

Factors associated with facilitators and barriers to gender-affirming care among transgender
and nonbinary youth and young adults in Washington: A mixed-methods approach

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Abstract

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Background: Access to gender-affirming care is associated with improved mental health among transgender and nonbinary (TNB) individuals, particularly among TNB youth. We conducted a mixed-methods study to examine the association of age with prevalence of facilitators and barriers to gender-affirming care among youth and adults who identify as TNB residing in Washington. In addition, we qualitatively assessed system and interpersonal level factors that potentially facilitate and/or create barriers to access among trans youth in Seattle.

Methods: In the quantitative study, sociodemographic characteristics and responses related to healthcare discrimination and access to gender-affirming medical care were collected via the 2022 Pride Survey by Public Health – Seattle & King County. Age was the exposure variable and various forms of facilitators and barriers to care were the outcome variables. Multivariate Poisson regression with robust standard estimates were used to estimate the association between age and facilitators and barriers to care. In the qualitative study, one-on-one interviews and a focus group were conducted with trans youth in the Seattle area. Participants were asked

questions related to navigating healthcare, disclosing gender identity in health-related situations, and experiences of receiving gender-related care. Integration of qualitative and quantitative data during analysis and interpretation occurred via a contiguous approach.

Results: Our quantitative findings (N=496) indicate that the prevalence of facilitators and barriers to care did not differ between TNB youth (13 to 24, n=189) and young adults (25 to 34, n=307). About a quarter (25%) of participants reported that they had access to all the gender-affirming treatments that they want or need. Youth were 45% less likely to experience provider refusal of care than young adults (PR=0.55, 95% CI: (0.38, 0.80), $p<0.008$). Interviews with youth participants (N=19) highlighted various facilitators and barriers to care, including ways in which providers interacted with the participant and their families, family support for or resistance to their transition, knowledge of gender-affirming care at the community-level and within healthcare settings, healthcare structure, and dominant narratives about transness.

Conclusion: Many TNB youth lack access to gender-affirming care. Our findings affirm the importance of creating a safe space for youth to explore their gender identity and have access to medical professionals and communities that validate their varied experiences. These findings indicate important policy implications on creating more equitable access to gender-affirming services.

INTRODUCTION

Transgender is an umbrella term that describes people who experience their gender in a way that does not align with their assigned sex at birth, while cisgender refers to people whose gender identity or expression aligns with their assigned sex at birth.^{1,2} The term “transgender” encompasses a wide range of gender identities and some transgender individuals may not identify with any gender or exist between outside binary notions of gender, such as nonbinary, agender, genderqueer, among others.² For the purpose of this paper, the term transgender and

nonbinary (TNB) will be used to try to best capture the range of transgender and gender diverse (TGD) communities.

Data from the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) 2014 survey that included 19 states estimate that 0.6% of US adults identify as transgender¹ (1.4 million); 0.7% of youth ages 13 to 17 (150,000) identify as transgender, and other studies estimate ranges of the TNB population between 0.39 to 2.7%.^{3,4} Based on local probability surveys and national convenience samples, the percentage of youth that identified as transgender ranged from 1.3 to 3.2%.⁴ It is estimated that there are 33,000 individuals within Washington state that identify as TNB.⁵ Of those individuals, 38% reported negative healthcare experience such as the need to educate providers on their trans identity and denial of care; 22% avoided seeking medical care out of fear. Approximately 60% of respondents that had a negative healthcare experience had at least one lifetime suicide attempt, and the lifetime risk of suicide attempt is 10 times that of the general population.⁵ TNB individuals disproportionately face higher rates of adverse mental health outcomes in addition to barriers to healthcare access, poverty, unemployment, and discrimination compared to the general population.^{2,5,6}

Gender-affirming care can encompass a wide range of services, including pubertal suppression, hormone replacement therapy (HRT), gender-affirming surgeries, speech therapy, behavioral health services, and preventative care visits.^{6,7} Access to gender-affirming care is associated with improved mental health among TNB individuals, particularly among TNB youth. Transgender adolescents who had access to puberty blockers were 70% less likely to consider suicide than those who did not use medications, and being supported through a social transition improves mental health outcomes.^{8,9} A recent study found that access to gender-affirming hormone therapy (GAHT) is associated with lower rates of depression, suicidal ideation, and

¹ BRFSS does not ask questions related to nonbinary gender identities.

attempted suicide among transgender and nonbinary youth; however, only 21% of youth who wanted to receive GAHT actually received it.¹⁰ Enabling TNB youth access to gender-affirming care can reduce symptoms of depression and anxiety, as well as improve gender positivity.¹¹

There are a growing number of TNB youth in need of gender-affirming care in the US. Reports suggest that the number of TNB individuals seeking pediatric care have increased in the last decade, but disparities in access to care are apparent.⁶ According to the US Transgender Survey, considered one of the most robust surveys to date with 27,715 respondents from the 2015 survey, 15% of respondents reported that at some point in their lives they wanted puberty-blocking medications, usually used by youth between the ages of 9 and 16. However, less than 1% of respondents reported ever having accessed them.¹² Other smaller studies report slightly higher ranges of access to gender-affirming care, although these are typically carried out in healthcare settings, selecting for those who are already accessing care.¹³ One study analyzed pediatric referrals of patients less than 18 years of age, and found of the 506 referrals, 173 (34%) were for puberty suppression and/or cross-sex hormones and 162 (32%) for gender-affirming surgery.⁶

TNB individuals experience significant barriers in access to health care compared to cisgender individuals, and these gaps are even greater among TNB youth. Barriers to care for TNB youth include limited insurance coverage, patient age requirements, limited or delayed access to pubertal blockers, financial barriers, lack of family approval, and lack of cultural competence by medical providers; these barriers overlap with those cited by transgender adults such as cost, limited access to gender-competent providers, experiences of misgendering, and uncoordinated care and gatekeeping.^{7,13} Substantial disparities in access by race and ethnicity are also apparent, with very few youth of color represented in clinic referrals that provide gender-affirming care.^{6,14} A large number of TNB individuals are low-income, another factor associated with access to gender-affirming care.^{15,16}

Substantial research is still needed to examine facilitators and barriers to gender-affirming care for TNB youth. Existing qualitative research has explored barriers to care and experiences of discrimination in healthcare settings among transgender individuals, but there is more limited quantitative and mixed-methods research examining these factors and in particular age disparities in access to care.^{13,17} Other studies have observed differences in healthcare utilization between TNB and cisgender youth and adults, but few studies examine these differences within TNB populations.¹⁸ There is limited literature that has quantified the proportion of TNB youth compared to adults who have accessed gender-affirming care. The experiences and needs of TNB youth differ from those of adults in experiences related to education, employment, accessing health care, and updating identity documents.¹² The purpose of this study was to conduct a mixed-methods analyses to examine the association of age with prevalence of facilitators and barriers to gender-affirming care among youth (13 to 24) who identify as TNB compared to young adults (25 to 34) within Washington State. In addition, we qualitatively assessed system and interpersonal level factors that potentially facilitate and/or create barriers to access among trans youth in Seattle.

METHODS

Quantitative

Study Participants and Procedures

The Public Health-Seattle & King County's Pride Survey is an ongoing annual public health surveillance survey. Due to the COVID-19 pandemic, the 2021 Pride Survey was conducted exclusively online. Supplemental data on Healthcare Access and Discrimination, an optional module developed by a Community Advisory Board (CAB) of queer and TNB adults from the Seattle area consisting of 10 survey items, were added to the online Pride Survey. While the supplemental survey questions on access to gender-affirming care were created de novo by the CAB, questions on healthcare-related discrimination were modified from the

TransPOP Study and the US Transgender Survey. Participants were recruited via virtual events and social media postings during Seattle Virtual Pride events in 2021 and eligible to participate if they identified as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, or Two-Spirit (LGBTQIA2S+) and lived in Washington state. Data for this project was collected via REDCap directly from participants who complete a self-administered anonymous online survey. The survey was offered in both English and Spanish. Individuals who completed the survey could choose to be entered into a raffle for prizes (iPads) and optionally provide their name and email address. All identifiable data were de-linked from survey responses and destroyed after the raffle was completed, which occurred prior to conducting analyses.

Participants included anyone who selected a sexual orientation other than heterosexual or anyone who indicated they were a gender other than cis who live in Washington state. Of the 2,275 respondents to the core survey, 1,560 completed the supplemental survey pertaining to gender care and access to services. The analytic sample was restricted to TNB youth (13-24) and young adults (25-34). Ethical approval for the supplemental survey was obtained from the University of Washington Institutional Review Board. The Pride Survey itself is considered a public health surveillance activity and did not require IRB review.

Variables

Core Pride Survey questions collected by Public Health Seattle & King County for surveillance purposes included questions about demographic characteristics (age, race, ethnicity, sexual orientation, gender identity), socioeconomics (income, education), HIV and STI prevention behaviors (e.g., testing, PrEP), STI history and HIV status, sexual behavior (e.g., gender of partners, types of sex, condom use), and substance use, among others. The supplemental survey included questions related to participants' interaction with providers, navigating access to gender-affirming care, types of gender-affirming care received, experiences of discrimination in healthcare settings, among others. The supplemental survey required participants to consent to this additional survey.

Participants were able to select more than one option for demographic characteristics such as sexual orientation, gender identity, and race and ethnicity. Regarding the questions, “Are you transgender?” and “Do you consider yourself to be...?”, participants were categorized as TNB if they responded “Yes” to the former question or if they responded “Transgender man/trans man,” “Transgender woman/trans woman,” “Non-binary,” “Gender non-conforming,” “Genderqueer,” or “Two-spirit” to the latter question. For the latter question, participants were also included as TNB if they responded “Woman/female” and “Male” to the question “What is your sex assigned at birth?” and vice versa for “Man/male” and “Female.”

The exposure of interest was age, with youth (13-24) considered as “exposed” and young adults (25-34) as “unexposed.” The outcomes of interest were based on whether the participant experienced various forms of facilitators and barriers to gender-affirming care, including whether participants accessed gender-affirming medical treatments, had taken hormones, experienced provider refusal, misgendering and deadnaming, or forms of verbal or physical abuse, among others. Definitions of these survey questions were not provided. Outcomes were all created as dichotomous variables. Individuals who responded “N/A” or “Not applicable” to questions were removed from analyses. Due to small sample sizes or related survey questions, some variables were comprised of responses to multiple questions. The coding of these outcome variables is further described in the table below (**Fig. 1, Appendix**).

