How Transmen’s Health Can Be a “Women’s Health” Issue: Expanding the Boundaries of Sexual and Reproductive Healthcare

By:
E. Cameron Hartofelis

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Approved by:

First Reader
Lewis Margolis, MD
Associate Professor
Maternal and Child Health

Second Reader
John Wood Sweet, PhD
Director/Associate Professor
Program in Sexuality Studies/History
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Introduction

In 2011 the first results of the first comprehensive survey of transgender discrimination in the United States were released in the report, “Injustice at every turn – A report of the National Transgender Discrimination Survey” (NTDS). The report was compiled over the course of three years by the National Gay and Lesbian Task force in conjunction with the National Center for Transgender Equality. The findings presented shed light on the structural and interpersonal discrimination faced by transgender people in the United States across contexts, from the home to the office and everything in between. What was captured in the report was a striking picture of imbalance, from the visible or public humiliation faced when denied or dismissed from a job due to transgender status, to the private suffering of transgender people eschewing needed medical care due to past discrimination. The survey results demonstrated discrimination across all sectors (age, race, and class), though the disabling effects of “persistent, structural racism was especially devastating.” Rates of harassment and discrimination based on gender non-conformity in grades K-12 were reported at 78%, with nearly one-sixth (15%) of survey respondents reported leaving school before graduation to avoid further harassment.

Less present in the report was information regarding insurance coverage for transgender and gender-nonconforming individuals. One statistic is provided, and warrants further attention. The report states simply, “Study participants were less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid, and less likely to be insured by an employer.” These findings are supported by previous work done by scholars such as Gehi and Arkes, who reported in 2007 that transgender individuals were likely to have disproportionately low incomes, with estimates in some US cities.
that close to 50% of transgender individuals report no stable source of income. Medicaid acts as a catchment for lower income individuals with no alternatives to insurance coverage, thus is a crucial resource to the transgender community in the US. However, Medicaid is largely unable to provide necessary and needed care to this population in its pre-Affordable Care Act form, wherein coverage isn’t guaranteed for non-pregnant adults without dependent children.

Preventative and gynecologic care services are also often provided along gendered lines (i.e., women’s wellness or men’s wellness visits) which might lead to disputes over insurance coverage for needed services for transgender and visually gender-nonconforming individuals.

This paper explores the sexual and reproductive health needs and barriers to care for transgender men, referenced in this paper as “transmen” for consistency and brevity. Not all members of this community identify with this term; other common terms of self-identification may include: transgender man, trans man, male, transgender, transsexual man, female-to-male or FTM, or gender non-conforming. This population is largely heterogeneous, though certain health needs affect many and warrant closer attention by health professionals and systems. This paper will first address the broad needs of transgender individuals in the United States context. Next, I will explore the specific health needs and barriers to care faced specifically by transgender men. Last, I present my findings from a review of literature on transgender health and medical research, the health needs of transgender men, and provider perspectives on the treatment of transgender individuals.

I argue that though transgender rights have garnered significant national attention in the past year (for example, it was widely reported that Vice President Joe Biden called transgender discrimination “the civil rights issue of our time” during the 2012 election), the population still faces many obstacles in accessing needed health care. In particular, transmen face significant barriers to accessing sexual and reproductive health care, a problem that I argue cannot be
remedied without rendering visible the systems, structures, and policies that support this inequity.

**Transgender health in the United States – an overview**

In specific regards to health, the NTDS shows serious barriers to competent services for transgender people in the United States. Of the 6456 people surveyed, rates of HIV infection, smoking, drug and alcohol use and suicide attempts were much higher than reported in the general population. Nineteen percent of respondents reported being outright denied medical care due to their transgender or gender non-conforming status, with 50% of those able to receive services reported having to teach their medical providers about transgender care. Additionally, many respondents reported postponing needed medical care due to discrimination (28%) or the inability to afford services (50%). Overall, the NTDS results show that significant barriers to care exist for many transgender-identified individuals, with provider discrimination, employment, and insurance coverage all substantially contributing barriers in service provision and access. Providers and medical organizations have, in the past five years, begun to strategize about how best to meet the needs of transgender patients. In 2011 the US Institute of Medicine (IOM) released a comprehensive report entitled, “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding”. The report was guided by four conceptual frameworks (life-course, minority stress, intersectionality, and social ecological), and included information on the history of the US LGBT population in addition to suggestions for research concerning and treatment of LGBT people through their lives. The report additionally emphasized contextual understanding of the issues affecting LGBT health,
and included historical, policy, demographic, and environmental data in addition to statistical findings.³

Similarly, the American College of Obstetricians and Gynecologists (ACOG) issued a report in 2011 titled, “Health Care for Transgender Individuals,”⁴ which identified key focus areas and recommendations for providers caring for transgender individuals in a variety of clinical settings. The report notes that transgender individuals, especially transgender youth, are disproportionately represented in the homeless community, and may subsequently be denied access to shelter due to their nonconforming gender status.⁴ Transgender individuals are also reported to have significant barriers to accessing care, with a resulting 54% of transgender youth attempting suicide, 21% reporting self-mutilation, and 50% of transgender individuals reporting obtaining hormones illegally or outside of a clinical setting.⁴(p.2) The ACOG guidelines provide information for both female-to-male and male-to-female transgender individuals, listing the top three health needs for both in regards to access to hormones, surgery, and age-appropriate screenings. Though the report is brief, it clearly speak to the need for OBGYN and other primary care providers to provide competent, compassionate, knowledgeable services to their transgender and gender nonconforming patients. Important to note is that prior to these reports by ACOG and the IOM released in 2011, no such attention by either organization had specifically been paid to the needs of transgender patients.

