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Experiences and Perspectives of Transgender Individuals Accessing Gender-Affirming Care in Manitoba, Canada

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Abstract

As the number of trans people seeking gender-affirming care (GAC) continues to increase globally, it is increasingly important to understand the experiences of this patient population to improve healthcare delivery and ensure identified needs are being met. This qualitative descriptive study describes the experiences and perspectives of trans people (age 18–34) accessing GAC in Manitoba, Canada based on data obtained from semi-structured focus groups and individual interviews ($N=10$). Three major themes were identified to capture key elements of seeking GAC: (1) the transition decision, (2) the transition process, and (3) barriers to receiving desired care. In each major theme, subthemes were described. In addition to providing insight into critical aspects of this journey, this study also highlights the importance of including a diverse variety of perspectives when considering the design of healthcare services for the trans community.

Keywords

transgender, health seeking, lived experiences, access to health care, Canada

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Introduction

According to 2021 national census data, approximately 0.33% of Canadians over the age of 15 living in a private household identified as trans or gender diverse (Government of Canada, Statistics Canada, 2022). This is in keeping with prevalence estimates in the United States (Meerwijk & Sevelius, 2017) and globally (Winter et al., 2016). The term "trans" encompasses a heterogeneous mix of gender identities and expressions. While not all trans individuals pursue medical and/or surgical interventions to affirm their identity, there has been a measurable increase in the number of referrals for gender affirming care (GAC) globally (Goodman et al., 2019; Nolan et al., 2019), as well as a decrease in the mean age when gender dysphoria is diagnosed, from 31.4 in 2017 to 26.7 in 2021 (Sun et al., 2023).

GAC refers to health care interventions that support an individual's gender identity and expression. While it is often discussed specifically in relation to transgender identities, it is worth noting that the majority of gender affirming interventions are actually provided to cisgender people (Schall & Moses, 2023). GAC includes surgical procedures such as facial feminization, mammoplasty, chest masculinization, testicular implants, and phalloplasty, as well as medical treatments like hormone replacement therapy (HRT) and temporary pubertal suppression. It can also encompass interventions provided outside of a strictly medical setting, such as laser hair removal and vocal training, among others.

GAC in the context of transgender healthcare is considered safe, effective, and medically necessary by major professional health organizations including the American Academy of Pediatrics, the Canadian Pediatric Society, the Endocrine Society, and both the American and Canadian Medical Associations (Bonifacio et al., 2019; Hembree et al., 2017; Rafferty et al., 2018; Vandermorris & Metzger, 2023). There is a robust body of evidence supporting the benefits of receiving GAC from a mental health perspective; trans youth

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under 18 receiving HRT and/or puberty blockers are less likely to report recent symptoms of depression or suicidal ideation (Green et al., 2022; Tordoff et al., 2022), and overall describe an improvement to both physical and mental well-being after receiving their desired interventions (Pullen Sansfaçon et al., 2019). A systematic review, which included both youth and adult populations, found that quality of life ratings improved following GAC, and depression and anxiety symptoms diminished (Baker et al., 2021).

While there is a need for more longitudinal follow-up data with this population, improvements in psychosocial functioning have been observed up to 2 years following initiation of HRT (Chen et al., 2023). A recent study demonstrated that a majority (>70%) of trans people who started HRT either as youth or adults were continuing their treatment 4 years later; furthermore, the authors acknowledge that continuation rates were likely underestimated due to methodological limitations (Roberts et al., 2022). There is also evidence suggesting that the rate of regret after pursing GAC is very low. A large cohort study found that only 0.6% of trans women and 0.3% of trans men who underwent gonadectomy reported "surgical regret"—though many of these individuals emphasized this was due to the stigma they faced from family and community, rather than the surgery itself (Wiepjes et al., 2018). This finding is reflected in other work, where pressure from family and non-affirming environments are among the most common reasons cited for regret or detransitioning (MacKinnon et al., 2021; Turban et al., 2021). While this does not negate the aforementioned need for further research into longitudinal outcomes, it does suggest that the majority of trans people who seek gender-affirming interventions are satisfied with their decision.

Despite the demonstrated benefits and potentially life-saving nature of GAC for this population in particular (Grant et al., 2011), trans and gender diverse people often face significant barriers when trying to access these services. This includes lack of providers knowledgeable about trans health, financial inaccessibility, and an overall increased risk of discrimination, harassment, and outright refusal of care in medical settings (Giblon & Baur, 2017; Grant et al., 2011). These experiences are reflected by the Canadian Trans PULSE study; 7.2% of transmasculine and 5.0% of transfeminine people reported being refused care or had a care relationship ended due to being trans. Nearly 38% of both transmasculine and transfeminine respondents reported at least one prior negative experience when accessing healthcare (Bauer et al., 2015). The Trans Youth CAN! study, which surveyed Canadian youth from ten gender clinics across the country, found that long wait times, clinic treatment protocols perceived as overly strict, and a lack of care options for non-binary people were significant barriers to accessing GAC (Pullen Sansfaçon et al., 2019).

There exist few, if any, formal avenues for the people actually utilizing these services to provide feedback and direct meaningful systemic change. There has been some recent research into the potential for patient centered outcome measures (PROMs) to help better align care with patient needs; their implementation with respect to GAC, however, has been inconsistent (Kamran, Jackman, Chan, et al., 2023; Kamran, Jackman, Laws, et al., 2023). While structured options for feedback could reduce barriers and identify facilitators, existing PROMs for GAC suffer from a myriad of implementation issues, including poor accessibility and patient mistrust with how PROM scores would be used, and a perception that they might delay or prevent access to care (Kamran, Jackman, Chan, et al., 2023).

There continues to be gaps in the literature with respect to understanding the experiences trans people who are trying to or who have accessed GAC in the healthcare system as it is currently structured, particularly from a Canadian lens. Furthermore, while there are several Canadian studies examining the experiences of trans Canadians accessing primary care or mental health care in general (Abramovich et al., 2020, 2023; Lam et al., 2022), there is an ongoing need for data directly exploring barriers and facilitators to GAC specifically.

As more Canadians require access to GAC, existing services will need to adapt and expand; incorporating perspectives of those with lived experience into this process will be critical to ensuring community-identified needs are being met. There is robust evidence demonstrating that actively centering the voices of marginalized populations provides numerous benefits to both front-line delivery of patient care and helps inform effective change at the broader systems level (Asquith et al., 2021; Byrne et al., 2018; Shaikh et al., 2016). The aim of the present study is to understand more about the experiences of trans individuals seeking GAC, in terms of arriving at their own decision to seek that care and then the journey they go through as they pursue various aspects of care. Further exploration of facilitators and barriers to positive health care experiences and outcomes can support the delivery of high-quality affirming care to trans people.