Covariates in adjusted multivariate models were selected a priori, including income, education, and health insurance. These variables were categorized as binary indicator variables for adjustment. Income was categorized as earning <\$15,000 vs >=\$15,000 and education was categorized as having a high school education vs no high school education.

Statistical Analyses

First, we conducted descriptive analyses of socio-demographic characteristics of TNB youth (13-24) and young adults (25-34) by age group. We initially examined these characteristics comparing TNB youth (13-17 and 18-24) only, but due to small sample sizes and

for the purposes of increasing study power, we collapsed the youth group and compared these characteristics to young adults aged 25-34. However, since we found it informative to highlight frequencies of facilitators and barriers to care among youth despite limited sample sizes, we included findings for youth only (13-17 and 18-24) in supplemental tables. Descriptive statistics were calculated to assess facilitators and barriers to gender-affirming care among TNB youth compared to young adults. Prevalence ratios (PRs) and 95% confidence intervals were then estimated via Poisson regression with robust standard errors to compare outcomes across age groups. Income, education, and health insurance were chosen as confounders since these variables were highly collinear with age. Controlling for confounders, we fit a multivariate regression model containing the main effects of the age variable as the exposure and the facilitators and barriers to care as the outcome variables.

Due to small sample sizes and confidentiality concerns, we were unable to assess effect modification analytically nor look at the intersection of gender identity and race and ethnicity; however, we descriptively examined the frequencies of the outcome variables by gender identity among TNB youth. TNB youth participants were categorized into four gender identity categories: trans men (TM), trans women (TW), nonbinary assigned male at birth (nonbinary AMAB), and nonbinary assigned female at birth (nonbinary AFAB). All analyses were conducted in R software version 1.3.1.

Qualitative

Participant Recruitment and Sampling

Qualitative data collection occurred between November 2018 and September 2019. Participants were recruited by posting information about this study on social media (e.g., Instagram), in addition to hard copy materials distributed at local organizations that serve youth, and LGBTQ+ youth advocacy and community organizing events. Information about the study was also posted electronically to existing parent support groups and shared with adults in supportive roles in youth's lives (i.e., parents, teachers, school counselors, therapists, etc.).

Inclusion criteria were age 13 to 17 at the time of interview, English-speaking, transgender-identified, and having sought care in Washington State. Youth participated in one-on-one interviews and one focus group with high school-age trans youth. Youth were given the option to interview in the presence of a youth advocate. Of the 11 participants, seven chose to participate without their parents present, with three of these youth requesting the presence of a youth advocate during consenting. The youth advocate was present during the focus group. A waiver of parental permission was obtained to allow the enrollment of youth under age 18 without parental involvement or consent. Ethical approval was obtained from the University of Washington Institutional Review Board. Prior to the start of the individual interviews and focus group, informed consent was obtained from participants.

The investigator used discursive interviewing techniques—informal conversational exchanges rather than other interviewing techniques and involved interviewers as active participants.¹⁹ Participants were asked questions related to navigating healthcare, disclosing gender identity in health-related situations, and experiences of receiving gender-related care. Interviews lasted between 60 to 120 minutes and were audio-recorded and transcribed. Participants were given an electronic copy of the transcript and invited to make edits or additions to the original interview material. Youth participants received a \$25 gift card for participating in interviews.

The focus group included youth who were part of an existing support group for TGD youth attending a high school in the Seattle area. To ensure confidentiality and comfort for the participants, the focus group was conducted privately at the hosting organization. In addition to the youth advocate, the discussion group moderator—an individual who had an existing positive relationship with focus group participants—and primary researcher were also present during the discussion. Ground rules for the focus group discussion were co-created by participants. The discussion lasted approximately 90 minutes and was audio-recorded and transcribed. Focus group participants received a \$20 gift card for participating in the discussion.

Data Analysis

The qualitative data analysis relied on a deductive approach that was used to develop a codebook a priori based on existing literature and quantitative data. An inductive approach was used to further refine the codebook by reading and rereading the transcripts, identifying codes ascertained via the interview text, and expanding the codebook.²⁰ Thematic analysis rooted in grounded theory methodology was used. Thematic analysis involves the identification of key themes that address the research question.²¹ ATLAS.ti version 9.1.3 were used for qualitative coding and analysis. The full codebook is available for auditing.

Mixed-Methods Design

Integration of qualitative and quantitative data during analysis and interpretation occurred via a contiguous approach, where the quantitative and qualitative findings are reported in different sections.²² This mixed-methods approach was used for complementarity purposes where the quantitative data identified associations between age and facilitators and barriers to care among TNB youth and young adults, while the qualitative data helped to further elucidate trans youth experiences with access and barriers to care to provide additional context to the quantitative findings.

RESULTS

Quantitative

Demographic Characteristics

A total of 496 youth (13-24, n=189) and young adults (25-34, n=307) were included in the final sample (demographic characteristics reported in **Table 1**). The majority of participants (79%) were assigned female at birth across both age groups, with similar proportions in each age group. More than half of participants identified as nonbinary and queer (61% and 53%, respectively), with similar proportions of nonbinary youth and young adults while there was a smaller proportion of queer youth compared to young adults. The majority of participants

identified as White (82%) across the whole study population and among youth and young adults. Nearly a third of participants (33%) had reported incomes of <\$15,000, with over half of youth and nearly a quarter of young adults reporting this income. The majority of participants (94%) had health insurance across the whole sample and both age groups.

Among youth ages 13-17 (n=33), demographic characteristics were qualitatively similar to those among youth ages 18-24 (**Supplementary Table 1, Appendix**).

Prevalence of Access, Facilitators and Barriers to Care

The prevalence of ever experiencing facilitators and barriers to gender-affirming care by age among TNB youth and young adults are shown in **Table 2**. Overall, 25% of participants who responded to the question reported that they had access to all the gender-affirming treatments that they want or need, with 26% of young adults being able to access gender-affirming treatments compared to 24% of youth. Nearly 34% of participants had ever taken hormones, 29% of youth compared to 36% young adults having ever taken hormones; 19% had taken hormones not prescribed by their doctor, while 10% of youth compared to 23% of young adults had taken hormones not prescribed by their doctor. Approximately 39% were unable to access or initiate gender-affirming treatments due to financial hardship, lack of medical access, lack of knowledge/resources, lack of facilities/providers, or another reason not listed, with similar frequencies across youth and young adults. Feelings of LGBTQ+ pride was experienced across the majority of participants (91%).

The only significant difference between youth and young adults was the proportion who reported provider refusal of care. Youth were 45% less likely to experience provider refusal than young adults (PR=0.55, 95% CI: (0.38, 0.80), $p<0.008$), adjusting for income, education, and health insurance. Although the unadjusted estimate showed that youth were less likely to encounter a provider they had to teach about trans people to get appropriate care (uneducated about trans health), this finding was not significant when adjusted for confounders.

Additional findings regarding the prevalence of ever experiencing facilitators and barriers to gender-affirming care by age among TNB youth only (13-17 and 18-24) are further described in the supplementary table below (**Supplementary Table 2, Appendix**).

Prevalence of Access and Barriers to Care by Gender Identity among Youth

The prevalence of facilitators and barriers to gender-affirming care by gender identity among TNB youth (N=189) are shown in **Table 3**. The majority of TNB youth identified as nonbinary AFAB (n=137), followed by trans men (n=42), trans women (n=13), and nonbinary AMAB (n=11). There were some differences in access and barriers to gender-affirming care by gender identity. Of those that responded, 41% trans men, 50% trans women, 0% nonbinary AMAB, and 21% nonbinary AFAB individuals had access to all the gender-affirming treatments that they want or need; 68% of trans men and 70% trans women have ever taken hormones compared to 13% nonbinary AMAB and 20% AFAB individuals. Simultaneously, 62% of trans men, 31% of trans women, 46% of nonbinary AMAB, and 34% of nonbinary AFAB individuals reported being unable to access care. In addition, feelings of LGBTQ+ pride were relatively consistent across gender identity.

Qualitative

A total of 19 participants were included with 11 individual interviews and one focus group (n=8). The mean age among participants was 15.4 (13-17). Participants lived in both urban (n=9) and rural (n=2) areas of Washington State. Participants identified as transgender male (n=6), transgender female (n=3), queer/gender non-conforming (n=1), and transmasculine/FTM (n=1). The majority of participants were White (n=10), with one multiracial participant (n=1). Participants discussed their experiences navigating the healthcare system and services such as psychotherapy, primary care, urgent care, gender clinics, surgery, sexual and reproductive health services, nutrition, laboratory, pharmacy, and school-based health services.

Participants highlighted facilitators and barriers of access to care at the interpersonal, community, institutional, structural, and systems-levels. These levels impacted individual health outcomes such as feelings of dysphoria, depression, internalized stigma, and self-worth. Facilitators to care included patient-provider connectedness, supportive relationships with adults, and community epistemologies. Barriers to care encompassed misinformation from adults, healthcare structure and timing of care, and dominant narratives around transness. These themes are described in detail below.

Facilitators

Patient-provider connectedness

Patient-provider connectedness appeared in the interviews through providers' use of gender-affirming language, respect of confidentiality, and sharing similar lived experiences to facilitate a trusting and safe environment for participants. Providers using gender-affirming language or legitimizing the participant's gender identity played an important role in improving access to care and reducing feelings of gender dysphoria. For instance, participants reported the importance of being asked their name or pronouns at the start of the visit, which one participant noted helped to "remove the culpability for me," particularly when navigating internalized transphobia. Participants also appreciated the use of gender-neutral terminology during visits. Rather than using gendered terms for body parts, providers' use of terms that are more gender-affirming helped to reduce dysphoria associated with talking about particular body part. For example, one participant noted that their provider said "people with cervixes are at risk for this" rather than gendering cervixes. Another provider asked the participant "how far along are you in your gender journey" rather than asking if they identified with a particular (binary) gender was very affirming for them.

Another important component around affirming one's gender identity was respecting confidentiality in provider-patient interactions. In particular, participants discussed their interactions with therapists, who sometimes were the first person that participants came out to.

So when I was talking with that counselor ... he was the first person I came out to. In person I said, this is what I think is going on and then he said, yeah that lines up with everything I've been noticing. I started getting better but [my parents] didn't really have communication with him so I didn't have to come out to my parents yet. And I remember he was super supportive, which was really nice.

