Health Equity for Transgender and Gender Diverse People

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Assistant Professor, Harvard Medical School & Harvard T.H. Chan Director of Transgender Health Research, BWH and Fenway Health

https://www.transhealthresearch.org/
Road Map

- Terminology and Framing
- Transgender mental health inequities
- Gaps and opportunities
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- Terminology and Framing
- Transgender mental health inequities
- Gaps and opportunities
“Sexual and gender minority” is an umbrella term that encompasses lesbian, gay, bisexual, and transgender populations as well as those whose sexual orientation, gender identity and expressions, or reproductive development varies from traditional, societal, cultural, or physiological norms. This includes individuals with disorders or differences of sex development (DSD), sometimes known as intersex.
Gender Minority and Cisgender

- **Gender minority** – Gender identity different than assigned sex at birth
  - Transgender, nonbinary, other gender diverse people
  - “Transgender and gender diverse” (TGD)

- **Cisgender** – Gender identity that is congruent with assigned sex at birth sex
  - Not gender minority
Gender Minority Population

- **Transgender man (he/ him/ his):**
  - Trans man, trans male, trans boys
  - Female assigned sex at birth

- **Transgender woman (she/ her/ her):**
  - Trans woman, trans female, trans girls
  - Male assigned sex at birth

- **Nonbinary (they/ them/ their):**
  - Outside the female-male gender binary
  - Genderqueer, genderfluid, agender, pangender, gender expansive
## Population Estimates: People Who Identify as Transgender in the U.S.

<table>
<thead>
<tr>
<th>Population</th>
<th>Source</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgender adults, ages 18+ years</td>
<td>Behavioral Risk Factor Surveillance System, 2014 [1]</td>
<td>0.58% (0.36%, 0.95%)</td>
</tr>
<tr>
<td>Transgender adults, ages 18+ years</td>
<td>Meta-analysis (27 studies) [2]</td>
<td>0.87% (0.52%, 1.22%)</td>
</tr>
<tr>
<td>Transgender high school students, grades 9-12</td>
<td>Youth Risk Behavior Survey, 2017 [3]</td>
<td>1.8% (1.0%, 3.3%)</td>
</tr>
</tbody>
</table>

Gender Affirmation

Social

Psychological

Medical

Legal

Reisner, Radix, Deutsch, JAIDS, 2016
Gender Identity ≠ Sexual Orientation

- Sexual orientation
  - How a person identifies their physical, romantic, and emotional attraction to others

- Gender minorities can be of any sexual orientation

Road Map

- Terminology and Framing
- Transgender mental health inequities
- Gaps and opportunities


1. Clinical (21%)
   - Psychiatric diagnosis (e.g., gender identity disorder, gender dysphoria)
   - Recipients of hormones, surgeries

2. Identity (79%)
   - Transgender status
   - Two-step method

Health Outcome Categories in Transgender Health, 2008-2014 (n=981 Data Points)

Health Outcome Categories in Transgender Health, 2008-2014 (n=981 Data Points)

- Mood Disorders (n=96)
- Suicide and Non-Suicidal Self-Injury (n=50)
- Anxiety Disorders (n=44)
- Interventions (n=0)

Health Outcome Categories in Transgender Health, 2008-2014 (n=981 Data Points)

- Substance Abuse, Dependence, Disorder (n=10 Data Points, 5.2%)
- Interventions (n=0)
Transgender Health Research: Number of Peer-Review Publications, 2009-2018

# of Publications

Year

Search performed 4/10/19
Transgender Health Inequities

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

- n=27,715 respondents
- 39% serious psychological distress in past 30 days
  - 5% U.S. general population
- 40% lifetime suicide attempt
  - 4.6% U.S. general population
- 7% suicide attempt in past year
  - 0.6% U.S. general population


- 19 U.S. states and Guam (n=151,456)
- Gender minority vs cisgender
- More days per month of...