Methods

Study Setting

Winnipeg is the capital city of centrally located Manitoba, Canada with a population of approximately 750,000. According to 2021 census data, there were 3,620 self-identified transgender and nonbinary people aged 15 or older living in Manitoba (Government of Canada, Statistics Canada, 2022). It is home to two clinics that provide specialized gender related care; the Trans Health Clinic, founded in 2009, and the Gender Dysphoria Assessment and Action for Youth (GDAAY) clinic, which accepted its first patients in 2011. Both clinics facilitate access to medical and surgical GAC, including providing hormones and facilitating surgical referrals, as well as social work services and some pathways to counselling.

Echoing aforementioned global trends, demand for GAC services in Manitoba has been increasing; since its inception, referrals to GDAAY have tripled, and in recent years have rapidly outpaced the clinic's yearly consultation capacity (Heard et al., 2018). Though Manitoba, like the rest of Canada, has universal healthcare coverage, not all GAC falls under this umbrella. According to a recent report published in a national Canadian newspaper, covered procedures within the province include chest masculinization and hysterectomy and oophorectomy, as well as "bottom surgeries" including metoidioplasty, orchiectomy, penectomy, and vaginoplasty (Mertz, 2022). Access to many procedures under the umbrella of bottom surgery requires out of province travel. Costs for feminizing voice therapy and laser hair removal are also fully covered, while hormones and breast augmentation are only partially or conditionally covered (Mertz, 2022).

In order to have surgery covered, trans Manitobans must have both a diagnosis of Gender Dysphoria and a letter from a provider who is on "both approved provider lists for Health Professionals as well as Mental Health Professionals" (Klinic Community Health, 2023). This is in contrast to the most recent version of the Standards of Care (SOC8) published by the World Professional Association for Transgender Health (WPATH). Per WPATH, any healthcare professional with competency in assessment of trans people is able to provide this documentation; for adolescents, while input from a multidisciplinary team that includes a mental health professional is recommended, any member of this team may provide the documentation (Coleman et al., 2022). Furthermore, wait times for a publicly funded diagnostic assessment can be on the order of 1 year or more, and while some private psychologists are able to complete these assessments, it can be a costly route, and there is no readily available list of providers who are considered "approved" in Manitoba.

Design

This qualitative descriptive study is based on a combination of focus group and individual semi-structured interviews conducted with transgender individuals. Qualitative description is particularly useful when little is known about a particular topic; the goal is to capture and stay close to participant descriptions and experiences, in contrast to other qualitative approaches that place more emphasis on theoretical context (Doyle et al., 2020; Sandelowski, 2000). It is also an important tool in healthcare research, as perspectives from a population affected by a particular phenomenon can provide a rich dataset that can be used to inform the direction of specific interventions or areas requiring further study (Bradshaw et al., 2017).

A convenience sample of participants were recruited through a targeted self-referral process. Physical posters advertising the study were placed in several locations where transgender individuals were likely to encounter them, for a period of 7 months; recruitment was open on a rolling basis while interviews were being completed. These included Klinic and GDAAY, Winnipeg's 24/7 mental health crisis centre, several Crisis Stabilization Units, Huddle Norwest, a drop-in service centre for youth ages 12 to 29, and the Rainbow Resource Centre. Digital versions of the recruitment poster were also distributed to several local online support groups via Facebook, with permission from group administrators.

Eligible participants were between the ages of 18 to 24; this was expanded to include participants from 18 to 35 to accommodate individuals who heard of the study and expressed a strong desire to be included. Eligible participants also had to self-identified as transgender, were either currently and/or had previously received gender-affirming healthcare in Winnipeg, Manitoba, Canada through the Gender Diversity and Affirming Action for Youth (GDAAY) program at the Manitoba Adolescent Treatment Centre, and/or the Trans Health Program at Klinic, and available and willing to participate in an interview or focus group. Eligible participants also needed reliable access to the internet and a private place to participate from. There were no exclusion criteria.

Interested individuals were invited to contact the study team via phone, email, or by completing a brief online survey via QR code indicating their age, pronouns, and interest in being contacted with further information. All participants utilized the online survey. A research assistant followed up with a detailed consent form outlining the study; participants were able to return and complete this digitally or via verbal consent prior to their interview, and were invited to ask questions about the process. For a given group interview, participants were provided with several options for date and time, and indicated their preferences. Once a date was agreed upon, all participants were notified individually by the research assistant and received a Zoom invite several days in advance. Individual interviews were coordinated directly between the participant and the interviewer. All communication with participants was done via a study-specific email account.

Interviews were based on a semi-structured guide that was initially designed by author EB, and further refined via input from all members of the research team. Topics covered included early experiences with gender exploration, what gender affirming care meant to each participant, experiences navigating the medical system, what barriers were encountered, and where participants wanted to implement changes in the future. The full interview guide is included as supplementary material. All interviews were conducted by author EB, with a research assistant present for technical support and safety considerations. Participants were provided with a list of local crisis resources via the consent form, and these resources were reviewed briefly at the start of all interviews. Participants were also given the option to contact the research assistant via Zoom chat to request being moved to a private breakout room if they were becoming distressed.

Chat capability was restricted such that participants were only able to directly message either the interview or the research assistant.

All interviews were conducted virtually via Zoom, and ranged from approximately 45 to 120 min in length. Interviews were audio-recorded and transcribed verbatim. Transcribed interview data was made anonymous by substituting numbers for participant names, and removing other personal identifiers throughout the transcript. Participants received an honorarium in the form of a $20CAD electronic retail gift card in recognition of their time and contributions. All participants provided written or documented verbal informed consent and agreed to having their interviews recorded.

Ethics approval was obtained from the University of Manitoba Health Research Ethics Board (HS25354 (H2022:046)).

Analysis

Transcript data was approached using template analysis; unlike other thematic approaches to coding, there were no pre-determined codes or template structure (Brooks et al., 2015). To start, reviewers (EB and GG) independently coded one randomly selected transcript line by line, developing emerging codes into broader themes and subthemes. Initial codes and themes were then compared and agreed upon by both reviewers and author JH, ensuring code validity. An initial template was then created and collectively reviewed and discussed by EB, GG, and JH until a consensus was reached on its construction and components. Using this initial template, reviewers EB and GG then independently coded and compared two transcripts; after this the template was revisited and further refined. The remaining transcripts were then coded in a similar fashion by EB and GG. Data was organized using QSR NVivo 12 software (QSR International, 2018).