Therapy was shown to be an important environment for youth to come out as trans in a safe and confidential space without feeling judgement. It also acted as a starting point for participants to prepare for transitioning or help facilitate coming out to their parents/caregivers. Parents/caregivers often took participants to therapists for gender or non-gender related topics, such as if the participant had been struggling with depression and suicidality. In these spaces, using gender-affirming language and maintaining confidentiality created a safe environment for youth to feel comfortable to speak freely.

Medical or mental health professionals sharing similar lived experiences with the participant helped to enhance a trusting environment. Participants discussed the importance of working with therapists who identify as trans or work with trans people. One participant interacted with a therapist who also identified as trans and shared a similar lived experience, which helped the participant feel more comfortable speaking about their gender identity without fear of judgement and described the experience as feeling like less work trying to "prove" that they are trans to the therapist.

The first three [therapists] were all cis women and then my therapist before my current one was like a transmasculine nonbinary person. My current therapist is also a transmasculine, nonbinary person ... My cis therapists were all like pretty accepting about [my gender identity], but I feel like it was a lot easier to talk about it with trans therapists because they could relate their own experiences.

Professionals within medical and mental health settings were frequently the first responders when dealing with youth navigating their gender identity, especially if they were not out to their parents yet, and thus creating an affirming environment was critical to open avenues for navigating the gender-affirming care youth needed.

Supportive relationships between and with adults

Youth having supportive relationships between and with adults was shown to help participants access gender-affirming care. These relationships occurred at two levels: the providers' relationship with the family and the family's relationship with their child. For instance, medical and mental health professionals validated the participants' gender identity, assisted them with coming out to their families, and educated their families on trans topics. Having that "expertise" from a therapist or provider created legitimacy for the participant's identity that would otherwise not be there if the participant tried to come out without that "medical standpoint."

I think it made it more legitimate to them. when I told [my parents] they looked at me and said, well that's wrong and they didn't believe me. Having the medical perspective [was] saying like, this is something real. When I initially started the hormone [my mom] was worried about depression, she was reading a lot of the research about it even though there isn't like a lot, but she was looking into that. I think it made it like more concrete and more real and smooth that they could actually like look at it and believe and explain to other people like so as family members they didn't have to like stutter over their words anymore and say we're supporting him. It was more so like, yes, this is how it is. We talked, he's been to a counselor, like this is the right decision for our kid.

Medical and mental health professionals who engage with trans patients acted as mediators to reassure families and facilitate family support when they were hesitant about their child's trans identity or starting the transition process. Another participant discussed how their provider—who specialized in gender-affirming care—was able to bring up difficult topics, such as top surgery, during a visit with the parents that the participant could not have brought up alone which helped facilitate conversation between him and his father about surgery.

Providers who also shared a similar demographic background with participants and their families appeared to be a significant facilitator for accessing gender-affirming care. One participant expressed the importance of having a doctor who shared the same racial and ethnic background as their family. The participant also noted that they were more likely to trust

providers who shared similar racial and ethnic backgrounds, in addition to citing the distrust in the medical system among people of color.

... my doctor is <ethnicity>.² My mom is also <ethnicity> and even though she was using the wrong terminology for talking to my mom and telling her that I really need to get into the gender clinic I feel like that definitely did it for my mom ... I think people of color are generally more likely to trust doctors of color and nurses of color. Me included, I definitely have and am less likely to trust, especially white cis hets³ telling me something, I'm like, no I'm not gonna believe that. I feel like if it was like a white doctor telling [my mom] that I think she'd maybe [be] less likely to be on board.

Parental/caregiver support for their child's identity was one of the largest facilitators to accessing gender-affirming care for youth under 18-years-old due age limits related to parental consent. Participants expressed concern about waiting to start hormones until they turned 18; those with supportive parents, while some initially hesitant, were able to start their transition earlier. One mother present during an interview expressed her knowledge and sympathy towards her child's transition. The mother and child recounted their experience with transitioning and the parent casually discussed topics in ways that indicated her support of the transition.

You were bulking up. You got the binder. July you changed your name because I'm like, fine. I mean, somebody asked me like, but what if he changes his mind? Okay, he changes it back. It costs 70 bucks.

Notably, the parents were able to pay for top surgery out of pocket since they had the finances to do so and deliberately avoided going through insurance under the assumption they would be rejected since the participant was under 18. Other supportive parents who were present during the interviews discussed their financial ability to help cover the costs of surgery if insurance was not going to cover it.¹ Participants with parents who were not only supportive of their child's decision but also had the financial means to do so tended to experience significantly less barriers in accessing care. In addition, parents that allowed their child the space and opportunity

² Ethnicity was masked for confidentiality purposes.

³ Cisgender and heterosexual.

to speak for themselves during healthcare interactions facilitated bodily autonomy for the participants.

Community epistemologies

Most participants were able to access gender-affirming care via the dissemination of informal knowledge from peers and community members. If participants were given insufficient or incorrect knowledge when receiving their medical care, they turned to online forums and social media for advice or to explore their gender. One participant said that “before I was out or even knew clearly what my identities were I was very active online and experimenting with different names and pronouns or online profiles and stuff like that.” Other participants watched trans YouTubers who shared their own experiences with transitioning to understand what they might expect during their health care visits, but also what it actually looked and felt like to transition. Participants who were not out to their parents yet or could not receive advice from a medical professional relied on online resources, such as this participant describing their research on binding when they experienced chest pain:

I was hoping for a very long time to just not go to a doctor and instead be a fabulous medical researcher. And so I might heal myself. And again heal my chest through medical knowledge and force of will. It didn't work. But I had done research. There was very little resources out there for binding explicitly but there was some for weightlifters. I found a whole bunch of different pages for just general chest pain. Meanwhile I actually did have a couple different communities that I was just asking questions in. Like I went on Instagram and asked this group of 13 to 14 year old boys who were trans men about like, hey have any of you ever had extreme pain after binding, specifically over-binding? And did it get better and how long did it take and how did you deal with it? The general recommendation is that people shouldn't bind for more than 6 to 8 hours a day, and should take some breaks sometimes.

In addition to finding gender specialists or information on how to start the transition process, having a close network of queer and trans peers helped participants to explore their gender identity. Participants described their process of questioning different gender identities and the significance of having friends that also identified as queer or trans. For instance, one

participant said that they relied on their queer friends to come to terms with their transness despite living in a more transphobic environment with less supportive parents.

... one of my friends who is actually a trans man but at the time he had just come out as a lesbian and my parents were like, well maybe we heard that this happened and maybe you're trying to fit in. I don't know that we can know that this is really you, which obviously is independent of whatever reason I had that pushed me to realizing about being trans. I don't know why that would invalidate me. But they were super hesitant about that and were kind of reaching. Which was tough for me too because I think going through transition school definitely did kind of get me closer to realizing I was trans. Inevitably I would have realized that it would have taken longer I think just being in like a setting, a generally more transphobic setting and a less supportive setting. I have a really supportive group of friends who largely ended up being queer just by coincidence. And so it was definitely a really good setting to realize stuff in. It was hard because I had to communicate to my parents, like no, [transition school] didn't make me trans but [it] did help me realize.

Barriers

Misinformation from adults

While supportive relationships between and with adults facilitated access to care for youth, misinformation from adults created barriers to care; this theme occurred in their relationships with families as well as in healthcare settings. For instance, when parents/caregivers were misinformed about gender-related topics, they placed additional burden on the participant to explain these topics or avoid having these discussions altogether. Sometimes the participants were the first trans person that the families had been exposed to. Some parents/caregivers were hyper-concerned about certain health risks associated with gender-affirming treatments, particularly with their child if they have attempted suicide or were suicidal.

I was the first person to introduce the topic to them. When I talked initially about top surgery I remember them like being like, wait, you want to do what? That could be like really dangerous. They hadn't looked it up beforehand or done any research. And my mom was just like, well what do you mean? You're a teenager ... she just didn't understand that coming with dysphoria like you hate a lot of your own body. And she hated the word 'hate', she was like, you can't use that about yourself. So my doctor would be like, well that's how they feel a lot, as a trans person. And then also my mental health to still be stable. And so when she learned that testosterone can make your mental health level shift a little bit she got concerned there too.

The parent needed their child to chart their feelings while taking testosterone and frequently check with a provider on their well-being, although the participant indicated improved mental health transitioning since depression stemmed from dysphoria. Other participants similarly experienced reduced feelings of suicidal ideation after transitioning.

Participants discussed challenges of coming out to their parents/caregivers while simultaneously educating them on gender and sexuality.ⁱⁱ One participant described a negative reaction to coming out, including the parents immediately deciding to have them see a pediatrician to get a recommendation with a therapist to confirm “if [they were] insane or something.” The parents also forced the participant to come out to other family members before they were allowed to start hormones. Discordance in parental support created additional challenges for participants. One participant’s mother became more accepting of her child’s transition after interacting with the gender specialist, while the father was still hesitant particularly due to the lack of exposure to the queer community. The father attended Gender Odyssey⁴ with the participant and while encountering other trans attendees, the father kept questioning whether the participant wanted this for themselves and brought his own biases into the conversation.

He was so uncomfortable and had never been exposed to any of this and was so uncomfortable with the idea of queerness and encountering that. There were plenty of people who were like visibly trans and I think he asked me a bunch of times, he was like, do you want that for yourself? I don’t want that for you. I want you to have like a healthy like normal life ... And the other thing is he tried to tell me ... you can’t really be a woman, you’ll just be trans and I don’t want that for you.

While on one level youth encountered parental misunderstanding at the interpersonal level, participants discussed issues related to a general lack of knowledge and information

⁴ Gender Odyssey is an annual international conference focused on workshops, education and networking opportunities, social events, and other programs for transgender and gender diverse children, their families and allies, and educators and providers who support them. (<https://genderodyssey.org/>)

about trans health in healthcare settings at an institutional level. This included interactions with providers, pharmacists, and people at the front desk. Participants illustrated the struggle of being misgendered in healthcare settings.

Healthcare is really frustrating especially when you're going to visit someone who is like supposed to be helping you feel better and then they use the wrong pronoun because it's like, that just defeated the whole purpose of you know almost like being here, not completely but in your head it can feel like that. Because if you're trying to feel more validated then that's the whole point of medically transitioning.