- Poor mental health ($\beta=1.7; \ 95\% \ CL=0.3, \ 3.1$)
- Poor physical health ($\beta=2.4; \ 95\% \ CL=0.6, \ 4.2$)

Meyer, Brown, Herman, Reisner, Bockting, AJPH, 2017
Mental Health of Transgender Youth: A Matched Retrospective Cohort Study (n=360; Mean age=19.6)

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

GM vs Cis Medicaid Beneficiaries

Table 2. ORs for Suicidality in Each Year 2009–2014 by Eligibility Cohort and Gender Minority Status

<table>
<thead>
<tr>
<th>Cohort</th>
<th>OR GM versus NonGM, (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidality (any) including suicide attempt, suicidal ideation, or potential attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td>2.10 (1.60, 2.75)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Disabled adults</td>
<td>1.95 (1.82, 2.09)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td>4.37 (2.26, 8.46)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Disabled adults</td>
<td>1.70 (1.50, 1.94)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td>2.61 (1.56, 4.37)</td>
<td>0.0003</td>
</tr>
<tr>
<td>Disabled adults</td>
<td>2.23 (2.05, 2.43)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Potential suicide attempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older adults</td>
<td>1.43 (1.01, 2.00)</td>
<td>0.0412</td>
</tr>
<tr>
<td>Disabled adults</td>
<td>1.36 (1.22, 1.50)</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Note: Results are from authors' analysis of 2009–2014 Medicare Research Identifiable Files. Boldface indicates Bonferroni-adjusted statistical significance of p<0.0008. All models adjust for age and behavioral health conditions (as binary indicators). Outcomes are modeled as repeated observations per individual; clustered error structure at the beneficiary level accounted for within- and between-subject variance. GM, gender minority.

Gender Minority: disabled, n=6,678; older adult, n=2,018

Cisgender: disabled, n=535,801; older adult, n=1,700,008

Health Disparity or Inequity

“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
Why Transgender Health Inequities?

Transgender and Gender Diverse ➔ Adverse Mental Health
Why Transgender Health Inequities?

Minority Stress
- Individual
- Interpersonal
- Structural

Transgender and Gender Diverse → Minority Stress → Adverse Mental Health

Why Transgender Health Inequities?

Transgender and Gender Diverse

Minority Stress
- Individual
- Interpersonal
- Structural

Adverse Mental Health

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

<table>
<thead>
<tr>
<th>Weighted Percent (%)</th>
<th>Adj. RR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>3.58 (2.74, 4.68)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2.93 (2.30, 3.72)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1.68 (1.29, 2.19)</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1.98 (1.55, 2.53)</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>3.02 (2.43, 3.75)</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>2.04 (1.62, 2.58)</td>
</tr>
</tbody>
</table>

Models adjusted for age, race/ethnicity, family SES, geographic context.

Reisner, Greytak, Parsons, Ybarra, Sex Res, 2015
IPV in TGD Populations: Systematic Review and Meta-Analysis

- 85 articles from 74 unique data sets (before July 2019)
  - $n_{total} = 49,966$ TGD participants
- Median prevalence in TGD individuals: 37.5% lifetime physical IPV, 25.0% lifetime sexual IPV, 16.7% past-year physical IPV, and 10.8% past-year sexual IPV
- TGD vs cisgender individuals:
  - Any IPV (RR = 1.66; 95% CI = 1.36, 2.03)
  - Physical IPV (RR = 2.19; 95% CI = 1.66, 2.88)
  - Sexual IPV (RR = 2.46; 95% CI = 1.64, 3.69)
- No evidence-based interventions to prevent IPV in TGD

Recalled Exposure to Gender Identity Conversion (GICE) Therapy in USTS

- Between Aug to Sept 2015: n=27,715 trans/NB
- Mean [SD] age, 31.2 [13.5] years, 42.8% MAB
- 71.3% had ever spoken to a professional about their GI
- 19.6% (95% CI, 18.7%-20.5%) reported GICE
- Associated with increased odds of:
  - Severe psychological distress, last 30 days (aOR=1.56; 95% CI=1.09-2.24)
  - Lifetime suicide attempts (aOR=2.27; 95% CI=1.60-3.24)
    [before the age of 10 years (aOR=4.15; 95% CI=2.44-7.69)]

Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults.
Turban JL, Beckwith N, Reisner SL, Keuroghlian AS.