Participant Characteristics

Ten participants were interviewed in total; this was a convenience sample, and the final number was reached based on ability to recruit within the study timeline. A total of three focus groups were completed; two groups of two participants and one group of three. Three individual interviews, following the same semi-structured interview guide, were also conducted; these participants indicated a strong desire to participate in the study, but had significant scheduling barriers that prevented participation in a focus group. Four participants were nonbinary, two were trans women, one was a trans man, one was transmasc, one was trans/nonbinary, and one participant described themselves as queer.

Gender identity information was collected via self-declaration; there was no requirement to disclose assigned sex at birth and no participants chose to disclose this during the interview process. While this demographic information can be valuable in some contexts, it is equally important to acknowledge that questions around assigned sex are not necessarily benign, and may in fact cause harm (Puckett et al., 2020). The average participant age was 22.9 years, with a range of 18 to 34.

Rigor

Rigor, or trustworthiness, was established based on the work of Lincoln and Guba (1985), and further discussed in the specific context of healthcare research by Bradshaw et al. (2017). Thorough documentation was used throughout the process of study design, implementation, and data analysis and the analysis itself adheres closely to the original data. Purposeful sampling of participants who had specifically received care through the two major clinics providing gender affirming care in Winnipeg increases the transferability of this work, as does the rich description obtained through a variety of participant viewpoints. Credibility was established via rapport building and a focus on empathy and validation during interviews. The main interviewer was also open about personally being trans; this has been identified as increasing trust and comfort among trans research participants (Owen-Smith et al., 2016). Multiple coders were utilized during data analysis bringing in a range of expertise in trans health, qualitative data analysis and health services research to enhance confirmability and dependability of the data (Bradshaw et al., 2017).

Reflexivity Statement

The authors come to this study from a variety of backgrounds and positions of expertise. Dr. Ezra Bridgwater is a nonbinary, transmasculine and queer psychiatry resident with a quantitative research background and lived experience accessing gender affirming care in Manitoba. Gagan Gill is a cisgender graduate student with substantial experience in qualitative research design, coding, and data analysis; she does not have any specific relationship to the trans community. Dr. Jennifer Ducharme is a cisgender clinical psychologist who works directly with trans youth and their families through the GDAAY clinic in Winnipeg, Manitoba; she also has significant qualitative research experience with this population, and is a coinvestigator on the Trans Youth Can! and Stories of Affirming Care studies. Dr. Jennifer Hensel is a cisgender psychiatrist and health services researcher; she does not have any specific relationship to the trans community.

Results

Most participant narratives followed a chronological description of their experiences, from the initial decision to reach out to the medical system to finally receiving their desired treatments. Throughout, various barriers and perceived areas for improvement were noted. From this, three major themes were identified; (1) the transition decision: deciding to reach out to the medical system to discuss care; (2) the transition process: starting gender affirming care; and (3) barriers experienced throughout the process.

The Transition Decision: Deciding to Reach Out to the Medical System

This theme focused on the initial decision to interface with the medical system to actively start talking about gender affirming care with providers. Subthemes included (1) considerations when preparing to reach out to the medical system, (2) first official contact with the medical system, and (3) the importance of early appointments in building therapeutic alliances.

Considerations When Preparing to Reach Out to the Medical System. Participants overwhelmingly described the process of deciding to reach out to the healthcare system for GAC as being gradual, rather than a single flashpoint. Most participants reached this point after a prolonged phase—in most cases over the course of several years—of self-discovery, information gathering, and disclosure to others. Several participants described being forced to delay this process, despite having reached a point of readiness to move forward, primarily due to personal safety concerns:

> *I didn't start accessing transitioning care until I was about 22 but I think if it wasn't for, like, the safety piece I would have started reaching out and accessing it like way earlier on. (Participant 3, queer, he/they)*

Unsupportive parents and living situations were identified several times as being the primary consideration for delaying care; one participant described "going back into the closet" because of the lack of familial acceptance. Another participant identified concerns over the reaction their church community, then a major support in their life, might have if they were to move beyond internal exploration.

First Official Contact with the Medical System. The subtheme relating to the first official contact with the medical system encompassed the initial points of contact including types of providers and the experiences of those early interactions. Participants discussed both positive and negative experiences, highlighting some facilitators of a more positive journey and factors that were not so supportive. Many participants discussed a fear of "not being considered trans enough" and how some early interactions helped to correct that perception.

Primary care providers were the most common first point of contact for participants when discussing GAC; most participants described some level of anxiety or stress related to the initial disclosure of their identity. Initial reactions from providers were mixed. Several participants spoke highly of the experience, describing it as affirming and supportive:

> *But [my family doctor] was really great, like the first question she asked me was, "Do you know about Klinic and their like trans healthcare program." And then like right away had also asked me about like, "What do you – like how can we make this better for you; like how can me and my staff support you?" which was really great. (Participant 3, queer, he/they)*

> *[my family doctor] was very accepting and she pretty much said the same thing that [name] just said was like "Have you heard of Klinic" and put me in contact with them and kind of sent me on my way that way. (Participant 1, trans woman, she/her)*

Negative reactions ranged from what one participant perceived as avoidance—*"all that he had to say about that was to go to GDAAY for anything related to that and he didn't really want to talk any further about that"*—to outright hostility. One nonbinary participant disclosed their struggle with gender identity when they were in their late teens, and described the initial interaction as follows:

> *[my family doctor] was like, well you're young and I don't want you to transition and for it to be a mistake and you don't know all the implications of switching genders, I think, is what she had said. And so, I kind of felt like really just invalidated. I was like, well OK, I guess maybe there is something wrong with me. . . (Participant 10, nonbinary, they/them)*

This participant felt their initial experience negatively impacted their later interactions with this physician when having to complete paperwork for gender-related care; they described being *"terrified"* that their physician would not provide a signature approving them for top surgery, or complete the required physical exam. They described feeling pressure to provide significant advance notice to their provider in order to give them *"ample time to process it"* and improve their chances of receiving the care they required.