Who are and aren’t “transmen?”

First and foremost, it’s critical to understand whom we refer to, and whom we are not referring to, when speaking about transmen. Before delving into specifics about this population, it might be helpful to go through a brief review of related terminology. Parsing the differences
between *sex* and *gender, transgender* and *cisgender* will provide helpful context for my broader discussion of the health needs and barriers to care for this population.

According to the World Health Organization, *sex* refers to the “biological and physiological characteristics that define men and women,” while *gender* describes the “socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women.”

5 The American Psychological Association defines “transgender” as “an umbrella term for persons whose gender identity, gender expression, and/or behavior does not conform to that typically associated with the sex to which they were assigned at birth.”

6 In contrast, a *cisgender* individual’s gender identity aligns with the sex assigned at birth.

*Transmen* were assigned a female sex at birth but have a male (or non-female) gender identity. As discussed in the introduction, transmen is not a finalizing term, and these individuals may describe themselves as transmen, female-to-male (FTM), male, or a range of other identifiers. Transmen are *not* a homogenous group and are *not* defined by what medical procedures they have or haven’t had. Transmen may seek a variety of medical procedures if they decide to undergo sexual reassignment surgery, including hormone therapy (e.g., androgen therapy) and reconstructive surgery (e.g., double mastectomy with nipple and areola reconstruction).

7 But, some who identify as transmen do not use hormones, have surgery, or seek other physical changes to their appearance as part of their transition, and only shift clothing and/or pronouns to signify their transition. This is of course a simplification of the complex means of expressing gender identity in this population. In overview, transmen:

- May or may not identify as male and use male pronouns
- May or may not have legally transitioned from female to male
- May or may not use hormones and/or have surgically transitioned
- Are *not* a homogenous group
- Are *not* defined by what procedures they have or haven’t had
Why this population?

Before delving further into the health needs and barriers to sexual and reproductive healthcare for this population, it is important to clarify why this population is at increased need for research and policy attention. In this section I will discuss gaps in research, high rates of discrimination, and the particular health needs of this population that add to their risk of unmet need of medical care.

Gaps in research

In order to better understand barriers to sexual and reproductive healthcare faced by transmen, I completed a review of all currently funded research relating to transgender health funded by the NIH, a primary funder of public health interventions. I conducted a text search of NIH funded projects using the NIH’s Research Portfolio Online Reporting Tools (RePORT) for the years 2011-2012, with “transgender” as the search term. Given these search conditions 41 projects were returned as having something to do with transgender health, though a review of project abstracts and related publications (if applicable) yielded only 10 projects with a specific focus on transgender health in their proposed intervention. Often, these projects grouped transgender health under the broader scope of LGBT-focused interventions. Six of the 10 transgender specific projects focused on the health needs of trans women, with most interventions focused on HIV prevention and risk reduction for this population. Notably, there was not one project whose primary focus was the health of transmen, though one of the Fenway Institute’s institutional grants included funding for a small (16 person) qualitative study with New England self-identified transmen.

And though national organizations such as the IOM and ACOG have specifically addressed transgender health in their recent reports, the health needs of transmen aren’t
emphasized. For instance, the IOM report de-emphasizes the health risks and barriers to care faced by transmen versus trans women, with 17 mentions of transgender men versus 42 mentions of transgender women (usually in conjunction with HIV risk) in their 2011 report.³

**High rates of discrimination**

As discussed in this paper’s overview of transgender health, the recent findings of the NTDS show disparities in access to services for all transgender individuals. Of those surveyed, transmen fared poorly in terms of barriers to care (perceived or experienced) in comparison with many of their peers.¹ Nearly half (42%) of transmen reported needing to teach their doctors how to provide trans care, with 42% postponing needed care and 48% of transmen postponing preventative services (compared with transwomen of whom 24% postpone needed, and 27% postpone preventative care).¹ (p.78) Transmen, in other words, report nearly double the rates of provider discrimination and subsequent postponing of needing care than their transwomen peers.

**Particular health needs and barriers to care**

Transmen have particular sexual and reproductive health needs, and though most needed services are routine care, transmen’s gender presentation and/or transgender status may lead to provider confusion or discrimination. Regardless of the gender-confirming or transition-related care transmen may or may not seek, most transmen are at-risk for what are deemed “women’s health” problems, such as ovarian, cervical and uterine cancers – before, during and after transition. The American College of Obstetricians and Gynecologists has stated that basic preventative services, such as sexually transmitted infection (STI) tests, comprehensive contraceptive counseling, and cancer screening, does not require “specific expertise in transgender care.”⁴ Thus providers must be educated in the provision of sexual and reproductive
care to all patients regardless of their gender presentation, and not expect their gender-
nonconforming patients to disclose their transgender identity or instruct them on transgender
care.

