Assessing health provider perspectives regarding barriers American Indian/Alaska Native transgender and Two-Spirit youth face accessing healthcare

Alessandra Angelino

A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Public Health

University of Washington

2019

Committee:

Teresa Evans-Campbell

Bonnie Duran

Program Authorized to Offer Degree:

Global Health

University of Washington

Abstract

Assessing health provider perspectives regarding barriers American Indian/Alaska Native transgender and Two-Spirit youth face accessing healthcare

Alessandra Angelino

Chair of the Supervisory Committee:
Teresa Evans-Campbell
UW School of Social Work

Background: American Indian/Alaska Native (AI/AN) youth disproportionately face barriers accessing healthcare when compared to non-AI/AN youth. Additionally, youth who identify as both AI/AN and transgender or Two-Spirit face higher rates of mental health issues and suicidality, along with increased rates of non-communicable and communicable disease. These disparities primarily result from severe health inequity and historical trauma. There is therefore a need to assess what barriers exist among AI/AN transgender and Two-Spirit youth. Understanding both provider and patient-side barriers in this vulnerable population has implications for improving patient care and reducing health disparities for AI/AN transgender and Two-Spirit youth.

Objectives: This project evaluated health provider knowledge of LGBTQ2S health and historical context surrounding gender identity in AI/AN communities. It assessed provider perspectives of provider-side and patient-side barriers accessing care, in order to gain insight and develop suggestions for improvement. Provider type, clinic affiliation, and clinic location were also evaluated to determine impact on provider perspectives.

Methods: Semi-structured interviews (SSI) and focus group discussions (FGD) were held among providers affiliated with three reservation-based tribal health centers and a non-tribal

tertiary children's hospital in the Pacific Northwest. The question guide used was developed using a community-based participatory research conceptual model, considering the impact of context, partnerships, and community knowledge on barriers to care and provider perspectives. SSI and FGD lasted for 30-60 minutes, were audio-recorded, and transcribed verbatim. All providers cared for AI/AN youth (≤ 18 years) who identify as transgender or Two-Spirit. SSI and FGD were analyzed using a grounded theory approach to understand barriers and themes. This project received exemption from the University of Washington IRB and approval from each tribal ethical and/or research committee.

Results: Twenty healthcare providers participated in this study and represented a number of geographic settings, provider types, and ethnic backgrounds. Participant knowledge regarding LGBTQ2S health and historical context surrounding gender in Native communities varied, although participants felt their understanding and comfort was limited. The long-standing effects of settler colonialism, trauma, and systemic issues such as marginalization and an antiquated medical system presented as overarching concepts. Participants also presented a number of patient-side and provider-side barriers impacting access to care for these patients, and suggested solutions to reduce these barriers at the provider, patient, and systemic levels. Geography, and occasionally provider type, appear to influence barriers and the solutions provided.

Conclusions: A number of patient and provider-side barriers inhibit AI/AN transgender and Two-Spirit youth access to healthcare. It is evident that historical trauma and community resilience play a role in health and healthcare for these youth. Understanding this history, the intersection of identities, and inherent community strengths can help with the development and implementation of solutions to provide high quality care to AI/AN transgender or Two-Spirit youth.

ACKNOWLEDGEMENTS

I would like to thank the Coast Salish peoples, the traditional owners of the land on which this project was completed; a resilient group of people who honor and bring light to their ancestral heritage.

Thank you to all the individuals who participated in this project with enthusiasm. Your dedication to your patients and the American Indian and Alaska Native transgender and Two-Spirit community inspires me.

This project would not be possible without the support of my thesis committee members, Dr. Tessa Evans-Campbell and Dr. Duran, my faculty advisor, Dr. Alison Roxby, and the Department of Global Health at the University of Washington.

Many thanks!

INTRODUCTION

Traditional perspectives on gender

AI/AN individuals have historically celebrated expansive definitions of gender and sexual orientation [1, 2]. The term Two-Spirit was created in 1990 by a group of AI/AN activists at an annual Native LGBTQ2S[1] conference to provide unifying, positive, encouraging language [3]. Two-Spirit terminology promotes reconnection to tribal traditions and transcendence beyond a colonized categorization of binary gender. While variety in terminology remains, the contemporary term Two-Spirit describes an individual who embodies multiple essences. One may have both male and female essences in one body or identify with both animate and inanimate essences. Further, Two-Spirit individuals are not bound by gender roles, gender expression, or sexual orientation, and have a fluid or non-linear identity that goes beyond Western notions of gender binaries. Two-Spirit embodies all aspects of identity including sexuality, culture, gender, and spirituality [4]. Historically, Two-Spirit individuals were embraced by their communities in different ways. Some Two-Spirit people held leadership roles such as mediators, medicine people, Holy people, peace makers, and teachers, while others were respected as simply part of the community.

Historical trauma, settler colonialism, and their impact on gender identity

Despite traditions celebrating diversity in gender and sexuality, settler colonialism systematically removed acceptance from Native communities. The US boarding school era (1880-1930), during which large numbers of Native children were taken from their homes on reservations and sent to boarding schools, contributed greatly to settler colonialism and

[1] LGBTQ2S: Lesbian, Gay, Bisexual, Transgender, Queer/questioning, Two-Spirit

profoundly impacted how communities viewed gender and sexual orientation [5, 6]. In a stringent and gender-binary environment, it was often difficult and dangerous for transgender and Two-Spirit individuals to express themselves openly.

Settler colonialism also exacerbated historical and intergenerational trauma (HT) present among Native communities. HT describes the cumulative emotional and psychological wounds spanning generations that result from large scale group trauma perpetrated on a group of people who share a specific group identity [4]. For AI/AN individuals, traumas typically involve the loss of culture, land, language, ways of life, and family separation over multiple generations. Thus, HT can impact individuals who were not directly involved with traumatic experiences. In the case of Native communities and gender identity, settler colonialism introduced a mentality of homophobia that replaced traditional acceptance of transgender and Two-Spirit individuals. As a result, Native transgender and Two-Spirit individuals were increasingly susceptible to struggles with identity, mental health, and physical health [4].