The Importance of Early Appointments in Building Therapeutic Alliances. The importance of early appointments in building therapeutic alliance between patient and provider was a common experience; from first disclosures to primary care providers to initial appointments with specialty services at Klinic and GDAAY. With respect to Klinic's Trans Health program, where the majority of participants in this study received care, the intake process involves an initial phone call with a social worker to collect a detailed history and gather a sense of the patient's expectations and desired care. Most participants reported approaching this initial appointment with few expectations, and found the initial length and detail of that first appointment surprising. As two participants described it,

> *I was actually very surprised, like I didn't realize how long the appointment with the social worker was going to be. Like I had assumed that it would be like 30 minutes to an hour and it ended up being like a two hour phone call. (Participant 3, queer, he/they)*

> *When it was the intake, I thought it would be kind of just general name, age, weight, whatever, which it was some of that. But it was, when did you start discovering gender identity and I was like, I'm not ready for these questions, you know what I mean or how do you identify and I was like, I don't know, so there was the big questions that I was not ready for. (Participant 10, nonbinary, they/them)*

Despite this initial surprise, participants spoke highly of their initial contact with Klinic's program; one person specifically highlighted employees' conscientiousness with confirming his pronouns at appointments, which he characterized as "fluctuating" at the time. Within our sample, all participants reported an overall positive experience interacting with specialty clinic staff—from peer support workers to medical personnel.

Several people described their initial intake appointment as being one of the first times they felt that someone was listening to their experience; as one trans woman put it, *"there was a lot of like emotion involved in it."* Another participant in the same group interview reported a similar experience, saying the following about the social worker who completed their initial interview:

> *she was just very like thoughtful and kind and like just was like very willing to let you take up space especially during like the intake process and just like gave you the space you needed to like talk and share your story. (Participant 3, queer, he/they)*

Participants also shared the ways in which they felt care providers made the process more comfortable to navigate. In particular, some self-disclosure by providers about their own journeys with mental health was felt to strengthen the patient-provider relationship and, as one individual put it, "*I really liked [the disclosure] because I think it kind of helped to like normalize it [. . .] and just like made me feel more comfortable."*

Several participants were impacted by changes to clinic procedures in response to the COVID-19 pandemic; the inability to attend appointments with a partner or trusted support person was something that was highlighted as being particularly difficult. One individual, who had wanted to share the moment of his first hormone injection experience with his partner, spoke warmly of the nurse who taught them how to self-inject, stating:

> *she also like let me film the injection so that I could like refer back to it later on which was also kind of nice because like my partner couldn't come because of COVID and so I also got to like then share that experience. . . (Participant 3, queer, he/they)*

Specific focus was also brought to the psychological evaluation (sometimes referred to as the "surgical readiness assessment") Participants reported varying degrees of anxiety and distress preceding the evaluation, with worries often centered around being told that they "weren't trans" and being denied care. Reflecting on the experience of actually going through the assessment, however, participants reported being put at ease by the direct approach of the psychologists they spoke with:

> *For me, she pretty much just asked me a bunch of questions. I was actually mainly worried she was going to tell me that I wasn't trans [. . .] And I get into the appointment and she's like, "I believe you, we just need to do this as a formality. Is literally all it was at clinic is, it was like, "This is a formality, I have to ask you a bunch of questions, you do have to answer them honestly. (Participant 9, trans/nonbinary, he/they)*

> *I'd say like for sure, especially because I was older. I remember when I was explaining it in my surgical readiness assessment that I wanted to get top surgery from the time I was like 14 and they were like, "Well, you know, OK, why do you want this?" I was like, "Because just like I always have" and it was like, "You know I'm not even going to question you that much further, clearly this is something that's for you. (Participant 4, nonbinary, he/they)*

Beyond specific experiences with specialty clinics, participants also brought attention to other ways that providers in general could help increase patient comfort and confidence, with particular emphasis on queer and LGBTQ+ friendly indicators:

> *Then like I said too, in my experience with hospitals and other kind of like temporary care specialists, sometimes they're really great and you know like they have their little queer-friendly flag on their door, you know like the sticker and then other times you walk in there is no indication this person has any understanding and it's very uncomfortable. (Participant 4, nonbinary, he/they)*

There was also an emphasis on the ways in which shared experience can bring increased comfort to the process. Several participants expressed wanting to see more trans and LGBTQ+ individuals providing GAC, as speaking about complex gender identity issues would feel easier with a shared language. As one participant put it:

> *[. . .] but having non-trans medical professionals doing trans things, I think it would be nice to have trans folks helping out other trans folks. I just – they can always research things but there's a different experience when you're living it. (Participant 8, transmasc, he/him)*

One participant who identified as Francophone, and using French as their primary language, spoke to the benefits of having a literal shared language between patient and provider. They described the difficulties they had in expressing nuanced thoughts about their identity and the care they wanted in a second language, and stated:

> *So definitely, I think if it was a French provider, I would have probably felt better or even someone who is bilingual. Often in the French community we'll use Frenglish be able to swap back and forth, that's often, you don't even realize you're swapping languages sometimes. So, having a provider that is either, that is bilingual would have definitely, I think, changed the whole experience probably. (Participant 10, nonbinary, they/them)*

The Transition Process: Starting Gender Affirming Care

Following initial discussions with primary care and being connected with specialty services, participants described the process of actually starting gender affirming care. Two major subthemes were identified: (1) gathering information and finding resources specific to the medical and surgical aspects of transition and (2) defining what one's personal gender affirming care journey looks like.

Gathering Information and Finding Resources. With respect to the information gathering process, this did not occur in a strictly sequential way after connecting with specialty services. Rather, it was often a concurrent or parallel process that participants engaged in while navigating the medical system. Participants discussed the various modalities they used to gather information about GAC procedures, which were grouped into three primary domains; formal and informal online sources, and formal offline sources.

Formal online resources were characterized as information from official medical or other trustworthy sources. Participants primarily used resources provided via Klinic's online webpage, with one participant referring to the program's welcome package as "the trans girl bible." The quality of Klinic's online information was felt to be quite high, with another participant commenting that:

> *Klinic I would say, like of any of the sites I've been on is probably the most comprehensive in terms of like the amount of links and like PDFs that you can actually access. Like I think that's fantastic especially compared to other ones I've seen in the past. (Participant 1, trans woman, she/her)*

In general, participants felt there was a noticeable lack of online resources from trustworthy sources available for the general public, which was especially pronounced when participants were looking for Canadian-specific information about GAC. Participants reported a desire for more accessible resources addressing topics such as differences in hormone administration (i.e. injection vs. gel vs. patch) and surgery results.