**Health needs of transmen**

In order to understand the extent and effects of inequity in access to sexual and
reproductive and preventative healthcare for transmen, one first must understand what needs this
population has that aren’t currently being met in health systems. Three primary, and often under-
studied, misunderstood, and under-funded areas of sexual and reproductive care that transmen
might seek to utilize are: 1) comprehensive cancer screenings, 2) HIV/STI counseling and care,
and, 3) family planning/abortion services.

**Cancer screenings**

On January 17, 1999 in a rural town in Georgia, Robert Eads died of complications from
metastasized ovarian cancer. For a year, Eads had been routinely denied treatment for an
unidentified illness, until the Medical College of Georgia accepted him as a patient in 1997. Eads underwent sexual reassignment surgery to physically transition from female to male in his
forties. As a post-menopausal woman prior to transition, he was told that removal of the uterus
and ovaries were not necessary for him to “complete” his reassignment. Unaware of the need
for regular screenings for ovarian and uterine cancers, Eads’ cancer went undetected until it was
untreatable. If Robert’s providers had counseled him about the need for preventative cancer
screenings post transition, he might have recognized sooner the warning signs for cancer and
sought treatment. Robert’s consented to have his final year of life filmed for a documentary film,
“Southern Comfort,” as he hoped to raise awareness for providers and the general public
regarding the need for comprehensive sexual health education and preventative care for female-born transgender identified people.

A 2005 guide, *Medical Therapy and Health Maintenance for Transgender Men: A Guide For Health Care Providers*, provides clear guidance on transmen’s need for comprehensive services, including cancer screenings, before, during, and after transition. It recommends that, in general, “screening *should continue until the patient no longer has the screened organ*” (emphasis added). The Guide notes that long-term androgen treatment and testosterone therapy — which aid the physical transition from one sex to another — are linked with high rates of Polycystic Ovarian Syndrome (PCOS). Left untreated, PCOS is associated with an increased risk of certain cancers (endometrial, breast) in addition to decreased fertility. The Guide stresses the importance of educating transmen who retain their uterus about the signs of endometrial cancers, and notes that,

> *Any patient* with a uterus/cervix should ideally have yearly pelvic exams with Pap smears…even if a Pap smear is not required ACOG still recommends yearly pelvic exams for any adult female-bodied person. This need for screening should be emphasized to transmen who have historically been reticent to seek out appropriate gynecologic care.” (Emphasis added)

Similar guidance about screening mammograms should be provided for treating transmen who have not undergone bilateral mastectomies, stating, “as with gynecologic screenings it is a general dictum that screening *should continue until the patient no longer has the screened organ*” (emphasis in original).

**HIV/STIs**

Another area of concern for transmen is susceptibility for and protection from HIV and other STIs. A 2010 study of New England transmen who have sex with men (TMSM) found that 87.5% of participants did not rank HIV/STI’s as in their top three health concerns. Lack of need
might partially be explained by the lack of information on STI/HIV risk for transmen, and partially by self-perceived risk in comparison to others, and thus this article speaks to the need for more research to be done concerning the individual, contextual, and psychosocial risk HIV/STI risk factors for TMSM despite perceived lack of need.

Another study completed by Kenagy and Hsieh researched HIV risk in female-to-male (FTM) transgender people based on health assessments undertaken in Chicago and Philadelphia. This study was one of the first larger-scale studies to specifically address FTMs and HIV. The authors note that FTMs might identify as a range of sexual orientations (gay, straight, bisexual, queer, etc.) and as such providers must not assume that they will only engage in sexual behaviors with female-bodied individuals. This study found that FTMs (29%) were significantly less likely than MTFs (59%) to have used protection the last time they had sex, which indicated a higher risk for HIV infection among FTMs. Similarly, FTMs (81%) were significantly more likely than MTFs (55%) to have engaged in high risk sexual activities during the three months prior to their survey interviews. Though this wasn’t a nationwide sample, the data presented by Kenagy and Hsieh clearly points toward a more complex understanding of HIV and STI risk for transgender men, taking into account the specific sexual behaviors engaged in by the individual being tested or treated. Individual and community specific preventative counseling about barrier methods, HIV/STI testing, and HIV/STI treatment should be offered to female-born transgender identified people so as to reduce sexual risk taking behaviors and risk of disease contraction.