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

+ Transgender and gender nonconforming adults

Streed, McCarthy, Haas, JAMA Intern Med, 2017
Mental Health + Social and Structural Vulnerabilities: Transgender Women in LITE

- N=1,020 transgender women
- March 18-March 2020 (pre COVID-19)
- >50% BIPOC
- 41% PTSD symptoms
- 27% living with HIV
- 27% Psychological distress
- 28% suicide ideation prior 6 mo
- 29% alcohol misuse
- 29% substance use disorder
- 54% unemployed
- 46% incomes below federal poverty level
- 13% homeless in prior 3 mo
- 21% engaged in sex work in prior 3 mo

https://www.litestudy.org/
Poteat, Reisner, Miller, Wirtz. J Acquir Immune Defic Syndr, 2020
LITE: Food Security

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

Food Insecurity Among Cohort Participants

Food Insecurity Among Cross-Sectional Participants

https://www.litestudy.org/

Reisner, Wirtz, The LITE Study Group, in prep.
Gender Affirming Clinical and Public Health Model

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

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

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

KEYWORDS
Health equity, Health care, Transgender

INTRODUCTION
Transgender people have an assigned sex at birth that differs from their current gender identity or expression. This report describes the evolution of Fenway Health’s multidisciplinary model of transgender health care, research, education, training, and dissemination of its practice. This includes the development of, and changes to, a community-based approach spanning almost two decades. Opportunities for future growth of transgender care and research locally and globally are discussed, with a focus on the linkage of clinical care with health research, education, training, and advocacy to promote social justice and health equity for transgender people across the world.
Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2019

Number (N) of Patients

Year

Series1
Series2
Series3
Series4
Series5
Series6
Series7
Series8
Series9
Series10
Series11
Series12

0 500 1000 1500 2000 2500 3000 3500 4000 4500

11 41 116 366 879 1208 1456 2017 2939 3454 3763 4238


33
Fenway Health in Boston, MA: Transgender Health Program Growth, 1997-2019
Gender-Affirming Research “With” Not “On” Trans Communities: Experientially and Contextually-Informed

- Sensitive, responsive, and affirming of gender
- Trans communities are meaningfully engaged
- Trust, authenticity, and reciprocity between trans communities and health and research settings
Participatory Population Perspective

Work “with” not “on” transgender communities

Lesotho: standing up for transgender health and rights

Living proudly as a transgender man in the small sub Saharan country of Lesotho has come at a serious price. My public activism on issues of sexual orientation and gender identity and expression makes me vulnerable to threats to my personal safety. The widespread instances of “corrective” rape against transgender men and lesbian women mean that I must constantly be careful and vigilant in every kind of public space, from entertainment venues to walks home from work. Gender prejudice is a norm in Lesotho, so in addition to these fears and the work I do as Director of the People’s Matrix Association (Matrix Support Group), gaining my family’s acceptance is its own burden.

Beyond fears for discrimination and violence in public and even private settings, there are country-wide infrastructure challenges, such as poor internet connection and capacity stressors. Like many such organisations, resources are limited and the People’s Matrix Association and there are few opportunities for professional development, which makes planning and implementation work extremely challenging. All of which seriously affects my professional and personal life, as I sometimes must sacrifice my personal resources just to keep the organisation running. The long hours this work often requires further endangers my personal safety, not to mention affecting my relationship with partners and friends.

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

Tompho-Mothopeng

Tompho-Mothopeng is the Director of the People’s Matrix Association (Matrix Support Group) in Lesotho, an organisation specializing in young people, health, human rights, policy advocacy, research, women’s issues, and youth empowerment. During his time at the People’s Matrix Association (Matrix Support Group), he has organised strategies to meet the health needs of transgender and non-conforming individuals and responded directly to health needs of gay and bisexual men through newly-developed programmes. Additionally, he has participated in programmes to combat HIV and gender-based violence and developed LGBT youth and advocacy networks.

South Africa: access to gender-affirming health care

My own reality as a transgender woman of colour from rural South Africa is what brought me to the legal fight for justice for other transgender women and people in South Africa and beyond. In South Africa, the legacy of colonialism, institutionalized inequality, and apartheid shaped the current reality of people of colour, especially for transgender people of colour. All of these intersecting factors lead to a complex array of colour of trans women that can only begin to add to: the legal context makes the fight for justice for other transgender women and people in South Africa and beyond.