One participant experienced deadnaming with a provider when they came to receive a doctor's note for the flu. While they had not seen this doctor since prior to their transition, the provider was aware that the participant had changed their name and still used the participant's deadname. The nurse was uncomfortable to speak up due to the power dynamics involved. The participant was also deadnamed at the front desk as well and were told that they could not change their name because they were not 18 (this was incorrect and were told by their therapist that they have the authority to do this at 13-years-old). Using the incorrect name while presenting a different gender also placed them at increased risk of being outed. Similar to other participants' experiences, instead of calling the provider out, the participant did what they needed to do to get through that moment.

Youth encountered providers who gave them incorrect medical information during their visit. For instance, one participant encountered communication issues with both the pharmacy and provider. Every month that they received their prescription they needed to correct the needle size, placing the risk on the participant on potentially being stigmatized or outed by needing to explain that the needle was for hormones rather than insulin. The provider did not understand the difference between administering HRT versus insulin.ⁱⁱⁱ Another participant was told that receiving an IUD was the only option for stopping periods, rather than being recommended hormone blockers. Not only did the participant undergo the invasive procedure of

inserting an IUD and experienced adverse side effects, the participant later learned from a different provider that they should be using hormone blockers instead.^{iv}

Beyond issues of the lack of knowledge within existing medical care, youth highlighted the problem of the general shortage of gender clinics and specialists who are knowledgeable about trans health. Most of the participants referred to a couple of the same gender specialists that were recommended via word of mouth. Due to the dearth of providers who are trained in gender care, there was a recurring issue among participants of long wait times to access these specialists.

Healthcare structure and timing of care

Structural-level issues related to healthcare created significant barriers for the majority of participants, including navigating insurance coverage, coordination issues, and parental consent restrictions, resulting in delayed timing of care. Navigating insurance in particular was frequently reported to be a challenge among participants. Insurance would either not cover the procedure or the individual would need to consistently advocate for a procedure to be covered after being rejected. One participant described their insurance not covering most of their HRT prescription as well as disparities in costs for testosterone versus estrogen:

Well we actually changed our pharmacist. [We] were going one place and so we had to change it to another place because my mom was researching it and she said the cost of testosterone is cheaper there because it's all pretty much out of pocket[,] we have to pay our insurance might pay like a fourth of it or something ... So insurance cost can be a little bit pricey. I know it's better for testosterone. I was looking up estrogen prices because I was curious, I was like, oh, my goodness that is awful just how much more expensive it is.

Insurance may cover for parts of the gender-affirming treatments by having gender dysphoria labeled as a medical condition, but no participant was able to get all of their care covered by insurance. Rather than navigating around getting rejected by their insurance, especially due to age barriers, participants' parents/caregivers would pay for these costs out of pocket. A parent recounted their experience with getting denied coverage for hysterectomy surgery:

P1: Four months where C was like a yoyo. Like one day it looked like it was gonna happen but the next day they say, oh, no, denial ... it was gonna happen and then it wasn't; it was gonna happen and then it wasn't. That was very taxing. Unlike the top surgery we couldn't have paid out of pocket for hysterectomy and an inpatient stay.

Accessing gender-affirming medical treatments required the lengthy process of initially accessing a therapist to then be referred for a consultation with a gender specialist, which are in limited supply, and additional delays if they were waiting for insurance to cover some of these costs. This process was further delayed due to age limits and parental consent restrictions. In particular, participants encountered barriers in accessing gender-affirming surgeries due to age restrictions. Some participants were not able to receive surgery referrals until they were 18.

She's like, I'm not going to refer you until you're 18 just because there's health risks with that. But that age was scary to me like what if I have to wait a whole other year? From a medical perspective the fact that I can't get a surgery yet is really frustrating for me.

Participants who were not out to their parents yet experienced even more barriers in accessing any type of gender-affirming care. For example, if a participant was on their parents' insurance and needed to visit a doctor for trans-related medical advice, they would be concerned of having the visit under the medical records. One participant in particular expressed their struggle with receiving medical advice on chest pain from over-binding while on their parents' insurance. In addition to not receiving helpful advice from the provider, the provider nearly risked breaking confidentiality by describing the visit in the visit notes when the participant clearly wanted this visit to not be on the medical records, potentially risking them being outed to their parents before they were ready. Other participants discussed the struggles of waiting for parental consent for starting gender-affirming medical treatments—such as HRT—and how their experiences belied the experiences of some of their trans peers with supportive parents.^v

Dominant narratives about transness

Participants encountered discourse around gender that perpetuated cisnormativity, the assumption that all individuals are cisgender, and transnormativity, which privileges trans

people who medically transition and marginalizes those who do not fit into traditional models of transness. These barriers appeared through interactions with providers, electronic health record systems, and insurance billing, among others. Youth frequently needed to justify their gender identity while being met with social norms around gender. Participants discussed gender norms in their interaction with healthcare settings such as encountering gendered environments (e.g., gynecologist's office) and discussing their body in ways that did not resonate with them. One participant highlighted this narrative of needing to struggle before transitioning.

Because I feel like it shouldn't be like a prerequisite to being trans and to be able to transition to have gone through like pain. I don't want to have to struggle to get there, you know. I don't think that trans kids or any trans person should have to wait for like healthcare that's going to make them happier. I don't think that people need to go through like puberty that isn't the puberty for them to know. So that's kind of why I was distrustful, I guess of some healthcare.

Participants expressed concerns of convincing providers, parents, etc. that they were 'trans enough', which largely involved reproducing dominant narratives around transness and binary gender norms. Youth were frequently met with skepticism and had their gender identity questioned by older people in their lives, including parents and providers.

I think the big question, the question I've come back to over and over again [the doctor] asked me is, what does being a girl mean to you? And I didn't have an answer. He was very skeptical of my lack of an answer for that. He was like, well I just – I feel like you should be able to talk about this. I think you might be moving too fast if you can't talk about this. And I was like, well, no I think it's just a stupid question. But I didn't say that because I was 14 and small and nervous ... And it's awkward too because of, I guess part of what it meant to me to like be a girl and want to transition was like just a lot of it was like the physical reality of it. I wanted hormones, I wanted to transition ... I wanted the secondary sex characteristics and whatever the hormones will get me. And I want a name and pronouns ... But it was hard. I didn't really have a vocabulary to like say that I just knew that I wanted that. And also what does transgender mean to you? I was like, well the word has a definition, I don't know ... And then when my parents came back in ... he said he wanted to caution us against moving too quickly because he's against permanent changes in children at a young age. He says he doesn't think it's a good idea. He hasn't seen it work out well in the past. He just doesn't think there's enough science behind it to back it up ... I guess I thought it was funny. At the time I was like just starting like assigned male at birth puberty stuff kind of. And he didn't conceive of that as a permanent change at all in any way.

This line of questioning by the provider placed the participant in the position of answering a complex question about gender itself, creating more self-doubt for the participant and invalidating their experience. The idea that undergoing cisgender puberty was not considered a permanent change also reproduced ideas of cisnormativity.

To also undergo medical transitioning to 'pass' at trans, this involved framing bodies as binary and cisgender. Participants expressed concern about dressing and acting more like the gender they want to transition to get access to the care they need.

The feeling going into it I was like, I have to say everything right, I have to dress correctly, my hair has to look good, I need to talk as well as I possibly can you know all of that. I think it was a lot in my head too, but ... I think I like just wanted her to like know for sure even though I had the note from my therapist like I did have gender dysphoria and that was something that she needed to recognize and that she needed to like ... prescribe me testosterone because that was what would make me happy, that was what would make me safe. And I just wanted her to understand that. I didn't want to act or portray as though I was at all feminine. She needs to know that I'm uncomfortable in this body. I wanted to portray that as much as I could.

Individuals who identified outside the gender binary or who expressed less certainty about their gender needed to conform to particular gender norms to access gender-affirming medical services. Furthermore, medical transitioning required one to be in a higher position of power to have access to adequate health insurance or to have the financial ability to pay for these treatments out of pocket. Most of the participants identified as White and were able to access gender-affirming care in some capacity. Barriers that trans folks experience in accessing gender-affirming health services are exacerbated by other positions of power and privilege, including socioeconomic status, race/ethnicity, and ability. Participants described these disparities and the dominant representation of "privileged trans people."^{vi} Trans representation was highlighted as a barrier for youth to explore their gender identity as well as for individuals outside of the trans community who are uneducated on these topics.^{vii} Representation is shown to be critical changing these dominant narratives around trans people's experiences and shift away from cis- and transnormative ideas.

DISCUSSION

We conducted a mixed-methods study to examine the association of age and facilitators and barriers to gender-affirming care among TNB youth and young adults, and qualitatively explore the facilitators and barriers of access to care among youth. Our quantitative findings indicate that the majority of participants were assigned female at birth, identified as nonbinary, White, and had health insurance. We found that TNB youth and young adults experienced similar prevalence of access and barriers to care. About a quarter of participants reported that they had access to all the gender-affirming treatments that they want or need and about a third had ever taken hormones. Youth (13-24) were 45 percent less likely to experience provider refusal of care than young adults (25-34). Interviews with youth participants highlighted various facilitators and barriers to care, including ways in which providers interacted with the participant and their families, family/caregiver support for or resistance to their child's transition, knowledge at the community-level and within healthcare settings, healthcare structure, and dominant narratives about transness. Our findings affirm the importance of creating a safe space for youth to explore their gender identity and have access to medical professionals and communities that validate their varied experiences.¹⁵

We found youth in general experienced facilitators and barriers to care at lower frequencies compared to young adults in the quantitative findings. Older TNB individuals may have had more opportunities to experience facilitators and barriers to care compared to TNB youth. Additional quantitative studies have documented differences in healthcare access among a community sample of racially diverse LGBTQ emerging adults (aged 18 to 27),²³ transgender and cisgender youth (9th and 11th grade),¹⁸ binary and nonbinary identified trans youth (aged 14 to 25),²⁴ and issues of primary care access and foregone health care among transgender adolescents and young adults (aged 14-25).²⁵ However, few studies have examined disparities within TNB populations¹⁸ or quantified the proportion of TNB youth compared to adults who

have accessed gender-affirming care. In addition, while these studies explored healthcare utilization and experiences of discrimination, none of these studies examined interpersonal forms of access and barriers to care, such as using gender-affirming language, experiences of provider refusal, and experiences of abuse, among others. Furthermore, these studies did not implement multivariate regression methods and mostly relied on other methods (e.g., Pearson's correlation,²⁵ chi-square^{18,23,24,25} and ANOVA tests,^{18,23,24} logistic and ordinal analyses²⁴). While this study is not considered a typical mixed-methods design since it relied on two different data sources, our findings complement each other such that the qualitative data allowed us to explore topics that came up in the quantitative data. The qualitative findings also provided additional insight into the experiences of youth under the age of 18, particularly since the sample in the quantitative data was too small to draw any meaningful results.