**Family planning and abortion access**

Along with researchers reporting a dearth of information about the HIV and STI risks associated with transmen, the family planning needs of female-born transgender identified
individuals are nearly absent from the medical and public health literature. For many, the only identification they have with transgender men and reproductive health is what anecdotal information they’ve heard regarding Thomas Beatie, self-identified as the world’s first “Pregnant Man.” Beatie was subject to intense media scrutiny after he decided to give birth when his female partner was found to be infertile. Beatie and his then wife have described the painful and extended process of seeking care during Beatie’s pregnancy, with some providers outright refusing to treat the couple.¹²

Though the possibility exists for transmen to carry a child to term if they do not undergo a hysterectomy, family planning counseling is largely left out of the clinical guidance around healthcare for this population. Many transmen have cisgender male sexual partners. As such, they might require stigma-free access to contraceptives or abortion, as these individuals are at risk for unintended pregnancy and STIs.¹³ Similarly, space needs to be made in our family planning and abortion clinics for gender non-conforming and transgender individuals who require pregnancy-related services. Clinics providing abortion and miscarriage-related care are especially contested in many US communities, with protestors situated outside on a daily basis, and clinics should take into account the added stigma that trans or gender non-conforming individuals might face when seeking necessary care.

**Barriers to care**

Even the best-educated patients might encounter barriers to care due to their legal status, policies surrounding care, and provider beliefs. This section includes a discussion of the major barriers to sexual and reproductive health care for female-born transgender spectrum individuals:
1) refusal of care to transgender patients, 2) lack of provider knowledge around transgender sexual and reproductive health needs, and 3) economic or insurance-based barriers to care.

**Refusal of care**

In a recent report on LGBT Health, the Institute of Medicine found that a significant number of transgender individuals across contexts have faced refusal of treatment by providers, in addition to verbal abuse, disrespect, and other means of providing less than adequate care. Three percent of transmen reported being outright denied medical care due to their transgender or gender-nonconforming status. In the National Transgender Discrimination Survey (NTDS), 20% of transmen reported being refused care in doctor’s offices and hospitals (24%), followed by emergency rooms (13%) and mental health clinics (11%). Visual conformers, or those whose gender presentation closely matched their reported sex, were less likely to face refusal of care, with 23% of those who were “out” to their provider as transgender or gender nonconforming being refused care versus 15% of individuals denied care without disclosure.

**Provider knowledge**

Without increasing provider knowledge about the sexual and reproductive healthcare needs of transgender patients, disparities in care and service provision are bound to persist. Providers need to inform their female-born transgender patients of the full range of preventative screenings, tests, and precautions they should take to maintain their sexual and reproductive health. Roughly 62 percent of transmen NTDS respondents reported, “having to teach their
medical care providers about transgender care. Because of this gap in provider knowledge, 95% of transmen who have sex with men reported getting inadequate information from providers about their overall sexual health.

Of particular concern are providers and medical contexts where transgender patients are put at risk due to their perceived or disclosed transgender or gender-nonconforming status. The NTDS reported that 28% of respondents had been verbally harassed while in a medical setting, with 2% reporting being physically attacked in a doctor’s office or hospital. Those most at risk for attack were people of color, those without stable employment, undocumented individuals, and those engaging in sex, drug, or other underground work. It is important for patients to disclose their transgender or gender-nonconforming status without fear of emotional or bodily harm, particularly when seeking emergency or urgent care services.

**Insurance/Monetary**

Transgender individuals also face economic barriers to sexual and reproductive health care that create disparities in their ability to access health care services. At the time of the NDTS survey, respondents reported nearly double the rate of unemployment than in the general population. Those able to find or maintain employment reported workplace abuse, including harassment, being forced to present as the wrong gender, and physical assault. Additionally, respondents reported being less likely to be covered by private, or work-based insurance programs, with 19% without access to any insurance coverage.

Transgender individuals face particular barriers to insurance coverage related to their gender-presentation and their legal status. In many states transgender individuals are required to seek the approval of a psychologist and receive a diagnosis of Gender Identity Disorder (GIS) in order to begin hormonal transition-related treatment. In late 2012 the Diagnostic and Statistical
Manual of Mental Disorders revised their treatment standards, dropping GIS from the record and replacing the diagnosis with “Gender Dysphoria,” defined as, “emotional distress over “a marked incongruence between one’s experienced/expressed gender and assigned gender”.

Prior to the passing of the ACA there were no protections for transgender patients to avoid being denied coverage or dropped from their insurance plans based “pre-existing conditions” such as a diagnosis of GID or Gender Dysphoria. Thus, those seeking “gender-confirming care” such as masculinizing hormone therapy might be left without insurance coverage with few options for alternatives for care. And, though some transition-related services are covered by insurance, many transgender patients resist disclosing their transgender status to healthcare providers for fear of loss of medical insurance coverage. For example, a transman who takes hormones and has legally changed gender from female to male might be denied coverage for a Pap smear, which is covered only as part of a woman’s wellness visit. So though the Affordable Care Act prevents discrimination based on transgender or gender-nonconforming status by Federally funded programs and organizations, it does not fundamentally ensure that all needed services will be covered or offered to these individuals.

