSTRACT: United States has a population of three hundred million, according to latest Census Bureau estimates. Forty-seven million, including many non-citizens, are uninsured. That is, 16% of the total United States population has no health insurance. Millions more have inadequate coverage and are in danger of losing that. Private, corporatized medical coverage, structured by the insurance industry, is the basis for the current system. This article is an attempt to lay out the principal health care issues, to look at the alternatives and the cost of those alternatives, and to try to determine whether there is a particular regime that, despite its imperfections, is the best available to us now.

Shaw, L., Wang, T. (2013). Anti-transgender discrimination in public accommodations: a critical public health issue for Massachusetts. Retrieved from Fenway Health: <http://fenwayhealth.org/wp-content/uploads/2015/11/Anti-transgender-discrimination-in-public-accommodations.pdf>

Shippard, J., Green, K., Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*(2), 94-108. doi: 10.1080/19359701003622875

ABSTRACT: This study examined mental healthcare use and barriers to mental healthcare utilization in a sample of 130 transgender volunteers. Roughly a third of participants sought treatment for mental health issues including depression, anxiety, and relationship problems. Sixty-eight participants (52% of sample) showed evidence of psychological distress but had not received mental health services in the past year. Results point to potential barriers to seeking mental health services. Specifically, cost of treatment, previous bad experiences with healthcare, fear of treatment, and stigma concerns were the most frequently endorsed barriers related to seeking mental health services. Implications for practitioners are discussed.

Society for Adolescent Health and Medicine. (2013). Recommendations for Promoting the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Adolescents: A Position Paper of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health (52)4*. 506-510. <http://dx.doi.org/10.1016/j.jadohealth.2013.01.015>

ABSTRACT: Adolescent health care providers frequently care for patients who identify as lesbian, gay, bisexual, or transgendered (LGBT), or who may be struggling with or questioning their sexual orientation or gender identity. Whereas these youth have the same health concerns as their non-LGBT peers, LGBT teens may face additional challenges because of the complexity of the coming-out process, as well as societal discrimination and bias against sexual and gender minorities. The Society for Adolescent Health and Medicine encourages adolescent providers and researchers to incorporate the impact of these developmental processes (and understand the impacts of concurrent potential discrimination) when caring for LGBT adolescents. The Society for Adolescent Health and Medicine also encourages providers to help positively influence policy related to LGBT adolescents in schools, the foster care system, and the juvenile justice system, and within the family structure. Consistent with other medical organizations, the Society for Adolescent Health and Medicine rejects the mistaken notion that LGBT orientations are mental disorders, and opposes the use of any type of reparative therapy for LGBT adolescents.

Spicer, S. (2010). Conference proceedings the psychiatric needs of the transgender homeless population: Healthcare needs of the transgender homeless population. *Journal of Gay & Lesbian Mental Health, 14*, 320-339. doi: 10.1080/19359705.2010.505844

ABSTRACT: This is the first of three articles in this issue of The Journal of Gay and Lesbian Mental Health documenting the proceedings of the workshop “The Psychiatric

Needs of the Transgender Homeless Population” at the 2009 American Psychiatric Association’s Institute on Psychiatric Services Conference in New York City. This article describes some of the healthcare needs of the transgender homeless population and potential ways of addressing these needs. Homelessness disproportionately affects the transgender population for many reasons. Transgender persons are often rejected by their families and peers, and marginalized in our society, leading to increased risks of unemployment and homelessness. They are frequently not engaged in necessary mental health and medical care due to barriers arising from both their gender minority status and the barriers associated with homelessness. In order for this population to gain access to necessary mental health and medical care, all providers interfacing with them need to identify and assess their individual needs as well as have a basic understanding of this population’s public health concerns.

Sperber, J., Landers, S., Lawrence, S. (2005). Access to health care for transgendered persons: Results of a needs assessment in Boston. *International Journal of Transgenderism*, 8(2-3), 75-91. doi: 10.1300/J485v08n02_08

ABSTRACT: The transgender community is a population group that has experienced an increase in visibility, with only a small, concomitant increase in understanding. This study reports on four focus groups, in which 34 transgendered individuals discussed their experiences and interactions with the health care system.

Staley, M., Hussey, W., Roe, K., Harcourt, J., Roe, K. (2001). In the shadow of the rainbow: Identifying and addressing health disparities in the lesbian, gay, bisexual, and transgender population— A research and practice challenge. *Health Promotion Practice*, 2(3), 207-211.

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Thaler, C. (2007). Representing Transgender Clients. *GPSOLO* (24)3. 18-21. Retrieved From: <http://www.jstor.org/stable/23673341>

Thornhill, L., Klein, P. (2010). Creating environments of care with transgender communities. *Journal of the Association of Nurses in AIDS Care*, 21(3), 230-239. doi:10.1016/j.jana.2009.11.007

ABSTRACT: Partnerships between transgender individuals and community health nurses have been a primary source of monitoring and responding to the impact of the HIV epidemic on transgender communities, specifically transgender women. This article provides two perspectives: first, from a transgender service provider, and second, from a public health nurse, on forming partnerships that brought consumers and providers together to create environments of care in which many transgender persons living with and at high risk of HIV were able to engage with medical providers who believed in their right to self-determination. The process led to an increased understanding of HIV prevention and treatment needs, better individual-level health outcomes, and institutional

change, including the creation of a transgender medical clinic serving homeless transgender individuals in greater Boston.

The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011. LGBTFieldGuide.pdf.