Our qualitative findings are consistent with other prior studies exploring experiences of TGD young people engaging with gender-affirming care^{15,26} and barriers to care for youth¹³ and adults.^{2,7} Participants cited facilitators to care mainly at the interpersonal- and community-level, while barriers to care were mostly present at the institutional-, structural-, and systems-levels. These findings indicate that challenges in navigating systems were not an individual-level problem, but rather systems work to create these structures of oppression and individuals and communities tried to mitigate these effects. Gender clinics are predominantly located in progressive urban areas²⁷; therefore, location/geography can play a large role as a facilitator or barrier to care. Living in a progressive area with more queer and trans inclusive spaces usually means that there are more providers in the area who specialize in trans health. Urbanicity also dictates proximity to gender-affirming medical treatments. Not only are living in rural areas more isolating and the long distances can create barriers to care, living in an area with predominantly conservative politics may create difficulties in comfortably discussing these topics with peers, family, and other social networks, and finding a doctor that is knowledgeable about trans topics is limited. As a result, many trans people avoid health care services entirely in conservative

regions, or are forced to accept what is available due to the lack of options.²⁷ There is a growing demand for providing services for rural TGD communities who face unique structural barriers in access to gender-affirming care.²⁸

The relationships adults had in youths' lives appeared to be the most significant facilitator or barrier to care. Access to gender-affirming care was highly dependent on parental support. For instance, one parent was highly educated (e.g., had a doctoral degree), which may have played a part in them being more knowledgeable and supportive of their child's transition, in addition to having the resources to access needed gender-affirming care. Misinformation from adults were influenced by dominant narratives around transness, indicating the interconnectedness of the various facilitators and barriers to care. The Intersectionality Research for Transgender Health Justice (IRTHJ) Framework posits that social inequities and are not random or accidental, but rather are systematically produced over time and help maintain structures of power.²⁹ Our findings presented ways in which structures of domination, institutional systems, and socio-structural processes produce transgender health inequities.²⁹ For instance, structures of domination are reinforced by institutional systems. Youth encountered instances of cisnormativity and transnormativity while navigating their care in health systems as well as in other systems by having their transness questioned or dismissed, being asked difficult questions about what gender means to them, and having assumptions be made about their transness if they did not fit into a binary definition of transgender. Youth needed to receive a medical diagnosis of gender dysphoria, which was dependent on convincing those around them a certain narrative around gender identity.

In addition to cisnormativity and transnormativity, we found youth experiencing ageism that resulted in them being infantilized by adults in their lives and not treated as authorities of experience. Not only did youth encounter age restrictions while attempting to access gender-affirming health services, they experienced issues within other systems like the education system, including one participant highlighting restrictions for teachers on calling students by

their preferred name unless they received parental consent or if the name was legally changed, which created significant barriers to students not out to their families yet. Youth were also positioned to teach the “adults” in their lives, challenging the notion that adults have more knowledge than youth. These youth illustrated a complex understanding of the medical system, sociocultural norms around gender, and dominant discourse produced in institutions such as the healthcare, education, and legal systems. This aspect of health inequity illustrated that trans youth needed to know how to navigate these systems, otherwise their needs would not be met. Navigating these complex structures appeared to enable agency by creating knowledge and addressing power imbalances rather than falling victim to medical saviorism. Similarly, while community and local knowledge was not treated as valid or rigorous knowledge, most of the participants relied on this knowledge to fill the gaps that biomedical knowledge lacked. Additionally, participants’ reliance on local knowledge indicated the importance of engaging with communities to enhance knowledge of trans health within medical and other systems. Furthermore, with our sample being predominantly White and insured, we must acknowledge structural inequities contributing to racial and ethnic disparities in access to gender-affirming care. Cisnormativity and transnormativity intersect with racism as an additional structure of domination. While this was not explored in our study, substantial disparities in access to gender-affirming care by race and ethnicity due to systemic racism are apparent.

Limitations

Despite this study contributing to the growing literature on facilitators and barriers to gender-affirming care among TNB youth and young adults, several limitations must be considered when interpreting the results. The survey was self-reported and may have introduced misclassification. Additionally, there are systematic issues related to missingness in the survey that need to be further explored. Selection bias may also be concern since the survey relied on a non-random sampling strategy, and the sample may not have been representative of the general population. Selection bias may have also been introduced in the

interviews in favor of youth who were interested and able to share their stories about accessing healthcare. Youth who were involved in these interviews were more likely to get the services they needed since many had support systems; thus, the barriers they faced may have been different from youth with less support systems. The two data sources utilized two different time periods and age ranges, which impacted the ability to make comparisons between these two groups. Due to small sample sizes in the quantitative data, we were limited in examining access and barriers to care among young people under the age of 18. The qualitative data may have helped supplement these findings and provide additional insight into the various facilitators and barriers to care for youth. Furthermore, small sample sizes limited our ability to examine robust multivariable models or examine effect modification. We were also unable to examine effect modification by race and ethnicity or the intersectional experiences of facilitators and barriers to care since the sample was predominantly White. Population-based studies with large samples are needed to generalize findings and make accurate comparisons between groups, in addition to targeted recruitment to ensure adequate sample sizes with respect to race and ethnicity.^{10,18} Despite these limitations, the results from this study help to understand the ways in which youth experience access and barriers to care and the nuances behind navigating systems.

Recommendations

Improving equitable access to gender-affirming care	
Incorporate comprehensive trans healthcare	<ul style="list-style-type: none"> • Recruiting and training culturally competent providers who specialize in working with TGD communities, improving diversity in the health care workforce.² • Inclusion of gender-affirming care in health science curricula – will facilitate the training of culturally competent providers and ensure that patients are given the care they need; using gender-affirming language (e.g., asking and recording chosen name and pronouns in electronic medical records)¹³ and modifying relevant medical terminology for the body to be gender neutral or tailored to the patient's needs.³⁰
Healthcare reform	<ul style="list-style-type: none"> • Mainstream treatment model in healthcare is the gatekeeping model, where service providers assess whether or not a patient should be allowed to access gender-affirming care and thus violating the autonomy of the patient.³⁰ The informed-consent model allows treatment to be a cooperative effort between the

	<p>patient and provider where patients are the primary decision makers regarding their care.³⁰</p> <ul style="list-style-type: none"> • The latter model should particularly be considered for TNB youth who face ageism and other barriers to gender-affirming care. • Disparities in health care access are further exacerbated for TNB individuals who also identify as Black, Indigenous, and People of Color and/or low income. Larger structural issues related to access, including structural racism, need to be accounted for when advocating for improved health care access, in addition to removing exclusions on gender-affirming care.
Education outside of healthcare	<ul style="list-style-type: none"> • Allow TNB youth to feel safe in other institutions, but also facilitate generational change and shift dominant norms around gender and sexuality. • Schools should incorporate LGBTQ+ health in core and sexual health education curriculums as well as train and enhance the diversity of educators.
Future research	
Better engage Black, Indigenous, and People of Color communities	<ul style="list-style-type: none"> • Future research in transgender health needs to better engage Black, Indigenous, and People of Color communities, particularly in areas that are predominantly White.
Prioritize community-based participatory research	<ul style="list-style-type: none"> • Transgender health research needs to acknowledge the ways in which power operates in creating health inequities by prioritizing community-based participatory research to center marginalized voices, facilitate power sharing, and integrate community knowledge.²⁹

CONCLUSION

As the growing need for gender-affirming care grows, these findings have important policy implications on creating more equitable access to these services. Furthermore, the recent legislative restrictions that deny youth access to transition-related health services will further inhibit access to gender-affirming care and exacerbate existing health disparities, including contributing to negative mental health outcomes for TNB youth.^{31,32,33} In addition to addressing this legislation, providers, families, the healthcare system, and education system must contribute to expanding access to gender-affirming care, reducing existing barriers to care, and promoting gender-affirming environments.

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TABLES

Table 1: Demographic characteristics of trans and nonbinary youth and young adults in Washington State, Pride Survey, 2021 (N=496)

	Age		
	13-24, n (%) (n=189)	25-34, n (%) (n=307)	Overall, n (%) (N=496)
Mean Age (years)	19.7	29.5	25.7
Sex Assigned at Birth			
Female	165 (87.3)	228 (74.3)	393 (79.2)
Male	19 (10.1)	73 (23.8)	92 (18.5)
Intersex	2 (1.1)	2 (0.7)	4 (0.8)
Don't know	3 (1.6)	4 (1.3)	7 (1.4)
Gender Identity*			
Cisgender man	4 (2.1)	11 (3.6)	15 (3.0)
Cisgender woman	23 (12.2)	27 (8.8)	50 (10.1)
Genderqueer	50 (26.5)	104 (33.9)	154 (31.0)
Gender non-conforming	45 (23.8)	67 (21.8)	112 (22.6)
Nonbinary	119 (63.0)	183 (59.6)	302 (60.9)
Transgender man	42 (22.2)	56 (18.2)	98 (19.8)
Transgender woman	13 (6.9)	26 (8.5)	39 (7.9)
Two-Spirit	3 (1.6)	4 (1.3)	7 (1.4)
Gender identity not listed above	10 (5.3)	28 (9.1)	38 (7.7)
Don't know	12 (6.3)	3 (1.0)	15 (3.0)
Sexual Identity*			
Asexual	27 (14.3)	44 (14.3)	71 (14.3)
Bisexual	66 (34.9)	101 (32.9)	167 (33.7)
Gay	24 (12.7)	58 (18.9)	82 (16.5)
Lesbian	40 (21.2)	40 (13.0)	80 (16.1)
Pansexual	25 (13.2)	78 (25.4)	103 (20.8)
Queer	74 (39.2)	189 (61.6)	263 (53.0)
Straight/heterosexual	1 (0.5)	4 (1.3)	5 (1.0)
Sexual identity not listed above	1 (0.5)	17 (5.5)	18 (3.6)
Don't know	3 (1.6)	1 (0.3)	4 (0.8)
Race/Ethnicity*			
American Indian/Alaska Native	8 (4.2)	19 (6.2)	27 (5.4)
Asian	29 (15.3)	25 (8.1)	54 (10.9)
Black/African American	9 (4.8)	9 (2.9)	18 (3.6)
Hispanic/Latinx	22 (11.6)	33 (10.7)	55 (11.1)
Pacific Islander/Native Hawaiian	2 (1.1)	12 (3.9)	14 (2.8)
White	151 (79.9)	257 (83.7)	408 (82.3)
Race/ethnicity not listed above	5 (2.6)	11 (3.6)	16 (3.2)
Don't know	1 (0.5)		1 (0.2)
Education			
Did not complete high school	32 (17.2)	6 (2.0)	38 (7.7)
High school graduate/GED	46 (24.7)	31 (10.1)	77 (15.6)
Some college/vocational school	52 (28.0)	66 (21.5)	118 (23.9)