**What’s being done: current research and interventions**

This section will address the current literature and interventions surrounding the sexual and reproductive health of transgender men, in the hopes of better marking gaps in the research and spaces for further investigation and action. I focus on three primary themes around which to organize the existing literature: 1) the state of transgender health research more broadly, 2) articles on transmen specifically, and 3) provider-attitudes on transgender patients. Table 1 includes information on the articles discussed in this section.
<table>
<thead>
<tr>
<th>Transgender Health Article (n=11)</th>
<th>Keywords</th>
<th>Method</th>
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<tbody>
<tr>
<td>On bodies and research: Transparency issues in health and HIV research articles: Melendez, R., Bonem, L., Sember, R. (2006)</td>
<td>gender dysphoria; gender identity disorder; transsexual; transvestite; FTM; MTF; HIV prevention</td>
<td>Systematic review of the transgender health literature published in scientific journals</td>
</tr>
<tr>
<td>&quot;I don't think this is theoretical; this is our lives&quot;: how erasure impacts health care for transgender people; Bauer et al. (2009)</td>
<td>cisnormativity, erasure, healthcare access, marginalization, social exclusion, transgender, transphobia, transsexual</td>
<td>Qualitative data collected from focus groups with 85 transgender community members</td>
</tr>
<tr>
<td>There’s No Pamphlet for the Kind of Sex I Have: HIV-Related Risk Factors and Protective Behaviors Among Transgender Men Who Have Sex with Non-Transgender Men; Sevelius, J. (2010)</td>
<td>gender identity; HIV/STI prevention; MSM; sexual risk; transmen</td>
<td>Quantitative (n = 45) and qualitative (n = 15) interviews exploring trans MSM and sexual decision-making.</td>
</tr>
<tr>
<td>Health professionals’ factual knowledge and changing attitudes toward transsexuals*; Franzini, L., Casinelli, D. (1986)</td>
<td>transsexual, clinicians, knowledge and attitudes, survey</td>
<td>Random survey of 202 clinicians on knowledge and attitudes of transsexuals</td>
</tr>
<tr>
<td>Medical students’ ability to care for lesbian, gay, bisexual, and transgendered patients; Sanchez, et al. (2006)</td>
<td>medical student, LGBT, lesbian, bisexual, gay, transgender</td>
<td>248 medical students took an online survey assessing their ability to care for LGBT patients.</td>
</tr>
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</table>
Transgender specific research/interventions:

Besides work that’s been conducted exploring provider and population specific needs related to transmen’s sexual and reproductive healthcare, a number of researchers have written specifically addressing gaps in the literature and problems in the field of transgender health. Of particular interest is a subset of articles that discuss the way that research is conducted amongst transgender populations.

Melendez, Bonem, and Sembers’ 2006 article, “On Bodies and Research: Transgender Issues in Health and HIV Research Articles” spotlight the ways in which transgender community and bodies are represented and rendered in academic writing. The article has two main purposes: first, the authors discuss the difficulties inherent in conducting methodologically sound, ethical research with transgender individuals; second, the authors present the results of a systematic review they conducted examining if researchers had conducted research on HIV and transgender health, and if they did, how those researchers conceptualized transgender identities and bodies in their research. The methodological difficulties presented in this article remain relevant today, as do the author’s findings regarding transgender representation in academic discourse. Transgender individuals are often referred to as a hidden population, emphasizing that members of this population can be difficult to identify without self-disclosure. Studies of “hidden populations” can be difficult to conduct, as those who come forward to be interviewed might not be representative of the larger group. Transgender individuals reticent to reveal their trans status might fear stigma and discrimination, might not have a way to mark their transgender status on research intake forms (for instance, where one questions asking for an individual’s biological sex is asked), and they might not identify as transgender, instead locating themselves “comfortably within the dominant gender system.” The authors note that another difficulty that arises for health researchers attempting to
conducted studies with transgender populations is that the CDC doesn’t collect specific data on transgender-identified individuals, including HIV infection rates. Without this larger demographic data, researchers are unable to track health trends in transgender populations over time, thus magnifying and perpetuating the “politics of invisibility” for gender-nonconforming and transgender individuals in research.16 (p.24)

The politics of transgender invisibility in research are specifically spoken to in a 2009 article written by Bauer et al., “‘I Don’t Think This Is Theoretical; This Is Our Lives’: How Erasure Impacts Health Care for Transgender People”17. The authors wrote this article to explore the ways in which transgender individuals were rendered accessible to HIV infection, and excluded from accessible and appropriate health services. Reiterated in the article is Namaste’s concept of erasure as a guiding framework, defining the concept as: “a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible”17 (p.350). Discussions with transgender individuals unearthed erasure in two key domains: informational systems and institutional policies and practices.17 Participants noted that health research systems often didn’t allow for issues relevant to transgender individuals to be addressed, and when they did, the research might be generated in ways that were “stigmatizing and alienating” to participants.17 (p.353) Participants described institutional erasure primarily as the lack of policies addressing transgender identities, bodies, and communities, or the lack of knowledge that such policies even need exist. Bauer et al. contend that institutional erasure is built upon a cisnormative foundation, with cisnormativity defined as “the expectation that all people are cissexual, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women”17 (p.356). Participants suggested that transgender individuals be included in the development of trans-specific research,
and that institutions and providers create safe and appropriate spaces for individuals of all gender presentations; recommendations that are still being made by transgender health advocates today.