In South Africa, the legacy of colonialism, institutionalized inequality, and apartheid shaped the current reality of people of colour. When legal documents do not match the identities of transgender persons, it presents a huge challenge for accessing health and other social services. The health context also affects our lives. There are only two facilities in South Africa where gender-affirming surgeries are done, and both have a short waiting list of many years. Often when transgender people do not get to be their authentic and true selves, the mental-physical disconnect factors into transgender people not “taking care” of themselves. This manifests in high-risk behaviours such as sex work that increases HIV risk.

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

Leigh Ann van der Merwe

Leigh Ann van der Merwe is the Coordinator and founder of S.H.E (Social, Health and Empowerment Feminised Collectives of Transgender and Intersex Women of Africa). Leigh Ann was born in Igwenyana, Eastern Cape of South Africa. Leigh Ann has extensive experience in research pertaining to health, sexual and reproductive health, and human rights. She holds a certificate in Community Journalism from the University of South Africa and is currently working on the postgraduate programme in Public Health at the University of the Western Cape. Over the past 8 years, Leigh Ann has held positions within several local and international agencies, and non-governmental organisations, and has presented and consulted on transgender women’s issues. She was also a fellow in the Open Society Australian American Foundation/Transgender Centre of Excellence programs.

### Mental Health and Substance Dependence Diagnoses Assessed via Clinical Interview (MINI) in Young Transgender Women, Overall and by Age (n=298, Mean age 23.4 Years)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. (%)</th>
<th>No. (%)</th>
<th>Age 16-19 y (n = 55)</th>
<th>Age 20-24 y (n = 146)</th>
<th>Age 25-29 y (n = 97)</th>
<th>Test Statistic</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major depressive episode</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>103 (35.3%)</td>
<td>51 (35.9%)</td>
<td>45 (46.9%)</td>
<td></td>
<td></td>
<td>13.0</td>
<td>.002</td>
</tr>
<tr>
<td>Current</td>
<td>42 (14.1%)</td>
<td>124 (6.4%)</td>
<td>15 (15.5%)</td>
<td></td>
<td></td>
<td>3.74</td>
<td>.15</td>
</tr>
<tr>
<td><strong>Suicidality (moderate/high), past 30 d</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>55 (18.8%)</td>
<td>28 (19.7%)</td>
<td>23 (23.7%)</td>
<td></td>
<td></td>
<td>5.02</td>
<td>.08</td>
</tr>
<tr>
<td><strong>Generalized anxiety disorder, past 6 mo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>25 (8.3%)</td>
<td>16 (11.0%)</td>
<td>8 (8.2%)</td>
<td></td>
<td></td>
<td>3.32</td>
<td>.19</td>
</tr>
<tr>
<td><strong>Posttraumatic stress disorder, past 6 mo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>25 (8.5%)</td>
<td>15 (9.7%)</td>
<td>9 (9.5%)</td>
<td></td>
<td></td>
<td>1.92</td>
<td>.38</td>
</tr>
<tr>
<td><strong>Alcohol dependence, past 12 mo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime</td>
<td>33 (11.0%)</td>
<td>16 (10.3%)</td>
<td>16 (10.3%)</td>
<td></td>
<td></td>
<td>4.23</td>
<td>.12</td>
</tr>
<tr>
<td><strong>Nonalcohol psychoactive substance use dependence, past 12 mo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of diagnoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>173 (60.1%)</td>
<td>79 (56.4%)</td>
<td>51 (54.3%)</td>
<td></td>
<td></td>
<td>10.7</td>
<td>.005</td>
</tr>
<tr>
<td>1</td>
<td>58 (20.1%)</td>
<td>32 (22.9%)</td>
<td>20 (21.3%)</td>
<td></td>
<td></td>
<td>3.10</td>
<td>.21</td>
</tr>
<tr>
<td>2</td>
<td>26 (9.0%)</td>
<td>13 (9.3%)</td>
<td>10 (10.6%)</td>
<td></td>
<td></td>
<td>0.76</td>
<td>.68</td>
</tr>
<tr>
<td>3</td>
<td>20 (6.9%)</td>
<td>10 (7.1%)</td>
<td>8 (8.5%)</td>
<td></td>
<td></td>
<td>1.15</td>
<td>.56</td>
</tr>
<tr>
<td>4</td>
<td>7 (2.4%)</td>
<td>4 (2.9%)</td>
<td>3 (3.2%)</td>
<td></td>
<td></td>
<td>1.00</td>
<td>.95</td>
</tr>
<tr>
<td>5</td>
<td>4 (1.4%)</td>
<td>2 (1.4%)</td>
<td></td>
<td></td>
<td></td>
<td>0.01</td>
<td>.99</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Notes:**
- Test statistics for binary data (e.g., lifetime major depressive episode) and categorical data (e.g., age) are χ² with 5 df (2 × 3 contingency table). Test statistics for continuous data (e.g., mean number of diagnoses) are t test. All reported test statistics are adjusted for study site (Boston vs Chicago).
- Includes current major depressive episode, suicidality (high/moderate), generalized anxiety disorder, posttraumatic stress disorder, alcohol dependence, and nonalcohol psychoactive substance use dependence.
LEGACY Cohort