Informal online information gathering was substantially utilized; the most common sources among this sample of participants were YouTube, Reddit, and Instagram. Participants felt the most helpful information came from other trans people documenting their transition experience; in some cases, direct lived experiences were seen as more reliable than information from medical professionals. In comparison, formal medical sources were perceived as presenting information about transition results in an overly cautious manner, and often overemphasizing side effects or potential negative outcomes. As one participant put it:

> *I kind of trusted more where it was like, it was real people's results and things like that where it wasn't just like everything that has to be taken with a grain of salt because yes they have to tell you all these other things as well on certain resources. So it was kind of nice seeing it through a bit less of a filter I would say. (Participant 1, trans woman, she/her)*

In some cases, people used informal online sources when there was a lack of locally available services. Voice training is an aspect of GAC commonly sought by trans people who wish to make their voice sound more feminine or masculine; formal teaching is often provided by Speech-Language Pathologists, but as several participants pointed out, the waitlists for such resources locally are often years long. Two trans women in this study reported turning to other online resources aimed at voice work - some specifically for trans people, but also more generalized voice acting and character imitation work. As one woman described it,

> *I've kind of started looking more into like character and voice actors more so who can just still use the same type of guidelines for the most part and show it's like, "Hey here's how I got the girl voice" and it's like, "OK that's how you get the girl voice" which there are lots of like options online for that. (Participant 1, trans woman, she/her)*

Despite robust utilization of the internet, participants also had a healthy degree of skepticism with respect to relying on this type of information. There was some concern about the accuracy of online information and the need for caution, with one participant stating that *"you've got to take everything online with a grain of salt."*

Options for formal offline resources were more limited. Several participants brought up accessing a non-profit organization that serves the 2SLGBTQ+ population in Manitoba and northwestern Ontario. Here participants were able to connect with a variety of local support groups, and also speak with staff familiar with the process for accessing GAC and completing related affirming tasks such as legal name and gender marker changes. The majority of participants cited their care team through Klinic as their main source of information; both for specific medical and surgical questions, as well as more general assistance with navigating the medical system.

Concerns were raised around personal comfort when trying to ask for more information from medical professionals. One individual described having recurring negative experiences when trying to speak with his primary care provider, which discouraged them from asking for other information they would have found useful:

> *I will say though a couple that I've asked I've had the doctor like laugh at the question which had made me like not want to ask some of the other questions that I have because I'm just like why are you laughing, like this is a legitimate question that I have. And I think that might be just because like it's so normal to them they're like, "Oh yeah I wouldn't have – like obviously the answer is this" to them. But I think sometimes they forget that like the patient is going through it for the first time. (Participant 3, queer, he/they)*

Defining One's Personal Gender Affirming Care Journey.

From the perspectives of participants, how one defines their own gender affirming care is very diverse with regards to desired outcomes and personal goals, access to which consistently resulted in euphoria and improved mental wellbeing.

Participants who were seeking or had already started receiving feminizing GAC both spoke strongly about the desire for HRT, with one trans woman stating that it was "*the first thing that comes to mind when I think of it because that was always like what I saw as like where I wanted to start*." Access to formal voice training resources was also a commonly expressed part of their desired affirming care. Neither expressed strong feelings either way about accessing surgical options at their current stage of transition; rather, there was a sense of anticipation seeing how medical advancements unfolded in the future, with one woman saying "*I'm quite young still so I kind of am excited to see when these other options kind of come up*."

Interestingly, those desiring masculinizing procedures showed something of an opposite pattern; the majority of participants desiring this type of change spoke confidently about their desire for top surgery, with one nonbinary individual stating that "*from 14 I knew I wanted top surgery; like it wasn't a question and that's never changed*." One participant, who felt unable to seek full top surgery while living with family, described having breast reduction surgery as an affirming procedure at the time, saying:

> [. . .] *it gave me the ability to use a binder. It gave me an option to like reduce my chest without having to have the implications and like that outing of having like a traditional top surgery did. (Participant 5, nonbinary, they/them)*

They subsequently sought and received full top surgery once their situation was more secure. Opinions around masculinizing bottom surgery were mixed; one participant expressed a desire to eventually get a phalloplasty procedure while simultaneously retaining their natal reproductive organs. They speculated on the reasons for this, stating rather colorfully,

> *who's going to be, like, yo, I got this thick dick from this doctor, it was, like, successful. You know, who's going to be vocalizing about their penis surgery? (Participant 6, trans man, he/him)*

Desires around testosterone-based HRT were quite varied; several trans men and nonbinary participants indicated having pursued full testosterone replacement, and others indicated they had no desire to start HRT and felt satisfied with the results of their top surgery alone. A nonbinary participant described their thoughts on testosterone as "*always kind of like a grey area for me where I wasn't sure because I very much identified as like closer to the middle non-binary.*" Another participant pursued microdosing as their preferred option, as they were hoping for more gradual changes and did not want the full masculinizing effects of a standard HRT regimen.

Outside of medical and surgical treatments, several participants included a desire for counseling or therapy under the umbrella of GAC. This was not explicitly for concerns related to gender identity or dysphoria specifically, but rather a desire to speak with *"someone who understands what I might be going through and can offer like guidance and support,"* and to be able to work through *"family stress with the process of coming out and stuff like that."* Despite the relatively universal experience of frustration with long wait times for referral and between appointments, no participant spoke negatively about receiving the care they desired. Though some, particularly those who were younger and/or earlier in their transition process, expressed having some uncertainty about what GAC they might want to pursue in the future, this came from a place of interest in ongoing self-discovery. As one individual described it:

> *I leave there with a smile on my face after a blood lab where I can see my levels raised. My emotional and like just mental aspect of everything has greatly improved and I think that's been a big aspect of it as well where it's just like I am mentally doing better because of the care I'm getting. (Participant 1, trans woman, she/her)*

This sentiment was echoed across all participants; one trans man reported feeling that HRT had made it possible for his external appearance to accurately reflect his internal one, stating "*basically with testosterone I'm able to be seen as me.*" Being able to connect with a community of people with similar lived experiences was also seen as a positive result of seeking GAC, with one trans woman speaking highly of the "*the community, friends I have met, people I've grown close with that I wouldn't imagine I would have otherwise. . .*".

One trans woman did express having periods of dissatisfaction regarding the pace of changes she was experiencing. Though overall she felt that having time to make measured decisions about her medical treatment was beneficial for her particular situation, she also described moments where she found it difficult to see the incremental changes:

> *. . .as a good thing on the bad days at all really where I'm just like hey I'm willing to do all this and it's – I'm kind of still waiting and I haven't been able to, I don't know, make the progress that I was hoping to at this point. (Participant 1, trans woman, she/her)*

No participant expressed regretting their transition or the care that they had received.