2-year college degree	18 (9.7)	26 (8.5)	44 (8.9)
4-year college degree	37 (19.9)	101 (32.9)	138 (28.0)
More than 4-year college degree	1 (0.5)	77 (25.1)	78 (15.8)
Income			
<\$15,000	97 (52.4)	65 (21.2)	162 (32.9)
\$15,000-\$30,000	30 (16.2)	76 (24.8)	106 (21.5)
\$30,001-\$50,000	12 (6.5)	75 (24.4)	87 (17.7)
\$50,001-\$100,000	6 (3.2)	71 (23.1)	77 (15.7)
>\$100,000	3 (1.6)	14 (4.6)	17 (3.5)
Don't know	37 (20.0)	6 (2.0)	43 (8.7)
Health Insurance			
Yes	175 (94.1)	290 (94.5)	465 (94.3)
No	11 (5.9)	17 (5.5)	28 (5.7)

* Participants could select multiple identities. Columns sum to >100%.

Minimal missingness was reported for the following variables: education (n=7), income (n=7), and insurance (n=7)

Table 2: Prevalence of ever experiencing access and barriers to gender-affirming care by age among trans and nonbinary youth and young adults in Washington State, Pride Survey, 2021 (N=496)

	Age			Prevalence Ratio (PR) ¹ (95% CI)			
	13-24, n (%) (n=189)	25-34, n (%) (n=307)	Overall, n (%) (N=496)	Crude PR	p-value*	Adjusted PR ²	p-value*
Facilitators to gender-affirming care							
Able to access needed care	32/134 (23.9)	61/237 (25.7)	93/371 (25.1)	0.93 (0.64, 1.35)	0.73	0.87 (0.57, 1.32)	0.56
Asked preferred terms/language	35/134 (26.1)	86/239 (36.0)	121/373 (32.4)	0.73 (0.52, 1.01)	0.11	0.71 (0.59, 1.02)	0.13
Treated with respect	65/134 (48.5)	118/239 (49.4)	183/373 (67.8)	0.98 (0.79, 1.22)	0.91	1.00 (0.79, 1.27)	1.00
Ever taken hormones	39/134 (29.1)	86/237 (36.3)	125/371 (33.7)	0.80 (0.59, 1.10)	0.25	0.78 (0.54, 1.13)	0.26
Taken hormones not prescribed by a medical provider ³	4/39 (10.3)	20/87 (23.0)	24/126 (19.0)	0.45 (0.16, 1.22)	0.14	0.54 (0.22, 1.34)	0.28
Barriers to gender-affirming care							
Unable to access care ⁴	74/189 (39.2)	116/305 (38.0)	190/494 (38.5)	1.03 (0.82, 1.29)	0.85	0.90 (0.70, 1.16)	0.54
<i>Financial hardship</i>	43/189 (22.8)	67/305 (22.0)	110/493 (22.3)	1.04 (0.74, 1.45)	0.84	0.83 (0.57, 1.20)	0.38
<i>Lack of medical access</i>	28/189 (14.8)	48/307 (15.6)	76/496 (15.3)	0.95 (0.62, 1.46)	0.82	0.81 (0.49, 1.34)	0.43
<i>Lack of knowledge/resources</i>	42/189 (22.2)	71/307 (23.1)	113/496 (22.8)	0.96 (0.69, 1.34)	0.84	0.83 (0.57, 1.21)	0.40
<i>Lack of facilities/providers</i>	28/189 (14.8)	55/307 (17.9)	83/496 (16.7)	0.83 (0.54, 1.26)	0.41	0.74 (0.46, 1.18)	0.25
<i>Another reason not listed</i>	19/189 (10.1)	23/307 (7.5)	4/496 (8.5)	1.34 (0.75, 2.40)	0.34	1.18 (0.61, 2.28)	0.64
Provider refusal of care**	30/133 (22.6)	94/237 (39.7)	124/370 (33.5)	0.57 (0.40, 0.81)	0.007*	0.55 (0.38, 0.80)	0.008*
Misgendered/dead-named**	79/134 (59.0)	151/237 (63.7)	230/371 (62.0)	0.93 (0.78, 1.10)	0.58	0.94 (0.78, 1.14)	0.71
Uncomfortable language/questions**	64/132 (48.5)	116/238 (48.7)	180/370 (48.6)	0.99 (0.80, 1.24)	0.97	0.97 (0.76, 1.23)	0.85
Provider uneducated about trans health	38/134 (28.4)	93/238 (39.1)	131/372 (35.2)	0.73 (0.53, 0.99)	0.04*	0.70 (0.49, 1.00)	0.10
Experiences of abuse in medical care							

Verbal abuse**	28/133 (21.1)	70/236 (29.7)	98/369 (26.6)	0.71 (0.48, 1.04)	0.13	0.81 (0.53, 1.24)	0.39
Physical abuse**	8/133 (6.0)	28/237 (11.8)	36/371 (9.7)	0.51 (0.24, 1.08)	0.09	0.54 (0.23, 1.28)	0.14
Sexual assault	7/135 (5.2)	17/236 (7.2)	24/369 (6.5)	0.73 (0.31, 1.70)	0.47	0.78 (0.29, 2.07)	0.61
LGBTQ+ Pride**	124/134 (92.5)	214/237 (90.3)	338/371 (91.1)	1.02 (0.96, 1.09)	0.83	1.03 (0.96, 1.11)	0.79

* Significant at the p<0.05 level

** Comprised of responses to multiple questions (**Appendix**)

¹ Poisson regression with robust standard error estimates

² Adjusted for income, education, and health insurance

³ Individuals who responded “yes” to “Every taken hormones” was asked this question

⁴ Dichotomous variable based on participants selecting on any of the responses below: *financial hardship, lack of medical access, lack of knowledge/resources, lack of facilities/providers, or another reason not listed*. Participants could also select multiple options to this question.

Table 3. Access and barriers to gender-affirming care by gender identity among trans and nonbinary youth in Washington State: Pride Survey, 2021 (N=189)

	Trans Men, n (%) (n=42)	Trans Women, n (%) (n=13)	Nonbinary AMAB¹, n (%) (n=11)	Nonbinary AFAB¹, n (%) (n=137)	Overall, n (%) (N=189)*
Facilitators to gender-affirming care					
Able to access needed care	14/34 (41.2)	5/10 (50.0)	0	20/94 (21.3)	32/134 (23.9)
Asked preferred terms/language	14/34 (41.2)	8/10 (80.0)	1/8 (12.5)	19/94 (20.2)	90 (47.6)
Treated with respect	29/34 (85.3)	9/10 (90.0)	3/8 (37.5)	36/94 (38.3)	65/134 (48.5)
Ever taken hormones	23/34 (67.6)	7/10 (70.0)	1/8 (12.5)	19/94 (20.2)	39/134 (29.1)
Taken hormones not prescribed by a medical provider ²	1/23 (4.3)	0	0	4/19 (21.1)	4/39 (10.3)
Barriers to gender-affirming care					
Unable to access care ³	26/42 (61.9)	4/13 (30.8)	5/11 (45.5)	47/137 (34.3)	74 (39.2)
Provider refusal of care**	10/34 (29.4)	0	0	19/93 (20.4)	30/133 (22.6)
Misgendered/dead-named**	26/38 (76.5)	6/10 (60.0)	4/5 (50.0)	50/94 (53.2)	79/134 (59.0)
Uncomfortable language/questions**	23/34 (67.6)	4/9 (44.4)	5/8 (63.5)	38/93 (40.9)	64/132 (48.5)
Provider uneducated about trans health	13/34 (38.2)	3 (23.1)	1/8 (12.5)	26/94 (27.7)	38/134 (28.4)
Experiences of abuse in medical care					
Verbal abuse**	5/34 (14.7)	1/10 (10.0)	1/8 (12.5)	22/93 (23.7)	28/133 (21.1)
Physical abuse**	4/34 (11.8)	0	0	7/95 (7.4)	8/133 (6.0)
Sexual assault	3/34 (8.8)	0	0	7/95 (7.4)	7/135 (5.2)
LGBTQ+ Pride**	31/34 (91.2)	8/10 (80.0)	7/8 (87.5)	90/94 (95.7)	124/134 (92.5)

* * Participants could select multiple identities. Columns sum to >100%.

** Comprised of responses to multiple questions (**Appendix**)

¹ AMAB= Assigned Male at Birth, AFAB= Assigned Female at Birth

² Individuals who responded "yes" to "Every taken hormones" was asked this question

³ Dichotomous variable based on participants selecting on any of the responses below: *financial hardship, lack of medical access, lack of knowledge/resources, lack of facilities/providers, or another reason not listed*. Participants could also select multiple options to this question.