Of interest are another set of articles explore interventions for addressing HIV/STD risk in transgender populations. These interventions attempting to reach transmen in addition to transwomen are still relatively rare, thus it’s important to note how researchers manage to approach and address the needs of these different communities in one study. A 2001 study by Clements-Nolle et al. was the largest of its kind at the time to describe HIV risk, health care use, and mental health status of male-to-female and female-to-male transgender individuals. The author’s findings from ten years ago remain true today. In this sample, a large proportion (52% of transwomen and 41% of transmen) didn’t have health insurance access, indicating the need for interventions to address gaps in access to services due to this lack of insurance coverage. (p.919) Also noted was the need for interventions to focus on African American transwomen, who tended to have a higher rate of HIV prevalence. The authors additionally suggest that public health providers be in a position to provide care or referrals to care for not only physical but also mental and emotional health, as high rates of depression and substance abuse were found in all study participants.

Bockting et al., building on findings of those such as Clements-Nolle et al., devised a transgender-specific sexual health based intervention to reduce HIV/STD infection. Building on Robinson’s Sexual Health Model, the researchers developed the All Gender Health seminar, which was meant to not improve participant’s attitudes toward condom use and safer sex self-efficacy and reduce their sexual risk behavior. The intervention included a two-day, 16-hour seminar tailored to meet the needs of the transgender community, with participants completing pre-, post- and three-month follow-up questionnaires to aid in evaluation. The intervention proved to be effective in improving participants’ attitudes toward condom use and safer sex self-
efficacy and in reducing their sexual risk behavior. At the three-month follow-up, the increase in participant self-sufficiency wasn’t sustained, indicating societal pressures and stigma that might have made sustaining this shift in attitude and confidence difficult. Also of note was that a majority of participants (92%) found the intervention to be a positive experience, with 78% reporting, “they thought the seminar would help them avoid unsafe sex” (p. 297). Though the intervention was largely successful, it had notable limitations. Due to funding constraints, no control group was utilized for the study. Additionally, the results of the intervention were specific to a specific state context, and thus serve only as a baseline and are not readily generalizable. This intervention points to the need for broader interventions and curricula to be developed to affect change for transgender individuals across contexts. This particular intervention is also limited in its scope, as it attempts to affect change at the level of the individual, but makes no attempts to link individual change to structural or policy change.

Trans Male Specific Research/Interventions

A growing, though limited, number of articles have been published in the past 10 years focused specifically on the needs of transmen. At this point, there are no interventions that I’ve identified that have sought to affect access to services for this population. Most of the research has been exploratory in nature, attempting to render the population visible to healthcare providers, and identifying community health needs.

The majority of studies focused on transmen’s health focus on the HIV risk for this population. Specifically, researchers were interested in the HIV risk for transmen who have sex with cisgender (often gay-identified) men. A 2005 risk assessment analysis of transgender populations in Chicago and Philadelphia sought to test the validity of the long-standing assumption that transmen (FTM’s) had a far lower HIV risk than their transwomen (MTF)
peers. This assumption made about comparative HIV risk between transmen and transwomen was based mostly on confusion and inattention to the realities of FTM sexuality and lived experience. This study found that in this particular population, transmen were less likely to use protection during sex, and more likely than to have engaged in high-risk sexual relationships in the previous months. These findings remained consistent even after controlling for demographic and knowledge variables. The authors discuss the need to re-examine assumptions about FTM HIV risk, and caution against an overreliance on a two-gender (FTM/FTF) categorization schema for exploring HIV risk in the transgender community.

These findings were reiterated in a 2009 study, "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care For Transgender People,” exploring the HIV-related risk factors for transmen who have sex with non-transgender men. HIV prevalence in the study population was low (2.2%), but inconsistent condom usage was reported amongst participants for anal and vaginal intercourse. The authors note that an area of primary intervention is working for trans-MSM have access to trans-knowledgeable providers in gay male spaces, in addition to having access to accurate sexual health information for themselves and their partners.

Other research focuses on the health needs of transmen more broadly, exploring sexual health and utilization of health care amongst these individuals. A 2010 study of the sexual health needs of transmen who have sex with men (TMSM) discerned similar results from previous studies focusing on transmen and HIV risk. Participants made needed areas of intervention clear. First, nearly all participants mentioned a lack of adequate information regarding sexual health for TMSM. Second, participants noted being pressured into sexually risky behaviors when early in or during transition, suggesting the need. Participants also discussed how they shared sexual health information through informal channels, such as the Internet.
work, though not generalizable to national populations, provides a strong background for understanding the needs of a specific community, while also providing context-specific data about how best to affect change and spread information.