Barriers Experienced Throughout the Process

Discussion about barriers that participants faced was rich. Two major themes, both with several subthemes were identified: (1) personal barriers and (2) systems-related barriers. A third theme, (3) mental health access, was separately identified, as participants consistently highlighted access issues and financial barriers specific to mental health resources as a major gap in available services. Table 1 provides a summary of all themes and subthemes, along with illustrative quotes from participants.

Financial barriers were both personal and systemic in terms of program funding and staffing. Affordability of GAC was a source of significant anxiety among participants. Participants taking HRT via injection remarked on the fact that while the hormones they were prescribed were covered, the required syringes and needles to inject them were not. This posed a significant access issue for many, particularly those on fixed or low incomes. In a similar vein, several people taking testosterone highlighted the lack of coverage for non-injectable forms of testosterone—and the significant cost associated with paying for modalities like gel or patches out of pocket.

Participants expressed a desire to see an expansion in coverage for not only for medical supplies like needles, but to other aspects of medical care that might not traditionally be considered GAC. This included items such as binders, which reduce the appearance of breast tissue, as well as services like physiotherapy to help treat back pain associated with improper binding.

One of the other major concerns with respect to finances was affording time off for surgeries. Canada's Employment Insurance (EI) program provides temporary income support to workers who require time off for selected reasons, including illness (Employment and Social Development Canada, 2022). However, as one participant pointed out, "*EI only covers like, it's like 52% or something, [and] I'm like that will not completely pay my bills*." They went on to express frustration at the lack of explicit discussion around available financial support prior to arranging surgery dates, stating:

> *I didn't even get that information until like I already had my surgery date. And one of the things that the social worker said was like, "Oh just have like a nest egg ready to like pay your bills like when you can't work." And I'm like, well surgery is like a month away, I don't really have time to like put money away at this point. (Participant 3, queer, he/they)*

This participant's concern around information about EI in the postoperative period ties into the systems level barrier of difficulties related to underfunding/staffing, as they felt that the social worker they spoke to simply did not have the time to walk them through the process due to an overwhelming caseload. In a similar vein, multiple participants spoke of difficulties connecting with staff members at Klinic, with one participant stating "*god I feel like Klinic is just the best at phone tag in the entire world. I've gone through quite a lot of it.*" Despite this, participants felt that these issues were primarily related to Klinic's lack of funding and provincial support, rather than an intrinsic fault of the program itself, as one participant pointed out: "*yeah they could use a lot more support from the province.*"

Participants identified multiple different barriers with respect to having their mental health needs met. Perhaps unsurprisingly, lack of financial accessibility for mental health care posed a major hurdle for many of those interviewed, who did not have access to coverage for private counseling sessions. Interestingly, the desire for therapy was not usually motivated by a desire to discuss issues related to gender identity or dysphoria specifically, as one participant explained:

> *one of the other things I was primarily looking for and I'm still in the process of doing so is like seeking that like counseling and therapy side of things as well for just like in general like not so much for like gender affirming but just for someone who understand what I might be going through and can offer like guidance and support. (Participant 1, trans woman, she/her)*

The need for—and current dearth of—culturally relevant mental health supports was also raised by an Indigenous participant, who stated that:

> *smudging and cultural supports have also been really important for me for my mental health and it's not always very easy to find like even like elders and knowledge keepers and that are gender affirming all the time. (Participant 3, queer, he/they)*

In general, participants reported difficulties when it came to finding mental health practitioners perceived as safe and understanding of trans identities, and not having to "*go in blind about knowing hey are they OK with like who I am as a human being?*" Several participants reported asking explicitly for queer-friendly therapy resources, and were subsequently directed to options like drop-in counseling at the Rainbow Resource Centre. Though participants did express appreciation for the availability of this type of service, as one individual put it,

> *I guess what I would say I was probably looking for more so was like a list of dedicated names and addresses and phone numbers of people who have experience in these types of things. And that is something I'm still kind of struggling with. (Participant 1, trans woman, she/her)*

Table 1. Themes and subthemes identified by participants during discussions of barriers to care.

Theme	Subtheme	Excerpts
Personal barriers	Finances	[Employment Insurance] only covers like, it's like 52% or something I'm like that will not completely pay my bills. And like I didn't even get that information until like I already had my surgery date. *(Participant 3, queer, he/they)* so then you're having to look for a psychologist and that runs $120, maybe $150 I don't know what the rates are now, it's expensive. *(Participant 9, trans/nonbinary, he/they)*
	Having to follow a script to get care	I was a bit anxious of saying the wrong thing because I was worried about not getting the care I was seeking. I didn't want them to be like, "Well we don't think you're trans enough for this" or something. *(Participant 1, trans woman, she/her)* And I remember feeling a bit, like, anxious because I was like, what if I go on testosterone and it's not for me. I mean I didn't even – I didn't vocalize that because I knew that if you vocalize that that they're probably going to, like, go against you kind of thing. *(Participant 6, trans man, he/him)* yeah I feel a certain stress to, you know, make sure that, you know, they are completely confident with everything that they're treating me with. I don't to give them any way to doubt that. I want to make sure that I get it. *(Participant 2, trans woman, she/her)*
	Unspoken requirement for self-advocacy and to have a pre-existing knowledge base about own care	it's kind of just assumed like you kind of have an idea of what you're talking about unless they—unless you explicitly are like, "Hey, hey, hey, hey hold on." *(Participant 1, trans woman, she/her)* with a lot of this you kind of have to be the one to instigate any conversation about anything in terms of changes. You don't really hear what your options are you kind of have to bring them up and they'll either tell you yes or no. And I think that was also a bit of a source of anxiety *(Participant 2, trans woman, she/her)*
Systems related barriers	Wait times	I can agree with [name] on the voice training. I think I've been on a waitlist for about like two and a half years still for—at Deer Lodge so I've kind of given up on like expecting to go to that at all. *(Participant 1, trans woman, she/her)* I feel it probably took six months to a year, to even hear from anyone at all. And then actually getting on hormones and stuff, I would say that was about another year wait. *(Participant 8, transmasc, he/him)*
	Difficulties related to underfunding & understaffing	when I did hear back it was like pretty much just a 10 minute phone call with the social worker and I was frantically writing things down. Like it was very clear that like she had a really big caseload and just like didn't have the time to like go through it all with me. *(Participant 3, queer, he/they)* Yeah, it's, it's really hard to ever get a hold of [Klinic]. They're always very backed on their phone answers I assume because they're understaffed. And yeah it's just, it's very hard to try to establish doing anything new with them when you can never actually get a hold to talk with anybody there. *(Participant 2, trans woman, she/her)*
	Discrepancies in ease of access for GAC for cis vs. trans people	I have a couple of friends that have gone for, like breast reductions and like the wait times that they had for their breast reductions were like half the wait times for top surgery but like we're still going to same surgeons. *(Participant 3, queer, he/they)* my sister, for instance, she's still cis female but lacks estrogen. She had to start taking hormones. They're willing to do that, to give you estrogen to a body that already produces so much, but the second it gets into trans matter and hormones, that's where it becomes a problem. *(Participant 7, nonbinary, they/them)* the first thing that comes to mind would be voice training because I feel like when there's any other problems with a person's voice like it's, it's considered a medical thing to see a speech therapist for it. Yet for trans people it's not and it's much harder to access because it's not viewed that way even though it is just as much a treatment as everything else is. *(Participant 2, trans woman, she/her)*