APPENDIX

Quantitative Codebook

Figure 1. Coding of Variables			
	Variable	Question(s)	Response(s)
Facilitators to gender-affirming care	Accessed needed gender care	Do you have access to all the gender-affirming medical treatments that you want or need?	<p>“Yes, I’ve been able to access all the gender-affirming medical treatments I want or need”=1/Yes;</p> <p>“No, I’ve not been able to access all of the gender-affirming medical treatments I want or need”=0/No;</p> <p>“Not applicable” excluded</p>
	Treated with respect	My doctor knew I was trans and treated me with respect.	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Asked preferred terms/language	My doctor or provider asked me what terms or language I prefer to use for my anatomy/body.	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Ever taken hormones	Have you ever taken hormones?	<p>“Yes”=1/Yes;</p> <p>“No”=0/No</p>
	Taken hormones not prescribed by doctor	Have you ever accessed hormones that weren't prescribed to you by a doctor (e.g. through friends, or other non-licensed sources like the black market, "dark web", streets)?	<p>“Yes”=1/Yes;</p> <p>“No”=0/No</p>

<p>Barriers to gender-affirming care</p>	<p>Unable to access gender-affirming care</p>	<p>In the last 12 months, have you been unable to access or initiate gender-affirming medical treatments due to...</p>	<p>“financial hardship” or “lack of medical access” or “lack of knowledge or resources” or “lack of facilities/providers” or “another reason not listed, please specify”=1/Yes;</p> <p>“None of the above, my access has not be interrupted”=0/No;</p> <p>“Not applicable” excluded</p>
	<p>Provider refusal of care</p>	<p>A doctor or other health care provider refused to give me TRANS-RELATED CARE. A doctor or other health care provider refused to give me trans-related care due to my BODY SIZE, WEIGHT, OR BMI. A doctor or other health care provider refused to give me SEXUAL OR REPRODUCTIVE HEALTH CARE (such as STI/HIV testing, pelvic exams, contraceptives, PrEP, HIV medications, abortion or pregnancy services). A doctor or other health care provider refused to give me OTHER HEALTH CARE (such as physicals, flu, diabetes).</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	<p>Misgendered/dead-named</p>	<p>I was called by the incorrect name or dead-named. I was misgendered or called by the incorrect pronoun.</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>

	Uncomfortable language/questions	<p>My doctor or provider used terms or language to describe my anatomy/body that I disliked or that made me uncomfortable.</p> <p> </p> <p>My doctor asked me unnecessary/invasive questions about my trans status that were not related to the reason for my visit.</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Provider uneducated about trans health	<p>I had to teach my doctor or other health care provider about trans people so that I could get appropriate care.</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Verbal abuse	<p>A doctor or other health care provider used harsh or abusive language when treating me.</p> <p> </p> <p>I was verbally harassed in a health care setting.</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Physical abuse	<p>A doctor or other health care provider was physically rough of abusive when treating me.</p> <p> </p> <p>I was physically attacked by someone during my visit in a health care setting (such as a hospital, office, clinic).</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>
	Sexual abuse	<p>I experienced unwanted sexual contact (such as fondling, sexual assault, or rape) in a health care setting (such as a hospital, office, clinic).</p>	<p>“Yes in the past 12 months” or “Yes more than 12 months ago”=1/Yes;</p> <p>“Never”=0/No;</p> <p>“N/A” excluded</p>

LGBTQ+ Pride	LGBTQ+ Pride	My LGBTQ+ identity makes me feel special and unique. I am proud to be a person whose is LGBTQ+.	"Agree" or "Strongly Agree"=1/Yes; "Strongly Disagree," "Disagree," and "Neutral"=0/No
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Supplementary Tables

Supplementary Table 1: Demographic characteristics of trans and nonbinary youth in Washington State, Pride Survey, 2021 (N=189)

	Age		
	13-17, n (%) (n=33)	18-24, n (%) (n=156)	Overall, n (%) (N=189)
Mean Age (years)	15.7	20.5	19.7
Sex Assigned at Birth			
Female	28 (84.8)	137 (87.8)	165 (87.3)
Male	5 (15.2)	14 (9.0)	19 (10.1)
Intersex		2 (1.3)	2 (1.1)
Don't know		3 (1.9)	3 (1.6)
Gender Identity*			
Cisgender man	1 (3.0)	3 (1.9)	4 (2.1)
Cisgender woman	2 (6.1)	21 (13.5)	23 (12.2)
Genderqueer	8 (24.2)	42 (26.9)	50 (26.5)
Gender non-conforming	9 (27.3)	36 (23.1)	45 (23.8)
Nonbinary	20 (60.6)	99 (63.5)	119 (63.0)
Transgender man	5 (15.2)	37 (23.7)	42 (22.2)
Transgender woman	2 (6.1)	11 (7.1)	13 (6.9)
Two-Spirit	1 (3.0)	2 (1.3)	3 (1.6)
Gender identity not listed above	1 (3.0)	9 (5.8)	10 (5.3)
Don't know	5 (15.2)	7 (4.5)	12 (6.3)
Sexual Identity*			
Asexual	4 (12.1)	23 (14.7)	27 (14.3)
Bisexual	14 (42.4)	52 (33.3)	66 (34.9)
Gay	2 (6.1)	22 (14.1)	24 (12.7)
Lesbian	6 (18.2)	34 (21.8)	40 (21.2)
Pansexual	4 (12.1)	21 (13.5)	25 (13.2)
Queer	10 (30.3)	64 (41.0)	74 (39.2)
Straight/heterosexual	1 (3.0)		1 (0.5)
Sexual identity not listed above		1 (0.6)	1 (0.5)
Don't know		3 (1.9)	3 (1.6)
Race/Ethnicity*			

American Indian/Alaska Native	2 (6.1)	6 (3.8)	8 (4.2)
Asian	7 (21.2)	22 (14.1)	29 (15.3)
Black/African American	4 (12.1)	5 (3.2)	9 (4.8)
Hispanic/Latinx	3 (9.1)	19 (12.2)	22 (11.6)
Pacific Islander/Native Hawaiian		2 (1.3)	2 (1.1)
White	25 (75.8)	126 (80.8)	151 (79.9)
Race/ethnicity not listed above		5 (3.2)	5 (2.6)
Don't know		1 (0.6)	1 (0.5)
Education			
Did not complete high school	22 (71.0)	10 (6.5)	32 (17.2)
High school graduate/GED	7 (22.6)	39 (25.2)	46 (24.7)
Some college/vocational school	1 (3.2)	51 (32.9)	52 (28.0)
2-year college degree	1 (3.2)	17 (11.0)	18 (9.7)
4-year college degree		37 (23.9)	37 (19.9)
More than 4-year college degree		1 (0.6)	1 (0.5)
Income			
<\$15,000	10 (33.3)	87 (56.1)	97 (52.4)
\$15,000-\$30,000		30 (19.4)	30 (16.2)
\$30,001-\$50,000		12 (7.7)	12 (6.5)
\$50,001-\$100,000		6 (3.9)	6 (3.2)
>\$100,000	1 (3.3)	2 (1.3)	3 (1.6)
Don't know	19 (63.3)	18 (11.6)	37 (20.0)
Health Insurance			
Yes	31 (100)	144 (92.9)	175 (92.6)
No		11 (7.1)	11 (5.9)
* Participants could select multiple identities. Columns sum to >100%.			
Minimal missingness was reported for the following variables: education (n=3), income (n=4), and insurance (n=3)			

Supplementary Table 2: Prevalence of ever experiencing access and barriers to gender-affirming care by age among trans and nonbinary youth in Washington State, Pride Survey, 2021 (N=189)

	Age			PR (95% CI)	
	13-17, n (%) (n=33)	18-24, n (%) (n=156)	Overall, n (%) (N=189)	Crude	p-value*
Facilitators to gender-affirming care					
Able to access needed gender care	4/18 (22.2)	28/116 (24.1)	32/134 (23.9)	0.92 (0.37, 2.32)	1.00
Asked preferred terms/language	4/18 (22.2)	31/116 (26.7)	35/134 (26.1)	0.83 (0.33, 2.08)	0.91
Treated with respect	9/18 (50.0)	56/116 (48.3)	65/134 (48.5)	1.04 (0.63, 1.71)	0.89
Ever taken hormones	2/18 (11.1)	37/116 (31.9)	39/134 (29.1)	0.35 (0.09, 1.32)	0.07
Taken hormones not prescribed by a medical provider ¹	0	4/37 (10.8)	4/39 (10.3)		
Barriers to gender-affirming care					
Unable to access care ²	11/33 (33.3)	63/156 (40.4)	74/189 (39.2)	0.83 (0.49, 1.39)	0.45
<i>Financial hardship</i>	2/33 (6.1)	41/156 (26.3)	43/189 (22.8)	0.23 (0.06, 0.91)	0.01*
<i>Lack of medical access</i>	2/33 (6.1)	26/156 (16.7)	28/189 (14.8)	0.36 (0.09, 1.46)	0.20
<i>Lack of knowledge/resources</i>	5/33 (15.2)	37/156 (23.7)	42/189 (22.2)	0.64 (0.27, 1.50)	0.28
<i>Lack of facilities/providers</i>	5/33 (15.2)	23/156 (14.7)	28/189 (14.8)	1.03 (0.42, 2.51)	1.00
<i>Another reason not listed</i>	4/33 (12.1)	15/156 (9.6)	19/189 (10.1)	1.26 (0.45, 3.56)	0.91
Provider refusal of care**	2/18 (11.1)	28/115 (24.3)	30/133 (22.6)	0.46 (0.12, 1.75)	0.34
Misgendered/dead-named**	10/18 (55.6)	69/116 (59.5)	79/134 (59.0)	0.93 (0.60, 1.45)	0.75
Uncomfortable language/questions**	8/16 (50.0)	56/116 (48.3)	64/132 (48.5)	1.04 (0.61, 1.75)	0.90
Provider uneducated about trans health	5/18 (27.8)	33/116 (28.4)	38/143 (28.4)	0.98 (0.44, 2.17)	0.95

Experiences of abuse in medical care

Verbal abuse**	1/17 (5.9)	27/116 (23.3)	28/133 (21.1)	0.25 (0.04, 1.74)	0.19
Physical abuse**	1/18 (5.6)	7/116 (6.0)	8/134 (6.0)	0.92 (0.12, 7.05)	1.00
Sexual assault	2/18 (11.1)	5/116 (4.3)	7/134 (5.2)	2.58 (0.54, 12.30)	0.52
LGBTQ+ Pride**	17/18 (94.4)	107/116 (92.2)	124/134 (92.5)	1.02 (0.90, 1.16)	1.00

* Significant at the p<0.05 level

** Comprised of responses to multiple questions (see **Appendix**)

¹ Individuals who responded “yes” to “Every taken hormones” was asked this

² Dichotomous variable based on participants selecting on any of the responses below: *financial hardship, lack of medical access, lack of knowledge/resources, lack of facilities/providers, or another reason not listed*. Participants could also select multiple options to this question.