All of the above studies were relatively small in scale, with the Kenagy and Hseih 2005 study including 184 total participants (62 of those transmen), the Sevelius 2010 article using a sample of 45 for their quantitative interviews and 15 for their qualitative interviews, and the 2009 study of New England transmen who have sex with men including 16 participants. These articles note the need for more comprehensive work exploring transmale health needs, while simultaneously noting the difficulty in identifying and marking a homogenous transmale “community.” And, these articles point toward areas of further intervention, mostly directed at the level of the provider.

**Provider-centered:**

Before researchers began to explore transgender health from the perspective of transgender individuals themselves, studies were conducted examining medical providers perspectives on and capacity to care for these patients. These studies provide important data regarding provider knowledge, and are especially useful in pointing out gaps in medical school curricula and training. This research also serves an important educational function, affording readers with up to date data on the best practices, guidelines, and policy surrounding care of transgender and gender-nonconforming patients. This type of study isn’t new; providers have been wondering how best to provide (or if to provide at all) care for transgender patients as long as they’ve been visible members of society. With transgender and gender-nonconforming visibility on the rise, it’s imperative for providers and health systems to be respectful of these patients, their privacy, and their health needs and barriers to care.
An early study of provider perspectives on the provision of care to transgender individuals demonstrates how much progress has been made in this realm in the past 20 years. In one of the first papers of its kind, a 1986 article by Franzini and Casinelli marked changes in health professionals’ knowledge and attitudes of “transsexuals” since a preliminary inquiry into the subject was made in 1966.\(^{21}\) The general findings of this survey of providers were encouraging, such as the author’s note that, “the trend from 1966 to 1982 is toward more favourable views of transsexuals as people not threatening to society and as less likely to be severely neurotic”\(^{21}\) (p.537). The authors also reported that 82% of all interviewed providers supported awarding transgender individuals the protections of civil rights and anti-discrimination legislation, while 72% of providers surveyed disagreed in the advisability of providing gender-reassignment surgery for transgender individuals.\(^{21}\) (p.537)

More recent research confirms the growing trend of provider acceptance of lesbian, gay, bisexual and transgender (LGBT) patients. A 2006 study reported on current medical students’ ability to care for LGBT patients.\(^{22}\) Of the 248 medical students surveyed, 91.5% of those had at least one clinical encounter with an LGBT individual during the course of their entire medical school career.\(^{22}\) (p.22) Regardless of their experiences treating LGBT patients, medical students, “demonstrated little knowledge in the areas of cancer risk, mental health, HIV risk, and nutrition”.\(^{22}\) (p.23)

Studies such as these demonstrate both the importance of ensuring that providers work with LGBT patients during medical school and of providing comprehensive information regarding the needs of these populations. Other studies speak directly to providers who might encounter transgender and gender-nonconforming patients. A 2005 handout by the Transgender Law Center of San Francisco offers “10 Tips for Working with Transgender Individuals: A guide for health care providers.”\(^{23}\) Included in the brief is an overview to the transgender population of
the US, their health needs, and a list of common-sense tips for appropriate and comprehensive care for this population. These tips are meant to effect change at the level of the individual, perhaps stretching as far as modifying behavior at the level of the clinic or hospital setting. Examples of suggestions are as basic as, “Treat transgender individuals as you would want to be treated,” and, “It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care,” to the more complicated, “Establish an effective policy for addressing discriminatory comments and behavior in your office or organization”\textsuperscript{23} (p.2-3).

Along these lines, a 2008 article was written by and for certified nurse midwives concerning the “Gynecologic Care of the Female-to-Male Transgender Man.”\textsuperscript{24} For this study, researchers conducted qualitative interviews with a convenience sample of 6 female-born transgender identified individuals. Participants stressed the importance of receiving regular gynecologic care, expressed conflicted feelings about their breasts, and raised questions around when and how to reveal their transgender identity and complete patient intake forms.\textsuperscript{24} Though the study sample was limited, the researcher’s suggestions for clinical practice derived from their findings are in line with broader guidance around transgender healthcare.\textsuperscript{3,24,25} Particularly important was the author’s call for midwives and women's health providers facing the frontline for trans masculine care to be educated in the cultural and biological specificities of care for these individuals.\textsuperscript{24}

**Discussion**

Barriers to sexual and reproductive healthcare exist for transmen, though progress has been made in recent years to erase these inequities in access. In order to affect change, we cannot rely on individual level, behavioral interventions. Instead, we need to develop synergistic
interventions that address inequities in health for transgender men at the individual, community, policy, and systemic levels. Without addressing disparities from the level of the provider-patient interaction to a reform of insurance coverage for sex-specific healthcare, inequity in access to services will persist.

Provider education and clinic-level changes are promising and necessary areas in which to focus immediate attention. For, if female-born transgender individuals are both reluctant to seek care due to previous negative experiences with providers, and highly uncertain about their sexual health, the population is doubly disadvantaged. The past 10-15 years have seen a slight increase in the attention paid by clinicians and other providers regarding trans-appropriate care, though the specific needs of sub-populations such as transmen are lacking in the broader medical literature on transgender health needs. Organizations such as the National Center for Transgender Equality still find themselves in the position of releasing factsheets reminding providers to uphold basic rights such as, “Follow[ing] accepted medical guidelines,” “Report[ing] Discrimination,” and, “Adopt[ing] policies of respect and nondiscrimination.”