(continued)

Table 1. (continued)

Theme	Subtheme	Excerpts
Mental health access	Lack of information on safe/affirming providers	And I have struggled a little bit to find like queer-inclusive therapists and when I do – and the one time that I did find one that I actually clicked pretty well with they made a comment that just like didn't really align. They were a white therapist and they just like didn't really align with some of my views as an indigenous person. And so like even when I did finally find someone it didn't end up working out because of my intersecting identities which sucked. *(Participant 3, queer, he/they)* I want to make sure I'm not just paying like someone downtown who doesn't really know much about what I'm going through. *(Participant 1, trans woman, she/her)* I have seen probably like a dozen different mental health specialists over the years. I've had a lot of support but one thing that's always been missing is that they don't have a good understanding on gender. *(Participant 4, nonbinary, he/they)*
	Financial inaccessibility	I actually would really like to talk to someone who's going to be like affirming and like I can't really afford to pay for this out of pocket even if I do find someone who's affirming *(Participant 3, queer, he/they)* but like sometimes it's just like you just—it's like, when you're in tough situations too, like when money's tight you're not going to be going out spending it on counselling, necessarily, you know? *(Participant 6, trans man, he/him)*
	Needing mental health support beyond dysphoria or surgical readiness assessments	So, that was just the thing in itself, to be able to talk about, just all the changes happening or things that were great or things that I was like, oh man, this is driving me nuts or, just having someone to vent to like that was really, really important for me. *(Participant 10, nonbinary, they/them)* For me access to mental health supports was not kind of related to my gender. I came out when I was 13 so I've been out for 12 years and following my like coming out as a teenager I went through some pretty serious mental health stuff and you know felt very chronically suicidal for quite some time. *(Participant 5, nonbinary, they/them)*

Discussion

This study's findings provide insight into the complicated reality trans people face when choosing to access gender affirming care through the medical system. It also demonstrated the considerable heterogeneity in what individual trans people consider important aspects of their own GAC, and builds on prior evidence demonstrating the positive benefits of accessing one's desired care (Burdge, 2014; Grant et al., 2011; Travers, 2018). This study also identified important barriers that trans people face throughout this process, from financial considerations to difficulties reliably finding affirming providers. This research works to fill a gap in the literature with respect to understanding the experiences of trans people accessing gender affirming care in a Canadian context. It also provides a rich data set regarding the current state of gender affirming care in Winnipeg, Manitoba, extending prior work done at the local and provincial level (Davis & Taylor, 2006; Heard et al., 2018).

A Well Thought Out Process

In this study, participants described a prolonged process of consideration before deciding to speak with any healthcare providers. This included ensuring personal safety, including physical living situation and having an affirming social network; several participants delayed their care because of this. Our participants also started a thorough process of research, often through formal and informal online sources, which started prior to connecting with healthcare systems and continued concurrently as they were navigating the system.

The Patient/Provider Relationship

Participants placed significant weight on the importance of working with providers who were affirming, respectful, and knowledgeable about trans health issues. Research from Ross et al. (2016) found a similar emphasis on the importance of patient experience, rather than outcomes alone, from their trans participants. Furthermore, there is some evidence that positive patient experiences lead to overall improved health outcomes (Manary et al., 2013).

While participants in general found practitioners at the trans health specialty clinic to be knowledgeable about trans issues, this did not hold true for primary care providers. Even participants who had supportive providers described frustration with perceived knowledge gaps. The paucity of formal medical education on 2SLGBTQ+ specific issues is not a new problem; in 2011, medical schools across Canada and the US reported a median of 5 hr of content devoted to this topic (Obedin-Maliver et al., 2011; Schreiber et al., 2021). Given the data suggesting that fears about discrimination and lack of provider expertise leads to adverse health outcomes for trans patients (Seelman et al., 2017), addressing this educational gap in medical teaching is an ongoing area of need.

Patient reported outcome measures (PROMs) could be a valuable tool in helping further understand the ways in which the patient-provider relationship could be improved. When implemented appropriately, PROMs have been shown to improve communication between patients and providers, enhance patient satisfaction, and improve care outcomes (Kamran, Jackman, Laws, et al., 2023). Despite these benefits in other areas of healthcare, unique barriers still exist when it comes to implementing PROMs in GAC settings, particularly when it comes to addressing concerns from patients about such tools potentially leading to delays in or denial of care, and both patient and provider concerns about data security and privacy (Kamran, Jackman, Chan, et al., 2023). While this is a potentially promising avenue to improve patient outcomes and care, more research is needed.

Old Problems, New Data: Waitlists and Financial Inaccessibility

Overall, the barriers identified at the local and systemic level are reflective of the current body of literature on the accessibility of gender-related care. In particular, previous local research has highlighted lengthy waiting periods to access care, and the resulting distress trans people experience as a result (Davis & Taylor, 2006; Heard et al., 2018). This reflects data seen across Canada and globally (Kearns et al., 2021; Pullen Sansfaçon et al., 2019) Similarly, financial considerations have long been identified as a major barrier to care for trans individuals. Though this is often conceptualized through a lens specific to healthcare coverage concerns in the United States (Puckett et al., 2018), participants in the current study highlighted many coverage gaps within the Canadian system as well, leaving some trans people with limited choice regarding treatment modality, or indeed struggling to afford the necessary equipment to administer those treatments. There is also little coverage available for gender affirming medical equipment such as binders, packers, and breast forms—all of which can potentially alleviate dysphoria and reduce mental distress.

The question remains, however—given the significant body of evidence demonstrating the negative impact long wait times and financial inaccessibility create, why has this issue persisted? From a Canadian perspective, this may in part be due to interprovincial variations in both coverage and physical proximity to specialized care. One study found that Quebec had the highest proportion of respondents indicating they had completed their desired GAC; Quebec, unlike Manitoba, has both a universal pharmacare program, and is home to the country's largest gender-affirming surgical centre—which until recently was the country's sole domestic provider of genital surgeries (Scheim et al., 2021). In a similar vein, respondents from Quebec were the least likely to be on a waitlist for GAC, followed by those in Ontario, which is home to Canada's first hospital-based gender-affirming surgery program (Scheim et al., 2021). The limited number of specialized programs and providers for some aspects of GAC creates a bottleneck, particularly as the number of Canadians seeking GAC is increasing. It also contributes to the financial inaccessibility of GAC, particularly with respect to surgical interventions; while the cost of the procedures themselves are generally covered, only two provinces and one territory currently provide some degree of coverage for any associated "personal expenses" such as airfare and accommodations (Mertz, 2022). A detailed analysis of the sociopolitical contexts affecting access to gender affirming care across the country is beyond the scope of this paper, however, there is certainly a need to ensure timely and equitable access for all trans Canadians, regardless of location or financial means.

Gatekeeping and Trans Exceptionalism in Medical Care

Specific to the Manitoba context is also the concern regarding the psychological assessment to access some surgeries which, as of the writing of this paper, is still mandatory in order to have procedure costs covered. Participants felt forced to choose between waiting potentially more than a year for the publicly funded psychologist working in the trans health specialty clinic, or seek private psychological assessment at great personal cost. Given that many trans people live in poverty and are precariously housed (Grant et al., 2011), the latter is often unattainable, and means delaying access to potentially lifesaving medical care (Coleman et al., 2022).

As aforementioned, it is important to note that the requirement for psychological evaluation itself represents a significant barrier, and is incongruent with the current recommended standard of care. While a multidisciplinary team that includes mental health expertise is recommended for adolescents, there is no recommendation that referral letters to access GAC must come from a mental health professional specifically (Ashley, 2019; Coleman et al., 2022). Though participants who had completed their assessments spoke positively about the experience and many emphasized the affirming approach of their psychologist, the majority nevertheless described experiencing anxiety and distress around the idea of being told they "weren't trans enough," and fears of being denied care. Strictly requiring these assessments to come from mental health practitioners represents additional hurdles in terms of financial accessibility, as well as the potential perceived stigma of needing a "mental health assessment" in order to access medically necessary care.

In a similar vein, participants also drew attention to the discrepancy in accessibility of GAC procedures for trans and cis people. While the phrase "gender affirming care" is almost exclusively discussed in relation to transgender medicine, cisgender people routinely seek similar procedures (Schall & Moses, 2023). This encompasses a wide range of procedures, from reconstructive mammoplasty following breast cancer and reduction mammoplasty to treat gynecomastia, to breast augmentation, testicular implants, and HRT. Participants in this study in particular commented on the difference in primary care providers' willingness to provide HRT to cis individuals, the lack of a mandatory psychological evaluation and substantially shorter waitlists for cis women seeking breast reduction, and the increased availability of referrals for voice training. This medical exceptionalism has been previously reported (Schall & Moses, 2023), and warrants further examination as a potential avenue to reduce inequity for trans patients.

Study Limitations

This research was based on a small number of interviews, with participants recruited by convenience sampling. They may have had more positive experiences overall during their care journeys, and thus have been more willing to be interviewed. Participants were also largely from urban areas and the experiences and perspectives of trans people living in rural and remote communities may differ significantly. The perspectives of trans women and Indigenous people were also underrepresented, with only two participants identifying as the former, and one as the latter. Furthermore, as pointed out by one participant, participation was limited to individuals with both reliable access to the internet and a private place to participate from, which presents a substantial barrier to a community that is often vulnerable and precariously housed.

Future Directions

It is important to acknowledge the limitations of the current body of research focusing on outcomes for trans people receiving GAC, particularly the need for more longitudinal follow-up data. While the phenomenon of trans identity is certainly not new, as Ashley and Domínguez (2021) point out, trans people have historically been excluded from participation in the very medical research that is integral to their healthcare. Additionally, many interventions beneath the GAC umbrella are not without risk—as is the case with any medical or surgical procedure. There is evidence for increased incidence of cardiovascular disease in trans people on testosterone-based HRT (Glintborg et al., 2021), and youth on puberty blocking agents may be at higher risk of low bone density (Guss & Gordon, 2022). Complications following gender-affirming surgical procedures have also been documented, including difficulties with operative site pain and sexual dysfunction (Potter et al., 2023) and urological complaints that can significantly impact quality of life (Fascelli et al., 2023). While some of these concerns are certainly not unique to trans healthcare, trans people often face unique barriers and significant discrimination when they require primary or emergency medical care (Grant et al., 2011); understanding these outcomes and particularly how to ensure appropriate and affirming management and follow-up, is vital to ensure equitable care.

There is also value in exploring the perspectives of healthcare providers, particularly nurses and family physicians in primary care who so often serve as the first point of contact for trans people seeking GAC. Several participants described having a provider who was reluctant to engage in discussions about or provide gender affirming care of any kind, and understanding the barriers and facilitators for these practitioners is important as services aim to be more inclusive. There is also a role for further research into how trans and other LGBTQ+ topics are incorporated into early education for medical students, nurses, and other allied health fields. Several small studies have shown a clear lack of such material in US medical and nursing school curricula (Lim et al., 2015; Schreiber et al., 2021), though there is evidence demonstrating that trans and LGBTQ+ focused content leads to students feeling more confident in their ability to provide respectful and affirming care for trans patients (Brown et al., 2017; Sherman et al., 2021).

Though both historically underrepresented racial minority patients and trans patients disproportionately report negative healthcare experiences compared to their white and cisgender contemporaries, there is limited data focusing on the unique experiences of transgender people of color (TPOC). Data that do exist suggest high rates of discrimination in the healthcare system; Black trans women in particular reported encountering negative provider assumptions about their HIV status, substance use, and involvement in sex work (Howard et al., 2019). There is also little qualitative work that captures the perspectives and experiences of Indigenous trans, two-spirit, and gender-diverse people; what data is available suggests higher levels of lifetime suicidality and transphobia-related violence compared to other TPOC, as well as increased risk of housing and food insecurity (Scheim et al., 2013). Ultimately, there is not enough existing research to ensure that the needs of communities with multiple intersecting minority identities are being correctly identified. Continuing involvement of a diverse range of trans people in service design and evaluation will continue to ensure that services meet the needs of the populations they are intended to serve in safe and culturally appropriate ways.

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Supplemental Material

Supplemental material for this article is available online.

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