Additional Quotes

Facilitator or Barrier	Theme	Quote(s)
<i>Facilitator</i>	Patient-provider connectedness	<p><i>I definitely appreciate it when anyone talking about medical things keeps it gender neutral, and just acknowledges that it's not a thing women experience, it's just a thing that some people experience if they have this body part. And he also said things like we were talking about the dosage that I would take and he was like, I think we should start you off on a lower thing so you don't ... look so much older than the other boys your age you know, and stuff like that. Casually being like, you and the boys, you know, which I was like that's nice, thank you.</i></p>
	Supportive relationships with adults	<p><i>So [the provider] was affirming though and basically told my parents at the end of that first session that if I'm saying that I'm trans I'm probably trans. She could pretty confidently say that I'm probably trans, which totally my dad was like, oh, shit! So he did not – it was not the response they wanted I think. They wanted someone to back them up that we should wait, which I'm so lucky that that didn't happen. Because if someone had said we should wait my parents that would have given my parents the backbone they needed to be like, yeah, we're waiting, this is what the therapist and the doctor said. You're 14, you don't know.</i></p> <p>...</p> <p><i>I mean for me I feel like I can say even if I'm doing something that maybe my parents wouldn't do if they would happen to be in my situation like with the ovary thing I kind of got the feeling that my parents maybe would rather I didn't get rid of both of my ovaries. We've talked about bottom surgery and they</i></p>

		<p><i>talked about like, oh, look at the different options. Maybe do something else, you know. But I know in the end that it would be up to me and I know in the end that it's my decision, which I think a lot of trans young people don't get to [do] ... I think it has been like that for most of the time that I've been out. So I think that's a big part of why I feel like I can talk to them about things.</i></p>
	<p>Community epistemologies</p>	<p><i>I would say the main people that have talked to me about it are other trans people. Surgeons have talked to me about that a little bit. I'm having a forearm phalloplasty and so they're going to talk about hand movement and hand therapy and stuff like that. I remember last year I met for the first time a guy that had had forearm phalloplasty and he asked me if I'd ever felt what an arm felt like afterwards before and I was like, no, because I've never met someone. And so he showed me and it felt kind of weird. And he was like, I just feel like you should know that. I've heard about sensation a little bit, I guess. I was thinking the other day that I have no idea if I'm going to be able to feel my arm or not. (Chuckles) So I should probably find out, but I don't think I care that much either really. But when I had top surgery we talked about sensation too.</i></p> <p>...</p> <p><i>A huge part of me realizing I was trans was I stumbled across this sub-reddit, which is our trans timelines and people taking hormones and seeing them transition. And I was like, shoot, I really wish I were trans because I want that. It really sucks for me that I'm not. Yeah so anyway, so I knew I wanted hormones before I knew that I was trans, I guess.</i></p>

<p><i>Barrier</i></p>	<p>Misinformation from adults</p>	<p><i>But [the doctor's] advice was kind of, well, I can't really tell. And meanwhile, are you sure you should be binding anyway, because you're awfully young? I was 16 at the time. They were like, I'm not really informed on trans issues but I think you know you're not fully grown yet and so are you sure that this is something you should be doing at all? And I was like, well, this is kind of something that's super important to my mental health. It tends to be that way for trans people or many trans people, many trans men it's something that's about comfort and being in my body for me and I'm willing to take a break but I certainly think that I wouldn't say that I shouldn't have been doing this at all. And she kind of hemmed and hawed and she was like, well, but like physical safety is more important, don't you think? And maybe just save it for when you're older. I was 16 at the time so I was – no I was 17 at the time. I was not very fond of that feedback considering first of all that that right there kind of revealed like a huge unfamiliarity with trans issues that I didn't expect. I know a whole bunch of teen youths who bind consistently and I'm not sure where this idea was coming from.</i></p>
	<p>Healthcare structure and timing of care</p>	<p><i>I had one friend who was also in the process of doing it and he'd been waiting oh gosh like two years or something. He came out his freshman year. I was talking to him and I was like, well what did you do? So we were just kind of talking about like he just had to go to a therapist for a year and then he had to go, so he had already done the steps I had done too so I was like, okay, I'm on track.</i></p> <p><i>...</i></p> <p><i>Well, I guess I sort of I just wanted the waiting period to be over ... I don't know if impatient is the right word but just kind of waiting to see if</i></p>

		<p><i>[the doctor] responded to our request for the consultation, waiting for the consultation, waiting for the sperm banking and the blood test and then waiting for the prescription and it just felt like a bunch of waiting. But it felt like I didn't need to do that waiting and on some level ... I could be doing it faster but I'm not. It's been like 6 or 7 months and there has definitely been marked changes ... I'm seeing the progress and the results ... [but] I felt like it could be accomplished much sooner.</i></p>
	<p>Dominant narratives around transness</p>	<p><i>I don't know what it means to be trans outside of – if anything I think of my trans-ness as very often is kind of like I'm trans by proxy, so that's maybe it. I'm trans by... just by virtue of having transitioned. I'm trans and that's a label that I'm okay with but like my gender is not transgender. We had the autumn resident survey for living here that I filled out yesterday and the gender options were male, female and transgender, which is not great.</i></p> <p>...</p> <p><i>And then for a long time it was just kind of, well I think I can cultivate it this in between space which was really where I was at that point. And right now to a certain extent. Presentation... not super masculine all the time, most of the time, I'm not. My school would be accepting but they have ties to my parents whereas this classroom I have no idea how accepting they'll be but they don't have ties to my parents so I can afford to be out there and not here. I can afford to use this name with these friends as long as I can ask them to not use it in these spaces. But this friend I almost exclusively see in this space so I'm just not going to come out to them but this friend I sometimes see in this space, which I can come out to them. And it was a... tangle. But I was trying to interrogate within myself of</i></p>

		<p><i>this idea of making progress towards trans-ness. And the idea specifically of transitioning like what counts as transitioning. So I was like, yeah, okay I'm going to decide that when I come out to my friends and I choose a name for myself and I put this name on my, some of my homework that's transitioning, that's me changing how I'm presenting myself to the world and to this institution. Just because my body isn't physically changing doesn't mean it's not transitioning. In that sense I'm still by a lot of classic definitions like pre-transition. I haven't started hormones yet therefore I'm not transitioning yet but I think I would rather read it as like these are acts of transitioning, I'm always transitioning. Lots of people are always transitioning.</i></p>
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Endnotes

ⁱ ... it really looked like this 18 was just going to be a big stumbling block. And so we had conversations ...this is going to be a lot of money. But we did say, and I always wanted to make sure C understood that like if the insurance was just like, no, we're never gonna pay for this, that we would have paid for it. But even then like that's lucky. We bought this house at a really good time so it's worth a ton of money. And it's not because we have a ton of money. So we knew like, okay, we have this Plan B that we're gonna take out a second mortgage on our house and just pay for it that way.

ⁱⁱ I remember having a conversation with my dad, he grew up in like the 90's, which was when the whole gay was an insult or just gay as a negative word was used all the time. The one thing that sticks out to me from him, I was reading his old yearbook from middle school and people were just like running the f slur and you know like saying gay in a really negative connotation. And I got to have a conversation about it with him because it made me really uncomfortable. I've just always had to be the one educating [my parents] just because they're not really up to date on things. I always try to mention it to them, which I mean sometimes they get annoyed because I'll just always bring it up.

ⁱⁱⁱ He was kind of confused at first. I think he thought it was insulin or something. And then I was like, oh, no it's testosterone. He was like, oh, okay, that's different. I was definitely the first person he taught how to do it. So I think he was teaching me just how to do like a standard shot, which is totally fine but like the needle is like thicker than usual and I just don't think you should put that back there.

^{iv} I was trying to figure out a way to stop having periods. I had not gotten on testosterone yet, and I had not gotten my hormone blocker yet. Didn't even know they existed. And this was when I had my old healthcare provider help out with this. And they said, yeah, good way to do this is to get an IUD. I was thinking, wow! Wait, is there any other kind of way? And they said, no, no, no, IUD. So, I went okay, okay, okay, fine, if that's what I have to do. Extremely uncomfortable. Did not like it ... And it was uncomfortable, and it continued to be uncomfortable. And I was not comfortable with the idea that that was what was keeping me from having periods. And then, got a new healthcare provider and one of the first things that he said for the initial appointment was wait, why don't you have a hormone blocker? And I went, uh sorry, a what?

^v For a long time when I was first coming out I was moving inside a lot of trans circles but had this kind of path where like you realize you're trans, you come out to your parents, they put you on hormones, they buy you a new wardrobe and then you're you. And you forget that you ever weren't and everything is dandy. And I'm like, well I failed step one. Can't come out to parents. What now? Guess I'm not making any progress. Guess I'm awaiting on being trans when I'm 20.

^{vi} I definitely feel like there is not a lot of representation like it's a lot of privileged trans people and there's nothing wrong with being a privileged trans person you still have to go through a lot of discrimination, you still have to go through a lot of painful stuff. But it's definitely an extra couple of steps when this stuff is setting you back. If you're a person of color that's trans or if you're low income and trans. It's definitely frustrating [with] people who assume like, oh, I came out. When I came out everybody was happy and I got like a big hug and everybody partied and it was like a great situation. And I called the gender clinic the next day ... that's not realistic. When I came out it was very frustrating, I was sobbing. I had been out for probably a month and a half when I came out to my mom and I had been getting severely bullied. And so she got a call from the school and she was like, why are you getting bullied? It was very frustrating because I had forced myself to act feminine because I wanted to be safe and I wanted to not break out of my comfort zone. It was very frustrating because it wasn't just a party ... That's not how it works ... most hormone therapy is extremely expensive. If you don't have insurance especially lower income you're screwed. And so I'm very lucky I have insurance and I know a lot of trans youth that don't have insurance and are lower income. And they just don't have any way.

^{vii} All I had in terms of trans people was the classic image of the man in a dress or whatever. I was like, I don't really love that for me. And even when trans-ness was [talked] about in a positive way towards me, like we have to be

accepting of trans people ... we have to be accepting of the quote man in a dress imagery or whatever, [but] no one got past that. My parents were confused too, they were like, well we feel like we've been positive and accepting and, you would have known when you were younger if this were true. It was just recently that I learned that trans people can transition in ways that don't look like this generally transphobic narrative.