ABSTRACT: To better understand the needs of LGBT patients, several professional associations, key stakeholders, and advocacy groups in the area of LGBT health care were invited to convene for a one-day LGBT stakeholder meeting (see “Expert Advisory Panel” in the Acknowledgments section, page v). The goal of the meeting was to identify and discuss how to advance effective communication, cultural competence, and patient- and family centered care specifically for the LGBT community. The Roadmap for Hospitals was used as a framework for the discussions. Participants were asked to build upon recommendations and practice examples in the Roadmap for Hospitals and tailor these with specific suggestions and strategies geared toward the unique health needs and concerns of those in the LGBT community. Recognizing that a hospital’s ability to advance these issues rests on its state of organizational readiness, participants were asked to categorize strategies and recommendations within the context of the following five domains*: • Leadership • Provision of Care, Treatment, and Services • Workforce • Data Collection and Use • Patient, Family, and Community Engagement

Information from the meeting was synthesized, and strategies were expanded and augmented by recommendations from current research, literature, and professional groups, as well as environmental, legal, and regulatory trends. In addition, testimonials and examples were collected from a variety of sources to inform the development of this field guide

TransPULSE (2010). Retrieved from: <http://transpulseproject.ca/>

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UNAIDS (2014). The Gap Report 2014: Transgender People. ISBN 978-92-9253-062-4.

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http://www.unaids.org/sites/default/files/media_asset/08_Transgenderpeople.pdf

University of California. (2016). Center of Excellence for Transgender Health. Retrieved from Enhancing Engagement and Retention in Quality HIV care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>

- University of California, San Francisco. (2016). Capacity Building Assistance for Community Agencies. Retrieved from UCSD Capacity Building Assistance Partnership: <http://cba.ucsf.edu>
- Canadian Psychological Association. (2016). *Policy & Position Statements*. Retrieved from Canadian Psychological Association: http://www.cpa.ca/aboutcpa/policystatements/#Gender_Identity
- University of California. (2016). *Center of excellence for Transgender Health*. Retrieved from Enhancing Engagement and Retention in Quality HIV Care for Transgender Women of Color: <http://transhealth.ucsf.edu/trans?page=programs-tetac>
- University of California, San Francisco. (2016, 06 16). *Capacity Building Assistance for Community Agencies*. Retrieved from UCSD Capacity Building Assistance Partnership: <http://cba.ucsf.edu/>
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- Wesp, L. (2016). Transgender Patients and the Physical Examination. Retrieved from: <http://www.transhealth.ucsf.edu/trans?page=guidelines-physical-examination>
- Williams, M., Freeman, P. (2008). Transgender health: Implications for aging and caregiving. *Journal of Gay & Lesbian Social Services*, 18(3-4), 93-108. doi: 10.1300/J041v18n03_06

ABSTRACT: Transgender people face many typical experiences associated with growing old compounded by unique stresses and challenges related to being transgender. Public and corporate policies and a history of discrimination tend to isolate transgender elders, potentially impairing their health, quality of life, and longevity. Health care providers and transgender people alike need accurate and representative information about the experiences and needs of these elders. Research on the lives and concerns of transgender elders is necessary to better understand their aging and caregiving experiences and to illuminate effective and respectful interventions to support them across the life course.

X

- Xavier, J., Bradford, J., Hendricks, M., Safford, L., McKee, R., Martin, E., Honnold, J. A., (2013). Transgender health care access in Virginia: A qualitative study. *International Journal of Transgenderism*, 14, 3-17. doi: 10.1080/15532739.2013.689513

ABSTRACT: We explored health care access experiences of 32 male-to-female (MtF) and 15 female-to-male (FtM) transgender people of different ethnicities in Virginia using data from focus groups conducted in 2004. Victimization associated with social stigmatization played a dominant role in participants' lives, manifested by discrimination; violence; and health care provider insensitivity, hostility, and ignorance of transgender health. Access to transgender-related medical services that would allow participants to pass in their chosen genders was their highest medical priority. Faced with barriers to access, hormonal self-medication was common, and silicone injections were reported by both MtF and FtM participants. Due to economic vulnerability, sex work was reported as a source of income by both MtFs and FtMs. MtFs expressed concern over confidentiality of HIV testing and additional discrimination if testing positive. FtMs expressed difficulty accessing gynecological care due to their masculine gender identities and expressions. Cultural and technical competency training for providers and implementation of local programs in transgender hormonal therapy are recommended to improve transgender health care access

Y

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WEBSITES:

- http://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2009/05/BC_Trans_Adult_Endocrine_Guidelines_2015-Ver1.2-updated-Jan-11-2016.pdf
- <http://link.springer.com/article/10.1007/s11524-015-9947-2>
- <http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People/LGBT%20report%20release%20presentation.pdf>
- http://www.glhv.org.au/sites/www.glhv.org.au/files/Tips_Paps_TransMen_0-1.pdf
- <http://transhealth.ucsf.edu/>
- <http://transhealth.phsa.ca/for-service-providers-2/resources>
- <http://www.raceconnect.ca/>
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- <http://sherbourne.on.ca/wp-content/uploads/2014/02/Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients-2015.pdf>
- <http://www.cancer-network.org/>
- http://www.lgbthealtheducation.org/wp-content/uploads/COM-2111-Brief_Collecting-SOGI-Data.pdf
- <http://www.lgbthealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf>
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- <http://transhealth.ucsf.edu/trans?page=guidelines-clinic-environment>
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- http://www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBHealtharticle_v3_07-09-12.pdf
- http://www.lgbthealtheducation.org/wp-content/uploads/COM-2111-Brief_Collecting-SOGI-Data.pdf
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