Though treating transgender patients doesn’t require special expertise, providers should attend to transgender sexual and reproductive healthcare needs and concerns with knowledge, respect, and non-judgment.

Even when patients seek needed services and disclose their transgender status so as to increase the competency of their care, that very disclosure might leave them without access to care due to provider refusal. Without attention to, and addressing of refusal of care for transgender patients, we won’t be able to fully meet the medical and personal needs of these patients. And, in the case of access to family planning services for transgender individuals, the disconnect between what providers and health care workers perceive transmen’s needs to be and their actual needs is severe. The problem is not so intractable, as it is frustratingly a symptom of
lack of space in clinics and exam rooms for transgender people to advocate for their needs and have those needs *heard*.

Though there is much work to be done to better address inequities in sexual and reproductive and broader health services for transgender and gender non-conforming individuals, a growing number of studies have brought attention to and investigated these issues. Many of these studies address specific health outcomes (HIV, mental health and suicide risk) and health risks facing all transgender individuals, with a minority specifically addressing the health needs of transmen. These are important steps forward in building a foundation of knowledge upon which systemic change can be made to address inequities in health, though there is far more work to be done. As a first step, the equitable inclusion, rather than mere mention of the sexual and reproductive healthcare of transmen should be incorporated in all further reports on transgender health. More work also needs to be done to better understand the needs of this heterogeneous community, from the perspective of community-members themselves.

**Recommendations**

- **Insurance Providers:** *Adopt full coverage insurance models for low-income individuals wherever possible.*

Though this is an idealized of recommendation, it’s important to stress. When full insurance coverage is mandated for all low-income individuals, issues surrounding coverage and coverage *loss* lose a significant amount of their meaning and power. Though guarantees of complete coverage do nothing to mitigate or end provider discrimination and refusal of care at the individual level, it would create a positive *right to coverage* for all – rendering these refusals easy targets for legal action.
• **Social Scientists:** conduct more community-based qualitative research to better understand the health needs and barriers to care for this particular population.

As mentioned at the start of this paper, transmen are not a homogenous group. Without qualitative analysis of the needs of individuals existing along the spectrum between female and male (some permanently and purposefully stationed in-between), we are no better able to address unmet need for healthcare and insurance coverage and advocate for policies protecting those individuals and fighting for their needs (and the needs of their communities) to be met. To quote Currah and Spade,

> Taking transgender lives as the starting point, the research question is no longer the riddle of gender or the particular gender configurations of transgender individuals; instead, the problem to be solved becomes the social and legal arrangements that structure gender nonconformity as problematic in the first place.\(^{26}\)

• **Medical providers:** move toward a paradigm of care delivery stressing the provision of essential services based on individual need rather than the individual’s sex or gender presentation.

There is some guidance in this area, but much more work is necessary to affect real change for transgender and gender-nonconforming patients. Without the buy-in of providers, insurance companies will continue to stress the dominance and efficiency of categorizing care by gender. Rather than arguing against the fields of “women’s” or “men’s health,” I call for a broadening of whom and what services fit underneath their umbrellas. Moreover, medical schools need to provide training for transgender populations, and those working in broader health-related fields should be made aware of the vast and varied needs of gender-nonconforming individuals (even if much of what they need is access to routine care restricted in provision to those of the gender they don’t represent or embody).
Conclusion

In 2011 ACOG’s Committee on Health Care for Underserved Women published an opinion noting that, “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.”27 The fact that key officials, health care associations, and policy-making entities are discussing transgender issues demonstrates a significant cultural sea change on this issue. Much more must be done, however, to ensure that health care providers and insurance companies are able and willing to provide necessary health care services to all who need them, regardless of their gender expression and identity. Doctor’s offices, Emergency Departments, labor and delivery rooms, and clinics must be safe spaces for individuals of any gender presentation, and services must be offered based on a person’s need rather than their appearance.
Works Cited


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i This is an important assumption made on my part in this analysis. As there is little data about sexual and reproductive health interventions in the United States. NIH funding was utilized, as they are the foremost funders of sexual and reproductive health interventions in the United States. A more conclusive analysis of all funding sources for public health interventions might have yielded more funding for transgender-related research, though the scope and scale of this particular project didn’t allow for such an analysis.

iii A health clinic named in Eads’ honor has been integrated as part of the yearly Southern Comfort conference, which attends to the needs of transgender (particularly trans-masculine) individuals.

iv For more on this see Mayer et al., 2008

v Transgender activists and allies have been attempting to rid the DSM of mention of GID for years, having only now succeeded in their goal of lessening the stigma attached to seeking transition-related mental and/or physical healthcare.

vi Dean Spade, among others, utilizes this term to refer to individualized treatment that differs according to the needs and pre-existing conditions of individual transgender people. Some transgender people undergo no medical care related to their expression of a gender identity that differs from their birth-assigned sex. Others undergo only hormone therapy treatment or any of a number of surgical procedures.