PI: Reisner
ClinicalTrials.gov ID: NCT03595956

https://www.pcori.org/research-results/2017/understanding-how-gender-affirmation-therapies-affect-hiv-related-health
Demographics (n=4330)

- Mean age 30.7 (SD=10.6)*
- 74.2% white, 5.3% Black, 5.8% Multiracial, 5.2% Asian, 1.0% Another Race, 8.5% missing, 10% Hispanic/Latinx
- 32.6% female, 32.9% male, 30.8% genderqueer or not exclusively male or female, 3.7% other/missing*
- 26.2% public insurance, 4.2% no health insurance*
- 80.2% current hormones
- 20.6% behavioral health visit in last 12 mo*
- 39.8% psychotropic medication*
- 47.8% depression diagnosis code*
- 19.0% (n=826) suicide ideation

*p<0.05
Suicide Ideation in LEGACY (n=4330): Subgroup Differences by Age, Gender Identity, and Health Insurance Status

<table>
<thead>
<tr>
<th>Age Group in Years (ref=40+)</th>
<th>Multivariable Logistic Regression Model</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group in Years (ref=40+)</td>
<td>aOR (95 CI)</td>
<td>p-value</td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>1.69 (1.23-2.32)</td>
<td>0.0011</td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>1.46 (1.06-2.00)</td>
<td>0.0196</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>1.08 (0.78-1.49)</td>
<td>0.6413</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender Identity (ref=Female)</th>
<th>Multivariable Logistic Regression Model</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1.39 (1.11-1.76)</td>
<td>0.0047</td>
<td></td>
</tr>
<tr>
<td>Genderqueer or not exclusively male or female</td>
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Model adjusted for: # behavioral health visits, psychotropic meds, depression diagnosis. Reisner et al, in prep
US National Survey of College Campuses: Mental Health in GM vs Cis Young Adults

- 2015-2017 Healthy Minds Study (N=65,213 randomly selected students on US college campuses)
  - n=1237 GM students → 2.1% prevalence
- Clinically-validated screeners: depression, anxiety, eating disorders, self-injury, suicidality
- Meet criteria for 1 or more mental health outcomes
  - 78% of GM vs 25% of cis students
  - 4.8 times higher odds (95% CI=3.6, 5.1)
  - 3.85 times higher for TM; 1.92 higher for TF [vs cis men]

Gender Minority Mental Health in the U.S.: Results of a National Survey on College Campuses.
Lipson SK, Raifman J, Abelson S, Reisner SL.
PMID: 31427032
## US National Survey of College Campuses: GM Subgroup Mental Health Differences