Health disparities a result of historical trauma

Because HT impacts spiritual, mental, physical, and emotional realms, it can contribute to poor physical and mental health outcomes. Poor outcomes are worsened by institutional racism and discrimination in the health care system. Understanding ways to overcome HT through a strengths-based approach is critical in being able to adequately reduce this disparity. Strategies include confronting trauma, embracing history, creating supportive environments, increasing education, fostering self-acceptance, and reconnecting to one's history through storytelling, cleansing, reverence, and group work.

Health disparities faced by transgender and Two-Spirit individuals

Transgender and Two-Spirit youth experience higher rates of health disparity compared to their cisgender and binary identifying peers. With regard to physical health, rates of non-communicable, communicable disease, and substance use are increased, most often due to lack in access to care and inequity [7]. In terms of mental health, youth who identify as transgender face increased levels of psychosocial distress including bullying, discrimination, violence, family and peer rejection, and homelessness [8]. These youth are also at increased risk for experiencing anxiety, depression, and suicidal ideation, as well as suicide completion [9, 10]. These disparities in health are exacerbated among AI/AN youth due to settler colonialism and social determinants such as socioeconomic status, education level, and geographic location, rather than genetics or predisposition [6, 11].

Native transgender and Two-Spirit youth are also impacted by systematic trauma and repeated discrimination. AI/AN transgender participants in the 2015 U.S. National Transgender Health Survey demonstrated that youth in kindergarten through twelfth grade experienced rates of harassment (86%), physical assault (51%), and sexual assault (21%) at school [12, 13].

Barriers to care

In addition to health disparities, there are a number of barriers to delivering and receiving healthcare for AI/AN transgender and Two-Spirit youth. It is difficult to assess the distinct barriers faced by AI/AN youth because there is a paucity of data related to a) Native youth who identify as transgender or Two-Spirit and b) barriers in their access to care. Instead, research portrays barriers in the general LGBTQ population (i.e. non-Native adults) and typically involves brief quantitative surveys from patients or health providers rather than qualitative approaches.

There is also limited information regarding barriers Native transgender and Two-Spirit youth face within their own families and communities.

Despite the lack of specific data, population trends in barriers to care for LGBTQ2S populations have been presented. Common reported provider-side barriers include provider lack of medical knowledge related to LGBTQ health, unfriendly health system organization, and improper use of pronouns [7, 14]. For youth patients, critical barriers include lack of access to gender-affirming care, lack of income or health insurance, lack of cultural competence among healthcare providers, socioeconomic barriers, and discrimination [15].

Research Aims

There is therefore a need to assess the barriers to healthcare that Native transgender and Two-Spirit youth face. Understanding health provider perspectives of provider-side barriers (i.e. barriers faced by healthcare providers) and patient-side barriers (i.e. provider perceptions of the barriers faced by patients) in this vulnerable population has implications for improving patient care and reducing health disparities. This project aims to accomplish this through a series of semi-structured interviews (SSIs) and focus group discussions (FGDs) that will:

a) explore participant knowledge of LGBTQ2S health and historical contexts surrounding gender and sexuality in Native communities,
b) assess health provider perspectives regarding barriers Native transgender and Two-Spirit youth face accessing healthcare, and
c) present culturally relevant suggestions for improvement based on participant responses.

METHODS

Overview

A qualitative approach involving semi-structured interviews (SSIs) and focus group discussions (FGDs) was used to explore perceptions and experiences of medical and mental health providers who care for AI/AN transgender and Two-Spirit youth. Qualitative methods were used to elicit participant perceptions and gather detailed suggestions surrounding what can be a sensitive topic. This project received exemption from the University of Washington IRB and followed appropriate tribal ethical and/or research procedures at each tribal affiliated site.

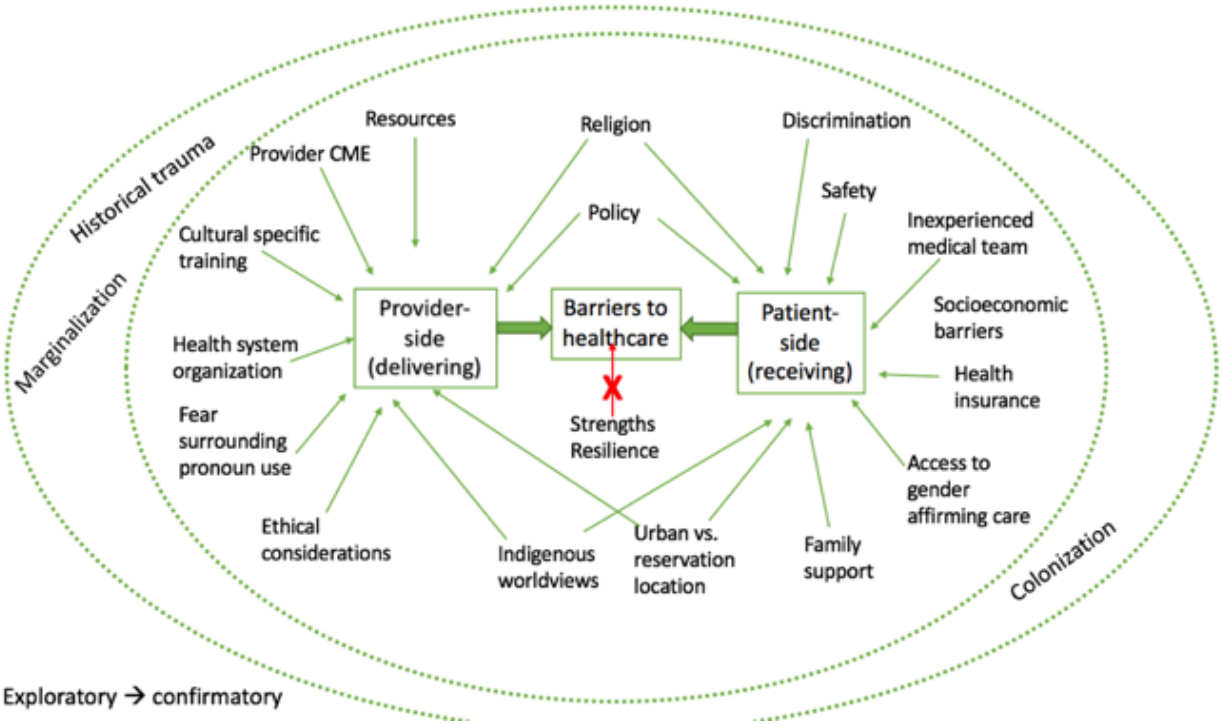
This study incorporates frameworks from two conceptual models. First, the Community Based Participatory Framework Conceptual Model (CBPR) was used to support decolonization and knowledge sharing throughout the project [16, 17]. Considerations included contexts, partnerships with tribal communities and providers (see settings and participants section below), and community involvement in developing the research goals to create sustainable outcomes and improve health equity. An explanatory project-specific framework was also created by the study team with input from community partners. This framework assisted in interview question development (Figure 1). Provider and patient-side barriers to healthcare for AI/AN transgender and Two-Spirit youth all fit within the systemic issues of marginalization, HT, and settler colonialism, which may be mitigated by factors such as strengths and resilience.

Study setting and participants

Participants were recruited from multiple clinical sites in the Pacific Northwest: three reservation-based tribal health clinics and one urban children's hospital. Sites were selected to

explore differences in the experiences and perceptions of providers who practice in reservation versus urban-based settings, and in tribal versus non-tribal health settings.

Figure 1: Project-specific framework



Study participants were nested within health site. All gendered healthcare providers who care for transgender and/or Two-Spirit youth 18 years or younger were eligible for participation. Providers included physicians, nurses, and behavioral health counselors. Participants were not required to identify as AI/AN themselves, and those without experience working with AI/AN youth were excluded from the study. No youth participated in this study.

Purposive sampling was used to identify healthcare providers within the selected clinical sites, as we were interested in a subset of providers with specific experiences. We attempted to maximize variation in responses by including medical and mental health providers across a number of sites. Community stakeholders engaged through the CBPR approach helped identify

additional participants via reputational sampling. We aimed to interview 1-2 providers per site through SSI (n=7). Based on site preference, we also held one FGD (n= 13 participants). This sample size allowed for generalizability of findings and saturation of responses.

Study procedures

SSIs and the FGD lasted between 30-60 minutes and took place in a location determined by each site. The study PI served as facilitator and field note taker and followed a semi-structured interview manual to guide discussions. SSIs elicited information related to experiences and beliefs of each participant, while the FGD explored development of solutions in greater detail. Combination of both allowed for full exploration of participant ideas. Written informed consent was obtained prior to each SSI and FGD, and participants were reminded of study intent, confidentiality practices, and withdrawal procedures. SSIs and FGD were audio-recorded and transcribed verbatim without personal identification information within 24 hours of interview.

Data analysis

Transcript files were imported into Atlas.ti 8 qualitative analysis software. Grounded theory analysis was performed in an explanatory and inductive manner to elucidate themes and modify the project-specific framework. Themes were also developed using phenomenology to present the overall essence of participant opinions. Themes were recorded in a codebook for reference, and the PI engaged in three rounds of open coding to identify themes. While the majority of coding was independent, the study team met on multiple occasions to review the codes, their definitions, and application of codes to the transcripts.

RESULTS

Participant characteristics

20 healthcare providers participated in this study, with 7 completing SSIs and 13 engaging in the FGD (Table 1). Four providers identified as AI/AN. 13 participants were medical professionals (including attending and resident physicians in family medicine, pediatrics, and internal medicine) and 7 were behavioral health practitioners (including nurse practitioners, mental health counselors, and a chemical dependency specialist). 18 providers worked in AI/AN-specific settings. All providers reported receiving AI/AN-specific cultural training, while only 7 reported training regarding gender-affirming care.

Table 1: Demographic characteristics of study participants

Healthcare provider	**N**	**Setting:** **Tribal= T Non-Tribal= NT** **Reservation= R Urban= U**
Medical	13	
Physician- attending	9	
Pediatrics	4	2: T, R; 2: NT, U
Family medicine	4	4: T, R
Internal medicine	1	1: T, R
Physician- resident	4	
Family medicine	4	4: T, R
Behavioral health	7	
Nurse practitioner	4	4: T, R
Mental health counselor	2	2: T, R
Chemical dependency prof.	1	1: T, R

Healthcare provider knowledge and context surrounding LGBTQ2S health

Knowledge surrounding AI/AN LGBTQ2S health and historical context were ascertained directly through questions regarding provider completion of training related to gender-affirming

care and provider experience working with AI/AN transgender or Two-Spirit youth. Indirect assessment also took place through compiling provider use of specific terminology and the manner in which they discussed key aspects of gender-affirming care. Discussion of historical context and systemic issues were also demonstrative of a provider's knowledge.

While all providers had received AI/AN cultural-specific training as a result of their employment in a tribal affiliated clinic or through personal motivation, there was limited use of Two-Spirit terminology or knowledge of what the term entailed. Participants also had limited understanding of gender and sexuality in the Indigenous context. Five providers (two physicians and three behavioral health specialists) were able to define Two-Spirit and used it frequently and appropriately throughout their interviews. These same providers discussed the connection between Native identity, history, and health.

There was also variety in provider education regarding LGBTQ2S health. Only seven providers received specific training on caring for LGBTQ2S patients. Their training ranged from clinic sessions on gender definitions and pronouns, to weekly virtual sessions on LGBTQ2S youth and their health. Other providers without formal training gained experience from working with LGBTQ2S patients in their daily practice.

A centralizing theme: impacts of settler colonialism, historical trauma, and systemic issues

The long-standing effects of settler colonialism, HT, and systemic issues such as marginalization and an antiquated medical system presented as overarching concepts. These centralizing issues allowed for contextualization of the study's major themes and provided a focus for analysis.

Participants concurred that AI/AN youth may experience mental and physical health disparities at a higher rate due in part to HT and settler colonialism. They agreed that health providers must acknowledge this in order to adequately care for their patients. Similarly, multiple providers contemplated what AI/AN health would like look if colonization had not taken place.

"I don't think we would be where we are today and need the services that we need for people in these communities if it weren't for colonization. It has everything to do with colonization. And I sometimes sit and wonder, what if history had been different? Where people had come here and instead of bringing disease, and manipulation, and murder and rape and stealing people's cultures and all of that…if they came here in peace, what would today look like? It might look the same in the sense that we see a blending of cultures a lot time. But I think what we wouldn't see are all the mental health issues, the traumas and the shame and all of that kind of stuff."
– Behavioral health provider, tribal clinic, Native

"I think that's the barrier. Not knowing what this would've looked like before colonization."
– Behavioral health provider, tribal clinic, Native

Some providers questioned whether social or medical transitions would be necessary without settler colonialism and the creation of a gender binary.

"And so it does beg the question, if we didn't have these rigid definitions of what gender was, being that it's a construct, would you have a need to transition at all?" – Behavioral health provider, tribal clinic, Native

Participants also described how settler colonialism led to HT, resulting in difficulties achieving health and hindering identity formation. They highlighted that HT continues to occur today, though it may present differently than it did generations ago.

"When people say that you know, 'Oh that was history, just get over it,' they don't understand that the trauma is still walking around. That the trauma is still happening, and that the kids are now experiencing just as much as their brothers or their fathers and grandfathers etc. in schools. The discrimination they're facing is astronomical." – Behavioral health provider, tribal clinic, non-Native

Participants continue to witness the impacts of HT due to boarding schools and religious indoctrination among their patients. Additionally, they perceive an increase in HT from youth

who are struggling to understand their identities and come to terms with how they fit in with Native culture, past and present.

"But as the decades have gone along, and more of the influence of the boarding schools and things like that, and the very aggressive, to put it lightly, approaches to how they instilled religious doctrine that seemed to influence the coming generations and influence the tribe to be less attached to their historical approach to transgender…and to now be less receptive to transgender members." – Nurse practitioner, tribal site, non-Native

Healthcare providers also agreed that the effects of settler colonialism and HT are compounded by systemic issues such as inequality, marginalization, and an outdated medical system. They perceived that racism and systemic norms impact health and an individual's ability to access quality healthcare, and that this was especially relevant for youth who identify as both AI/AN and LGBTQ2S.

"I have tons of kids who have during those [transition] times needed extra help navigating the system. And more so navigating our society. The problem isn't inherent. What I'm trying to say is that the problem isn't like when you get to your gender identity stage and you're unsure or nonbinary or identify as a gender that is different from your sexual organs… those are not the problems. The problem is, okay, well now I'm different than most of society and society's norms, so how do I navigate this?" – Physician, non-Tribal site, Native

Respondents believed youth may also lack the language to describe their identities or lack the knowledge to seek out appropriate care. They expressed that this may be a result of societal norms shared through social media, entertainment, schools, and communities that uphold a gender binary. Some providers were also concerned that systemic marginalization may counter the positive influence of tribal traditions centered on an individual's contribution to society rather than gender identity and classification.

"I feel as if [youth are] not necessarily influenced by their tribal experience but more of their societal and cultural experience and the lack of societal acceptance. Versus you know as my colleague said this historical acceptance of Two-Spirit." – Behavioral health, tribal site, non-Native

"I think that the [discrimination] continues even within the Natives. Even though there's a heritage of being more open, and gender being a different concept in the Native American community historically, I still think that there's a lot of…cause again also like you know a lot of Native Americans went to public schools like everybody else. They were you know raised in cultures and areas to some extent along like everybody else. And so those sociocultural, or those cultural and subconscious cultural influences are present with them just as much as others." –Nurse Practitioner, tribal site, non-Native

Participants also agreed that an outdated medical system perpetuates these colonialized norms, contributing to health disparities and establishing barriers to health and healthcare.

"I think in many ways medical culture is really not keeping up with the times. I think that we're all playing catch up…and it's an interesting issue in that I think culturally many parts of society are moving way faster than the medical system." – Physician, non-tribal site, non-Native

Concerns about the medical system included mental health and the way it is incorporated, or excluded, throughout gender-affirming care. In the early assessment stages for a patient who identifies as transgender or Two-Spirit, providers typically must use the diagnosis 'gender dysphoria' to qualify and justify their patient receive gender-affirming services. Many providers expressed that listing gender dysphoria as a diagnosis medicalizes and stigmatizes gender and gender-identity, prohibiting acceptance and perpetuating stereotypes. Definitions are also incongruent with the language transgender identifying individuals use to describe themselves.

"Gender dysphoria, which again is an issue in and of itself as a diagnosis…and a stigma creating diagnosis. Mental health shouldn't be a gate keeper, but it should be kind of like a part of the journey." – Physician, non-tribal site, Native

"Well and the difference between the DSM-5 codes and the ICD-10 is their definition of the same type of thing. Like the ICD is like way far back. They're like fetishizing it still. It's icky to even read the descriptors." – Behavioral health, tribal site, Native

Providers explained that this creates an environment that is unsupportive of gender non-conforming youth, spanning from the larger system to the individual clinic setting. Further, providers described that some clinic environments are not culturally supportive for AI/AN youth,

which makes the medical system even less welcoming. One provider shared the following sentiments regarding what she and her patients regularly experience within the hospital walls.

"I wanna see myself when I'm walking down the hall in the hospital. I wanna see other Indigenous people. I wanna see artwork from Indigenous artists. I want to hear our languages. I wanna feel like…everybody is represented. And not just the lack of culture, which is really ultimately whiteness being celebrated…you know if it's not an Indigenous picture or artwork, then there is something else there. And that to me just furthers whiteness in my view of the day. That's what I see all day long instead of myself reflected back at me." – Physician, non-tribal site, Native

Despite these overarching themes of colonization, HT, and systemic issues, AI/AN youth and communities have demonstrated strength and resilience. This positive trend was consistently mentioned by providers and will be discussed later on.

Barriers to health and healthcare: provider perceptions of patient-side barriers

Healthcare providers were asked to share their perceptions of the barriers AI/AN transgender and Two-Spirit youth experience accessing healthcare. These perceptions were ascertained based on participant experiences with youth patients—in the form of direct communication from patients or indirect observation of barriers. The most commonly shared patient barriers were community acceptance, familial acceptance, service and provider availability, and societal determinants of health (SDH). This paper focuses on community acceptance as well as clinic service and provider availability as patient-side barriers. The remainder of barriers are listed in Table 2.

There was consensus that youth experience difficulty finding acceptance within their communities. This included challenges fitting in at school and religious groups, difficulty finding support from elders and community members, and an inability to find a safe environment to develop identities. As a result, youth are uncomfortable acting as their true selves.

"To find a place that feels safe, both gender-affirming and culturally-affirming, there's not like a list…there's no website to go to… when I'm talking to them, what I hear the most is that, "I just don't know. I don't know where I'm safe and so I'm constantly like should I be myself in this moment, in that moment?" – Physician, non-tribal site, Native

Table 2: Provider perceptions of barriers to healthcare faced by AI/AN transgender and Two-Spirit youth

Barrier	Example of statements
PATIENT SIDE BARRIERS	
Community acceptance	And it may go without saying, but there's obviously a lot of prejudice against Natives out there in the community
Familial acceptance	His family still calls him a her—calls him by his female name. He is not ready to discuss it because of that fear of rejection by his family and that's still a big anxiety for him.
Services/provider available	…at clinics where hormone therapy was difficult for patients to access. And so there were cases where if I didn't help provide the care myself, they weren't gonna get it
Mental health	So I think when the younger folks come along and there's a stigma about mental health services. And they've never had counseling before
SDH	I work at a safety net clinic so almost all of my patients experience huge barriers to healthcare…I absolutely see that in our Native families. I would say most of what I see are related to poverty.
Culture	But I think they're also a little bit torn about culture, because in their culture I think there's stigma around it
Geography	If they are in a rural setting or reservation, or…I have a lot of folks who have to drive from really far south um and they access things in a lot of different places
Insurance	It's just like a whole nother job to do that for families. Like it is literally you could have your full-time job being trying to get insurance to cover all the services you need to provide care that affirms your gender.
Transport	Transportation becomes an issue, time becomes an issue, because that can interfere with their ability to go to work, which then causes even further financial conflict
School	The things that my patients actually care of the most or at least tell me the most about are mostly social. So things like at school…
PROVIDER-SIDE BARRIERS	
Education	So you have to wonder like how much are we not being trained it? And that was really obvious to me by the time I graduated medical school. Like for example LGBTQ medicine, it just doesn't make the cut.
Comfort	Because different residents will have different transgender patients and will be more comfortable than the next one. And it's kind of hard to know at times what their comfort level is and what they feel comfortable with...and the same sort of thing with each different preceptor.
Provider Belief	And then you know as a provider yourself, you know depending on your philosophical beliefs, this could also be an issue that could directly contradict something in your own belief system, and then you have to confront that yourself.
Role of Provider	And in those moments I don't even feel like a doctor, I feel like maybe I don't even know what I would compare it to…social work slash public health slash auntie
SDH	I think definitely one of the barriers has been really understanding that some tribes get better care than others.
Referral	I think I have three physicians that I feel comfortable referring patients to for gender-affirming care. That's not a lot. I see 2000 kids a year…you know, they're not all trans, Two-Spirit, or non-binary but still I think if I, you know, if I you know I had a kid who needed to see an ENT I have like 200 people I could refer them to

Insurance	…getting any of the gender-affirming medical interventions like um puberty blockers, cross hormones, surgeries uhh even like binders and things like that is, it's just like a whole nother job to do that for families.
Location	You are in a place where you're not even seeing it, I could see how you could go for years and years and years and not address it. And then I wonder if it's a little bit of a vicious cycle, like, you don't see it, you don't learn about it, patients don't come to you…you know what I mean?
EMR	EMR being able to reflect a child whose gender at birth is male or female and then shifts you know
Time	…capacity to care from training or time to devote to learning that…

Limited availability of healthcare services that are safe and gender-affirming is another significant barrier for youth. Services range from primary care and gender-transition related care to dental and mental health care. In cases where safe clinics are identified, the availability of providers is often limited, and youth may have to wait months or years on waiting lists to be seen. These issues are influenced by social determinants, particularly those related to a youth's place of residence, geographic location, and ability to access transportation.

"I think for youth in general you're basically trying to find a provider that you feel safe enough with that you can go into this, and I think that's the same whether it's a Native youth or not a Native youth. I think the difference potentially could be that perhaps Native youth have fewer people to choose from if access is an issue." – Physician, non-tribal site, non-Native

Similarly, providers expressed that while there are unique challenges related to living on a reservation or receiving care at a tribal clinic, many challenges AI/AN youth face are characteristic of those faced by the larger LGBTQ2S community.

"But it's hard to find those people, so the LGBTQ community in general just feels very frustrated with everything. They constantly feel like they are shuttled from one provider to the next, and no one kind of says, 'I got you, I'll cover everything you need.' So they kind of like come to us for their normal medical needs, but as soon as they wanna take hormones or wanna discuss transition surgery, you're possibly like, 'oh I don't know. I have no idea.' " –Resident physician, tribal site, non-Native

Barriers to health and healthcare: provider-side barriers

With regard to provider-side barriers, education, provider comfort, and provider role were most frequently mentioned. This article will cover these barriers and present the remaining

challenges including social determinants of health, referrals, insurance, and geographic location in Table 2.

With regard to education, insufficient training for medical and mental health providers was concerning to participants of all specialties. They expressed that all levels of education, for all types of health providers, do not adequately address issues impacting LGBTQ2S patients. In particular, participants focused on medical school, nursing school, fellowship training, and continuing medical education as necessary points of intervention. Participants explained that there are gaps surrounding general definitions (i.e. cisgender, transgender, gender, sexuality), use of pronouns, understanding implicit biases, strategies to interact with LGBTQ2S patients, and performing clinical encounters. Provider training on supporting transgender patients through social and medical transitions is also lacking. Lastly, there are gaps in cultural training related to AI/AN history, culture, and traditional medicine.

Further, participants shared that provider comfort with the social, medical, and mental health aspects of care for transgender and Two-Spirit AI/AN youth was a barrier. While some felt the discomfort stems from lack of education, other providers felt that differences in background and potential inability to relate to LGBTQ2S youth played a greater role. There was consensus that this variety in comfort levels may contribute to difficulties creating unified standards and inhibit care.

In a similar manner, some providers were inhibited by uncertainty regarding the role they should play in a patient's gender-affirming journey. Some providers questioned whether they should serve as a key decision maker for the patient along the journey, versus someone who collects and organizes information for a patient in order to create a medical home. Others described hesitancy regarding taking on the role of counselor or mental health provider,

particularly in scenarios where mental health support was inadequate or overwhelmed by high demand. In these situations, providers recognized gaps in care for their patients but explained they did not have a framework to follow or the capacity to effectively care for patients.

Resilience

Despite these barriers, providers emphasized the resilience and strengths inherent in AI/AN communities. They agreed that Native youth have the unique opportunity to find grounding and assurance in a culture that has historically celebrated gender-expansive folks.

"I also think you know as a teenager or young adult…sometimes you just feel like you're floundering around, and to be able to ground yourself in something that's bigger than yourself, that has a history, can be very grounding. It can be very grounding for someone, so I think it's really powerful if it exists. It makes me feel like Native youth are lucky that they have this paradigm to embrace, compared to kids in other cultures who don't" – Attending physician, non-tribal site, non-Native

Additionally, participants explained that AI/AN communities typically have a deep-rooted respect for their youth and work to support them throughout their lives. Similarly, many AI/AN individuals naturally support and accept their community members, regardless of gender-identity or other identity choices. This is a crucial part of healing from the impacts of HT and settler colonialism.

"And I think when you understand oppression to the degree that Native people do, I don't think they want to oppress anybody else" – Behavioral health, tribal site, Native

In addition, many providers spoke about fostering resilience through reconnection.

"With the trauma, what we know when it comes to healing from generational trauma, one of the best things to approach and the best ways to counter and move forward from that trauma and generational trauma is reconnecting with your culture, and reconnecting with your heritage, and reconnecting with your people."– Nurse practitioner, tribal site, non-Native

Suggestions for improvement

Provider-level

Participants shared a number of suggestions to reduce the provider-side barriers described earlier. The most common solutions shared were related to provider education. Some providers suggested that the medical education system, including medical school, residency, fellowship, and continuing medical education, should be modified to include increased training on Indigenous culture, traditional healing, and best practices for gender-affirming care. There was consensus that education should better incorporate social determinants of health and continual engagement with community organizations.

Even with these improvements to education, participants believed that providers need to be willing to self-educate and dedicate time to learning about how to care for transgender and Two-Spirit youth; the medical system may not change fast enough and thus the large number of youth in need may not receive care without these additional efforts. While everyone can invest in learning, providers felt that electing a champion may help encourage other providers to engage in training and ultimately propel systemic change.

"We really need people who are providing gender-affirming care and who are out about providing gender-affirming care; who are seeking out opportunities to do it." – Physician, tribal site, non-Native

Participants also expressed that education should reach all members of society, not just healthcare providers, to increase awareness of gender, sexuality, and Indigenous history. Advocacy and policy level changes to this end can help improve societal awareness and reduce stigma.

"We need as a culture to be more comfortable with this topic…to not have it be a taboo…to normalize it." –Physician, non-tribal site, Native

Such a change may improve community and familial acceptance of LGBTQ2S youth. Improved systemic acceptance may also indirectly help reduce barriers surrounding prioritization of and insurance coverage for gender-affirming care.

"But why would we say we're not gonna pay for this life saving care that affirms somebody's gender identity? Which in my opinion is life saving." –Physician, non-tribal site, Native

Other provider-side solutions focused on creating welcoming, safe, and supportive clinic environments. This includes incorporating gender and cultural conversations early on in visits, making it part of the visit routine, and shifting EMR to reflect a youth's chosen name and pronoun.

Patient-level

Participants shared the opinion that communities should encourage youth to reconnect with traditions and understand the historical context of gender and sexuality within AI/AN culture. They explained that participation in cultural events can help youth improve their self-esteem and opportunities for peer connection. Similarly, they reiterated that reconnection to tradition may help overcome negative impacts of settler colonialism and HT, many of which are tied to barriers patients face. Youth can find such support and opportunities for reconnection through online forums and resources, when safe in-person connection is not available. Participants shared success stories from their youth patients engaging in online connections.

Early support and connection with both mental health and medical providers from a young age was also believed to help prevent mental health issues. This includes forming connections when youth are beginning to solidify their gender identity, as early as two years old. These connections are focused on social support and developing a trusting relationship between patient and provider, rather than medical intervention.

Systemic solutions

Systemic solutions were grouped into two main categories: national and tribal level. On a national level, many participants agreed that increased cultural competency and knowledge of systemic issues (i.e. marginalization, racism, sexism, etc.) and their connections to health are necessary.

"Yea, so I think we need people to understand Native culture and Indigenous culture better. I think people who understand racism and understand systems of oppression and who recognize how that plays out in our health…I want medical systems that value the things that our Indigenous belief system brings to the table" – Physician, non-tribal, Native

A society comprised of individuals who have a better understanding of systemic issues and therefore capacity to produce change are more likely to recreate a medical system that values diverse ideas and practices. Advocacy and policy change can support this.

"We should be fighting on a policy and advocacy level for equal rights and equitable rights for all people including youth who are gender non-conforming." – Physician, non-tribal, Native

Participants also expressed that healthcare provider desire to learn must be self-motivated. While requiring training and education may increase exposure, it may not result in an increase in providers actually engaging in culturally appropriate gender-affirming care.

"The problem is that that doesn't put the onus on the people who are not doing this work. And I do wish that there was a culture change that you know you can't just assume that you're not doing something. Or you know I don't know, I'm like dancing around like it should be a requirement. And I don't know if that's really a solution. Because I don't want somebody to do it because they have to. I want people to want to do it, that's what I want." – Physician, non-tribal, Native

Participants were also asked to provide suggestions for tribal communities to help strengthen already resilient customs and to support community needs. Both Native and non-Native participants discussed the importance of reconnection to traditional practices through cultural events. Pow Wows and coming of age ceremonies were listed as potential opportunities for intervention, along with tribal support of changes in name and gender marker. Again,

celebration within AI/AN communities may help transgender and Two-Spirit youth feel grounded and supported in their gender-affirming journeys.

DISCUSSION

SSIs and FGDs explored healthcare provider knowledge of contexts surrounding LGBTQ2S health. This qualitative study suggests that the majority of participants had robust knowledge of systemic issues impacting AI/AN communities. Participants recognized the importance of incorporating historical context into clinical encounters and acknowledging that HT and settler colonialism are not limited to the past. Despite this awareness, participants felt insufficiently trained in best practices and cultural norms for LGBTQ2S and AI/AN communities. Instead, they report that the majority of their cultural competency derives from self-motivated attempts to learn more about the population and their specific needs. These sentiments were consistent between providers at tribal and non-tribal sites. What motivated some individuals more than others to seek out additional training and self-study remains unclear. This study population may have also been unique in participant desire to self-educate and research systemic issues.

Opportunities for education and training varied by clinical site type (tribal versus non-tribal). While tribal sites had established AI/AN-specific cultural training, LGBTQ2S training was limited or non-existent. Healthcare providers at tribal sites who were knowledgeable about LGBTQ2S issues had developed this awareness because of self-motivated education outside of the workplace. On the contrary, LGBTQ2S education was already occurring at the non-tribal site, although participants felt it could still be improved. At this site, AI/AN cultural training was deficient.

When participants provided feedback on training, desires for improvement were similar regardless of provider type, stage of training, or clinical setting. We were unable to determine the impact of method of training (i.e. in-person workshops, online tutorials, textbooks) on provider competency in this study. It was also difficult to ascertain whether a provider's ability to engage in training was supported by the tribal community and their Indigenous traditions.

This study also demonstrated barriers to healthcare for AI/AN transgender and Two-Spirit youth, as perceived by healthcare providers. These barriers impact provider ability to deliver healthcare and patient ability to access healthcare. Participants perceived significant overlap in barriers faced by healthcare providers and youth, particularly those related to geography, roles of provider and parents, social determinants of health and systemic issues, insurance, and education and awareness. Results from SSIs and the FGD also support the barriers hypothesized in the project-specific conceptual framework developed prior to the study.

Participant opinions regarding the impact of geographic location (rural or urban) and reservation setting on healthcare varied by site. Some participants saw location as a promoter of healthcare, while others viewed it as a barrier. Providers in rural reservation settings in the PNW explained that their youth patients have expressed high levels of community acceptance and support. On the other hand, providers with past experience or close contact with colleagues working in rural reservation settings in the Midwest US described a less inclusive environment. These providers viewed reservation setting as a barrier to healthcare.

These perceptions regarding location may be unique as this study took place in the PNW where reservation sites are located in close proximity to a major city with large academic hospital centers (within 2 hours). Still, close proximity was not equivalent to improved access to care for these patients. This study is limited by the fact that there were no participants from an

urban tribal setting or remote rural setting, although some participants had prior experience working in remote and rural areas outside of the PNW.

Participants also had varying opinions related to provider role in gender-affirming care. Participants who were physicians questioned the limits of their role as a provider for youth along their gender-affirming journeys. For example, physicians struggled with how much time to dedicate to social issues or mental health, as their profession incorporates mental health but may not be specifically focused on it. This was relevant especially when access to mental health care was limited and physicians were the only resource a patient had to address mental health. Participants from other specialties did not share these sentiments, as nurses or mental health professionals do not typically assume responsibility over medical care for a transgender youth.

It was interesting that providers mentioned parental role as a patient-side barrier, based on conversations with youth, but did not mention parents as a provider-side barrier. This was surprising as there are multiple issues surrounding parental consent and patient compliance that may arise in treating transgender and Two-Spirit youth. Future studies engaging parents and families may help evaluate the role of parents and relatives further.

In addition to sharing specific patient-side and provider-side barriers, participants theorized that larger systemic issues such as HT and discrimination were the underlying causes of barriers to care. This is not surprising as HT often causes changes in identity and health status. When HT is compounded by systemic issues such as racism and discrimination, AI/AN individuals, transgender or Two-Spirit youth in particular, have a more difficult time accessing appropriate care. Multiple providers questioned if these access issues and systemic problems would exist had settler colonialism not taken place. They also pondered whether transgender and

Two-Spirit youth would still feel the need to medically transition. This has implications for framing and creating of interventions and developing topics for future research.

Medical system inefficiency was another systemic barrier discussed by participants. While Native youth face unique challenges in accessing healthcare, providers communicated that LGBTQ2S Native youth and non-Native youth may experience some similarities in terms of their access to healthcare because of underlying system issues. Challenges included those related to finding both a safe environment (clinic and outside of clinic) and healthcare providers who are willing and able to provide gender-affirming care. This would suggest that interventions could be draw upon previously existing strategies used in the larger LGBTQ2S population and modify them to be culturally relevant.

In terms of methods to overcome barriers, study participants emphasized that the resilience present in Native communities can inform strengths-based solutions. Solutions fell into the following categories: provider-side barriers, patient-side barriers, and societal level barriers. While the majority of providers discussed how resilience is fostered through reconnection to tradition and customs, only a few of providers connected resilience directly to identity and identity formation in children. Pediatricians were the most likely to discuss resilience and identity, regardless of tribal site affiliation.

The study team was also interested in determining whether participant demographics influenced the solutions provided. All providers brought up education as a key solution, regardless of specialty or geographic location. They all discussed the importance of requiring education on these topics while ensuring that providers are also self-motivated to carry out this work.

Solutions related to access to resources and provider role differed by clinic setting. Participants from tribal sites believed that healthcare providers on reservations took on a greater role in delivering gender-affirming care and serving as a bridge between patients and the larger medical system. Their solutions focused on facilitating this bridge and reducing the disconnect between youth and resources available. Providers at the non-tribal site focused more on policy and advocacy changes to address systemic issues, compared to providers at tribal sites focused on inter-tribal relationships. Thus, there were more tribal-focused solutions from providers working in reservation clinics, namely those related to cultural practices and ceremonies. This may be a result of how the tribal health clinics and the level of influence tribal council and leadership has on decision making.

Lastly, with regard to difference by provider identify as Native or non-Native, Native providers typically shared systemic solutions that were informed by personal experiences engaging with the health system as a patient. Non-Native providers discussed the importance of listening, admitting lack of knowledge, and demonstrating interest to learn and willingness to engage with Indigenous culture.

Limitations:

There were a few limitations to this study. For one, we were unable to perform more than one FGD due to site preferences. Performing additional FGDs may have been useful to supplement SSIs and further develop participant ideas. Nevertheless, we achieved saturation in themes and answered our research questions in a comprehensive manner. Further, healthcare provider willingness to participate in the study may have contributed to selection bias. The study

team hoped to overcome this by including providers from many different backgrounds, specialties, and sites.

With regard to site classification as urban versus rural, we recognize that reservation sites in the PNW may be different from sites in the Midwest or other US regions. We also were limited by not having participants currently working at an urban, tribal clinic setting, although multiple providers had worked at these locations in the past or were in close communication with colleagues at these sites. Additional studies adjusting for this may lead to some additional information regarding barriers and provider perceptions of barriers.

Future studies may also include interviews with AI/AN transgender and Two-Spirit youth themselves to better understand youth perspectives on barriers accessing care. However, the focus of this paper was to assess provider perceptions of the barriers youth face to get providers thinking about what youth experience and encourage the development of patient-centric solutions.

CONCLUSIONS

This study provided a lens into the experiences and perspectives of medical and mental health providers who work regularly with AI/AN transgender and Two-Spirit youth. Discussions with providers illuminated barriers that their AI/AN youth patients experience, as well as the barriers they face as providers delivering safe, effective, and culturally relevant care. A mix of both SSI and FGD enabled documentation of gaps in resources and present services, as well as identification of strengths among AI/AN youth and their providers. This strengths-based and resiliency centered mindset is critical for community engagement and creating sustainable results.

As the first study to explore healthcare provider perceptions regarding barriers faced by AI/AN transgender and Two-Spirit youth, this work sets the stage for increasing awareness about the unique challenges these youth experience. The use of qualitative methodology and community based participatory practices facilitated discussion and knowledge sharing among community members. Presenting patient and provider barriers in the context of systemic issues and complementing them with solutions increases the likelihood of specialized, action-based interventions. Future research should engage AI/AN transgender and Two-Spirit youth to develop additional solutions and continue building resilience.

References:

1. Jacobs, S.-E., W. Thomas, and S. Lang, *Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality*. 1997: University of Illinois.
2. Pruden, H., *Two-Spirit People: Then & Now*, in *LGBTQ2 Well-Being Education* 2014, Indian Health Service.
3. McLeod, A., *"History of Two-spirited People in Manitoba" in Alley Yapput*, in *Two-spirited Outreach Project*. 2004, Egale Canada Human Rights Trust: Ottawa.
4. Walters, K., et al., *BODIES DON'T JUST TELL STORIES, THEY TELL HISTORIES: Embodiment of Historical Trauma among American Indians and Alaska Natives.* Du Bois Review: Social Science Research on Race, 2011. **8**(1): p. 179-189.
5. Evans-Campbell, T., et al., *Indian Boarding School Experience, Substance Use, and Mental Health among Urban Two-Spirit American Indian/Alaska Natives*. Vol. 38. 2012. 421-7.
6. Tuck, E. and K. Wayne Yang, *Decolonization Is Not a Metaphor*. Vol. 1. 2012.
7. Safer, J.D., et al., *Barriers to healthcare for transgender individuals.* Current opinion in endocrinology, diabetes, and obesity, 2016. **23**(2): p. 168-171.
8. Olson, J., C. Forbes, and M. Belzer, *Management of the Transgender AdolescentManagement of the Transgender Adolescent.* Archives of Pediatrics & Adolescent Medicine, 2011. **165**(2): p. 171-176.
9. Spack, N.P., et al., *Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center.* Pediatrics, 2012. **129**(3): p. 418-425.
10. Harrison-Quintana, J., E. Fitzgerald, and J. Grant, *Injustice at Every Turn: A look at American Indian and Alaskan Native respondents in the National Transgender Discrimination Survey* N.G.a.L.T.F. National Center for Transgender Equality, Editor 2015, National Center for Transgender Equality: Washington DC.
11. Jernigan, V.B.B., et al., *Beyond Health Equity: Achieving Wellness Within American Indian and Alaska Native Communities.* American Journal of Public Health, 2015. **105**(S3): p. S376-S379.
12. Harrison-Quintana, J., E. Fitzgerald, and J. Grant, *Injustice at Every Turn: A look at American Indian and Alaskan Native respondents in the National Transgender Discrimination Survey*, N.G.a.L.T.F. National Center for Transgender Equality, Editor. 2015, National Center for Transgender Equality: Washington DC.
13. James, S., et al., *The Report of the 2015 U.S. Transgender Survey*. 2016, National Center for Transgender Equality: Washington, DC.
14. Gridley, S.J., et al., *Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth.* Journal of Adolescent Health, 2016. **59**(3): p. 254-261.
15. Snyder, B.K., G.D. Burack, and A. Petrova, *LGBTQ Youth's Perceptions of Primary Care.* Clinical Pediatrics, 2016. **56**(5): p. 443-450.
16. Wallerstein, N. and B. Duran, *Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity.* American journal of public health, 2010. **100 Suppl 1**(Suppl 1): p. S40-S46.
17. Wallerstein, N., et al., *Community-based participatory research for health : advancing social and health equity*. Third edition. ed. 2018, San Francisco, CA: San Francisco, CA : Jossey-Bass, a Wiley Brand.