<table>
<thead>
<tr>
<th>Gender</th>
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<th>(N=330)</th>
<th>Transgender FAB</th>
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</tr>
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<tr>
<td></td>
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<th>Another self-identified gender FAB</th>
<th>Another self-identified gender MAB</th>
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Weighted percentages and age-adjusted odds ratios (OR). Dep (depression) is ≥10 on the PHQ-9. Anx (anxiety) is ≥10 on the GAD-7. ED (eating disorder) is ≥3 on the SCOFF. NSSI is non-suicidal self-injury in the past year. Suicidal attempts are in the past year.
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Noninbary Adult Health in MA

- Mean age=32.6, 63% FAB, 20.6% POC (2.9% Black, 9.5% Latinx, 5.3% multiracial, 2.9% other)
- 40.9% nonbinary → nonbinary vs binary:
  - Younger age, trans masc vs trans fem, sexual minority vs not
  - Recognized their TGD identity at older age
  - Less likely to medically affirm gender (27.0% affirmed, 21.6% plans to, 30.8% no plan to, 13.0% do not know)
  - Not up-to-date on annual wellness visit
  - Increased odds of depressive distress in last 7 days and AUDIT+ for hazardous alcohol use
  - Lower odds of receiving MH care in last 12 mo

Intersectionality
Health Effects of Stigma, Social Exclusion, and Violence

2019

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

- Terminology and Framing
- Transgender mental health inequities
- Gaps and opportunities
Sexual Orientation and Gender Identity (SOGIE): Data Collection in Clinical Settings

Adding Questions to Registration Forms

SOGI questions can be integrated into the demographics or social history section of the registration form. The SOGI questions in Figure 3a have been studied in different health center populations and have been found to be acceptable by most patients. For definitions of SOGI categories and terms, see Figure 3b on page 5. For information on how to code and report SOGI data in the Uniform Data System (UDS), see the most up-to-date UDS manual reporting instructions from BHPC.

Figure 3a. Recommended SO/GI Questions

Do you think of yourself as (Check one):
- Straight or heterosexual
- Lesbian, gay, or homosexual
- Bisexual
- Something else
- Don’t know
- Choose not to disclose

What is your current gender identity? (Check one):
- Male
- Female
- Transgender Male/Trans Man/ Female-to-Male (FTM)
- Transgender Female/Trans Woman/ Male-to-Female (MTF)
- Genderqueer, neither exclusively male nor female
- Additional gender category, please specify: ______________
- Choose not to disclose

What sex were you assigned at birth? (Check one):
- Male
- Female
- Choose not to disclose

Important Note: the reason for asking both gender identity and sex assigned at birth is because some transgender people will identify their gender as ‘male’ or ‘female,’ and not as ‘transgender’ or ‘genderqueer.’
Tools for Epidemiology: Two-Step Method

- Step 1: Assigned Sex at Birth
- Step 2: Current Gender Identity

Leverage Factors Associated with Favorable Mental Health in Transgender and Gender Diverse People

- Gender affirmation
- Integrated healthcare delivery services
- Family acceptance
- Peer support
- Community engagement and advocacy
- Adaptive coping
- Resiliency (“bouncing back”)
- Protective laws and inclusive policies
World Health Organization (WHO) Change in Classification: Gender Incongruence

- International Classification of Diseases (ICD)-11
- Transsexualism → gender incongruence
- Mental health disorders → sexual health conditions
- Effective 2022

[Video Link](https://www.youtube.com/watch?v=KCK5QmLXJ90)
Gaps and Opportunities

- Collect and use SOGIE
- Train providers and increase capacity of care systems
- Conduct intervention design and testing
- Identify strategies to engage TGD people
- Develop tools to assess TGD-specific exposures and outcomes
- Strategic science to inform human rights
Considerations for Advancing Health Equity for TGD People

- TGD umbrella is comprised of multiple subgroups (community → communities)

- Health inequities are not equally distributed across the TGD population

- TGD intersects with other social identities and positions

- Multilevel contexts shape TGD health across the lifecourse

- Tailored approaches and strategies are needed, developed in collaboration with TGD communities
“Despite substantial gaps in empirical research, there are sufficient actionable data … surrounding health risks and resiliencies for transgender people that need interventions.”


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

Contact:
sreisner@bwh.harvard.edu

https://www.transhealthresearch.org/
Please cite this presentation as follows: